

Human Services Subcommittee of Appropriations Questions
March 10, 2021

1. Positions

Funded vs unfunded vacancies

The Department has 1,895 authorized positions. Based upon a preliminary review of the Governor's Recommended funding levels, it is estimated that we will be able to support 1,776 positions during SFY 2022. That leaves us with an estimated 119 unfunded vacancies. As of the 2/5/21 payroll, we had 1,588 full-time equivalent positions, but we are actively working on position approval and recruitment for the balance of positions up to our 1,776 funded level.

2. Use of CRF and Enhanced FMAP

Detail on federal funds related to COVID relief (amount distributed, purpose, recipients if possible)

- a. Please see exhibit 1 for additional detail on the use of **Coronavirus Relief Funds** allocated to the Department, primarily for provider relief and community testing support.
- b. Other federal funds received include the following allocations:

1. Program: Community Services Block Grant

Connecticut award amount: 12,041,000

Federal Grantor Agency: Administration for Children and Families

Brief Description: The Coronavirus Aid, Relief, and Economic Security Act, 2020, Public Law 116-36, was signed into law on March 27, 2020, providing additional funds to the CSBG program. The funds to states, territories, and tribes authorized under the CSBG are intended to address the consequences of increasing unemployment and economic disruption as a result of COVID-19. Funding has been distributed through contracts with each of the nine Community Action Agencies covering the period March 27, 2020 through September 30, 2022. Services supported by these funds address a variety of economic and social service supports to help eligible participants (income at or below 200% of the federal poverty level \$52,400 annual income for a family of four) address the consequences of increasing unemployment and economic disruption as a result of COVID-19, and to assist individuals and households impacted directly or indirectly by the virus to successfully quarantine and self-isolate to prevent the further spread of COVID-19.

2. Program: Low Income Home Energy Assistance Program

Connecticut award amount: \$14,070,000

Federal Grantor Agency: Administration for Children and Families

Brief Description: Congress appropriated these funds under the Coronavirus Aid, Relief, and Economic Security (CARES) Act which was signed into law on March 27, 2020. This act provided supplemental LIHEAP funding to help "prevent, prepare for, or respond to" home energy needs surrounding the national emergency. The Department allocated the LIHEAP funding under the CARES Act in the same manner as regular LIHEAP block grant funding which is directed to and administered by the Community Action Agencies. The LIHEAP funding under the CARES Act provided \$382,805 for CAA administration costs and \$8 million in addition to the \$10.5 million of LIHEAP regular FFY 2020 funding to provide a supplemental payment of \$250 that was credited to the electric accounts of 74,000 households that were eligible for a Basic Benefit.

3. **Program:** **Family Violence Prevention**

Connecticut award amount: \$375,000

Federal Grantor Agency: Administration for Children and Families

Brief Description: This supplemental funding comes through provisions of the CARES Act, which was signed into law on March 27, 2020. Through the CARES Act, the FVPSA Program received supplemental funding for the National Domestic Violence Hotline. This funding will provide flexibility in how agencies can prevent, prepare for, and respond to the COVID-19 public health emergency while addressing the evolving needs of domestic violence survivors and local domestic violence programs within their communities. These funds were added to the Department's contract with the Connecticut Coalition Against Domestic Violence (CCADV). CCADV further distributed the funds to the individual domestic violence shelters to successfully implement non-congregate sheltering in hotels/motels for victims of domestic violence during the public health emergency. Such supports ensured that individuals and children would have needed shelter, food, clothing, and necessities to support them in an alternate setting that ensures appropriate social distancing.

4. **Program:** **Adult Protective Services**

Connecticut award amount: \$1,023,000

Federal Grantor Agency: Administration for Community Living

Brief Description: This funding is intended to enhance, improve, and expand the ability of Adult Protective Services to investigate allegations of abuse, neglect, and exploitation in the context of COVID-19. The Department's spending plan proposes to utilize funds in support of Adult Protective Services consistent with the purposes of the authorizing legislation, specifically: (1) Improving and supporting remote work through the purchase of tablets to support client communication, information collection and referral; the purchase of satellite phones to support staff in rural areas with poor cellular services, creation of a secure website for reporting allegations of abuse, neglect and exploitation; and enhancements to the telephone intake line and case management system; (2) establishing new or improving existing processes for responding to alleged scams and frauds, especially related to COVID-19 vaccine or cure scams through the development, purchase and distribution of educational materials and purchase and distribution of durable contact cards for ready access to the state APS program; (3) investments in training specific to health and safety measures related to prevention protocols for infectious diseases, including COVID-19; training to support remote supervision; and forensic investigation training; and (4) goods and services to APS clients related to COVID-19 including temporary non-congregate housing as a wraparound service; Personal Protective Equipment kits and In-home Nurse Consultation.

Funding Status: On March 3, 2021, the Department of Social Services submitted to the Administration of Community Living (ACL) the Letter of Assurance and the Agency spending plan for their \$1 million allotment under this funding opportunity. The Agency is awaiting grant award approval from ACL. Awards made under this announcement have an estimated start date of April 1, 2021 and an estimated end date of September 30, 2022, for an 18-month budget and performance period.

5. **Program:** **Emergency Food Assistance Program (TEFAP) 1**

Connecticut award amount: \$3,829,000

Federal Grantor Agency: USDA

Brief Description: In FY 2020, The Emergency Food Assistance Program (TEFAP) received additional funding for food purchases and administrative expenses through the Food Purchase Distribution Program (FPDP) and Families First Coronavirus Response Act (FFCRA) in response to the public health emergency.

Funding Status: Of the \$3,829,000 awarded, \$964,000 was allocated for administrative expense; DSS has issued the full administrative amount to authorized food banks. The balance of \$2,865,000 was allocated for food; food banks have issued orders against the full food allocation.

6. **Program:** **Emergency Food Assistance Program (TEFAP) 2**
Connecticut award amount: \$4,309,000
Federal Grantor Agency: USDA

Brief Description: In FY 2020, The Emergency Food Assistance Program (TEFAP) received additional funding for food purchases and administrative expenses through the Food Purchase Distribution Program (FPDP) and Families First Coronavirus Response Act (FFCRA) in response to the public health emergency.

Funding Status: Of the \$4,309,000 awarded, \$777,000 was allocated for administrative expense; DSS has issued the full administrative amount to authorized food banks. The balance of \$3,532,000 was allocated for food; food banks have issued orders against the full food allocation.

7. **Program:** **Emergency Food Assistance Program (TEFAP) 3**
Connecticut award amount: \$3,571,000
Federal Grantor Agency: USDA

Brief Description: The CARES Act, 2021 (COVID Third Supplemental), signed into law as part of the 2021 Appropriations Act provided additional food funding for TEFAP in FY 2021. Up to 20% is available for conversion to administrative funding.

Funding Status: On 3/2/21, DSS received authorized administrative funding of \$482,000. Food bank contract amendments to obligate administrative funding are in process. Balance of \$3,089,000 is for food allocation; food banks have not issued food orders against the new allocation yet, but allocation is expected to be fully expended.

8. **Program:** **Supplemental Nutrition Assistance Program (SNAP) Emergency Allotments**
Connecticut award amount: \$216,000,000
Federal Grantor Agency: USDA

Brief Description: Provide an emergency allotment to address temporary food needs to households to bring all households up to the maximum benefit due to pandemic-related economic conditions.

Funding Status: Emergency Allotment (EA) benefit issuance for FFY 20 totaled \$119,215,000. In FFY 21, DSS has issued \$99,218,000 in EA benefits to date and expects to issue another \$42,800,000 in March and April. The ability to distribute funding is tied to the state public health emergency; DSS will continue requesting EA benefits as allowable with an estimate of \$21,400,000 monthly.

9. **Program:** **Supplemental Nutrition Assistance Program (SNAP) State Administrative Expense**
Connecticut award amount: \$840,000
Federal Grantor Agency: USDA

Brief Description: The Consolidated Appropriations Act, 2021, provides additional funds for SNAP administrative expenses in FFY 2021 to assist state agencies in carrying out legislative provisions. These funds are available at a 100% reimbursement rate and are provided as a grant to offset the costs

associated with the implementation of the temporary benefit increase and other allowable SNAP administrative costs.

Funding Status: DSS recently received funding authority to cover agency SNAP administrative costs at 100% up to \$840,000 in FFY 2021. This amount will be fully expended by funding period end date of September 30, 2021.

10. Program:	Pandemic-EBT (P-EBT)
Connecticut award amount:	\$105,778,000
Federal Grantor Agency:	USDA

Brief Description: Through P-EBT, eligible school children receive temporary emergency nutrition benefits loaded on EBT cards that are used to purchase food. Children who would have received free or reduced-price meals under the National School Lunch Act if their schools were not closed or operating with reduced hours or attendance for at least 5 consecutive days are eligible to receive P-EBT benefits.

Funding Status: P-EBT benefit issuance for FFY 20 totaled \$105,778,000. The estimated P-EBT issuance for FFY 21 is \$219,984,000 to cover the 10-month school year (September 2020 – June 2021).

11. Program:	Pandemic-EBT Admin
Connecticut award amount:	\$3,633,000
Federal Grantor Agency:	USDA

Brief Description: Grant award provided to cover P-EBT administrative costs with a performance period of October 1, 2020 through September 30, 2021. The administrative grant funds are available for all allowable administrative costs incurred by the agencies within each state that operate the SNAP and the Child Nutrition National School Lunch Program.

Funding Status: DSS submitted an estimated P-EBT Administrative plan amount request to FNS for \$3,633,000, which FNS has approved. On March 31, 2021, DSS received authorized funding of \$2,037,000 with balance due from FNS at a later date. Contract amendments to obligate funding are in process.

3. Explanation of the enhanced FMAP- process/basis for calculation, how the amount impacts spending in the Medicaid line item vs federal grants, current year lapse

Under the public health emergency, since the quarter ending March 31, 2020, states have been provided with an additional 6.2% in federal matching reimbursement under Medicaid for services other than those provided to low-income adults covered under the Medicaid expansion (which are already reimbursed at 90%). This provides approximately \$107 million per quarter in additional reimbursement against eligible Medicaid expenditures. Approximately 70% of this additional reimbursement results in a reduction of the state share of Medicaid costs, with the balance of the funding deposited as General Fund revenue (as it supported other state agency Medicaid reimbursement that is traditionally deposited as revenue). It is now anticipated that the Biden administration will continue this enhanced reimbursement through December 31, 2021.

