

**Responses to Requests for Additional Information for Review at Human Services  
Subcommittee of Appropriations Work Session  
Department of Social Services  
March 6, 2023**

1. Redeterminations- Please provide a brief overview of how this will roll out over the next year. How many passive vs active redeterminations? How are we explaining the process to clients?

*DSS recently presented an [overview](#) of unwinding, including the projected volumes of passive vs active redeterminations as well as marketing and outreach efforts, at a joint informational forum of the Human Services and Insurance & Real Estate Committees. Access Health CT also presented at that forum and their [presentation](#) included additional information about our collaborative approaches to marketing and outreach related to the unwinding.*

*For specific data on the number of passive vs active redeterminations, see slides 6-7 in the DSS unwinding presentation, also included as an attachment. For information about communications with clients around unwinding, see slides 10-19 in the DSS presentation. A one-page summary of ongoing communications campaigns is also included as a separate attachment.*

2. Please provide a brief overview of HUSKY Health by eligibility group- caseload and PMPM for HUSKY A, C, D and B.

***Enrollment Data at end of January 2023***

*HUSKY A enrollment: 554,635*

*HUSKY B enrollment: 14,560 (average for QE 12/31/22)*

*HUSKY C enrollment: 79,869*

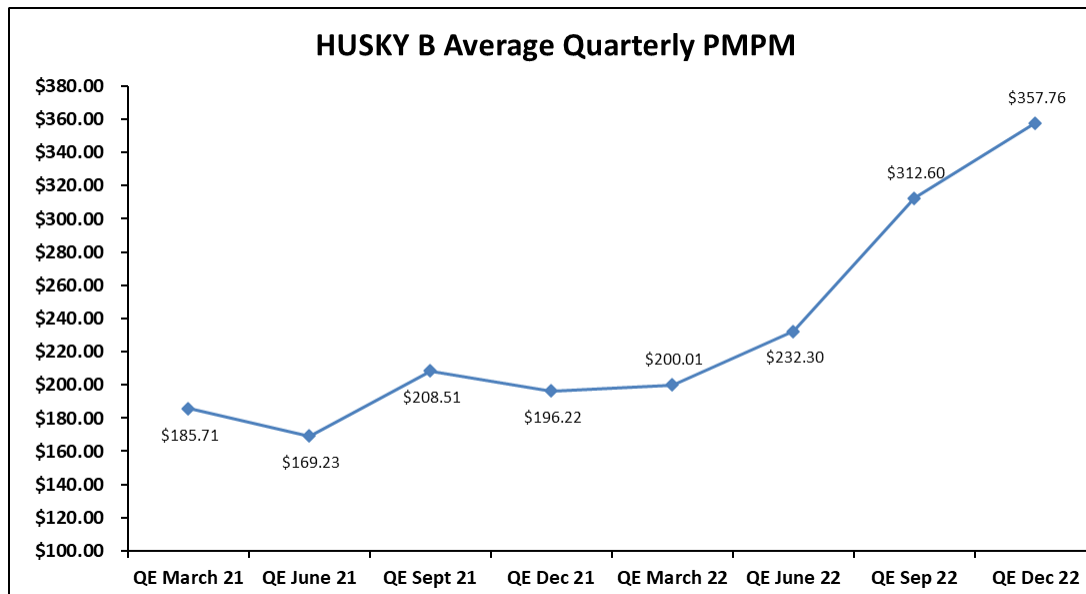
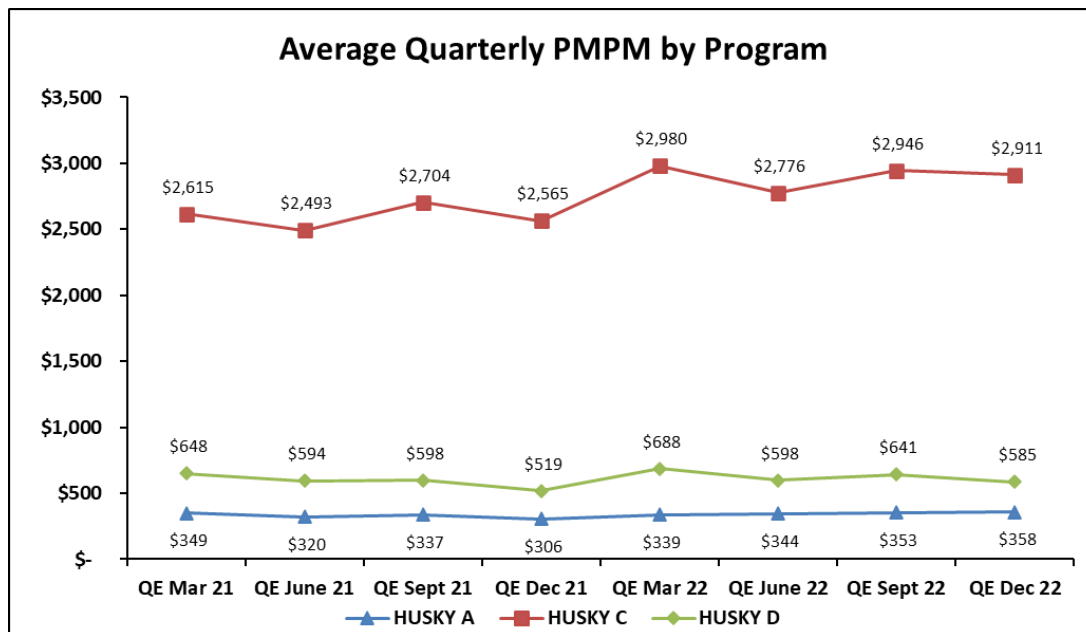
*HUSKY D enrollment: 361,815*

