



Senate

General Assembly

File No. 345

January Session, 2007

Substitute Senate Bill No. 3

Senate, April 5, 2007

The Committee on Human Services reported through SEN. HARRIS of the 5th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING INCREASED ACCESS TO HEALTH CARE THROUGH THE HUSKY PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 17b-261 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective July 1, 2007*):

3 (a) Medical assistance shall be provided for any otherwise eligible
4 person whose income, including any available support from legally
5 liable relatives and the income of the person's spouse or dependent
6 child, is not more than one hundred forty-three per cent, pending
7 approval of a federal waiver applied for pursuant to subsection (d) of
8 this section, of the benefit amount paid to a person with no income
9 under the temporary family assistance program in the appropriate
10 region of residence and if such person is an institutionalized
11 individual as defined in Section 1917(c) of the Social Security Act, 42
12 USC 1396p(c), and has not made an assignment or transfer or other
13 disposition of property for less than fair market value for the purpose
14 of establishing eligibility for benefits or assistance under this section.

15 Any such disposition shall be treated in accordance with Section
16 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of
17 property made on behalf of an applicant or recipient or the spouse of
18 an applicant or recipient by a guardian, conservator, person
19 authorized to make such disposition pursuant to a power of attorney
20 or other person so authorized by law shall be attributed to such
21 applicant, recipient or spouse. A disposition of property ordered by a
22 court shall be evaluated in accordance with the standards applied to
23 any other such disposition for the purpose of determining eligibility.
24 The commissioner shall establish the standards for eligibility for
25 medical assistance at one hundred forty-three per cent of the benefit
26 amount paid to a family unit of equal size with no income under the
27 temporary family assistance program in the appropriate region of
28 residence, [pending federal approval, except that the] Except as
29 provided in section 17b-277, as amended by this act, the medical
30 assistance program shall provide coverage to persons under the age of
31 nineteen [up to one hundred eighty-five per cent of the federal poverty
32 level without an asset limit. Said medical assistance program shall also
33 provide coverage to persons under the age of nineteen] and their
34 parents and needy caretaker relatives, who qualify for coverage under
35 Section 1931 of the Social Security Act, with family income up to one
36 hundred [fifty] eighty-five per cent of the federal poverty level without
37 an asset limit. [upon the request of such a person or upon a
38 redetermination of eligibility.] Such levels shall be based on the
39 regional differences in such benefit amount, if applicable, unless such
40 levels based on regional differences are not in conformance with
41 federal law. Any income in excess of the applicable amounts shall be
42 applied as may be required by said federal law, and assistance shall be
43 granted for the balance of the cost of authorized medical assistance. All
44 contracts entered into on and after July 1, 1997, pursuant to this section
45 shall include provisions for collaboration of managed care
46 organizations with the Nurturing Families Network established
47 pursuant to section 17a-56. The Commissioner of Social Services shall
48 provide applicants for assistance under this section, at the time of
49 application, with a written statement advising them of (1) the effect of

50 an assignment or transfer or other disposition of property on eligibility
51 for benefits or assistance, (2) the effect that having income that exceeds
52 the limits prescribed in this subsection will have with respect to
53 program eligibility, (3) the availability of HUSKY Plan, Part B health
54 insurance benefits for persons who are not eligible for assistance
55 pursuant to this subsection or who are subsequently determined
56 ineligible for assistance pursuant to this subsection, and [(2)] (4) the
57 availability of, and eligibility for, services provided by the Nurturing
58 Families Network established pursuant to section 17a-56.

59 (b) For the purposes of the Medicaid program, the Commissioner of
60 Social Services shall consider parental income and resources as
61 available to a child under eighteen years of age who is living with his
62 or her parents and is blind or disabled for purposes of the Medicaid
63 program, or to any other child under twenty-one years of age who is
64 living with his or her parents.

65 (c) For the purposes of determining eligibility for the Medicaid
66 program, an available asset is one that is actually available to the
67 applicant or one that the applicant has the legal right, authority or
68 power to obtain or to have applied for the applicant's general or
69 medical support. If the terms of a trust provide for the support of an
70 applicant, the refusal of a trustee to make a distribution from the trust
71 does not render the trust an unavailable asset. Notwithstanding the
72 provisions of this subsection, the availability of funds in a trust or
73 similar instrument funded in whole or in part by the applicant or the
74 applicant's spouse shall be determined pursuant to the Omnibus
75 Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of
76 this subsection shall not apply to special needs trust, as defined in 42
77 USC 1396p(d)(4)(A).

78 (d) The transfer of an asset in exchange for other valuable
79 consideration shall be allowable to the extent the value of the other
80 valuable consideration is equal to or greater than the value of the asset
81 transferred.

82 (e) The Commissioner of Social Services shall seek a waiver from

83 federal law to permit federal financial participation for Medicaid
84 expenditures for families with incomes of one hundred forty-three per
85 cent of the temporary family assistance program payment standard.

86 (f) To the extent permitted by federal law, Medicaid eligibility shall
87 be extended for one year to a family that becomes ineligible for
88 medical assistance under Section 1931 of the Social Security Act due to
89 income from employment by one of its members who is a caretaker
90 relative or due to receipt of child support income. A family receiving
91 extended benefits on July 1, 2005, shall receive the balance of such
92 extended benefits, provided no such family shall receive more than
93 twelve additional months of such benefits.

94 (g) An institutionalized spouse applying for Medicaid and having a
95 spouse living in the community shall be required, to the maximum
96 extent permitted by law, to divert income to such community spouse
97 in order to raise the community spouse's income to the level of the
98 minimum monthly needs allowance, as described in Section 1924 of
99 the Social Security Act. Such diversion of income shall occur before the
100 community spouse is allowed to retain assets in excess of the
101 community spouse protected amount described in Section 1924 of the
102 Social Security Act. The Commissioner of Social Services, pursuant to
103 section 17b-10, may implement the provisions of this subsection while
104 in the process of adopting regulations, provided the commissioner
105 prints notice of intent to adopt the regulations in the Connecticut Law
106 Journal within twenty days of adopting such policy. Such policy shall
107 be valid until the time final regulations are effective.