It should be noted that this reimbursement increase is available for expenses incurred and does not represent a new source of grant-type funding that can be utilized for new Medicaid investments without corresponding state obligations. The additional reimbursement is applicable only to underlying expenses incurred – the state is still required to contribute 43.8% towards the cost of any new expense. Thus, this new funding cannot be freely distributed without corresponding state obligations. While any new Medicaid investments can leverage this enhanced reimbursement, such

investments still require state funding of 43.8% of the new expense. The following should also be noted:

- Enhanced federal reimbursement (EFMAP) was time-limited and not fully predictable under the prior administration making longer term commitments problematic
- EFMAP funds have eligibility-related maintenance of effort (MOE) requirements which increase state costs
- EFMAP funds were not only meant to support additional MOE and other state Medicaid actions, but were also intended to help mitigate the need for state Medicaid budget reductions
- Per a recent NCSL report*, when enhanced federal reimbursement was provided during the Great Recession, the use of such funds included the following:
 - Close or reduce Medicaid budget shortfalls
 - Cover increased Medicaid enrollment
 - Close or reduce state general fund shortfalls
 - Avoid benefit cuts
 - Avoid reduced provider reimbursement rates
 - Avoid or restore eligibility cuts
- Per that same NCSL report*, examples of reductions implemented or considered in other states as a result of the pandemic's impact on state budgets included:
 - Nevada and Colorado adopted across-the-board rate decreases of 6% and 1%, respectively
 - Michigan plans to cut \$250 million from Medicaid largely by reducing rates paid to managed care organizations
 - Florida's governor vetoed planned increases to reimbursement for services provided to people with disabilities
 - Washington and Colorado proposed reductions to adult dental benefits
 - New York proposed changes to eligibility criteria for personal care services
 - Colorado proposed increasing copayments for prescriptions and physician visits and adding new copays to dental and non-emergency medical transportation
- While CT has been fortunate to carry a high rainy day fund balance and has experienced higher than expected tax revenues, the state still faces structural budget deficits of over \$1 billion
- This EFMAP has significantly reduced budget pressures on the Medicaid program and the broader human services support system, along with other areas of the budget
- In CT, there have been significant investments of additional resources into the human services system, with much of the Medicaid provider relief funded through the state's allocation of federal Coronavirus Relief Funds (CRF)
- Over \$225 million in federal CRF funding has been provided to DSS and targeted for Medicaid provider relief (\$159 million) and community testing (\$66 million)
- In addition, the maintenance of effort requirement is estimated to cost as much as \$630 million through June 2022, of which as much as \$185 million is the estimated state share of those costs
- In addition, funds related to the state share of Medicaid costs have been invested in several different areas including Medicaid rate relief for nursing homes, residential care homes and intermediate care facilities for individuals with intellectual disabilities, hospital COVID DRG enhanced reimbursement, and COVID-related coverage for uninsured individuals.

* Per November 2020 National Conference of State Legislatures report:
[Medicaid-State-Budgets_snapshot_35149.pdf \(ncsl.org\)](#)

4. MSP Asset Test

- a. What is the anticipated impact to MSP clients? How many people are estimated to lose benefits? How many might transition to other coverage?

MSP enrollees who would not be eligible under this proposal would be required to contribute their own funds to support the cost of their Part B premiums, currently at \$148.50 per month, and the cost of Medicare coinsurance and deductibles. Currently the average level of coinsurance and deductible payments for all MSP recipients is \$120 per month. Their Medicare coverage would continue to provide the range of health care supports available to all Medicare enrollees, but their annual premium and average coinsurance and deductible costs of approximately \$3,240 would shift to become their responsibility.

To the extent that MSP enrollees would not otherwise qualify for the Medicare Part D Low Income Subsidy (LIS, or “Extra Help”) because eligibility for Extra Help is ordinarily more restrictive than current MSP eligibility in Connecticut, then MSP enrollees who are over assets for MSP will need to make payments for their Medicare Part D costs that Extra Help otherwise covers. Extra Help has an asset test of \$14,790 for an individual, or \$29,520 if married and living with a spouse. If a person is eligible for MSP under state MSP rules then they are automatically eligible for Extra Help.

An estimated 21,200, out of a total of approximately 188,500 enrollees will lose their state support as a result of this change. They will retain their Medicare coverage but will not be able to shift to any other level of either MSP or Medicaid support unless they experience a change in their financial condition that otherwise makes them eligible.

Additional demographic information on MSP enrollees:

- Approximately 30% are under the age of 65
- Approximately 70% are 65 or older

Current MSP enrollment as of January 2021:

- Total – 188,539 (QMB – 173,880; SLMB – 10,615; ALMB/QI – 4,044)

Below are the income limits for the three MSP programs, which are not affected by this proposal. Connecticut has by far the highest income limits of any other state. It should be noted that enrollment now exceeds 188,500, an increase of almost 170% from the enrollment level of 69,970 in August 2009, the month prior to the eligibility levels being significantly increased – and the asset test eliminated – in FY 2010.

MSP Income Limits (not changing)

Household Size	QMB 211%	SLMB 231%	ALMB 246%
Annual			
1	\$27,177	\$29,753	\$31,685
2	\$36,756	\$40,240	\$42,853
Monthly			
1	\$2,265	\$2,480	\$2,641
2	\$3,064	\$3,354	\$3,572

Please note that there were many references to this proposal being instituted in 2017-2018. Please note that the 2017-2018 change to MSP was an income reduction, not the asset test change that has been proposed in the current budget recommendation. Income eligibility remains unchanged, far exceeding the vast majority of states (44) that are at the federal minimum. (The Governor's SFY 2020 - 2021 biennial budget had included a proposal to institute an asset test at the federal minimum, but that proposal did not move forward. This proposal would double the level of assets allowed.)

b. What will count as assets?

Consistent with federal rules, countable resources would include money in a checking or savings account, stocks, and bonds. An individual's home, one car, a burial plot, up to \$1,500 in a burial account, life insurance with a cash value of less than \$1,500, and household and personal items would be excluded.

5. RCH under Medicaid

a. Which services are Medicaid eligible?

Currently, RCHs are not enrolled as Medicaid Providers and do not bill for Medicaid coverable services. DSS proposes a Medicaid state plan amendment (SPA) to cover personal care services provided to RCH residents (*effective April 1, 2022*). Currently, the Department of Social Services pays for these services at 100% state expense. Adding these services to our Medicaid state plan will allow for 50% federal financial participation.

Federal claiming will permit the state to reinvest 25% of the new federal revenue into RCH rate increases.

RCHs will bill all-inclusive codes for "Personal Care" or "Personal Supports." This will include the following:

- Assistance with activities of daily living such as bathing and dressing;
- Instrumental activities of daily living such as meal preparation, laundry, general housekeeping; and
- Medication administration.

The Department anticipates amending the Medicaid State Plan by April 1, 2022 to allow RCHs to bill for personal care services and medication administration. Aside from amending the State Plan, no other changes are necessary to implement this change.

b. How will this change impact RCHs?

The proposed SPA will allow DSS to claim federal match for these services and reinvest 25 % of that revenue into RCHs. The reinvestment will be in the Room & Board component of the rate. RCH rate increases could support facilities in making necessary investments, such as capital improvements for example.

RCHs will be able to claim for Medicaid reimbursement of eligible services and permit the state to reinvest a portion of the new federal revenue into RCH rate increases. The reinvestment will be in the

Room & Board component of the rate. RCH rate increases could support facilities in making necessary investments, such as capital improvements for example.

DSS will issue explanatory provider guidance that will instruct the RCHs on what they are authorized to claim. DSS' contractor, Gainwell Technologies (formerly DXC), will then support RCHs in enrolling as Medicaid providers and provide training sessions on how to bill medical claims. Gainwell has considerable experience in doing this with smaller entities such as homemaker/companion agencies and autism providers.

Once the RCHs are enrolled as providers, residents of RCHs will be assessed to determine their level of care need. RCHs will then bill for services directly and payment will be reimbursed under three levels of service, or tiers. As is the case for all Medicaid providers, RCHs may then claim and be paid on a biweekly basis for providing services.

6. Obstetrics Bundle

a. Please describe how the expanded bundle will result in fewer c-sections.

Medicaid covers over 40% of the births in Connecticut, and the incidence of births to mothers served by Medicaid is as high as 70% in cities and distressed municipalities. Over the last several years, HUSKY Health has implemented a number of relevant interventions including 1) an obstetrics pay-for-performance (P4P) initiative; 2) Intensive Care Management supports; and 3) strict prior authorization requirements for prescribed opioids. These have reduced the rate of cesarean sections and incidence of neonatal abstinence syndrome (NAS), among other benefits. That said: 1) C-section rates have remained constant for Black members served by Medicaid; and 2) Black, African-American, non-Hispanic members were much more likely to have an adverse maternal outcome when compared to other racial and ethnic groups. Further, Connecticut has the 8th highest NAS Rate per 1000 births among states.

For these reasons, the Department feels tremendous urgency around moving forward efforts that will build on our present work. DSS' current obstetrics pay-for-performance (OBP4P) initiative has illustrated that many of these outcomes and risks can be addressed when the right incentives are in place, but also that the incentives must be more broadly applied and routinized across the profession.

The Department's proposed obstetrics bundle is an episode of care approach which seeks to improve maternal and neonatal outcomes by paying obstetrics providers based upon better maternal and neonatal outcomes. Currently, the majority of the professional obstetrics care for which the department pays is based upon professional services provided throughout a pregnancy, not the outcomes of the pregnancy.

The Department's proposed bundle will replace the current payment model and will make bundled payments based upon specific outcomes of the pregnancy, such as a vaginal birth versus a Cesarean section birth; a full term, normal weight newborn versus a premature or low birth weight birth; births requiring routine care versus NICU care; and/or normal maternal outcomes versus adverse preventable maternal outcomes. Additionally, the intervention will also build in and specifically recognize the roles of nurse midwives and doulas.

These efforts are anticipated to have the impact of reducing the rates of Cesarean section births. The savings included in SFY 2023 anticipates that a 5% reduction in C-section birth rates will be achieved.

- b. Does DSS currently offer incentives for reduced c-sections (pay for performance in obstetrical care program)?

The Department's OBP4P is a value-based approach that has already helped to reduce primary Cesarean section rates, while improving early prenatal referrals to the medical ASO to address social determinant needs and untreated substance abuse disorders. Specifically, the OBP4P awards the highest number of points for full-term (39 weeks gestation) vaginal delivery. The program also incentivizes early engagement with prenatal care, which may have an indirect impact on c-section rates.

Despite the progress that has been achieved with this model, however, adverse maternal and neonatal outcomes persist, especially among women of color. The c-section rate has remained around 33% which the Department would like to continue to improve upon with further value-based payments as noted above.

- c. If midwives are paid at 10% of the OB rate- how does this work under the bundled rate?

Nurse midwives are currently paid at 90% of the rate that DSS pays obstetricians. Nurse midwives accounted for 8.3% and 8% of HUSKY Health births in CY2018 and CY 2019 respectively. Through development of the bundled rate, DSS has the opportunity to address reimbursement levels both for nurse-midwives and also to consider reimbursement of related services, such as doulas and breast-feeding coaches.

YEAR	CY2018	CY2019
Total Deliveries	15,474	15,218
Delivery w/ Midwife	1,280	1,223
Midwife % of Deliveries	8.3%	8.0%
YEAR	CY2019	CY2020
C-section rate	33.8%	33.2%
Vaginal rate	66.2%	66.8%

7. Minimum Wage Increases:

- a. Which home health services are included? Which services are not (ex. skilled home health)?

The minimum wage increase for certain home health services was provided for home health aide services given the lower wages associated with that work and was not provided for higher wage skilled services under that service category.

- b. Has DSS considered the impact of minimum wage increases on other providers primarily funded via Medicaid?

Yes, the Department also made an adjustment to waiver services, for services that generally used lower wage staffing.

c. Does funding include increases for Meals on Wheels?

Meals on wheels was not included in the minimum wage adjustments. However, effective for dates of service July 1, 2019 and forward, the rates for Meals on Wheels single, double and kosher meals were increased by 10%.

d. Have concerns about wage compression been raised/discussed?

The funding provided was solely focused on those estimated to be directly affected by the minimum adjustment and did not address wage compression.

e. How are the increases for private providers estimated?

The Department will provide additional detail shortly under separate cover.

8. QA/Program Integrity Activities and Quantity Limits/Payment Adjustments

a. Provide detail on changes DSS is currently implementing to achieve these savings in FY 22 and FY 23.