*Medicare Savings Program (MSP) enrollment: 202,301*

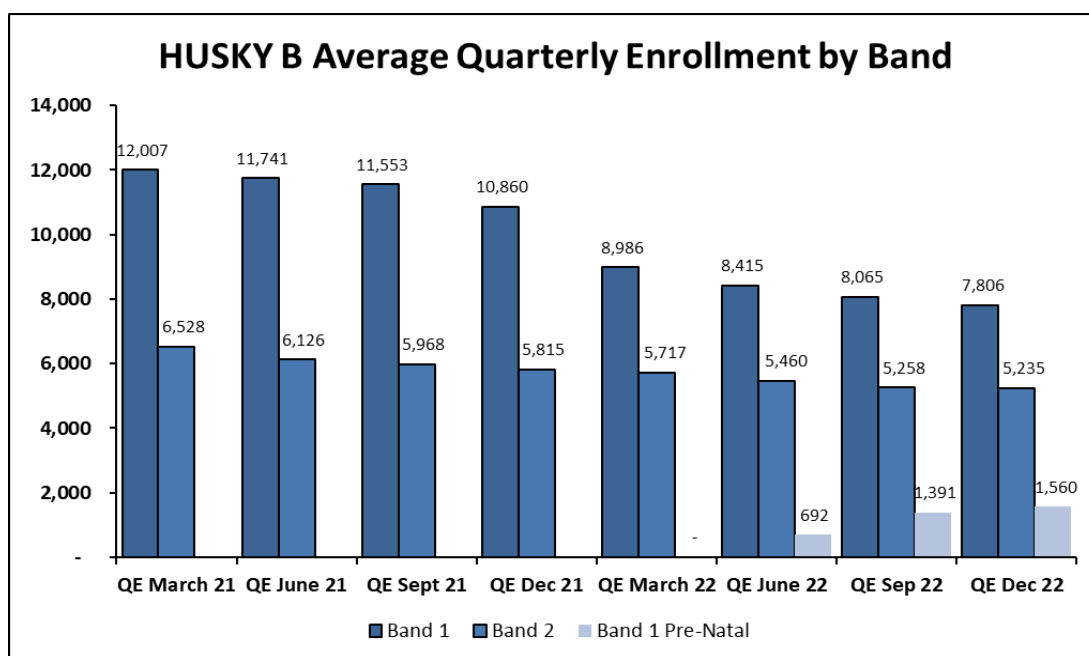
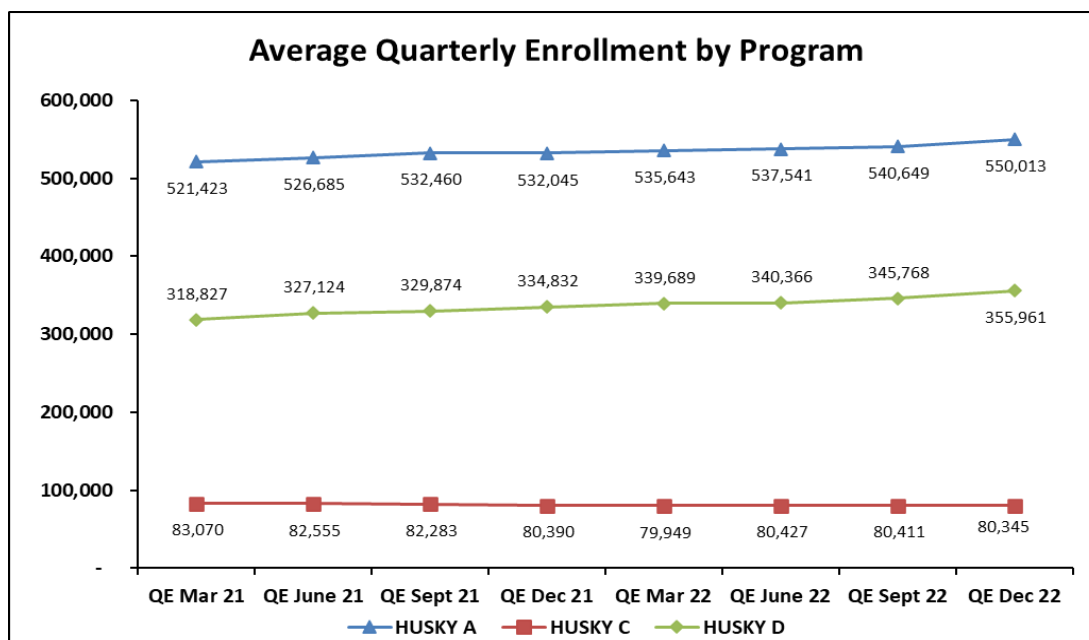
*\*Note that individuals can be enrolled in MSP and HUSKY simultaneously*

*General HUSKY Health eligibility information can be found on the DSS website here:  
<https://portal.ct.gov/HUSKY/How-to-Qualify>*

*Quarterly PMPM Data by HUSKY Program*



*\* The increase in HUSKY B PMPM is driven by enrollment in the new HUSKY B Prenatal Care coverage group for unborn children of non-citizen pregnant individuals that began in QE 6/30/22.*



*Please also find the attached HUSKY Enrollment Trends by Program for Calendar Years 2019-2022.*

- Is it possible to identify Medicaid rates that have/haven't changed in the past 5 years, 10 years, 20+ years?

*DSS currently lacks a systematic approach to assess rates across provider types on a consolidated or summarized document. As a managed fee-for-service state, Connecticut sets rates and fees for all its Medicaid providers. Often changes to the rates or fee schedules are reactive or situational in nature and rely upon appropriation or legislative changes enacted by the General Assembly, subject to stakeholder input and feedback received. The result is an uneven rate setting process that leads to*

*inequities between similarly situated providers and services. It is essential that DSS establish a framework for a more comprehensive and well-informed approach to provider rates and fee schedules.*

*The Governor's recommended budget allocates \$1.0 million in ARPA funding to enable DSS to contract with a vendor to undertake a comprehensive Medicaid rate study. The consultant will also develop recommendations on payment reform methodologies and assist with prioritizing rate setting policies that are likely to reduce future costs and improve member outcomes. This funding is essential to comprehensively study this issue. There are roughly 430 separate provider types in the Medicaid program. Collecting and studying the rates across each of those provider types is a massive undertaking. While we were not able to generate a complete list, we were able to pull together a high-level summary of rates for selected provider types. This analysis focuses on some of the providers that account for a large amount of HUSKY spending. The table does not cover all provider types and does not summarize all recent provider rate increases (for example, rate increases that went into effect in 2022 or 2023 for home health, behavioral health, chronic disease hospital vent beds, adult dental, substance use disorder outpatient, psychiatric residential treatment facilities, hospitals, and home-based services for children with behavioral health conditions).*

*Please see the table below, which includes a summary of some of the Department's rate increases between 2008 and 2022.*