108 [(h) The Commissioner of Social Services shall, to the extent
109 permitted by federal law, or, pursuant to an approved waiver of
110 federal law submitted by the commissioner, in accordance with the
111 provisions of section 17b-8, impose the following cost-sharing
112 requirements under the HUSKY Plan, on all parent and needy
113 caretaker relatives with incomes exceeding one hundred per cent of the
114 federal poverty level: (1) A twenty-five-dollar premium per month per
115 parent or needy caretaker relative; and (2) a copayment of one dollar

116 per visit for outpatient medical services delivered by an enrolled
117 Medicaid or HUSKY Plan provider. The commissioner may implement
118 policies and procedures necessary to administer the provisions of this
119 subsection while in the process of adopting such policies and
120 procedures as regulations, provided the commissioner publishes notice
121 of the intent to adopt regulations in the Connecticut Law Journal not
122 later than twenty days after implementation. Policies and procedures
123 implemented pursuant to this subsection shall be valid until the time
124 final regulations are adopted.]

125 [(i)] (h) Medical assistance shall be provided, in accordance with the
126 provisions of subsection (e) of section 17a-6, to any child under the
127 supervision of the Commissioner of Children and Families who is not
128 receiving Medicaid benefits, has not yet qualified for Medicaid benefits
129 or is otherwise ineligible for such benefits because of institutional
130 status. To the extent practicable, the Commissioner of Children and
131 Families shall apply for, or assist such child in qualifying for, the
132 Medicaid program.

133 [(j)] (i) The Commissioner of Social Services shall provide Early and
134 Periodic Screening, Diagnostic and Treatment program services, as
135 required and defined as of December 31, 2005, by 42 USC 1396a(a)(43),
136 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal
137 regulations, to all persons who are under the age of twenty-one and
138 otherwise eligible for medical assistance under this section.

139 (j) Notwithstanding the provisions of this section, the Commissioner
140 of Social Services, pursuant to 42 USC 1396a (r)(2), shall file an
141 amendment to the Medicaid state plan that allows the commissioner,
142 when making Medicaid income eligibility determinations, to establish
143 and maintain the level of eligibility for persons who are aged, blind or
144 disabled at the same income level used to determine eligibility for
145 parents and needy caretaker relatives under the HUSKY Plan, Part A,
146 by establishing a special income disregard that is applicable only to
147 aged, blind or disabled individuals and only under the Medicaid
148 program.

149 Sec. 2. Section 17b-297 of the general statutes is repealed and the
150 following is substituted in lieu thereof (*Effective July 1, 2007*):

151 (a) The [commissioner] Commissioner of Social Services, in
152 consultation with the Children's Health Council, the Medicaid
153 Managed Care Council and the 2-1-1 Infoline [of Connecticut]
154 program, shall develop mechanisms [for outreach for] to increase
155 outreach and maximize enrollment of eligible children and adults in
156 the HUSKY Plan, Part A [and] or Part B. [, including, but not limited
157 to, development of mail-in applications and appropriate outreach
158 materials through the Department of Revenue Services, the Labor
159 Department, the Department of Social Services, the Department of
160 Public Health, the Department of Children and Families and the Office
161 of Protection and Advocacy for Persons with Disabilities.] Such
162 mechanisms shall include, but not be limited to, the development and
163 implementation of a mail-in and on-line application systems. In
164 addition, the Commissioner of Social Services shall develop
165 appropriate outreach materials and in collaboration with the
166 Departments of Public Health, Children and Families, Mental Health
167 and Addiction Services, Mental Retardation, Education, Revenue
168 Services and Motor Vehicles, the Labor Department and the Office of
169 Protection and Advocacy for Persons with Disabilities and, as
170 appropriate, disseminate such outreach materials. All outreach
171 materials shall be approved by the commissioner pursuant to Subtitle J
172 of Public Law 105-33.

173 [(b) The commissioner shall include in such outreach efforts
174 information on the Medicaid program for the purpose of maximizing
175 enrollment of eligible children and the use of federal funds.]

176 [(c)] (b) The commissioner shall, within available appropriations,
177 contract with severe need schools and community-based organizations
178 for purposes of public education, outreach and recruitment of eligible
179 children and adults, including the distribution of applications and
180 information regarding enrollment in the HUSKY Plan, Part A and Part
181 B. In awarding such contracts, the commissioner shall consider the

182 marketing, outreach and recruitment efforts of organizations. For the
183 purposes of this subsection, (1) "community-based organizations" shall
184 include, but not be limited to, day care centers, schools, school-based
185 health clinics, community-based diagnostic and treatment centers and
186 hospitals, and (2) "severe need school" means a school in which forty
187 per cent or more of the lunches served are served to students who are
188 eligible for free or reduced price lunches.

189 [(d) All outreach materials shall be approved by the commissioner
190 pursuant to Subtitle J of Public Law 105-33.]

191 [(e)] (c) Not later than January 1, [1999] 2008, and annually
192 thereafter, the commissioner shall [submit a] report, in accordance
193 with section 11-4a, to the Governor and the joint standing committees
194 of the General Assembly having cognizance of matters relating to
195 human services, public health and appropriations and the budgets of
196 state agencies on the implementation of and the results of the
197 [community-based outreach program] outreach efforts specified in
198 subsections (a) [to (c), inclusive,] and (b) of this section.

199 Sec. 3. Section 17b-297b of the general statutes is repealed and the
200 following is substituted in lieu thereof (*Effective July 1, 2007*):

201 (a) Each local or regional board of education or similar body
202 governing a nonpublic school or schools shall, at the beginning of each
203 school year, provide to the parent or guardian of any pupil attending
204 such school outreach materials concerning eligibility for health
205 insurance coverage under the HUSKY Plan, Part A or Part B. Such
206 outreach materials shall be developed by the Department of Social
207 Services in accordance with the provisions of section 17b-297, as
208 amended by this act, and disseminated by the department to schools.

209 [(a)] (b) To the extent permitted by federal law, the Commissioners
210 of Social Services and Education shall jointly establish procedures for
211 the sharing of information contained in applications for free and
212 reduced price meals under the National School Lunch Program for the
213 purpose of determining whether children participating in said

214 program are eligible for coverage under the HUSKY Plan, Part A and
215 Part B. The Commissioner of Social Services shall take all actions
216 necessary to ensure that children identified as eligible for the HUSKY
217 Plan are able to enroll in said plan.