Additional detail on all QA/Program Integrity Activities actions are noted below:

Pursue Enhanced QA Review, Provider Training and Up-Front System Edits for Certain Behavioral Health (BH) Providers

- Development of an attestation form that will require BH providers to document that they have received, read and will act on all relevant program enrollment and billing requirements.
- Development and implementation of a targeted training curriculum for behavioral health providers that will be a requisite for enrollment and re-enrollment of HUSKY Health providers.
- Implementation of Medicaid Management Information System billing edits to prevent excessive payment for services.

Build on Partnership with Pulselight for Audit Leads

- Integrate Electronic Visit Verification (EVV) data for home-based long-term services and supports into Pulselight to enhance QA's capacity to target and audit those providers.
- Develop COVID-specific data queries (e.g. telehealth review).

Continue Enhanced QA Activities Authorized in SFY 2020-21 Biennial Budget

- Due to COVID-19 related and other disruptions to staff recruitment, many of the efforts authorized in the SFY 2020-21 biennial budget did not reach expected levels of staffing and implementation. These previously authorized actions have been recently restarted and include staffing enhancements for the QA audit area, the QA Special Investigations group, and the Financial Services revenue group to ensure federal claiming compliance.

Additional detail on all Quantity Limits/Payment Adjustment actions are noted below:

Implementing Medicare crossover payment changes

- Updating the MMIS to ensure that when crossover claims are submitted by providers that the member has active Medicare eligibility for the date of service and, if not, the crossover claim will deny.

- Updating the MMIS to process outpatient hospital crossover claims for each individual detail (line item) versus the overall claim total (header level). This will allow the MMIS to compare each detail to determine if the detail should be capped based on the Medicaid usual reimbursement or to pay an amount towards the Medicare coinsurance / deductible / copayment. Processing the claims at the detail level will allow the MMIS to cap the overall reimbursement amount for outpatient hospital claims similar to how professional claims are processed and reimbursed. This methodology will provide for a more accurate reimbursement process for crossover claims and limit instances of overpayment.
- DSS will be reviewing the claim adjustment reason codes (CARCs) that providers use to identify the reason for a Medicare denial or non-payment on a crossover claim. DSS maintains a list of codes within the MMIS that if submitted on a crossover claim the claim will deny. These codes generally refer to negligence on the part of the provider as the result of the denial from Medicare and thus the claim should not be automatically reimbursed under Medicaid. DSS will ensure that the list maintained is comprehensive to ensure that only the crossover claims that have been submitted appropriately for review and processing under Medicare as the primary payer are eligible for processing and payment under Medicaid.
- DSS will continue to research specific provider categories, such as federally qualified health centers, to identify specific Medicare reimbursement and claims processing policies that impact how the crossover claim should be processed and reimbursed under the Medicaid program in order to minimize inappropriate overpayments.

Implementing quantity limits on medical equipment devices and supplies (MEDS)

- The current quantity limitations for various categories of MEDS will be lowered. This revision will bring the quantity limits reimbursed by CT Medicaid in alignment with the quantity limits maintained by neighboring states. Some examples of the changes include: (1) orthotic and prosthetic such as lumbar and cervical supports for which there currently is not a monthly or yearly limitation, DSS will implement yearly quantity limits similar to neighboring states, (2) for DME items such as wheelchairs and hospital beds, DSS will implement a threshold of one unit per 5 years similar to Medicare, and (3) for medical surgical items, such indwelling catheters, for which there currently is a CT Medicaid quantity limit, DSS will reduce the current threshold similar to neighboring states. The limitations will be controlled via the MMIS. If a claim includes quantities in excess of the established limits and does not have an approved prior authorization on file, the claim will be cut back to the revised quantity limits. Prior authorization requests for quantities in excess of the established limits will be reviewed consistent with medical necessity.

Diabetic Test Strips

- a. The current rates for diabetic test strips and lancets on the Medical Equipment Supplies and Devices – Medical/Surgical fee schedule will be revised to 100% of the Medicare rate. Reimbursement will be controlled systematically via the MMIS as with all other services reimbursed based upon an established fee schedule. Similar to other services reimbursed on the fee schedule, there will not be a prior authorization or alternate process for obtaining reimbursement in excess of the established rates. This will reduce the overall DSS expenditures on diabetic test strips and lancets when billed under the MEDS category.

9. Statutorily Required COLAs & Rate Increases

a. How does removing this funding impact clients? Providers?

The anticipated level of COLA for clients in the absence of this change is estimated to be 1.2% in SFY 2022 and 2.1% in SFY 2023. As an example, a Temporary Family Assistance family of three receiving a full benefit of \$597 per month would have received a \$7 increase in their monthly benefit in SFY 2022 and \$13 in SFY 2023. A SAGA recipient who pays for shelter would see their \$219 per month benefit increase \$3 in SFY 2022 and \$5 in SFY 2023. A SAGA recipient who does not pay for shelter would see their \$55 per month benefit increase by \$1 in each of SFY 2022 and 2023. A State Supp recipient living in the community with a maximum SSI award would see their \$138 per month benefit increase by \$1 in SFY 2022 and \$2 in SFY 2023 (State Supp benefit increases round down per federal rules).

Boarding homes, which includes residential care homes and community living arrangements (primarily DDS non-medical private group homes) for room and board costs, nursing homes and intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs) were estimated to receive a 2.4% increase in SFY 2022, followed by a 2.5% increase in SFY 2023.

The overall funding reduction for boarding homes as a result of this change is \$2.0 million in SFY 2022 and \$4.1 million in SFY 2023.

The overall funding reduction for ICF-IIDs as a result of this change is \$0.7 million in FY 2022 and \$1.5 million in FY 2023 (\$1.4 million in FY 2022 and \$3.0 million in FY 2023 after factoring in the federal share).

The overall funding reduction for nursing homes as a result of this change is \$11.1 million in FY 2022 and \$24.3 million in FY 2023 (\$22.2 million in FY 2022 and \$48.6 million in FY 2023 after factoring in the federal share).

b. Over the past 10 years, how often have these increases been funded?

The following summarizes action on statutorily required COLAs and rate increases over the past ten years:

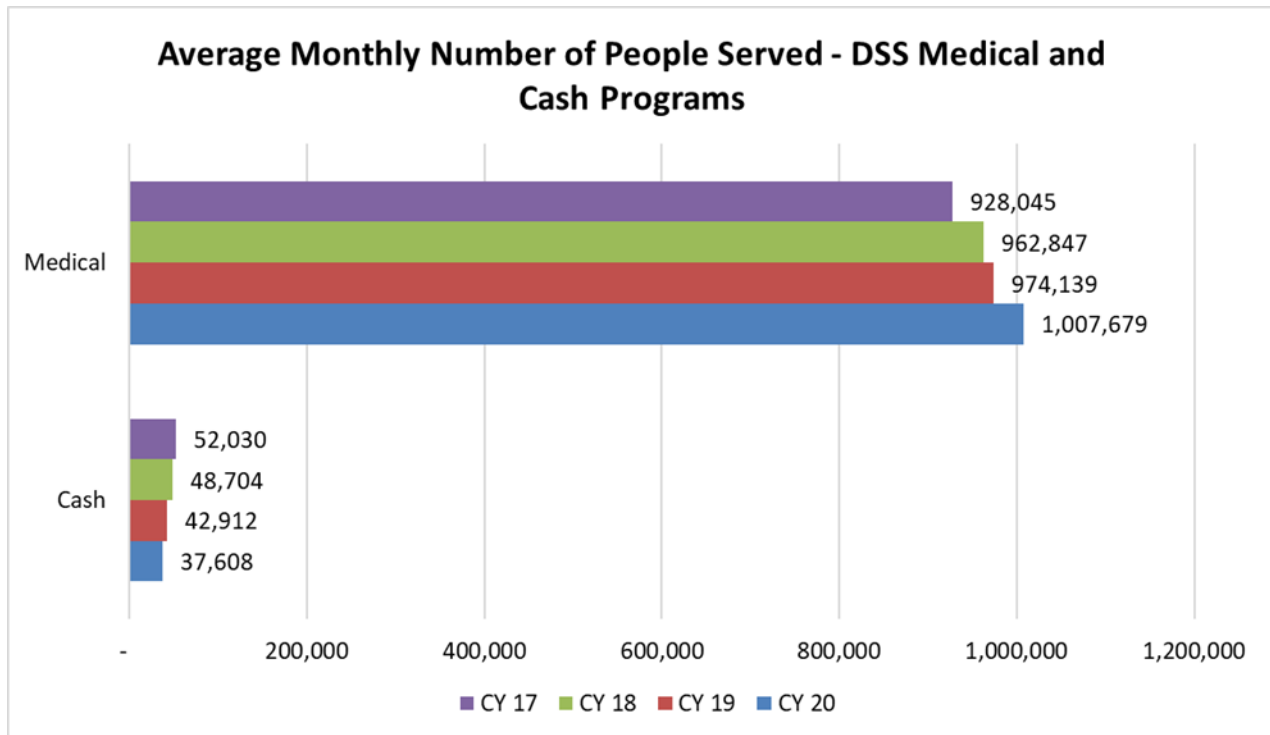
- Temporary Family Assistance, State Supplement for the Aged, Blind and Disabled, and State Administered General Assistance received rate increase in SFY 2014 and 2015 only.
- Boarding home rate increases, which includes residential care homes and community living arrangements (primarily DDS non-medical private group homes) for room and board costs, are detailed in exhibit 2.
- Rate increases for nursing homes and intermediate care facilities for individuals with intellectual disabilities are also detailed in exhibit 3.

10. Current Services Program Updates

a. Discuss caseload/expenditure trends- what is driving the decline in caseload?

- Enrollment is not down in all programs. Medicaid enrollment overall is up significantly due to eligibility policies implemented during the public health emergency (PHE). While fully federally funded, SNAP enrollment increased notably at the outset of the PHE but has since largely flattened out. Cash programs continue longstanding trends of decreased enrollment. The graph below shows the changes to Medical and Cash program enrollments over the last four calendar years.

Additional more focused graphs with more historical information can be found in Exhibit 5 for Medicaid and in exhibit 6 for cash assistance programs.