Summary of Rate Adjustments									
----- Medicaid -----									
Fiscal Year	Nursing Homes	Hospitals - Inpatient	Hospitals - Outpatient	Specialists (Excl Obstetricians)	Primary Care Physicians	FQHCs	Home Health	Waiver Services	ICF/IID
2008	2.9%	37.0%	11.4%	To 57.5% of 2007 Medicare	12.3% (to 57.5% of 2007 Medicare)		3.0%	3.0%	2.9%
2009			2.75%						
2010						Per			
2011						Federal			
2012	3.7%					Requirements			6.835%
2013	0.33%				100% of 2013 Medicare	Indexed to MEI			2.0%
2014	0.273% Rate Reduction				100% of 2014 Medicare				1% Rate Reduction
2015							1.0%	1.0%	
2016	3.0%						15% Med Admin Reduction		
2017									
2018		31.7%	6.5%		Aug Reduced to 90% of 2014 Medicare Nov Adjusted to 95% of 2014 Medicare				
2019	2.0%						2.0%	2.0%	4.5%
2020	2.0% *	2.0%	2.0%				**	**	
2021	2.0%	2.0%	2.0%				**	**	
2022	4.5%	2.0%	2.0%				3.5% **	3.5% **	4.5%
Notes: Shaded items reflect adjustments associated with implementation of the user fee.									
Excludes temporary rate increases related to the COVID-19 pandemic.									
* Excluding impact of rebasing.									
** Adjusted for minimum wage increases for select waiver and home health services of 1.0% in FY 2020, 2.3% in FY 2021, and 6.0% in FY 2022									

4. Residential care homes- why is the state not moving forward with claiming for certain services under Medicaid as originally anticipated in the FY 22-23 biennial budget?

*The enacted budget had assumed DSS would be able to claim applicable RCH services under the Medicaid program and the appropriations for the State Supplement accounts were reduced based on the assumption that RCHs would be billing Medicaid for medical services rendered. The expectation was that the state would be able to leverage federal dollars for services that are already being provided under State Supplement but are not yet federally reimbursed. The enacted budget had assumed net savings of \$12.7 million in FY 2023 when this initiative was to be fully annualized. Of the additional federal reimbursement, 25% (\$4.2 million in FY 2023) was to be reinvested in RCHs, allowing them to make necessary investments, which could include capital improvements and/or increases to wages and*

*benefits to improve employee retention. After an extensive review by DSS, it was determined that, after factoring in applied income, this initiative would actually result in additional costs to the state and would have been very difficult for many homes to administer due to its complexity. In addition, the changes in the payment structure would have negatively impacted numerous residents who, ultimately, would have lost both their cash and medical assistance. (Individuals receiving State Supplement benefits are categorically eligible for Medicaid, meaning the loss of cash assistance under the State Supplement program can directly impact receipt of Medicaid.) ARPA funding of \$3.7 million in FY 2023 was allocated to RCHs to help support these homes as a “bridge” until the Medicaid billing would be in place. Recognizing the continued need for supports, the Governor’s budget includes \$5.2 million to rebase rates based on the 2022 cost reports, the most recently audited rate year. (Rates were last rebased in FY 2013 based on 2011 cost reports.) ARPA funding of \$5 million is also proposed to encourage grandfathered RCHs to comply with current health and safety codes (e.g., installing a generator, fire safety, etc.). Upgrading these older homes will not only help ensure the proper safety of residents, but it will also help ensure that these RCHs provide quality services, remain viable and can be sold to new owners when the time comes.*

*In addition, \$900,000 is added over the biennium to fund retroactive payments under the State Supplement program. The State Supplement and Medicaid programs function together to help individuals in RCHs and rated housing facilities (RHF), who generally have increased needs due to medical conditions that require assistance with their activities of daily living. In some instances, this assistance allows individuals to continue living in the community and avoid institutionalization. Currently, the State Supplement application process is initiated when an individual requests cash assistance on a DSS application, with the date the application is signed being the earliest possible date assistance may be provided. Similar to nursing home admissions, many individuals moving into an RCH or RHF do not have the opportunity to apply for assistance prior to the admission or at the time of admission – many admissions are unexpected or result from an emergency placement after a serious injury or hospitalization. In order to provide a safety net for these individuals in need and ensure that the RCHs and RHF serving this population are made whole, this proposal aligns State Supplement rules concerning the start date of assistance with the rules that apply for Medicaid beneficiaries in need of nursing home care. This change will allow individuals seeking coverage under the program to receive State Supplement benefits for up 90 days prior to the date of the application if otherwise eligible for the program. This will help stabilize payments for RCHs and RHF and will help impacted residents with the costs of care and room and board during that interim period*

- |                                                                                |                              |
|--------------------------------------------------------------------------------|------------------------------|
| • <b>Rebase Rates for Residential Care Homes</b>                               | <b>\$5.2 million</b>         |
| • <b>Invest in Capital Funding for RCHs Grandfathered Under Outdated Codes</b> | <b>\$5.0 million</b>         |
| • <b>Allow for Retroactive Payments Under the State Supplement Program</b>     | <b>\$383,800 / \$515,200</b> |

5. FQHCs- how are they funded? Are there alternative payment methodologies the state can consider?

*Federally Qualified Health Centers (FQHCs) are health centers that receive Public Health Service Act, Section 330 funds, and provide primary care services in underserved, urban and rural communities. FQHC is a federal designation from the U.S. Dept. of Health & Human Services, Health Resources & Services Administration (HRSA), Bureau of Primary Health Care, and the Centers for Medicare and Medicaid Services (CMS) that is assigned to private non-profit or public health care organizations that serve predominantly uninsured or medically underserved populations.*

*The primary purpose of FQHCs is to expand access to primary health care for uninsured and underserved populations, who experience financial, geographic, or cultural barriers to care and who live in or near federally designated health professional shortage areas and medically under-served areas.*

*What federal rules say about how FQHCs are paid?*

*Medicaid payment rules for FQHCs differ sharply from those for other providers because federal law sets forth a very specific prospective payment system (PPS) prescribing how FQHCs are to be paid for each encounter or visit. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (P.L. 106-554) ("BIPA") created the PPS for Medicaid FQHCs in all states and territories. Prior to the PPS established under BIPA, FQHCs were paid based on cost.*

*Pursuant to 42 USC § 1396a(bb), a state Medicaid agency may set rates in accordance with the PPS methodology or based on an alternative payment methodology (APM). Following the enactment of BIPA, DSS chose to follow the PPS rate methodology. In Fiscal Year 2001, PPS rates were set in accordance with the following:*

*Subject to paragraph (4), for services furnished on and after January 1, 2001, during fiscal year 2001, the State plan shall provide for payment for such services in an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services, or based on such other tests of reasonableness as the Secretary prescribes in regulations under section 1395l(a)(3) of this title, or, in the case of services to which such regulations do not apply, the same methodology used under section 1395l(a)(3) of this title, adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001. See 42 USC § 1396a (bb) (2).*