218 [(b)] (c) The Commissioner of Education shall establish procedures
219 whereby an individual may apply for the HUSKY Plan, Part A or Part
220 B, at the same time such individual applies for the National School
221 Lunch Program.

222 Sec. 4. (NEW) (*Effective July 1, 2007*) (a) The Department of Social
223 Services, in consultation with the Department of Public Health, shall
224 establish a joint program between public and private entities for the
225 establishment and implementation of a multiyear, state-wide public
226 information campaign for the purpose of promoting enrollment in the
227 HUSKY Plan, Parts A and B of all persons who may be eligible for such
228 health insurance benefits.

229 (b) Notwithstanding the provisions of sections 4-212 to 4-219,
230 inclusive, of the general statutes the Department of Social Services, in
231 consultation with the Department of Public Health, shall solicit bids
232 from private organizations for the design and operation of said media
233 campaign. Such bids shall be solicited by sending notice to prospective
234 organizations and by posting notice on public bulletin boards within
235 said departments. Each bid shall be opened publicly at the time stated
236 in the notice soliciting such bid. Acceptance of a bid by said
237 departments shall be based on standard specifications adopted by said
238 departments. The Department of Social Services may accept gifts,
239 donations, bequests, grants or funds from public or private agencies
240 for any or all of the purposes of this section.

241 (c) On January 1, 2008, and annually thereafter, the Commissioner
242 of Social Services shall report, in accordance with section 11-4a of the
243 general statutes, to the joint standing committees of the General
244 Assembly having cognizance of matters relating to human services,
245 public health and appropriations and the budgets of state agencies on
246 the status of the program established pursuant to this section.

247 Sec. 5. Section 17b-289 of the general statutes is repealed and the
248 following is substituted in lieu thereof (*Effective July 1, 2007*):

249 (a) Sections 17b-289 to 17b-303, inclusive, and section 16 of public
250 act 97-1 of the October 29 special session* shall be known as the
251 "HUSKY and HUSKY Plus Act".

252 (b) Children, caretaker relatives and pregnant women receiving
253 assistance under section 17b-261 or 17b-277 shall be participants in the
254 HUSKY Plan, Part A and children receiving assistance under sections
255 17b-289 to 17b-303, inclusive, and section 16 of public act 97-1 of the
256 October 29 special session* shall be participants in the HUSKY Plan,
257 Part B. For purposes of marketing and outreach and enrollment of
258 persons eligible for assistance, both parts shall be known as the
259 HUSKY Plan.

260 Sec. 6. Section 17b-292 of the general statutes is repealed and the
261 following is substituted in lieu thereof (*Effective July 1, 2007*):

262 (a) A child who resides in a household with a family income which
263 exceeds one hundred eighty-five per cent of the federal poverty level
264 and does not exceed three hundred per cent of the federal poverty
265 level may be eligible for subsidized benefits under the HUSKY Plan,
266 Part B.

267 (b) A child who resides in a household with a family income over
268 three hundred per cent of the federal poverty level may be eligible for
269 unsubsidized benefits under the HUSKY Plan, Part B.

270 (c) Whenever a court or family support magistrate orders a
271 noncustodial parent to provide health insurance for a child, such
272 parent may provide for coverage under the HUSKY Plan, Part B.

273 (d) A child who has been determined to be eligible for benefits
274 under either the HUSKY Plan, Part A or Part B shall remain eligible for
275 such plan for a period of twelve months from such child's
276 determination of eligibility unless the child attains the age of nineteen
277 or is no longer a resident of the state. An adult who has been

278 determined to be eligible for benefits under the HUSKY Plan, Part A
279 shall remain eligible for such plan for a period of twelve months from
280 such adult's determination of eligibility unless the adult is no longer a
281 resident of the state. During the twelve-month period following the
282 date that an adult or child is determined eligible for the HUSKY Plan,
283 Part A or Part B, the adult or family of such child shall comply with
284 federal requirements concerning the reporting of information to the
285 department, including, but not limited to, change of address
286 information.

287 [(d)] (e) To the extent allowed under federal law, the commissioner
288 shall not pay for services or durable medical equipment under the
289 HUSKY Plan, Part B if the enrollee has other insurance coverage for
290 the services or such equipment.

291 [(e)] (f) A newborn child who otherwise meets the eligibility criteria
292 for the HUSKY Plan, Part B shall be eligible for benefits retroactive to
293 his date of birth, provided an application is filed on behalf of the child
294 within thirty days of such date.

295 [(f)] (g) The commissioner shall implement presumptive eligibility
296 for children applying for Medicaid. Such presumptive eligibility
297 determinations shall be in accordance with applicable federal law and
298 regulations. The commissioner shall adopt regulations, in accordance
299 with chapter 54, to establish standards and procedures for the
300 designation of organizations as qualified entities to grant presumptive
301 eligibility. Qualified entities shall ensure that, at the time a
302 presumptive eligibility determination is made, a completed application
303 for Medicaid is submitted to the department for a full eligibility
304 determination. In establishing such standards and procedures, the
305 commissioner shall ensure the representation of state-wide and local
306 organizations that provide services to children of all ages in each
307 region of the state.

308 [(g)] (h) The commissioner shall enter into a contract with an entity
309 to be a single point of entry servicer for applicants and enrollees under
310 the HUSKY Plan, Part A and Part B. [The servicer] The commissioner,

311 in consultation with the servicer, shall establish a centralized unit that
312 is responsible for processing all applications for assistance under the
313 HUSKY Plan, Part A and Part B. The department, through its contract
314 with the servicer, shall ensure that a child who is determined to be
315 eligible for benefits under the HUSKY Plan, Part A, or the HUSKY
316 Plan, Part B has uninterrupted health insurance coverage for as long as
317 the parent or guardian elects to enroll or re-enroll such child in the
318 HUSKY Plan, Part A or Part B. The commissioner, in consultation with
319 the servicer, and in accordance with the provisions of section 17b-297,
320 as amended by this act, shall jointly market both Part A and Part B
321 together as the HUSKY Plan [Such servicer] and shall develop and
322 implement public information and outreach activities with community
323 programs. Such servicer shall electronically transmit data with respect
324 to enrollment and disenrollment in the HUSKY Plan, Part A and Part B
325 to the commissioner.