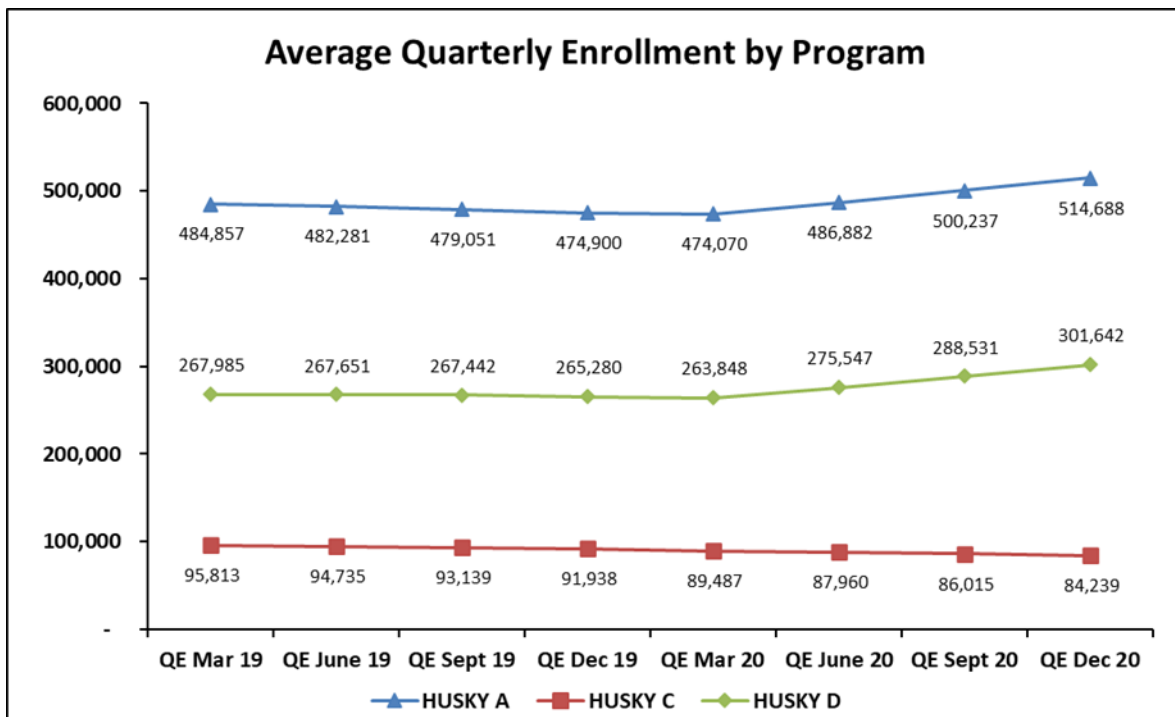
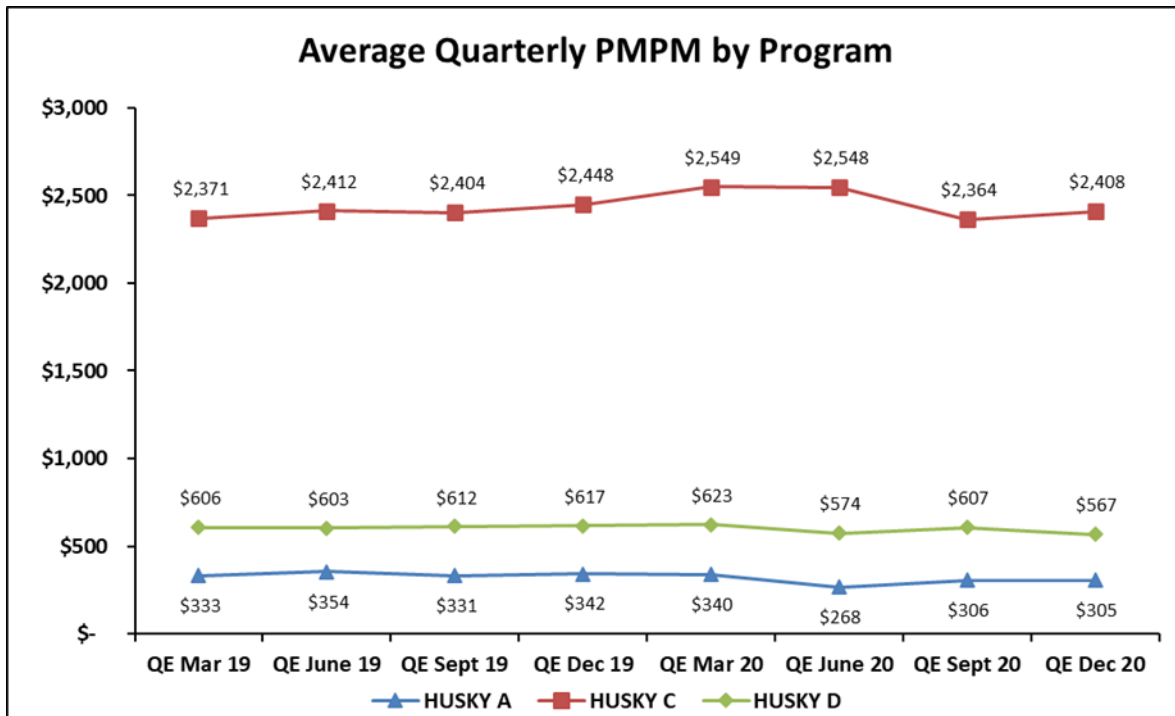


- Some of the possible reasons for enrollment decreases in cash programs include: the success of unemployment benefits as a safety net support (receipt of unemployment often precludes eligibility for cash assistance), program time limits (TFA), a relatively small benefit value (SAGA), low income eligibility thresholds that have not risen with the cost of living, and the decreasing value of cash benefits over time.

11. Questions not Associated w/specific Write-up

- Please breakout enrollment and PMPM for HUSKY by eligibility group (feel free to provide a pre-pandemic reference point as well).

Please see the graphs below showing the HUSKY enrollment and PMPM by HUSKY A, C and D groups.



b. How is the Fatherhood Initiative funded?

Six Fatherhood Initiative programs currently receive state funding through DSS:

- Career Resources, Inc., Bridgeport - Fathers for Life Program
- Family Strides, Inc., Torrington - Fatherhood Initiative Program
- GBAPP, Inc., Bridgeport – Teens Fathers Program

- Madonna Place, Inc. Norwich - Fatherhood Initiative Program
- Urban Community Alliance, Inc.(formerly New Haven Family Alliance), New Haven - Male Involvement Network
- New Opportunities, Inc., Waterbury - Fatherhood Initiative Program

These agencies are contracted with the Department to provide a Fatherhood Initiative Program to assist at least 50 (per program site) unduplicated low-income noncustodial fathers with services including but not limited to economic self-sufficiency; positive involvement and interaction with their children; outreach/recruitment to engage noncustodial fathers, intensive case management (i.e., establishment of paternity, responding to support order, linking with necessary human services including DSS assistance, housing, employment, education, training, parenting, self- help, counseling, transportation, legal assistance, mental health, substance abuse, pregnancy prevention, domestic violence, conflict resolution, anger management, relationship mediation, personal development, life skills, core interventions, responsible fatherhood, health and sexuality and other regionally available programs); and curriculum-based group sessions.

Currently, state funding totals \$310,498 for the six programs noted above at \$48,416 each.

- c. What is the status of acuity-based rates for nursing homes? What does that process look like over the biennium?

DSS plans to transition the way in which it pays for Medicaid-funded nursing home care from a cost-based method to a new acuity-based approach, phased in starting July 1, 2021. In brief, this will involve moving from a retrospective, cost-based, one-size-fits-all method to a method that specifically relates to the care needs of nursing home residents.

This chart illustrates key differences between the two approaches:

Current Payment System: Cost-Based	New Payment System: Acuity-Based
Pays the same for all Medicaid residents	Pays more for more complex patients
Does not reward homes for admitting complex residents	Provides incentives to care for complex residents
Incentivizes homes to admit low-acuity residents	Promotes serving less complex people in the community
Does not address quality of care	Will incorporate payment incentives related to quality of care
Adjusted annually	Adjusted quarterly
Based on five components of cost, one of which is direct care staffing	Based on the five components of cost, with more explicit relationship to staffing needs of residents

While DSS is conscious of the impact of the COVID-19 public health emergency on the nursing home industry, events of the last year have, if anything, increased the urgency of the need to move from the historical, cost-based method of paying for Medicaid-funded nursing home care to an acuity-based model.

Specifically, transitioning to this model will:

- promote access and high-quality care for residents, especially for those with extensive needs (e.g., ventilators, bariatric care);
- enable Medicaid to pay nursing homes based on the complexity of the care that their residents require;
- follow the lead of 33 other states and the District of Columbia, all of which have already implemented this well-accepted, proven method;
- permit nursing home rates to be adjusted on a more timely basis (quarterly, as opposed to annually);
- enable Connecticut to move towards value-based payment (linking reimbursement to quality measures) for nursing homes; and
- enable policymakers to achieve stated goals of the recent executive/legislative branch Nursing Home and Assisted Living Oversight Working Group (NHALOWG) while avoiding pitfalls associated with investing additional funding that is not directly related to quality (e.g., increased administrative costs, costs for unused space).

The acuity-based method uses data on nursing home residents' care needs (their acuity level) and the amount of direct staff support that they are predicted to need to calculate and update the rates that nursing homes are reimbursed. Data collected from nursing homes, along with information on direct care staff levels, are used to develop a score for each resident. The score is translated into a reimbursement rate for each home, which is adjusted over time to reflect changes in residents' conditions.

Recognizing concerns raised by nursing homes, DSS and its contractor Myers & Stauffer are building in the following protections:

- an extensive stakeholder process that will (1) use a Myers & Stauffer tool to model financial impact on a facility-by-facility basis and (2) educate and respond to nursing homes' questions on the model;
- use of the town-by-town data previously produced by Mercer Government Consulting to document local need and access to nursing home care;
- an ongoing option for homes to request approval of a voluntary reduction in their number of licensed beds;
- phase-in of the new rates effective 7/1/21 and use of "corridors" that will limit reductions ("stop loss") and cap increases in rates;
- regional adjustment (recognizing the higher costs in Fairfield County as compared to the rest of the state);
- assessment of the need, if any, for specialty services;
- quarterly adjustment of rates, based on clinical Minimum Data Set information submitted by nursing homes;
- reporting of quality measure data by homes for 1 to 2 years and discussion of the proposed financial model prior to implementing any value-based payment arrangement; and

- a model that will be cost neutral, but can be readily be adjusted if overall appropriations for nursing home rates are either increased or decreased.

There will be no inflationary rate increases included in the rates established under the new system over the biennium, resulting in state savings of \$11.1 million in SFY 2022 and \$24.3 million in SFY 23. After factoring in the federal share, this proposal will reduce total Medicaid expenditures by \$22.2 million in SFY 2022 and \$48.6 million in SFY 2023.

12. Questions from the Appropriations Hearing

- Provide a listing of all programs by budget line item with a description of services, federal/state funding mix, and a three year census of individuals served

Please refer to exhibit 4 for this detail that includes all information requested with the exception of the client data. The Department will send the requested census data by program shortly under separate cover.

- Provide additional information on the Personal Needs Allowance including information of the federal minimum allowance

State Medicaid agencies are required to reduce their costs using available beneficiary income for coverage of institutional services provided. Residents of nursing facilities pay their Social Security and other unearned income towards their cost of care with the exception of a monthly personal needs allowance (PNA) and other allowable deductions, such as medical premiums.

As shown below, the current Connecticut PNA level of \$60 is above the average for the states in the Northeast and is \$30 above the federal minimum.

State	Monthly PNA
Connecticut	\$60
Maine	40
Massachusetts	73
New Hampshire	70
New Jersey	50
New York	50
Pennsylvania	45
Rhode Island	50
Vermont	48
Northeast Average	\$53

Changing the PNA is estimated to result in annualized state share adjustment of approximately \$100,000 for each dollar by which the PNA is altered (\$200,000 including both the federal and state share).

c. Provide additional information on the impact of the Diaper Bank reduction on service levels

The Diaper Bank estimates that they have been able to provide diapers to an additional 2,330 infants and toddlers per month with the funding provided in SFY 2020 and 2021. The proposed reduction in funding, approximately 50% from SFY 2020 and 2021 levels, would likely reduce that number to approximately 1,165 infants and toddlers who can be served.

d. Provide additional information regarding access to durable medical equipment for dual eligibles

A dual eligible member (Medicare and full Medicaid coverage) has access to a variety of durable medical equipment (DME) items under the Medicare program including, but not limited to, glucose testing supplies, continuous positive airway pressure devices (CPAP), canes, commode chairs, crutches, hospital beds, walkers, patient lifts, nebulizers etc.. A dual eligible member also has access to DME that is not covered by Medicare (or denied by Medicare) but that is covered under the Medicaid program. As with majority of services, a claim for a dual eligible member must first be submitted to Medicare for processing and payment purposes. For items that are covered by Medicare, Medicare will process the claim according to the applicable Medicare rules. Once Medicare makes its payment, the claim, typically referred to at this point as a crossover claim, can be submitted to Medicaid for processing and payment of any remaining coinsurance/deductible/copayment. If Medicare denies payment, for reasons such as, the item is not covered under Medicare, the claim will be submitted to Medicaid with the appropriate Medicare denial reason code and the claim will be processed in the CT MMIS similar to a straight Medicaid claim. The reimbursement for this type of claim will be based on the CT Medicaid fee schedule amount.