*The state and each FQHC may enter into an agreed APM and the APM must result in a payment that is at least equal to the Medicaid PPS rate. See 42 USC § 1396a (bb) (6). To date, no FQHC has sought an APM reimbursement methodology.*

*How we reimburse FQHCs?*

*Effective January 1, 2001, FQHC rates were set using the average of an FQHC's 1999 and 2000 costs and inflated annually thereafter using the Medicare Economic Index (MEI). DSS established baseline encounter rates for each FQHC in existence during fiscal years 1999 and 2000 using cost reports for those years and has increased the encounter rate each year by the MEI. See 42 USC § 1396a (bb) (2) & (3). For FQHCs established after 2000, DSS used the average rate for FQHCs within the same peer grouping.*

*Each FQHC has a specific encounter rate for every medical, dental, and behavioral health visit they provide. Federal law also provides that rates may only be adjusted based on an increase or decrease in the scope of services provided by an FQHC. See 42 USC § 1396a (bb)(3)(B). Rates are updated with the MEI annually on 10/1 and are posted to the DSS website: <https://portal.ct.gov/DSS/Health-And-Home-Care/Reimbursement-and-Certificate-of-Need/FQHC-Medicaid-Reimbursement/FQHC-Medicaid-Rates>.*

*How do we compare with other states?*

*All states are required to set rates in accordance with the federal regulations. Some states have entered into APMs. The state and each FQHC may enter into an agreed APM and the APM must result in a payment that is at least equal to the Medicaid PPS rate. See 42 USC § 1396a (bb) (6). As noted above, to date, no FQHC has sought an APM reimbursement methodology.*

6. Please explain CFC and how the program is expanded in the Governor's budget.

*Currently, under the Community First Choice (CFC) program, services must be self-directed with consumer-employers or their authorized representatives responsible for hiring, managing, and training personal care attendants, respite workers and companions of their choosing. Recognizing that this is difficult for many, the Governor is proposing to expand CFC to include an agency-based option for these services. This change supports consumer choice and increases access to long-term services and supports in the community while also leveraging enhanced federal reimbursement of 6% under CFC on agency-based services currently provided under DSS' home and community-based services waivers.*

*The Governor's budget assumes savings of \$12.3 million in FY 2024 due largely to the enhanced federal reimbursement, as well as modest savings from averting institutionalization. It is expected that costs will increase over time as additional individuals who are at nursing home level of care but are relying on informal supports for their care avail themselves of this new state plan coverage, but it is also likely that with the aging demographic, this expansion will result in additional cost avoidance due to less reliance on more expensive nursing home care.*

*Adding an agency-based service option provides Medicaid consumers with true choice in where, how, and by whom they receive their care and supports Connecticut's goal of rebalancing the state's long-term care system by reducing the number of consumers receiving services in – and Medicaid funding going towards – institutional care and increasing consumer access to long-term services and supports in the community. Unlike the self-directed model, the agency-based model provides supervision by a care manager to ensure quality of care and to monitor consumer conditions, potentially catching changes in health conditions and implementing interventions sooner, such as providing additional supports to help the individual remain safely at home. It could also result in the reduction in hospitalization or institutionalization due to informal caregiver burnout, inability to find a PCA, unstable back-up systems, sudden and unexpected loss of the informal caregiver(s), etc., as well as the potential reduction or avoidance of consumer mental and physical health decline attributed to the inability to secure and receive care at the appropriate level and quality. While these have not been factored into the model, they are illustrative of the gains that could be achieved under this proposal.*

7. Does DSS cover non-Hyde abortions for residents? Are these state-only funded? If so, what is the cost?

*Yes. HUSKY covers abortion services for people enrolled in the program. We do not determine Hyde eligibility for our members, so we cannot break this out by Hyde eligible versus non-Hyde eligible abortions. We do not receive federal match on this portion of the HUSKY program.*

8. Are Peer Support Recovery Coaches covered under Medicaid?

*Recovery coaches are part of a larger service delivery category called certified peers. Many certified peers, including recovery coaches, are state or grant funded through DMHAS. As part of the Substance Use Disorder (SUD) demonstration waiver approved by CMS in April of 2022, Medicaid reimburses for services provided by certified peers, inclusive of recovery coaches, within SUD residential treatment settings and some ambulatory settings. Additionally, peer support services are available to Medicaid members who receive supports under the Mental Health waiver.*



*DSS continues to work collaboratively with our sister state agencies, DMHAS and DCF, to explore additional opportunities to include individuals with lived experience as part of a treatment or support team for Medicaid members.*

9. Can you identify the number of clients dropped from HUSKY C and solely onto MSP, during the Trump administration? Do we have a sense of the cost for retroactive payments?

*As of February 1, 2023, DSS has taken steps to stop the Medicaid termination of any member currently on Medicaid who, prior to March 31, 2023, would no longer meet eligibility requirements for Medicaid but would otherwise be eligible for a Medicare Savings Program (MSP). DSS has also directed its IT contractors to engage in database report generation to identify any member terminated from Medicaid, but continued on MSP, as a result of agency compliance with HHS/CMS' November 6, 2020 Interim Final Rule. That database report configuration and member identification and verification is currently ongoing, with results and member identification anticipated to be completed in early March, though changes in CMS guidance could affect that timeline.*

*Once the members are appropriately identified and verified, reinstatement will be completed retroactively in accordance with CMS guidance, without, to the greatest extent possible, a requirement that individuals affirmatively request to re-enroll. The Department anticipates that costs related to this change in federal policy would include ongoing program enrollment/service provision and the administrative/system actions required to effectuate the change in policy. Costs related to eligibility retroactivity are unclear, as DSS is awaiting CMS guidance on the steps that need to be taken to reinstate retroactively and then will need to conduct a further investigation into the reinstated population.*

10. Covered CT- Please provide updated member data (PMPM, caseload, budget assumptions). What is the potential cost to expand coverage to 200% FPL?