326 [(h)] (i) Upon the expiration of any contractual provisions entered
327 into pursuant to subsection [(g)] (h) of this section, the commissioner
328 shall develop a new contract for single point of entry services and
329 managed care enrollment brokerage services. The commissioner may
330 enter into one or more contractual arrangements for such services for a
331 contract period not to exceed seven years. Such contracts shall include
332 performance measures, including, but not limited to, specified time
333 limits for the processing of applications, parameters setting forth the
334 requirements for a completed and reviewable application and the
335 percentage of applications forwarded to the department in a complete
336 and timely fashion. Such contracts shall also include a process for
337 identifying and correcting noncompliance with established
338 performance measures, including sanctions applicable for instances of
339 continued noncompliance with performance measures.

340 [(i)] (j) The single point of entry servicer shall send [an application]
341 all applications and supporting documents to the commissioner for
342 determination of eligibility. [of a child who resides in a household with
343 a family income of one hundred eighty-five per cent or less of the
344 federal poverty level.] The servicer shall enroll eligible beneficiaries in

345 the applicant's choice of managed care plan. Upon enrollment in a
346 managed care plan, an eligible HUSKY Plan Part A or Part B
347 beneficiary shall remain enrolled in such managed care plan for twelve
348 months from the date of such enrollment unless (1) an eligible
349 beneficiary demonstrates good cause to the satisfaction of the
350 commissioner of the need to enroll in a different managed care plan, or
351 (2) the beneficiary no longer meets program eligibility requirements.

352 [(j)] (k) Not [more than twelve] later than ten months after the
353 determination of eligibility for benefits under the HUSKY Plan, Part A
354 and Part B and annually thereafter, the commissioner or the servicer,
355 as the case may be, shall determine if the child continues to be eligible
356 for the plan. The commissioner or the servicer shall mail or, upon
357 request of a participant, electronically transmit an application form to
358 each participant in the plan for the purposes of obtaining information
359 to make a determination on continued eligibility beyond the twelve
360 months of initial eligibility. To the extent permitted by federal law, in
361 determining eligibility for benefits under the HUSKY Plan, Part A or
362 Part B with respect to family income, the commissioner or the servicer
363 shall rely upon information provided in such form by the participant
364 unless the commissioner or the servicer has reason to believe that such
365 information is inaccurate or incomplete. The Department of Social
366 Services shall annually review a random sample of cases to confirm
367 that, based on the statistical sample, relying on such information is not
368 resulting in ineligible clients receiving benefits under HUSKY Plan
369 Part A or Part B. The determination of eligibility shall be coordinated
370 with health plan open enrollment periods.

371 [(k)] (l) The commissioner shall implement the HUSKY Plan, Part B
372 while in the process of adopting necessary policies and procedures in
373 regulation form in accordance with the provisions of section 17b-10.

374 [(l)] (m) The commissioner shall adopt regulations, in accordance
375 with chapter 54, to establish residency requirements and income
376 eligibility for participation in the HUSKY Plan, Part B and procedures
377 for a simplified mail-in application process. Notwithstanding the

378 provisions of section 17b-257b, such regulations shall provide that any
379 child adopted from another country by an individual who is a citizen
380 of the United States and a resident of this state shall be eligible for
381 benefits under the HUSKY Plan, Part B upon arrival in this state.

382 Sec. 7. Section 17b-192 of the general statutes is repealed and the
383 following is substituted in lieu thereof (*Effective July 1, 2007*):

384 (a) The Commissioner of Social Services shall implement a state
385 medical assistance component of the state-administered general
386 assistance program for persons with income that does not exceed one
387 hundred per cent of the federal poverty level and who are ineligible
388 for Medicaid. [Not later than October 1, 2003, each] Earned monthly
389 gross income of up to one hundred fifty dollars shall be disregarded.
390 Unearned income shall not be disregarded. No person who has family
391 assets exceeding one thousand dollars shall be eligible. No person shall
392 be eligible for assistance under this section if such person made,
393 during the three months prior to the month of application, an
394 assignment or transfer or other disposition of property for less than
395 fair market value. The number of months of ineligibility due to such
396 disposition shall be determined by dividing the fair market value of
397 such property, less any consideration received in exchange for its
398 disposition, by five hundred dollars. Such period of ineligibility shall
399 commence in the month in which the person is otherwise eligible for
400 benefits. Any assignment, transfer or other disposition of property, on
401 the part of the transferor, shall be presumed to have been made for the
402 purpose of establishing eligibility for benefits or services unless such
403 person provides convincing evidence to establish that the transaction
404 was exclusively for some other purpose.

405 (b) Each person eligible for state-administered general assistance
406 shall be entitled to receive medical care through a federally qualified
407 health center or other primary care provider as determined by the
408 commissioner. The Commissioner of Social Services shall determine
409 appropriate service areas and shall, in the commissioner's discretion,
410 contract with community health centers, other similar clinics, and

411 other primary care providers, if necessary, to assure access to primary
412 care services for recipients who live farther than a reasonable distance
413 from a federally qualified health center. The commissioner shall assign
414 and enroll eligible persons in federally qualified health centers and
415 with any other providers contracted for the program because of access
416 needs. [Not later than October 1, 2003, each] Each person eligible for
417 state-administered general assistance shall be entitled to receive
418 hospital services. Medical services under the program shall be limited
419 to the services provided by a federally qualified health center, hospital,
420 or other provider contracted for the program at the commissioner's
421 discretion because of access needs. The commissioner shall ensure that
422 ancillary services and specialty services are provided by a federally
423 qualified health center, hospital, or other providers contracted for the
424 program at the commissioner's discretion. Ancillary services include,
425 but are not limited to, radiology, laboratory, and other diagnostic
426 services not available from a recipient's assigned primary-care
427 provider, and durable medical equipment. Specialty services are
428 services provided by a physician with a specialty that are not included
429 in ancillary services. In no event shall ancillary or specialty services
430 provided under the program exceed such services provided under the
431 state-administered general assistance program on July 1, 2003.
432 [Eligibility criteria concerning income shall be the same as the
433 medically needy component of the Medicaid program, except that
434 earned monthly gross income of up to one hundred fifty dollars shall
435 be disregarded. Unearned income shall not be disregarded. No person
436 who has family assets exceeding one thousand dollars shall be eligible.
437 No person eligible for Medicaid shall be eligible to receive medical
438 care through the state-administered general assistance program. No
439 person shall be eligible for assistance under this section if such person
440 made, during the three months prior to the month of application, an
441 assignment or transfer or other disposition of property for less than
442 fair market value. The number of months of ineligibility due to such
443 disposition shall be determined by dividing the fair market value of
444 such property, less any consideration received in exchange for its
445 disposition, by five hundred dollars. Such period of ineligibility shall