During the public health emergency (PHE) period, DSS has implemented the following flexibilities for items covered under MEDS to assist with ensuring access:

- (1) allowance of three-month's advance supply of medically necessary medical and surgical supplies including oxygen and respiratory supplies,
- (2) waiving the requirement for MEDS providers to obtain the member or the member's designee signature on the delivery receipt at the time that the supplies or equipment are delivered to the member's home
- (3) allowance of the face-to-face encounter that is required by 42 C.F.R. § 440.70 for specific durable medical equipment to be performed via telehealth (audio and visual telehealth only, not audio-only telephone)
- (4) For members in need of a customized wheelchair: extension of the time frame for completion of the physiatrist's evaluation by an additional 90 days for members residing in a skilled nursing facility and extension by 90 days for the face-to-face physician visit for members residing in the community
- (5) Customized wheelchair repairs: the requirement to obtain a prescription for a customized wheelchair repair has been waived when the DME provider has a valid prescription for the wheelchair on file

e. Provide additional information on the rate reduction for Natchaug Hospital

When the Natchaug Hospital rate increase was originally provided, it was only included in the budget and in statute for the fiscal year ending June 30, 2021. The rate reduction in the Governor's budget recognizes this statutory change effective July 1, 2021. A comparison of the rates for Natchaug Hospital are shown below:

	<i>Rate prior to 7/1/20 and potential rate post 6/30/21</i>	<i>Rate increase for the 7/1/20 to 6/30/21 period</i>
Adults days 1-29	\$814.65	\$975.00
Adults days 30+	\$692.45	\$828.75
Child acute days	\$829.96	\$975.00
Child discharge delay	\$705.47	\$828.75

- f. Concerns regarding reductions in Hispanic Human Resource Development-what are services provided and what will be the impact of the changes?

Services provided under Hispanic Human Resource Development could include at least one of the following services: employment assistance; education and training or remedial education services for individuals who self-report as Hispanic and request assistance.

1. The Governor's budget proposes to eliminate funding tied to Hurricane Maria as the displaced population is no longer as significant as it was closer to the event and it is increasingly difficult to spend the dollars on this target population.
2. The Governor's budget proposes to eliminate funding associated with a historical under expenditure in the account that will not directly impact client services.

- g. Concerns regarding reductions in Community Services and holdbacks-what are services provided and what will be the impact of the changes?

The Community Services line item includes funding for five organizations:

- **Person to Person** utilizes Community Services funding to provide housing supports and emergency housing funds to low-income persons residing in lower Fairfield County. Person to Person is still able to operate services and reduce their emergency housing fund maximum amount.
 - Funding will be maintained for case management, the reductions are to the direct client emergency housing fund amounts.
- **Jewish Federation (JFACT)** – JFACT operates a citizenship training program. The proposed change eliminates this program. A number of cities operate free citizenship training programs. For example, Hartford's public library offers a free virtual course. <https://www.hplct.org/library-services/immigration-citizenship/citizenship>.
- **The Diaper Bank of Connecticut** – The Diaper Bank provides diapers to infants and toddlers in low-income families through a network of community providers around the state. The budget proposal reduces this funding by about 50%. Approximately 1,165 fewer toddlers and infants will receive diapers each month as a result of the reduction.
- **Fair Haven Community Health Care**
- **Charter Oak**

Funding reductions incorporated into the Governor's Recommended Budget are noted below:

	FY 22 Baseline	Annualize Holdbacks	Remaining Balance	Add'l FY 22 Reductions	FY 22 Total
Connecticut Diaper Bank	\$500,000	(\$163,399)	\$336,601	(\$168,300)	\$168,301
Charter Oak Urgent Care	430,000	(140,523)	289,477	0	289,477
Fair Haven Clinic	300,000	(98,039)	201,961	0	201,961
Person-to-Person Program	250,000	(81,699)	168,301	0	168,301
Jewish Federation Association of CT	50,000	(16,340)	33,660	(33,660)	0
	\$1,530,000	(\$500,000)	\$1,030,000	(\$201,960)	\$828,040
	FY 23 Baseline	Annualize Holdbacks	Remaining Balance	Add'l FY 23 Reductions	FY 23 Total
Connecticut Diaper Bank	\$500,000	(\$163,399)	\$336,601	(\$168,300)	\$168,301
Charter Oak Urgent Care	430,000	(140,523)	289,477	(72,369)	217,108
Fair Haven Clinic	300,000	(98,039)	201,961	0	201,961
Person-to-Person Program	250,000	(81,699)	168,301	0	168,301
Jewish Federation Association of CT	50,000	(16,340)	33,660	(33,660)	0
	\$1,530,000	(\$500,000)	\$1,030,000	(\$274,329)	\$755,671

h. Data on impact of COVID on knee and hip replacements

The COVID-19 impact has had a minimal impact on hip and knee replacements for HUSKY Health members with a decrease of less than 5% from CY 2019 to CY 2020. This data does not represent CT residents that have healthcare coverage only through Medicare, which may be have been more impacted.

Hip and Knee Replacements

Members	CY 2019	CY 2020
Total	816	781
Husky C	113	82

i. Concerns regarding the Allied contract-when will it be rebid, what are performance standards, where is it funded in the budget and at what level?

Allied is budgeted within the broader Medicaid account.

DSS, in coordination with DDS, plans to release an interagency RFP in May 2021. The agencies are utilizing the 'Results Driven Contracting Sprint model' facilitated by staff from the Harvard Government Performance Lab, Harvard Kennedy School, to develop the RFP.

The total SFY 2021 budget for Allied, as funded by the DSS contract, is \$14,749,045. Of the \$14,749,045, \$775,377 is directly attributed to processing PCA payroll. Allied also receives a significant amount of additional funding unrelated to personal care assistants' payroll. Allied receives funds for worker's compensation costs, Money Follows the Person Demonstration, hazard pay, etc. Allied receives funds for these functions in the amount of \$8,104,228. Program funds are directly disbursed according to program rules. No program funds are retained by Allied. Lastly, Allied receives funds for quality assurance functions, provider enrollment functions, and training functions. Budgeted funds related to these functions, as well as general management is \$5,869,440.

Performance standards directly related to timely payment include the following:

Expectation: Allied must process and distribute payments to participants for distribution to household employees or directly to household employees on behalf of the participant as authorized by the participant by Friday of the week following the Contractor's receipt of an accurate timesheet.

Expectation: Allied must implement an internal process to review transmission time of each payroll deposit each Thursday. If for any reason the payroll successful transmission time is after 8 PM on Thursday, Allied must inform all PCAs by 8 AM the following morning (Friday), that wages should not be expected until 5 PM.

Expectation: Allied must implement a process to reduce error rate on payroll submission and ensure timely payment of timesheets. This process must include Allied's communication with employers to resolve all errors on submitted timesheets and immediately requires Allied to accept the employer's verbal confirmation of the correction in order to support timely payment each Friday. Further, Allied is required to contact the personal care attendant regarding certain errors.

- j. Provide additional information on the transfer of funds to DAS for the costs of the Microsoft 365 licenses

The full statewide transfer of funds to the Department of Administrative Services for the centralized purchase of Microsoft 365 licenses is \$1.7 million for all state agencies. Of this amount, DSS was assessed a contribution of \$513,693 for support of this effort.

- k. Pandemic EBT – who gets it? Amounts paid?

Please refer to the attachments in exhibits 7 and 8 which provide supporting information on Pandemic EBT. Due to its length, we will forward the full pandemic EBT plan under separate cover.

Exhibit 1 – Federal Coronavirus Relief Fund (CRF) – State Allocations to DSS

		<u>Current Distributions</u>	
Medicaid Provider Supports			
	Nursing home across-the-board grants	48,030,801	10% add to Apr, 20% May-Jun; full allocation of \$52 m
	COVID Recovery facilities	14,100,000	\$600/day; dedicated COVID facilities
	Nursing home hardship relief	929,155	
	Nursing home reporting/audits	200,000	
	Nursing home across-the-board grants (Nov-Dec 20)	21,081,510	10% for Nov-Dec 20
	Chronic disease hospital relief	2,401,103	10% for Apr-Jun 2020; based upon Jan-Mar 2021;
	Private Psychiatric Residential Treatment facility relief	-	20% for Apr-Jun 2020; based upon Jan-Mar 2020
	Substance abuse residential detox facility relief	555,391	20% for Apr-Jun 2020; based upon Jan-Mar 2020
	Home health provider relief	1,679,471	10% for Apr-Jun 2020; based upon Jan-Mar 2020
	Home care and waiver service provider relief	5,139,814	10% for Apr-Jun 2020; based upon Jan-Mar 2020
	Community First Choice funding relief	3,031,050	7.5% for Apr-Jun 2020; includes \$281,050 for admin
	CCMC relief	16,300,000	Mar-Sep 2020 covered period
	Behavioral health clinician relief	498,463	10% for Apr-Jun 2020; based upon Jan-Mar 2020
	Behavioral health clinic relief	1,488,712	10% for Apr-Jun 2020; based upon Jan-Mar 2020
	Methadone maintenance provider relief	908,392	10% for Apr-Jun 2020; based upon Jan-Mar 2021
	PPE distribution for self-directed care staff	781,179	Kennedy Center contract
	General acute care hospitals (excluding Dempsey)	40,000,000	
	Subtotal - Provider Supports	157,125,041	
Other Provider Support			
	DV Shelter Compression	165,000	
	Emergency Feeding	1,492,164	
Administrative			
	DSS Technology & Systems Support	9,918,016	
Other Administrative			
	Provide clinical monitoring through CHNCT	10,650	
Testing			
	Community Partners Testing Support	66,615,520	
	Total - DSS CRF	235,326,391	

Exhibit 2 – Boarding Home Rate History

Community Living Arrangements

FY 21	Rate freeze 0%
FY 20	Rate freeze 0%
FY 19	Rate freeze 0%
FY 18	Rate freeze 0%
FY 17	Rate freeze 0%
FY 16	Rate freeze 0%
FY 15	Rates updated for inflation
FY 14	Rates updated for inflation
FY 13	Rates updated for inflation
FY 12	Rate freeze 0%
FY 11	Rate freeze 0%
FY 10	Rate freeze 0%

Note 1: From FY 10 forward, on a facility by facility basis, health & safety were added to rates (passed through) for approved improvements

Residential Care Homes

FY 21	Rate freeze 0%, fair rent and 0.4% minimum wage add on
FY 20	Rate freeze 0%, fair rent add on and temporary COVID increase
FY 19	Rate freeze 0%, fair rent and wage add on
FY 18	Rate freeze 0%, fair rent add on only
FY 17	Rate freeze 0%, fair rent add on only
FY 16	Rate freeze 0%, fair rent add on only
FY 15	Rates updated for inflation with 0.45% increase
FY 14	Rates updated for inflation, greater of cost based rate or prior year
FY 13	Rates updated for inflation, with 1% additional increase 1/1/13
FY 12	Rate freeze 0%
FY 11	Rate freeze 0%
FY 10	Rate freeze 0%

Note 1: For FY 10 to FY 12, rates were increased for costs to comply with section 19a-495, the administration of medication by unlicensed personnel.