*To date, individuals have been able to retain their Medicaid coverage due to the numerous extensions of the federal public health emergency. With those extensions, DSS was required to suspend most discontinuances under Medicaid. Pursuant to the federal Consolidated Appropriations Act, 2023, that continuous enrollment requirement ends on March 31, 2023. Thus, individuals who are no longer eligible for Medicaid could begin coming off Medicaid following a redetermination starting in April 2023, which is when we expect enrollment in Covered CT to start to increase at a more accelerated pace. By June 2025, consistent with earlier projections, the Department anticipates that nearly 40,000 individuals will be enrolled in the program.*

*This program receives substantial federal financial support, both through enhanced subsidies for individuals purchasing qualified health plans through the state-based marketplace, as well as from Medicaid through the 1115 waiver. These federal enhanced subsidies are currently authorized at the federal level until December 31, 2025, and federal financial participation through the 1115 waiver is authorized until December 31, 2027. State costs for the current program are anticipated to be \$20 million in SFY 2023 (based upon end of year enrollment of 19,700 enrollees), \$29.9 million in SFY 2024 (based upon end of year enrollment of 36,800 enrollees), and \$42.2 million in SFY 2025 (based upon end of year enrollment of 40,400 enrollees). Overall, approximately 50% of all funding for Covered CT comes from the federal government, with the remainder coming from the state. This percentage excludes the cost of the federal premium subsidies and reduced cost sharing currently available.*

*The estimated cost of the expansion of the program to 200% FPL is expected to be significant. Additional financial details will be provided as the Department finalizes its estimates related to the costs of the expansion of the program. Preliminary estimates of the incremental, annualized state share of the cost of expanding from 175% to 200% FPL could be in the range of \$30 to 40 million. This assumes the approval of the expansion and the availability of federal funds under a revised 1115 waiver, as well as the continuation of additional federal qualified health plan (QHP) cost sharing provisions. In addition to the programmatic and fiscal concerns, the overall costs that are not included in the Governor's budget and the uncertainty of federal funding to help subsidize any expansion, the Department notes that it would require substantial ongoing administrative resources to support this change, as well as start-up resources to implement related system changes.*

*Finally, the Department notes that the volume of operational, system and administrative work being performed to conduct the unwinding of the Medicaid continuous enrollment provisions and the implementation of the significant new eligibility expansions over the past year has stretched Department resources. To expand eligibility for the Covered CT program to 200% FPL, the Department would be required to divert key resources from the unwinding process and the implementation of other eligibility expansions, thereby jeopardizing the success of that important work.*

11. Can you identify DSS programs that affect birth outcomes and maternal and child health (ex. prenatal, postpartum)? What has participation looked like over the past 1-2 years in these programs?

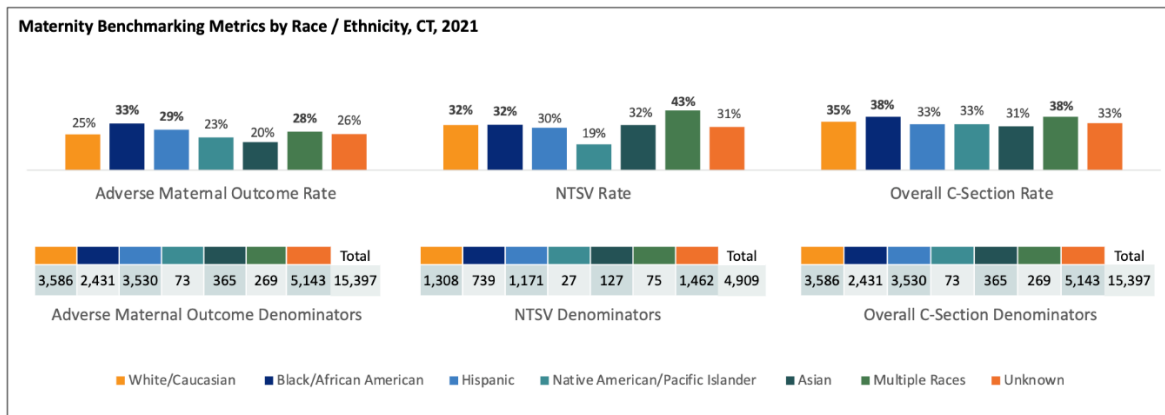
*There is a growing body of research that demonstrates that the economic, social, and emotional environment can impact birth outcomes and maternal and child health – if one took a very broad lens, every program at DSS can have some potential impact child and maternal health. While we welcome the opportunity to speak more about DSS' programs, for now we are focusing our response on recent reform efforts in HUSKY maternal health.*

*Covering over 40% of births in the state, DSS understands the vital importance of addressing and remedying disparities of access, utilization and outcomes for maternal health which will lead to improved children's health outcomes. Acknowledging ongoing maternal health equity gaps, the Department in collaboration with stakeholders is working to finalize the Medicaid Maternity Bundled Payment program, which has an emphasis on addressing health disparities for people of color. A bundled payment program combines payment for services provided during the maternity care experience (prenatal, labor and delivery, postpartum) into a single, episode-based payment. This is different from today's fee-for-service reimbursement which pays providers for each individual service. Bundled payments aim to align incentives for providers and encourage collaboration to improve the quality and coordination of care across care settings. The approach reduces silos in a member's care experience, creates efficiencies that lower unnecessary costs, and improves the quality of care a member receives throughout the episode, ultimately leading to better patient experiences and health outcomes.*

*With a key goal to close gaps in racial disparities in maternal health and birth outcomes, equity is at the center of DSS' work on developing the maternity bundle. DSS utilized a health equity framework to intentionally apply an equity lens at each stage of development for all design elements of the bundled payment program. After program launch, DSS will evaluate program success using six key programmatic outcome measures with an emphasis on addressing racial disparities: NICU Utilization, Neonatal Opioid Withdrawal Syndrome, Overall Neonatal Abstinence Syndrome, Adverse Maternal Outcome, NTSV (Low-Risk) C-Section, and Overall C-Section rate. 2021 outcomes for these measures*