446 commence in the month in which the person is otherwise eligible for
447 benefits. Any assignment, transfer or other disposition of property, on
448 the part of the transferor, shall be presumed to have been made for the
449 purpose of establishing eligibility for benefits or services unless such
450 person provides convincing evidence to establish that the transaction
451 was exclusively for some other purpose.]

452 [(b) Recipients covered by a general assistance program operated by
453 a town shall be assigned and enrolled in federally qualified health
454 centers and with any other providers in the same manner as recipients
455 of medical assistance under the state-administered general assistance
456 program pursuant to subsection (a) of this section.]

457 (c) [On and after October 1, 2003, pharmacy] Pharmacy services
458 shall be provided to recipients of state-administered general assistance
459 through the federally qualified health center to which they are
460 assigned or through a pharmacy with which the health center
461 contracts. [Prior to said date, pharmacy services shall be provided as
462 provided under the Medicaid program.] Recipients who are assigned
463 to a community health center or similar clinic or primary care provider
464 other than a federally qualified health center or to a federally qualified
465 health center that does not have a contract for pharmacy services shall
466 receive pharmacy services at pharmacies designated by the
467 commissioner. The Commissioner of Social Services or the managed
468 care organization or other entity performing administrative functions
469 for the program as permitted in subsection (d) of this section, shall
470 require prior authorization for coverage of drugs for the treatment of
471 erectile dysfunction. The commissioner or the managed care
472 organization or other entity performing administrative functions for
473 the program may limit or exclude coverage for drugs for the treatment
474 of erectile dysfunction for persons who have been convicted of a sexual
475 offense who are required to register with the Commissioner of Public
476 Safety pursuant to chapter 969.

477 (d) The Commissioner of Social Services shall contract with
478 federally qualified health centers or other primary care providers as

479 necessary to provide medical services to eligible state-administered
480 general assistance recipients pursuant to this section. The
481 commissioner shall, within available appropriations, make payments
482 to such centers based on their pro rata share of the cost of services
483 provided or the number of clients served, or both. The Commissioner
484 of Social Services shall, within available appropriations, make
485 payments to other providers based on a methodology determined by
486 the commissioner. The Commissioner of Social Services may reimburse
487 for extraordinary medical services, provided such services are
488 documented to the satisfaction of the commissioner. For purposes of
489 this section, the commissioner may contract with a managed care
490 organization or other entity to perform administrative functions,
491 including a grievance process for recipients to access review of a denial
492 of coverage for a specific medical service, and to operate the program
493 in whole or in part. Provisions of a contract for medical services
494 entered into by the commissioner pursuant to this section shall
495 supersede any inconsistent provision in the regulations of Connecticut
496 state agencies. A recipient who has exhausted the grievance process
497 established through such contract and wishes to seek further review of
498 the denial of coverage for a specific medical service may request a
499 hearing in accordance with the provisions of section 17b-60.

500 (e) Each federally qualified health center participating in the
501 program shall [, within thirty days of August 20, 2003,] enroll in the
502 federal Office of Pharmacy Affairs Section 340B drug discount
503 program established pursuant to 42 USC 256b to provide pharmacy
504 services to recipients at Federal Supply Schedule costs. Each such
505 health center may establish an on-site pharmacy or contract with a
506 commercial pharmacy to provide such pharmacy services.

507 (f) The Commissioner of Social Services shall, within available
508 appropriations, make payments to hospitals for inpatient services
509 based on their pro rata share of the cost of services provided or the
510 number of clients served, or both. The Commissioner of Social Services
511 shall, within available appropriations, make payments for any
512 ancillary or specialty services provided to state-administered general

513 assistance recipients under this section based on a methodology
514 determined by the commissioner.

515 (g) On or before [March 1, 2004,] January 1, 2008, the Commissioner
516 of Social Services shall seek a waiver of federal law [under the Health
517 Insurance Flexibility and Accountability demonstration initiative] for
518 the purpose of extending health insurance coverage under Medicaid to
519 persons qualifying for medical assistance under the state-administered
520 general assistance program. The provisions of section 17b-8 shall apply
521 to this section.

522 (h) The commissioner, pursuant to section 17b-10, may implement
523 policies and procedures to administer the provisions of this section
524 while in the process of adopting such policies and procedures as
525 regulation, provided the commissioner prints notice of the intent to
526 adopt the regulation in the Connecticut Law Journal not later than
527 twenty days after the date of implementation. Such policy shall be
528 valid until the time final regulations are adopted.

529 Sec. 8. Subsection (a) of section 17b-277 of the general statutes is
530 repealed and the following is substituted in lieu thereof (*Effective July*
531 *1, 2007*):

532 (a) The Commissioner of Social Services shall provide, in accordance
533 with federal law and regulations, medical assistance under the
534 Medicaid program to needy pregnant women [and children up to one
535 year of age] whose families have an income [up to one hundred eighty-
536 five] not exceeding three hundred per cent of the federal poverty level.

537 Sec. 9. (NEW) (*Effective July 1, 2007*) On or before January 1, 2008,
538 the Commissioner of Social Services, shall seek a waiver under federal
539 law under the Health Insurance Flexibility and Accountability
540 demonstration proposal to provide health insurance coverage to
541 pregnant women, who do not otherwise have creditable coverage, as
542 defined in 42 USC 300gg(c), and with incomes above one hundred
543 eighty-five per cent of the federal poverty level but not in excess of
544 three hundred per cent of the federal poverty level. The waiver

545 submitted by the commissioner shall specify that funding for such
546 health insurance coverage shall be provided through a reallocation of
547 unspent state children's health insurance plan funds.