Note 2: For FY 14 and subsequent years, RCH's may receive a rate increase for capital improvements made for the health and safety of residents.

Exhibit 3 – Nursing Home and ICF-IID Rate History

Nursing Homes

FY 21	1% increase effective 10/1/20, additional 1% on 1/1/21, adjustments to fair rent recognized
FY 20	2% increase effective 7/1/19, adjustments to fair rent recognized
FY 19	2% increase effective 11/1/18, adjustments to fair rent recognized
FY 18	1.6% stop loss, overall rates decreased 1.2%
FY 17	Rate freeze 0%, adjustments to fair rent recognized, wage enhancement funds of \$35.6 m
FY 16	Rate freeze 0%, adjustments to fair rent recognized
FY 15	Rate freeze 0%, adjustments to fair rent recognized
FY 14	0.3% decrease in rates
FY 13	1.0% stop loss, average rate was minor reduction
FY 12	3.7% increase
FY 11	Rate freeze 0%
FY 10	Rate freeze 0%

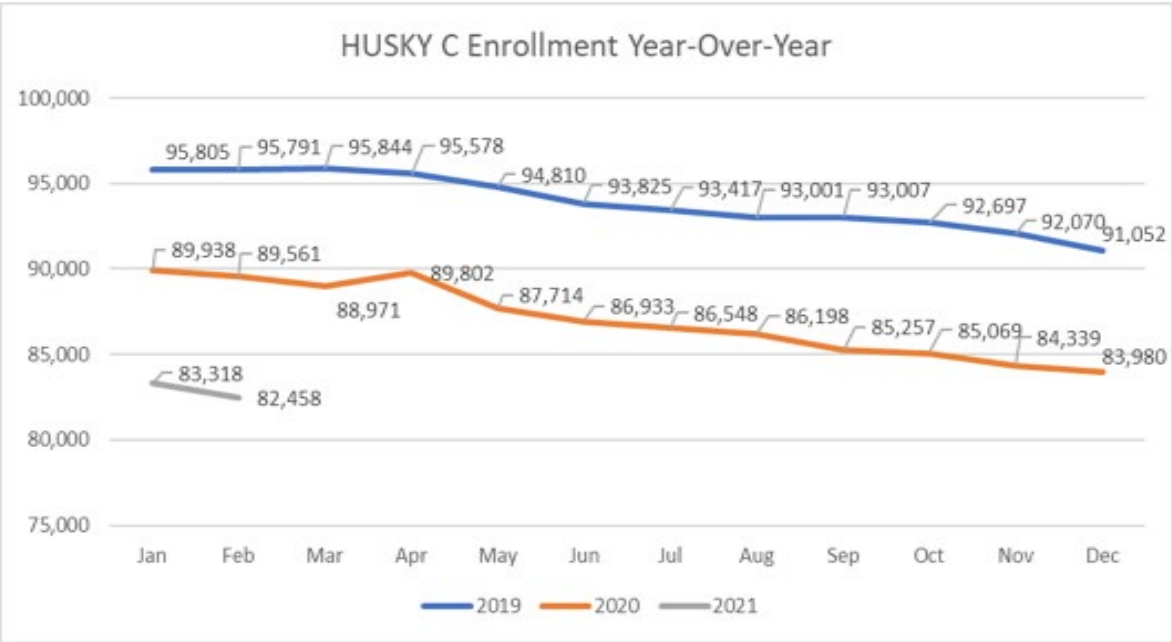
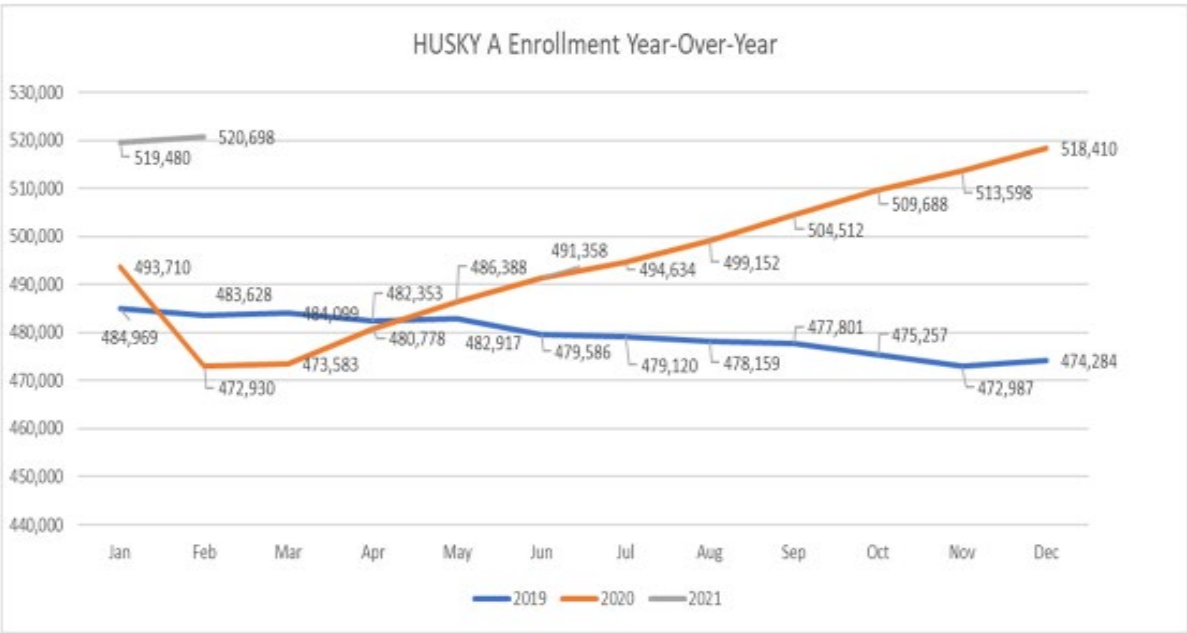
Intermediate Care Facilities for Individuals with Intellectual Disabilities

FY 21	Rate freeze 0%, adjustments to fair rent recognized
FY 20	Rate freeze 0%, adjustments to fair rent recognized
FY 19	Rate increase of 4.5%, adjustments to fair rent recognized
FY 18	Rate freeze 0%, adjustments to fair rent recognized
FY 17	Rate freeze 0%, adjustments to fair rent recognized
FY 16	Rate freeze 0%, adjustments to fair rent recognized
FY 15	Rate freeze 0%, adjustments to fair rent recognized
FY 14	1% decrease from FY 13
FY 13	Rates updated for inflation plus \$21.40 increase (associated with user fee increase)
FY 12	6.835% increase
FY 11	Rate freeze 0%
FY 10	Rate freeze 0%

Exhibit 4 - Summary of General Fund DSS Program Allocations, Descriptions and Individuals Served (Client Data to be Submitted Shortly)				
Program	Description	Recommended SFY 22 Funding	Recommended SFY 23 Funding	Funding Mix (State/Fed)
HUSKY B Program	HUSKY B is Connecticut's Children's Health Insurance Program (CHIP) which provides health care coverage for uninsured children who are not eligible for Medicaid. Under HUSKY B, children with family incomes between 201% and 254% of the federal poverty level qualify for coverage without a monthly premium. For those children with family income between 254% and 323% of the federal poverty level, a monthly premium of \$30 per child, up to a maximum of \$50 per family, is required. Children enrolled in HUSKY B with special health care needs may receive supplemental services from the HUSKY Plus program. This account is net budgeted with only the state share of expenditures appropriated. Federal law increased federal reimbursement for CHIP by 23 percentage points effective October 1, 2015 through September 30, 2019 and 11.5 percentage points effective October 1, 2019 through September 30, 2020. For Connecticut, reimbursement is increased from 65% to 88% for the period ending September 30, 2019 and from 65% to 76.5% for the period ending September 30, 2020. The federal reimbursement returned to 65% as of October 1, 2020.	15,460,000	17,270,000	65% Fed; 35% State*
Medicaid	Connecticut's Medical Assistance Program (Medicaid) provides health coverage to people who meet financial and functional eligibility criteria. In order to receive assistance, an individual must qualify under one of the state's medical coverage groups (HUSKY A – children and caregivers; HUSKY C – older adults and people with disabilities; and HUSKY D – expansion group adults). Medicaid is a state-administered program, jointly funded by the federal government and the state, which operates within federal rules. This account is net budgeted with only the state share of expenditures appropriated. Most expenditures are federally reimbursed at 50% (E-FMAP during PHE 56.2%). HUSKY D expenditures are reimbursed at 90% since 1/1/20.	2,718,795,000	2,923,705,000	60% Fed; 40% State*
Old Age Assistance	The Old Age Assistance program provides supplemental cash assistance, as part of the State Supplement program, to individuals 65 years of age or older. In order to receive Old Age Assistance benefits, individuals must have another source of income such as Social Security, federal Supplemental Security Income (SSI) or Veteran's Benefits. Although this program operates under a federal statutory provision, it is funded entirely with state funds.	39,100,000	30,360,000	100% State
Aid to the Blind	The Aid to the Blind program provides supplemental cash assistance to individuals disabled due to blindness as part of the State Supplement program. In order to receive Aid to the Blind benefits, individuals must have another source of Income such as Social Security, federal Supplemental Security Income (SSI) or Veteran's Benefits. Although this program operates under a federal statutory provision, it is funded entirely with state funds.	512,500	520,400	100% State
Aid to the Disabled	The Aid to the Disabled program provides supplemental cash assistance to adults between the ages of 18 and 65 who are disabled as part of the State Supplement program. In order to receive Aid to the Disabled benefits, individuals must have another source of income such as Social Security, federal Supplemental Security Income (SSI) or veteran's benefits. Although this program operates under a federal statutory provision, it is funded entirely with state funds.	48,340,000	35,150,000	100% State
Temporary Asst to Families-TANF	This account funds the Temporary Family Assistance (TFA) program, which provides cash assistance to families for basic and special needs. Families with an employable adult are eligible to receive assistance for 21 months, during which the adult member must make a good faith effort to find employment. Exemptions from and extensions to the 21-month time limit are available under certain circumstances.	41,370,000	39,880,000	State funds w/ fed reimb
DMHAS-Disproportionate Share	The Omnibus Budget Reconciliation Act of 1990 allows Medicaid to make disproportionate share hospital (DSH) payments for the care of uninsured low-income persons who receive care in state psychiatric hospitals. As a result, a portion of the cost of care in DMHAS hospitals is paid by DSS under the DSH program in order to maximize federal revenue.	108,935,000	108,935,000	State funds w/ fed reimb
Connecticut Home Care Program	The Connecticut Home Care Program for Elders (CHCPE) provides home and community based services to individuals age 65 and older who meet financial eligibility guidelines and who would be at risk of hospitalization or nursing home placement if preventative home care services were not provided. The majority of participants are served through a Medicaid "waiver" under which the federal government reimburses for services at a rate of 50%. This account funds the remaining participants, who are fully state-funded, but tend to progress in functional need and financial circumstances to ultimately be served under the waiver. This account also supports the Connecticut Home Care Program for Adults with Disabilities, which provides home-based services to up to 100 persons, age 18 – 64, with degenerative, neurological conditions, who are not eligible for other programs and who need care management and other supportive services to remain in the community.	32,800,000	34,190,000	100% State