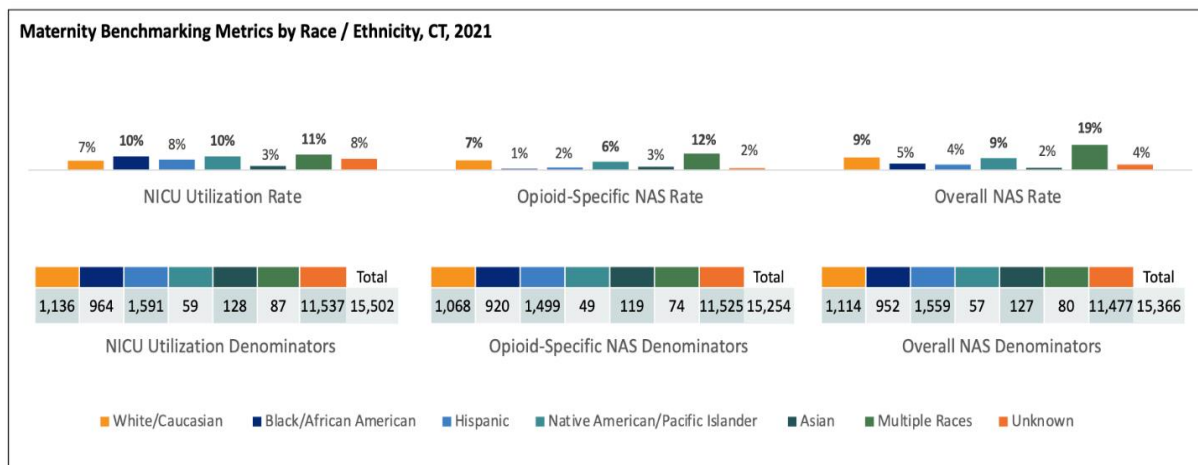
are inserted below, disaggregated by race and ethnicity. Through the bundled payment program, DSS will strive to cut racial disparities in half by 2027 and to eliminate them for each measure by 2032.

## 2021 Maternal Health Outcomes by Race & Ethnicity



**About the Metrics:** **Adverse Maternal Outcome** – Race based on mother’s member record. Current outcomes defined as Adverse Maternal Outcomes: Acute Myocardial Infarction, Cerebral Infarction, Disseminated Intravascular Coagulation, Eclampsia, HELLP Syndrome, Hemorrhage, Maternal Death within 1 year, Peripartum Cardiomyopathy, Placenta Accreta, Placenta Increta, Placenta Infarction, Placenta Percreta, Placenta Previa, Preeclampsia, Premature Separation of Placenta, Stillborn, Thrombosis Embolism. **NTSV** – Race based on mother’s member record. **Overall C-Section** – Race based on mother’s member record. Determined by match in the C-Section value set.

## 2021 Infant Health Outcomes by Race & Ethnicity



**About the Metrics:** **NICU** – Race based on baby’s member record. Defined by a stay under revenue codes 0174 or 0203 prior to baby turning 29 days old. **Opioid-Specific NAS** – Race based on baby’s member record. Determined by diagnosis code P96.1 on baby’s birth claim. **Overall NAS** – Race based on baby’s member record. Determined by presence of one of the following diagnosis codes on baby’s birth claim: P96.1, P04.42, P04.1A, P04.14, P04.40, P04.41, P04.81, P04.49, and P04.16.

The Department covers approximately 15,000 births a year in Connecticut, all of which would be eligible for participation under the maternity bundled payment program. For further information, the

*Department has presented details on the maternity bundle to MAPOC which can be found on the MAPOC website at the following links ([slide materials](#) and [video](#)).*

12. TFA- Please fully explain the proposed 6-month extensions and benefit reduction; Are we accounting for increases in min wage? Is it possible to transition from TFA to SAGA?

*TFA program participants are currently allowed to remain on TFA as long as their employment earnings do not exceed 100% of the federal poverty level (FPL). Thus, earned income up to 100% FPL is “disregarded” when determining eligibility for TFA benefits. Given the relatively high cost of living in Connecticut compared to national averages, increases in the state minimum wage, the amount of money required for a family to reach a living wage, as well as the typical career paths of in-demand jobs such as nursing, it is vital that program participants be incentivized and supported in their efforts to enter career paths that will lead their families out of poverty. This can be accomplished in part by allowing TFA participants to have basic financial support that endures during the critical early career years when education and training leave families with modest income. To encourage TFA participants to pursue and continue on career paths that lead to higher-paying jobs, the Governor is proposing to increase the earned income disregard and to do so in a manner that reduces benefit cliffs.*

*Under his proposal, families with income (1) at or below 100% FPL can remain on the program with no impact to their benefits; (2) above 100% FPL but at or below 170% FPL can remain on the program for six months with no impact to their benefits; and (3) above 170% FPL but at or below 230% FPL can remain on the program for six months with a 20% reduction in their benefit level. Increasing the earned income disregard from 100% FPL to 230% FPL (from \$30,000 to \$69,000 for a family of four) will allow families to remain on TFA longer while pursuing their careers.*

*Note: 170% FPL roughly correlates with a full-time minimum wage job for a family of two:*

Family Size	----- FPL -----		
	100%	170%	230%
2	\$19,720	\$33,524	\$45,356
3	24,860	42,262	57,178
4	30,000	51,000	69,000

### Background on SAGA

*The State-Administered General Assistance (SAGA) program is a cash assistance program operated by DSS. The program typically serves adults who are either permanently or temporarily unable to work due to a documented medical condition and whose income and assets are below program limits. Individuals who applied for and are waiting to receive Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) benefits from the Social Security Administration typically apply for SAGA while waiting for a decision. Those eligible for SAGA receive a small cash amount each month. Individuals cannot receive SAGA if they are eligible for any other state or federal cash assistance program.*

*What are the SAGA rules about being unable to work? To receive SAGA, a person must be either: unable to work for a short-term period (2-6 months); or unable to work, including unable to participate in education or training, for a long-term period (6 months or more). Individuals may also qualify as unemployable for certain specific, non-medical reasons which include: (1) being over age 55 with a*

*limited work history, (2) being over age 65, or (3) needed in the home to care for an incapacitated spouse or child. Those unable to work for a short-term period also need to have a recent connection to the labor force to qualify.*

*Under current program rules, the only type of individual that can transition from TFA to SAGA is an unmarried person between the ages of 18 and 21 who lived with a TFA family assistance unit and is no longer a member of such assistance unit due to attaining 18 years of age. These individuals are not required to meet the “unable to work” requirements generally used in the SAGA program.*

13. United Way- Can you identify necessary staffing and associated funding under the contract?

*DSS’ current contract with the United Way of Connecticut covers the period July 1, 2021 – June 30, 2023.*

*Payments in SFY 2022 totaled \$4,918,000 which supported the following services:*

*Core Information and Referral Services – 2-1-1 is a free and confidential health and human service contact center and website that provides individuals with information on and connects individuals to essential health and human services provided through federal and state agencies and nonprofit providers of health and human services. 2-1-1 operates twenty-four hours a day, seven days a week with staff that include bilingual contact specialists and resource specialists, fluent in both English and Spanish. Total payments to support these services for SFY 2022 were \$3,343,000.*

*Electronic Visit Verification (EVV) Support for Self-Directed Medicaid Programs – providing targeted outreach to homecare providers, offering direct assistance with utilizing the mandated EVV system which documents the precise time and type of care provided by homecare workers. The contract was amended to add these services effective September 1, 2021. For SFY 2022, the total payments issued for these services was \$1,325,000.*

*My Place CT Support – providing information and referrals associated with My Place CT, helping individuals learn about their options and helping them find long-term services and supports best suited to their needs and goals. For SFY 2022, the total payments issued for these services was \$250,000.*

*The core information and referral services, and My Place CT services will be renewed following the passage of the budget. The EVV supports will also be renewed for an additional term.*

14. Regional offices- Please provide office hours for all locations. Have any locations closed? Reduced hours? Regarding Wednesdays, what supports are necessary to resume the same level of service and access available other days of the week?