548 Sec. 10. Section 17b-282b of the general statutes is repealed and the
549 following is substituted in lieu thereof (*Effective July 1, 2007*):

550 [(a) Not later than July 1, 2004, and prior to the implementation of a
551 state-wide dental plan that provides for the administration of the
552 dental services portion of the department's medical assistance, the
553 Commissioner of Social Services shall amend the federal waiver
554 approved pursuant to Section 1915(b) of the Social Security Act. Such
555 waiver amendment shall be submitted to the joint standing committees
556 of the General Assembly having cognizance of matters relating to
557 human services and appropriations and the budgets of state agencies
558 in accordance with the provisions of section 17b-8.

559 (b) Prior to the implementation of a state-wide dental plan that
560 provides for the administration of the dental services portion of the
561 department's medical assistance program, the Commissioner of Social
562 Services shall review eliminating prior authorization requirements for
563 basic and routine dental services. In the event the commissioner adopts
564 regulations to eliminate such prior authorization requirements, the
565 commissioner may implement policies and procedures for the
566 purposes of this subsection while in the process of adopting such
567 regulations, provided the commissioner prints notice of intention to
568 adopt the regulations in the Connecticut Law Journal not later than
569 twenty days after implementing the policies and procedures.]

570 (a) The Commissioner of Social Services shall establish a fee
571 schedule for dental services provided to children under nineteen years
572 of age who are eligible for medical assistance under section 17b-261, as
573 amended by this act, or section 17b-292, as amended by this act. The
574 schedule shall provide for a fee for each dental service provided on or
575 after July 1, 2007, except for an orthodontic service, that is equal to the
576 seventieth percentile of normal and customary private provider fees,
577 as defined by the National Dental Advisory Service Comprehensive

578 Fee Report. The schedule shall provide for a fee for each orthodontic
579 service, which may be less than the seventieth percentile of normal and
580 customary private provider fees, as defined by the National Dental
581 Advisory Service Comprehensive Fee Report.

582 (b) The Commissioner of Social Services shall evaluate whether the
583 fee schedule established pursuant to subsection (a) of this section
584 results in improved access to oral health care for medical assistance
585 recipients under nineteen years of age, as measured by the increase in
586 the number of providers registered to provide dental services under
587 the medical assistance programs described in section 17b-261, as
588 amended by this act, and section 17b-292, as amended by this act. Not
589 later than December 31, 2008, the commissioner shall submit the
590 evaluation and any recommendations that the commissioner may have
591 with respect to improving access to oral health care for medical
592 assistance recipients to the joint standing committees of the General
593 Assembly having cognizance of matters relating to human services,
594 public health and appropriation and the budgets of state agencies, in
595 accordance with the provisions of section 11-4a.

596 Sec. 11. (NEW) (*Effective July 1, 2007*) The Commissioner of Social
597 Services shall reimburse providers of medical services under the
598 medical assistance program, operated in accordance with section 17b-
599 261 of the general statutes, as amended by this act, at a rate that is
600 equal to the rate paid for the provision of such services under the
601 Medicare program.

602 Sec. 12. Section 17b-28e of the general statutes is repealed and the
603 following is substituted in lieu thereof (*Effective July 1, 2007*):

604 (a) Not later than September 30, 2002, the Commissioner of Social
605 Services shall submit an amendment to the Medicaid state plan to
606 implement the provisions of public act 02-1 of the May 9 special
607 session* concerning optional services under the Medicaid program.
608 Said state plan amendment shall supersede any regulations of
609 Connecticut state agencies concerning such optional services.

610 (b) The Commissioner of Social Services shall amend the Medicaid
 611 state plan to include foreign language interpreter services provided to
 612 any beneficiary with limited English proficiency as a covered service
 613 under the Medicaid program.

614 Sec. 13. Section 17b-261c of the general statutes is repealed. (*Effective*
 615 *July 1, 2007*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2007</i>	17b-261
Sec. 2	<i>July 1, 2007</i>	17b-297
Sec. 3	<i>July 1, 2007</i>	17b-297b
Sec. 4	<i>July 1, 2007</i>	New section
Sec. 5	<i>July 1, 2007</i>	17b-289
Sec. 6	<i>July 1, 2007</i>	17b-292
Sec. 7	<i>July 1, 2007</i>	17b-192
Sec. 8	<i>July 1, 2007</i>	17b-277(a)
Sec. 9	<i>July 1, 2007</i>	New section
Sec. 10	<i>July 1, 2007</i>	17b-282b
Sec. 11	<i>July 1, 2007</i>	New section
Sec. 12	<i>July 1, 2007</i>	17b-28e
Sec. 13	<i>July 1, 2007</i>	Repealer section

Statement of Legislative Commissioners:

Section 10 of the committee bill concerning an amendment to the Medicaid state plan with respect to eligibility determinations for the aged, blind and disabled was deleted for clarity and to maintain consistency with the purposes set forth in subsection (j) of section 1 that also requires the commissioner to file an amendment to the Medicaid state plan for the same purpose as was contained in the former section 10.

HS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either chamber thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 08 \$	FY 09 \$
Department of Social Services	GF - Cost	Significant	Significant

Municipal Impact: None

Explanation

This bill makes various changes to the Department of Social Services' (DSS) health care programs. The quantifiable costs of these changes are \$1,144,300,000 in FY08 and \$1,215,900,000 in FY09. The majority of these costs would be reimbursable at varying levels by the federal government, as detailed below.

Section 1 of the bill expands eligibility for parents of children enrolled in the HUSKY A program from 150% of the federal poverty level (FPL) to 185% FPL. The Office of Fiscal Analysis (OFA) estimates that this will add an additional 9,700 clients to the program when fully annualized, at a cost of \$23,500,000 in FY08 and \$31,300,000 in FY09. This estimate includes the rate increases implemented in section 11 of the bill. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Section 1 also requires DSS to increase the Medicaid medically needy income limit to 185% FPL. This change is expected to increase Medicaid eligibility by 43,200 individuals, at a cost of \$214,700,000 in FY08 and \$227,500,000 in FY09. These costs would be reimbursed 50% by the federal government under the Medicaid program.