Program	Description	Recommended SFY 22 Funding	Recommended SFY 23 Funding	Funding Mix (State/Fed)
Human Resource Dev. - Hispanic	Funds are provided to community-based organizations to improve the workforce viability of low-income residents of Hispanic descent through training, education, employment, supportive services and coordinated case management.	802,885	803,704	100% State
Safety Net Services	These services help clients who have exhausted their 21 months of time-limited assistance, are not eligible for an extension for any reason and who have income below the payment standard. Services may include payments for basic needs (through vouchers), services to address barriers to employment, as well as assistance in finding employment.	1,329,873	1,329,873	100% State
Services for Persons w/ Disabilities	This account funds: (1) short-term clinical and residential supports to persons who recently sustained brain injuries; (2) supported independent living for persons with traumatic brain injury, helping clients with impaired independent living skills achieve self-reliance at home and work, and in re-integrate into the community; and (3) the Family Support Grant, which provides a monthly subsidy of up to \$250 to families with a child with a developmental disability in order to meet the extraordinary expenses of caring for a child with special support needs.	276,362	276,362	100% State
Nutrition Assistance	This account supports the provision of nutritional assistance to needy families and individuals through food pantries, outreach activities, and the state Supplemental Nutrition Assistance Program operated by Connecticut Food Bank, which distributes high protein foods to food banks, food pantries and soup kitchens statewide.	749,040	750,204	100% State
State Administered General Assistance	Individuals and families who do not have sufficient financial support from other sources are eligible for SAGA cash assistance provided they have a medical or physical impairment that precludes employment for at least two months. Unemployable individuals (unable to work for six months or more) are eligible to receive up to \$219 per month. Other individuals may receive \$219 per month (if responsible for the full rent or a portion of the rent) or \$55 per month (if no rent costs). This account also pays a funeral and burial allowance up to \$1,200 for indigent persons.	15,730,000	15,580,000	100% State
Connecticut Children's Medical Center	This account provides funding for a direct grant payment to the Connecticut Children's Medical Center. This support is provided in recognition of the extraordinary costs borne by the hospital related to the high proportion of Medicaid members it serves, its special equipment needs and its status as a teaching facility. Payments from this account receive federal matching funds under the Federal Hospital Disproportionate Share program.	10,125,737	10,125,737	State funds w/ fed reimb
Community Services	Currently supports Safety Net services (in conjunction with SID 16128) which help clients who have exhausted their 21 months of time limited assistance, are not eligible for an extension for any reason and who have income below the payment standard. Services may include payments for basic needs - through vouchers, services to address barriers to employment, as well as assistance in finding employment.	1,103,416	1,031,047	100% State
Human Svc Infrastructure/Comm Act Pgm	Funds are provided to United Way/Infoline and the Community Action Network to provide a coordinated, statewide social service system that will better use existing resources, identify barriers and gaps in services, and track client outcomes to create a more efficient system of connecting people to the services they need.	3,282,728	3,291,676	100% State
Teen Pregnancy Prevention	The purpose of the Teen Pregnancy Prevention Program is to prevent first time pregnancies in at-risk youth. The program utilizes two evidence-based models to improve the well-being of youth by preventing teen pregnancy.	1,251,432	1,251,432	100% State
Domestic Violence Shelters	Funds non-profit organizations that provide emergency housing, case management and social services for victims of household abuse. The program supports domestic violence shelters and related supports.	5,321,749	5,425,349	100% State
Hospital Supplemental Payments	This account funds hospital supplemental payments that are in addition to the regular reimbursement that hospitals receive under Medicaid for services provided. Funds currently support both a capped and uncapped inpatient pool, a mid-sized inpatient pool, an outpatient pool, and a small hospital pool. Note: Prior to FY 17, funding for hospital supplemental payments was included in the Medicaid account. In FY 17, funding was moved to its own account and was net budgeted with only the state share of costs appropriated. Beginning in FY 18, the account was gross budgeted (i.e., included both the state and federal share of the payments) and significantly increased in conjunction with an increase in the hospital user fee. The supplemental payment amounts appropriated to this account are consistent with the hospital settlement.	568,300,000	568,300,000	100% State
Teen Pregnancy Prevention- Municipal	The purpose of the teen pregnancy prevention initiative is to prevent first time pregnancies in at-risk youth. The program utilizes two evidence-based models to improve the well-being of youth by preventing teen pregnancy.	98,281	98,281	100% State
*Does not include enhanced federal match received under the pandemic emergency				

Exhibit 5 Medicaid Enrollment Trends



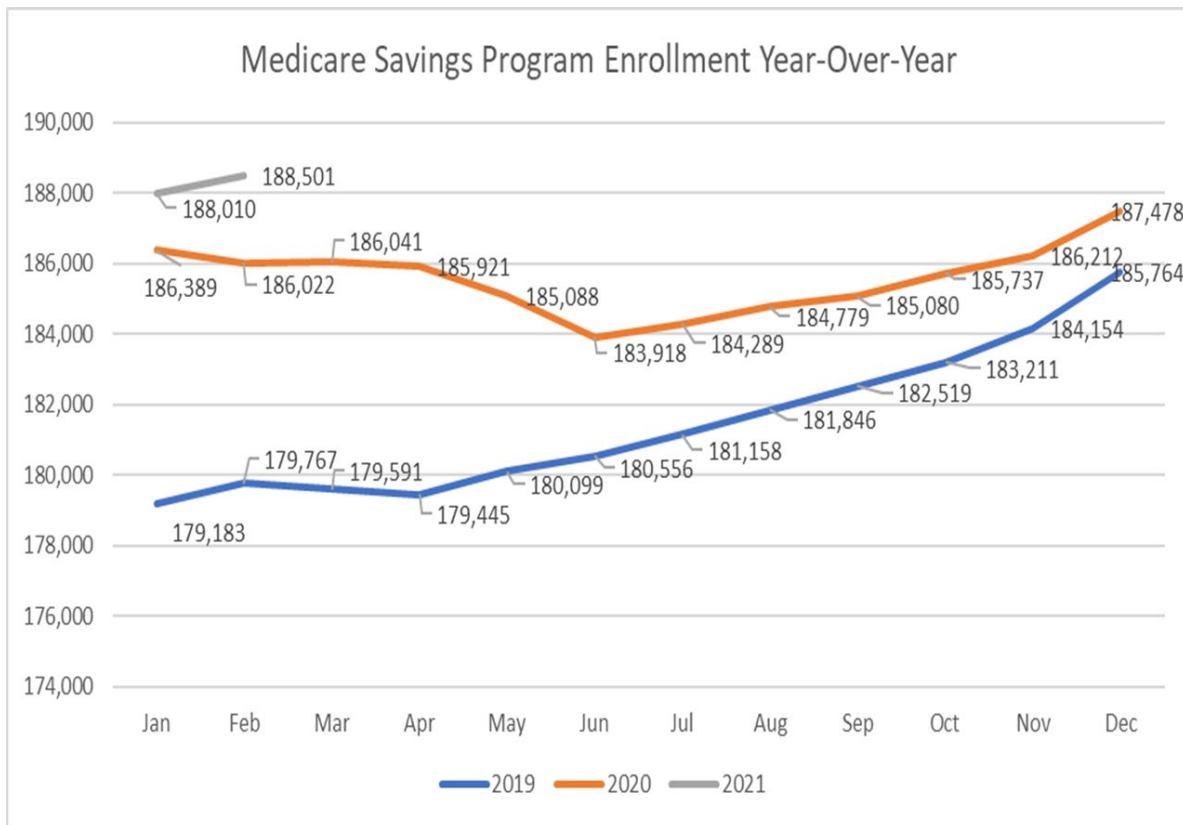
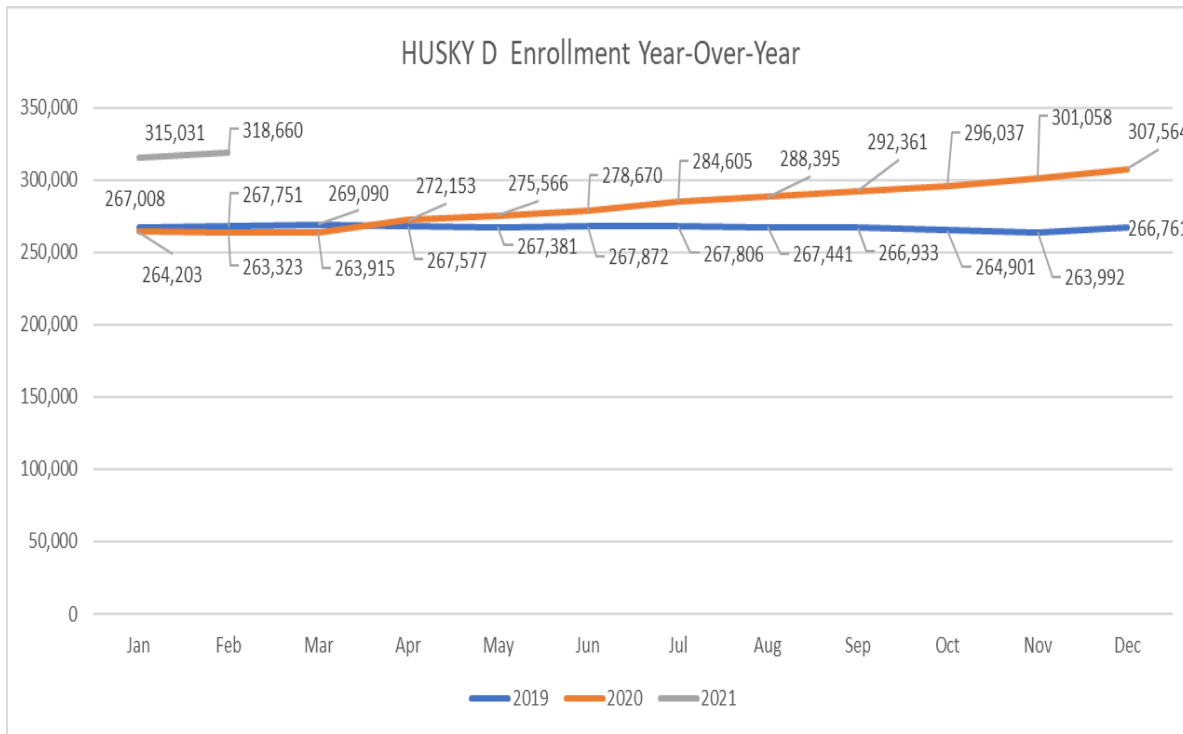
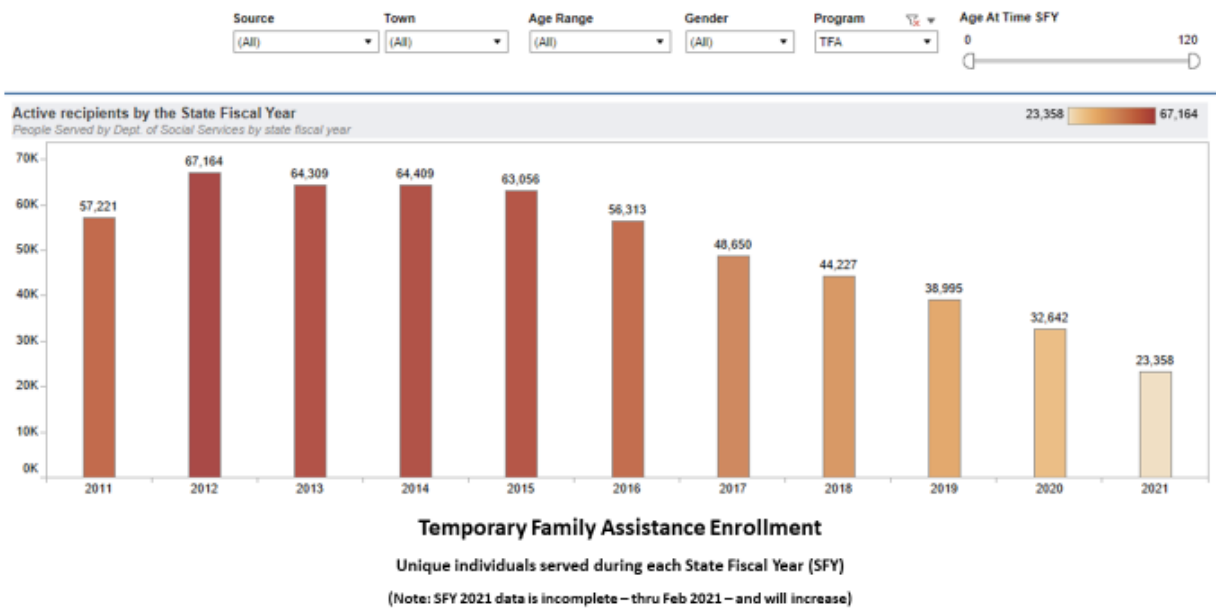
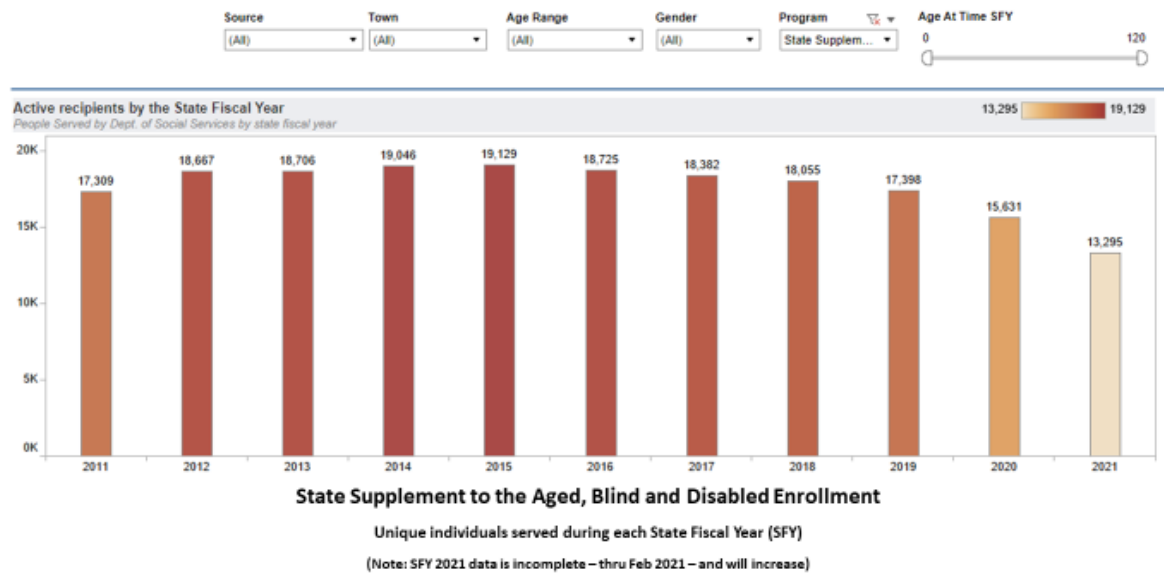
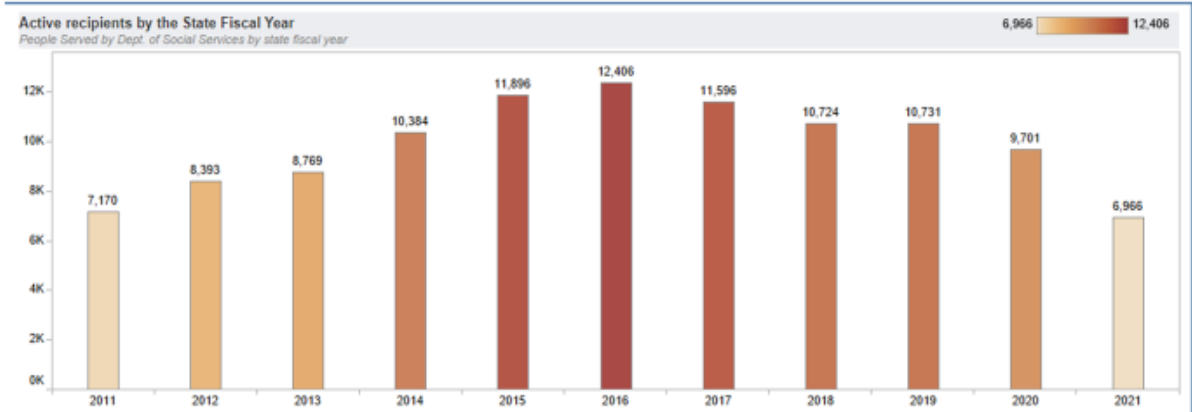