- *Office hours for all locations: 8 to 4:30*
- *Have any locations closed: No*
- *Reduced Hours: No, although office services are limited on Wednesdays to allow the staff more time to focus on processing online and mail-based work*
- *Re: Wednesdays operational hours:*
  - *The key steps to being able to provide full service through all service channels require advancement in several areas:*

- *Increasing operational capacity to complete a higher volume of work through a combination of hiring, training, and contracting for support services;*
- *Continuing the ongoing process of identifying operational efficiencies and automation to reduce the volume of client interactions; and*
- *Taking the required time to ensure that clients contacting the agency through online and mail channels receive service as rapidly as those who contact the agency by phone or in person.*
- *Among other actions, the agency is onboarding and training to fill vacancies at a rapid pace. Over 100 staff have been hired over the past several months and are currently in training, and the current target date to complete onboarding of the remaining 145 vacancies is June 30, 2023, followed by 3 months of in-class training and an additional 3-6 months of on-the-job training.*
- *DSS is also exploring options to expand capacity and triage incoming calls to allow for rapid resolution of those calls that are not required to be handled by skilled eligibility staff. By bifurcating the incoming calls, there is an opportunity to handle more calls quickly, thus reducing repeat call volume and providing superior customer service.*
- *As the Department adds operational capacity, it will also need to ensure that processing speeds for the online and mail channels are sufficiently current to allow staff to expand phone and in-person services. If the online and mail channels are not attended to quickly enough, clients contact the agency by phone or in person to follow up on online or mail submissions, leading to a circle of excess client contacts that reduce overall Departmental responsiveness. With increased capacity and reduced repetitive client interactions, the Department can maintain timeliness across all operational channels and expand the phone and in-person service channels to five days a week.*

15. Can you provide the number of DSS staff and number of clients served 20 years ago (or other reasonable point in time) vs today?

*It is extremely difficult to compare past staffing and work volumes to current staffing and work volumes because the way social services program eligibility work is done has changed dramatically over the past 20 years. The agency has made massive changes in automation, centralized services, online offerings, and business processes over this time. Just 10 years ago there was no online application option or meaningful internet presence, a decentralized network of local phone systems with limited voicemail, an entirely paper filing system, an old monochrome computer interface for workers, and no state-based marketplace. The Affordable Care Act had not been implemented, there were no real-time eligibility determinations and no passive renewal processes. Enrollment trends by program over time can be viewed through the CT Open Data portal (examples [here](#) and [here](#)), or on the [DSS website](#), but the enrollment data alone will not adequately identify the level of work that is required to support eligibility and enrollment in DSS programs given the extent of administrative changes over this same time period.*

*Current front line eligibility staffing count (Connecticut Careers Trainees, Eligibility Services Workers, Eligibility Services Specialists) = 788. Hiring rates were low prior to August 2022. Recruitment has been aggressive since August 2022 and is continuing.*



	<i>New Hires</i>	<i>Promotions (Supervisors &amp; Specialists)</i>	<i>Social Services Operations Managers</i>
<i>2020</i>	<i>0</i>	<i>2</i>	<i>0</i>
<i>2021</i>	<i>75</i>	<i>29</i>	<i>2</i>
<i>2022</i>	<i>198</i>	<i>104</i>	<i>7</i>
<i>2023</i>	<i>0</i>	<i>1</i>	<i>6</i>
<b>Total</b>	<b>273</b>	<b>136</b>	<b>15</b>

16. Proposed ARPA allocations:

- Who operates the mobile vans/clinics? What services do they provide?

*The Governor is proposing to provide capital grants to purchase or upgrade mobile vans for the free clinics operating in Connecticut that provide mobile health care. These clinics are operated through donations and are not allowed to accept any form of payment or government funding for services. Mobile vans will expand access to these free health services across the day, by allowing clinicians to go into underserved communities and provide free preventive care and other health services. Access to free clinics will be critical during the unwinding of the public health emergency when thousands will be redetermined for Medicaid eligibility and may lose coverage. Free clinics can also provide health services to undocumented individuals who don't qualify for HUSKY Health and are not eligible to enroll in a health plan on the exchange or access tax credits to help pay for coverage.*

- Can you provide further detail on the \$10 million for two months of premium assistance?

*To help minimize health disruptions, the Governor is proposing a one-time pool of funding to provide two months of premium payments for individuals with income between 175% FPL (\$25,515) and 200% FPL (\$29,160) who enroll in a benchmark silver plan (and thus qualify for maximum federal subsidies and out-of-pocket cost-share reduction). This will help smooth the unwinding of the public health emergency by providing coverage on the exchange for individuals with income above the Covered CT income threshold of 175% FPL. It will also strengthen the exchange by adding more covered lives, potentially attracting additional carriers and competitive rates. This proposal is based on Rhode Island's successful model that found that many retain the coverage after the two-month period having learned that, with the federal subsidies available under the benchmark silver plan, quality health care coverage is surprisingly affordable.*

- Re: \$10 million to Community Action Agencies, what do client support funds support?