Section 1 also eliminates certain cost sharing requirements for parents in HUSKY A. As this policy was never implemented, this

provision has no fiscal impact.

Section 2 of the bill requires DSS to increase outreach and maximize enrollment of eligible children and adults in the HUSKY programs. Increased outreach will result in increased administrative costs, the extent of which is dependent upon the outreach mechanisms used. Should such outreach efforts succeed, additional enrollment in these programs would result in additional state costs.

Section 3 requires boards of education to provide HUSKY outreach materials to parents and guardians of students at the beginning of each school year. There is no increased cost for these boards as the information would be disseminated through the existing practices for school notices. DSS will incur administrative costs to prepare the materials for the approximately 562,000 students in 1,000 separate schools. Should such outreach efforts succeed, additional enrollment in these programs would result in additional state costs.

Section 4 requires DSS, in consultation with the Department of Public Health, to establish and implement a multi-year, statewide public information campaign to promote HUSKY enrollment. DSS must solicit bids from private organizations to design and operate the campaign. This will result in significant increased costs to DSS, the extent of which will depend upon the scope and design of the campaign. Should such outreach efforts succeed, additional enrollment in these programs would result in additional state costs.

Section 5 and 6 require DSS to establish a centralized unit responsible for processing all HUSKY (both A and B) applications. This change is expected to streamline the application processes for HUSKY A and HUSKY B, and will provide eligible clients with more continuous medical coverage. DSS will incur additional administrative costs to centralize these processes, but may also incur offsetting administrative savings through a reduction in unnecessary reapplications.

Sections 6 and 13 also re-establish the continuous eligibility policy

for children in the HUSKY plan. Assuming the rate increases included in section 11, this change is estimated to cost \$2,800,000 annually. These costs would be reimbursed 50% by the federal government under the Medicaid program. The bill also establishes a continuous eligibility policy for adults in the HUSKY programs. This change is estimated to cost approximately \$925,000 annually. Based on current federal policy, it does not appear that these funds will be federally reimbursable.

Section 7 increases eligibility for the State Administered General Assistance (SAGA) to 100% FPL. OFA estimates that this increase will serve an additional 22,000 individuals, at a cost to DSS of \$105,000,000 in FY08 and \$111,300,000 in FY09. Should the General Assistance Managed Care program under the Department of Mental Health and Addiction Services receive a proportional increase, the total cost of this expansion would be \$160,100,000 in FY08 and \$169,700,000 in FY09. These estimates assume that the current service structure and benefit package in the SAGA program remains in place.

This section further directs DSS to seek a federal waiver to enroll SAGA clients within the Medicaid program. Currently, the state receives federal reimbursement for a portion of SAGA hospital costs under the Disproportionate Share Hospital program. A waiver enrolling SAGA clients into Medicaid would enable the state to receive a 50% reimbursement on all SAGA medical costs. The impact of this would depend upon the conditions of the federal waiver. Should the state be able to enroll all SAGA clients in Medicaid while retaining the current program structure and benefits, the additional federal funds would basically offset the SAGA expansion costs noted above. However, as the Medicaid benefits package is richer than the SAGA package, and is provided on a full entitlement basis, the federal government, if they choose to accept such a waiver, may require the state to make significant changes to the SAGA program. Therefore, the net impact of this proposal is not known.

Sections 8 and 9 expand Medicaid coverage for pregnant women

from 185% FPL to 300% FPL, and require DSS to seek an SCHIP waiver for this expanded population. OFA estimates that this expansion would cost \$5,000,000 in FY08 and \$5,300,000 in FY09, assuming the rate increases implemented in section 11. These costs would be eligible for 50% federal reimbursement (65% if the federal government approves the SCHIP waiver).

Sections 10 and 11 increase Medicaid rates. Section 11 specifies that DSS shall reimburse providers of medical services under the Medicaid program at the rate that is paid under the Medicare program. Although the bill does not specify, it is assumed that rates for both HUSKY and the Medicaid fee-for-service program will be increased.

It should first be noted that DSS does not directly reimburse medical providers under the HUSKY programs. The Department pays a capitated rate to managed care organizations (MCO's), who then reimburse medical providers in their systems. Secondly, given the disparate populations served (HUSKY is predominantly women and children, while Medicare serves the elderly and disabled), there may not be Medicare rates that correspond with HUSKY rates. Also, rates paid by the MCO's to providers in their system are not available as they are considered proprietary.

Assuming that DSS was to implement the provisions of this section by increasing the rates under Medicaid fee-for-service, the behavioral health partnership and the capitated rates paid to the HUSKY MCO's, OFA estimates that this would cost approximately \$711,000,000 in FY08 and \$753,700,000 in FY09. Of this increase, \$326,700,000 in FY08 and \$345,800,000 in FY09 is attributable to the HUSKY programs. As stated above, exact comparisons between current HUSKY rates and Medicare rates are not possible. Based on data included in the Office of Health Care Access' 2005 Annual Report on the financial status of Connecticut's hospitals, it would require a 38% Medicaid rate increase to match the hospital rates paid under the Medicare program. As reliable data does not exist for rate comparisons, OFA used this 38% rate increase as a proxy. The increases cited above would be eligible

for federal reimbursement under the Medicaid and SCHIP programs, which would generate an estimated \$357,200,000 in FY08 and \$379,100,000 in FY09.

Section 10 also requires that the reimbursement to dental providers under the HUSKY program be equal to the 70th percentile of the normal and customary fee, as defined by the National Dental Advisory Service Comprehensive Fee Report. Based on the latest such fee report, OFA estimates that this increase would cost \$27,000,000 annually over the current HUSKY dental expenditures. It would represent a \$20,000,000 increase over the Medicaid to Medicare rate increases calculated above. These costs would be reimbursed 50% by the federal government under the Medicaid program. The bill also requires DSS to assess access to dental services and report to the General Assembly by December 31, 2008.

The rate increases included in sections 10 and 11 of the bill may lead to increased access to services as providers may be more willing to serve HUSKY and Medicaid clients. Should this be the case, it is likely that the MCO's would seek a future increase in their capitated rates to compensate for this change. It is not known what this increased utilization may be. However, any increased utilization in either the HUSKY or Medicaid fee-for-service programs will result in significant increased state costs. For example, a 5% increased utilization for all services would result in increased costs of \$118,000,000 annually.