Exhibit 6 Cash Assistance Enrollment Trends



Source: (All) Town: (All) Age Range: (All) Gender: (All) Program: SAGA Age At Time SFY: 0 to 120



State Administered General Assistance Enrollment

Unique individuals served during each State Fiscal Year (SFY)

(Note: SFY 2021 data is incomplete – thru Feb 2021 – and will increase)

Pandemic EBT Quick Facts

Pandemic-Electronic Benefit Transfer (P-EBT) provides food benefits to students who have temporarily lost access to free or reduced-price meals at school due to COVID-19.

Will Connecticut be issuing P-EBT Benefits for the 2020 – 2021 school year?



Yes.

What will the amount of benefits be for the 2020 – 2021 school year?



The amount you will receive depends on what the learning model your child was in each month and could be different from child to child. For more information, or for tips on how to maximize your nutrition benefits including P-EBT, SNAP, and WIC visit: <https://portal.ct.gov/p-ebt>

When will P-EBT benefits be issued?



P-EBT benefits will be issued in two phases.

The 1st phase covers the months of September-January. Phase 1 benefits will begin being issued in early April.

The 2nd phase covers the months of February - the end of the school year. Phase 2 benefits will be issued beginning in late June into July.

Will everyone who received P-EBT benefits in the summer also receive benefits this year?



No. The following groups are no longer eligible for P-EBT benefits:

- Students who are no longer eligible for free or reduced-priced school meals.*
- Students who received P-EBT benefits in the summer of 2020 but have since graduated from High School.
- Students who received P-EBT benefits in the summer of 2020 but have since moved out of the state and are not attending a school in Connecticut.
- Students who are learning in person at their school for the entire school year.

*The majority of CT schools are able to offer meals at no cost to all students for School Year 2020-21, due to the public health emergency. However, P-EBT eligibility is determined by having a school meals application approved for free or reduced-priced meals on file with the student's school, direct certification for free or reduced-priced school meals, or enrollment in a school participating in the Community Eligibility Provision (CEP).

Do I need to do anything to receive 2020 - 2021 P-EBT benefits?



No. The CT Dept. of Social Services (DSS) and CT Dept. of Education (CSDE) use information provided by the students' schools to determine who is eligible for P-EBT. P-EBT benefits will be issued automatically.

What do I do if I do not have a P-EBT card?



If you currently receive SNAP or TFA benefits, P-EBT benefits will be added to your existing card. If you do not currently receive SNAP or TFA benefits, a P-EBT card will be mailed to your home. No benefits will be added to your original card sent in the summer of 2020. However, it is important you retain the card mailed to you in phase 1, as phase 2 benefits will be added to that same card.

Do my homeschooled child/children qualify for P-EBT food benefits?



Only Students who receive free, or reduced-price lunch at school are eligible for P-EBT food benefits. Households with homeschooled children do not usually receive free, or reduced-price school lunches, and therefore are not eligible for P-EBT food benefits.



For questions visit us online at <https://portal.ct.gov/p-ebt> or call DSS at 1-855-626-6632.

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WHEN WILL YOU GET YOUR BENEFITS?

You will receive two benefit deposits. The first deposit is already on this card. The second deposit will occur in late June/early July.

Deposit 1: Covers the months of September 2020 - January 2021.

Deposit 2: Covers the months of February 2021 - The end of the school year

SAVE THIS CARD, ALL P-EBT DEPOSITS WILL GO ON THIS CARD!

HOW MUCH WILL BE ON THE CARD?

The amount of benefits on your card depends on the learning model your child or children were in each month and can differ from child to child.

Monthly Benefits are broken into 3 categories based on attendance data and may change as the state reviews the learning models of students statewide:

Fully Remote: \$122.76
⇒ Students who attended school remotely for the entire month.

Mostly Remote: \$88.66
⇒ Students who attended school remotely for more than half the month, but not for the entire month.

Hybrid: \$34.10
⇒ Students who attended school remotely for up to half the month.

HOW TO ACCESS YOUR P-EBT SNAP BENEFITS

P-EBT SNAP benefits can be used at most corner or grocery stores, online at ALDI via Instacart, Amazon, ShopRite, and Walmart, as well as at many farmer's markets.

In fact, you can double the value of your P-EBT SNAP benefits at farmers' markets participating in CT Fresh Match!

Prior to shopping, look for the Quest Logo or another sign that states EBT or SNAP is accepted.

KNOW YOUR BALANCE BEFORE USING YOUR CARD

Save your receipt. It will show you information about your P-EBT SNAP transaction and your available balance.

There are no limits on the dollar amount or number of P-EBT SNAP transactions you can make each month. P-EBT usage is subject to account balance and availability of funds.

WHAT CAN YOU BUY?

Food like fruits and vegetables, dairy, breads and cereals, meats/poultry/fish, and even seeds and plants, which produce food for the household to eat.

To see more information about what foods you can and cannot buy with SNAP go to:
<http://www.cta.usda.gov/snap/eligible-food-items>

WHY ARE YOU RECEIVING THIS CARD?

You are receiving this P-EBT card because one or more children in your household are eligible for free or reduced-priced meals at their school(s).

You did not apply for these benefits. You automatically get these benefits because your child or children are learning remotely for all or part of the school year.

Benefits can be used to buy food anywhere SNAP/EBT benefits are accepted including online. The federal government approved these benefits to make sure children have food during the pandemic and to help your local economy.

Only your household may use the card to buy food. There are penalties if you let other people use your card or if you sell your card. After you buy the food, you may consume, share, or donate the food.

You do not have to participate. If you choose not to participate, you do not need to call and select a PIN number. Instead, please dispose of your card by cutting through the magnetic stripe and discard the card in a secure manner. The benefits will then be returned to the federal government.

HOW TO USE YOUR P-EBT (Pandemic Electronic Benefit Transfer) SNAP CONNECT CARD



All you have to do is select a PIN.

To do this, call: 1-888-328-2666

You will need:

- The 18-digit card number;
- The DOB of the person whose name is on the card; and
- **EITHER** the last four digits of the SSN for the parent/guardian whose name is on the card **OR** enter four zeroes (0000) in place of the SSN if the card is in your child's name

DO NOT WRITE YOUR PIN on the card and DO NOT let anyone know your PIN. You must protect the EBT card and PIN. Lost or stolen benefits will not be replaced.

To report a card as lost or stolen, you should immediately call 1-888-328-2666.

For questions, or if you need a new EBT card, contact the CT DSS Benefit Center at 1-855-626-6632.

For more information, please visit:
<https://portal.ct.gov/p-ebt>



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