*Funding is provided to the community action agency network to distribute flexible client support funds that will assist vulnerable and at-risk populations facing immediate economic hardship with basic income assistance and emergency aid. Distributions under the current \$5 million ARPA allocation are being prioritized and limited in a manner which allows for availability of these funds – under a reduced scope of supports – through FY 2024. With the additional \$10 million proposed*

*by the Governor, the community action agency network will be able to support the level of services comparable to that provided during the pandemic, as those needs have not subsided in the post-pandemic period. Such aid may include:*

- *Food programs – provision of food vouchers; food boxes through a food pantry or bags of groceries; or nutritious home-delivered meals*
- *Rent, mortgage, and utility aid – security deposits, short-term rental, or mortgage assistance (up to two months); mid-term rental or mortgage assistance (three to twelve months); and current utility bills*
- *Internet access programs – assistance with current internet bill or arrearage*
- *Eviction prevention – assistance with housing and utility arrearages*
- *Job training assistance – support for sectoral job-training, subsidized employment, employment supports or incentives*
- *Other economic supports – purchase of PPE or COVID-19 home tests, car repairs or insurance necessary to ensure transportation to employment or medical appointments; emergency hygiene services; public transportation costs; minor home repairs; unreimbursed insurance costs; property liens; moving expenses for relocation due to loss of income; and temporary storage costs.*

17. Extension of the TFA 21-month time limit to 60 months.

*The Department is currently reviewing and drafting an estimate of the impact of changes to the 21-month time limit and will share them once completed.*



## Supplemental Request for the Subcommittee Work Sessions

### Headcount questions:

1. What is the authorized headcount, the funded headcount and the filled headcount for your area?

***Filled General Fund Positions = 1,656 (includes 53 positions targeted for DAS BITS)***

***Approved General Fund Vacant Positions = 254 (includes 22 positions targeted for DAS BITS)***

***Total Authorized Position Count = 1,910***

***Total Funded Position Count = 1,776***

2. If there is change in headcount (either up or down) please provide an explanation of the change.

- a. *If there is a positive change in headcount, please explain why these positions are needed*

*The Governor's recommended budget does include changes to the position count. The budget recommends shifting 75 positions to DAS BITS but leaving the funding for these positions within DSS. This will allow for DSS to continue to claim for federal match on these positions but reduces the authorized position count by 75. Additionally, to enhance quality assurance efforts, the Governor's recommended budget includes funding for an additional 27 positions. Please see the table below showing the net impact of these adjustments.*

Total Current Position Count	1,910
Transfer of Positions (not funding) to DAS BITS	(75)
Add Positions to Support Enhanced QA Efforts	27
Recommended Position Count	1,862

- b. If these adds are legislatively driven, what piece of legislation is driving the increase?

*Please see response to a. above.*

3. Are there any vacant positions in your headcount?

- a. If yes, how are they budgeted into your plan? (as a full year FTE or partial? Are they fulltime or part time?)

*The Governor's recommended budget includes 1,862 authorized positions. DSS estimates that the funding provided will support an average of 1,776 filled positions during each of the 26 pay periods. This amount includes the positions that will be transferred to DAS BITS. After consideration of normal position turnover, we believe the recommended funding would support the majority of our vacancies.*

- b. What is the anticipated start date of your vacancies? Are they staggered throughout the year, or all anticipated to start on July 1?

*Vacancies would be staggered.*

4. How many vacancies did you have at year end on 06/30?

*There were approximately 352 General Fund vacancies as of 6/30/22.*

- a. How many vacancies did you have throughout the year last fiscal year?

*This data will take additional time to complete. We will follow up with this information.*

- b. How many new hires did you have in the same time period?

*DSS had 151 hires and 146 promotions during FY 2022 for a total of 297 positions filled.*

5. What is the average cost of an FTE for your area?

*The average cost for a full-time equivalent position at DSS is approximately \$2,980 per pay period, or \$77,480 annually (based on 26 pay periods).*

6. What is the average fringe cost of an FTE in the comptroller's area?

*Fringe benefits costs are based on the retirement plan in which each employee is enrolled. Average rates, as a percentage of payroll, for FY 2023 are as follows:*

	Retirement Plans				
	SERS Reg	SERS HD	ARP	Judges	TRS
SERS Regular	67.40%	n/a	n/a	n/a	n/a
SERS HD	n/a	91.49%	n/a	n/a	n/a
ARP	n/a	n/a	14.60%	n/a	n/a
Judges	n/a	n/a	n/a	111.34%	n/a
TRS	n/a	n/a	n/a	n/a	38.89%
Unemployment Comp	0.18%	0.18%	0.18%	0.18%	0.18%
Group Life	0.23%	0.23%	0.23%	0.23%	0.23%
Social Security FICA	6.20%	6.20%	6.20%	6.20%	6.20%
Social Security					
Medicare	1.45%	1.45%	1.45%	1.45%	1.45%
Active Health	<u>22.00%</u>	<u>22.00%</u>	<u>22.00%</u>	<u>22.00%</u>	<u>22.00%</u>
<b>TOTAL FRINGE RATE</b>	<b>97.46%</b>	<b>121.55%</b>	<b>44.66%</b>	<b>141.40%</b>	<b>68.95%</b>

Lapse Questions:

1. Were there any lapsing accounts on 06/30?
  - a. If yes, what were the accounts?
  - b. If yes, what was the lapse balance?
  - c. If yes, what drove the lapse? What spending didn't occur that was planned to occur?

*Please refer to the Office of the State Comptroller's Budgetary/Statutory Basis (GAAP Based Budgeting) Annual Report: [Budgetar 2022.pdf \(ct.gov\)](#). Exhibit B-3 shows, in the right-hand column, FY 2022 appropriations that were continued to FY 2023 for the General Fund.*

2. If there is a lapsing balance, do you anticipate it carrying forward?
  - a. If yes, how do you propose to use that lapse?
  - b. Will it be for one-time expenses?
    - i. If so, what are those one-time expenses?
  - c. If ongoing expense is that expense built into this budget in FY 25?

*The Governor's proposed FY 2024-2025 budget does not rely on any carryforwards of FY 2023 appropriations to fund ongoing operations, with the exception of OPM's Reserve for Salary Adjustment account.*

## ARPA

1. Did you receive any ARPA funding in your department?
  - a. If yes, have you assumed the programs/staffing established with the ARPA funding is now in your General Fund budget as an ongoing expense?
    - i. If not all, how much?
  - b. Are there still ARPA funds included in this budget?
    - i. If yes, how much of this budget is continuation of ARPA funding?
    - ii. How much ARPA do you still have in the budget that may need to be picked up as ongoing expenses in out years?

*Many of the ARPA funded projects will need to be evaluated further to determine ongoing funding needs. Support for these projects will need to be addressed by the Governor and Legislature as part of a future budget.*

## General Questions:

1. Is there anything you would change about this budget?
2. Is there anything you would add to this budget?
3. Is there anything you would remove from this budget?
4. Is there any legislation that was passed you feel you are not adequately prepared to enforce?
  - a. If so, what would we need to change to make it administer-able?

*The agency fully supports the Governor's recommended budget as presented to the legislature. Many of the recommended changes will provide significant additional supports to those receiving our services, while continuing to maintain a strong safety net for those most in need of the array of supports we provide.*