Section 12 requires DSS to amend the state Medicaid plan to include foreign language interpreting services. The cost of this change will be dependent upon the structure of the service included in the state plan amendment. Estimates of providing this service have ranged up to \$4,700,000 annually for face to face interpreters. These costs would be reimbursed 50% by the federal government under the Medicaid program.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis**sSB 3*****AN ACT CONCERNING INCREASED ACCESS TO HEALTH CARE THROUGH THE HUSKY PROGRAM.*****SUMMARY:**

This bill expands access to public health insurance by making a number of changes in the HUSKY, Medicaid, and State-Administered General Assistance (SAGA) programs. Specifically, it:

1. raises the income limit for HUSKY A (Medicaid) coverage for caretaker relatives,
2. eliminates never-implemented cost sharing requirements for HUSKY A recipients,
3. restores continuous eligibility for children enrolled in HUSKY A or B,
4. requires the Department of Social Services (DSS) to increase the HUSKY A income limit for pregnant women,
5. requires the DSS commissioner to establish a provider fee schedule for services to children enrolled in HUSKY,
6. requires all Medicaid providers to be reimbursed for services at the same rate Medicare pays,
7. enhances the state's HUSKY outreach efforts,

8. requires DSS to increase the income limit for the SAGA medical assistance program and seek a federal waiver to convert the program from a fully state-funded program to a Medicaid-funded one, and
9. requires DSS to cover the cost of interpreter services as an optional Medicaid service.

EFFECTIVE DATE: July 1, 2007

HUSKY CHANGES

Increase in Income Limit for HUSKY A Coverage for Adult Caretaker Relatives; Elimination of Cost Sharing in HUSKY A (§§ 1(a), (h))

The bill increases, from 150% to 185% of the federal poverty level (FPL, from \$25,755 to \$31,764 annually for a family of three in 2007), the income limit for HUSKY A adult caretaker coverage. This higher limit already applies to children applying for and enrolled in the HUSKY A program.

The bill also requires the DSS commissioner, at the time individuals or families apply for Medicaid coverage, to advise them of the (1) effect that having income over the limits has on program eligibility and (2) availability of HUSKY B for those children ineligible for HUSKY A. (HUSKY B provides virtually identical subsidized medical coverage to children in families whose income is between 185% and 300% of the FPL.) (This section applies to all Medicaid applicants, not just HUSKY A, but as a practical matter, only children could be moved into HUSKY B.)

The bill repeals provisions requiring DSS to require HUSKY A families with incomes above 100% of the FPL to pay part of the insurance cost, including premiums and co-payments, as allowed by federal law or waivers. DSS has never implemented these provisions.

Continuous Eligibility (§ 6)

The bill provides that any child determined eligible for HUSKY A or B, and any adult caretaker eligible for HUSKY A, must remain eligible for assistance for 12 months from the eligibility determination date, unless they are no longer state residents, or, in the case of the child, turn age 19. During this period of continuous eligibility, the family must comply with the federal requirements concerning reporting information to DSS, including a change of address. Currently, families must report changes in financial circumstances within the 12-month period, which can render the child, adult, or both ineligible for assistance. Federal law does not appear to allow adults to be continuously eligible for Medicaid without a waiver. The bill's passage could affect the state's eligibility for federal matching funds.

The bill makes a corollary change by repealing a separate provision that prohibits adults enrolled in HUSKY A from being guaranteed eligibility for six months without regard to changes in circumstances that would otherwise render them ineligible. Federal law provides for guaranteed continuous enrollment of adults in Medicaid managed care for the first six months they are enrolled in a plan.

Although, under the bill, children remain continuously eligible for HUSKY, the bill requires DSS within 10, instead of 12, months from its HUSKY eligibility determination to determine if the child will continue to qualify once the 12-month period ends. It requires DSS, if a HUSKY beneficiary requests, to send renewal applications electronically instead of automatically mailing a renewal form, which the law continues to require if no request is made.

Coverage for Pregnant Women (§ 9)

The bill requires DSS to increase the income limit for HUSKY A coverage for pregnant women from 185% to 300% of the FPL (\$31,764 to \$51,510 for a three-person household) who do not otherwise have "creditable coverage." It requires DSS to seek a federal Health Insurance Flexibility and Accountability demonstration waiver by January 1, 2008 to cover these women. The waiver must specify that

the expanded coverage will be provided through a re-allocation of the state's unspent State Children's Health Insurance Program (SCHIP) block grant funds. Federal law generally prohibits the use of SCHIP funds to assist people covered by private insurance.

Reimbursement (§§ 10 & 11)

Dental Services. The bill requires the DSS commissioner to establish a fee schedule for dental services provided to children eligible for HUSKY A or B. The schedule must provide a fee for each dental service provided on and after July 1, 2007, except for orthodontia, that is equal to the 70th percentile of normal and customary private provider fees, as defined by the National Dental Advisory Service (NDAS) Comprehensive Fee Report. The schedule also must provide for a fee for each orthodontic service, which can be less than the 70th percentile.

The commissioner must evaluate whether the schedule results in improved access to oral health care for these children, as measured by the increase in the number of dental providers registered under the programs. By December 31, 2008, the commissioner must submit the evaluation and any recommendations related to improving access to the Human Services, Public Health, and Appropriations committees.

Under current practice, DSS maintains a pediatric dental fee schedule, but it is not generally used because children in HUSKY receive most medical services through the managed care organizations (MCO) that contract with DSS. The MCOs subcontract with dental providers, including managed dental care plans, for these services, and these plans set the reimbursement rates for dental providers. Presumably, DSS will amend its contracts with the MCOs to ensure that the new rates are paid.

The bill removes language requiring DSS, by July 1, 2004, to amend its Medicaid managed care waiver to allow for a separate dental program for the HUSKY A program. DSS never implemented the separate program.

Other Medicaid Providers. The bill requires the DSS commissioner to reimburse all Medicaid providers for services at the same rate paid by Medicare. This presumably would apply to both HUSKY A and Medicaid fee-for-service recipients. The HUSKY A providers are not paid by DSS, but by the MCOs. DSS would presumably amend the MCO contracts to ensure these rates are paid.

Outreach (§§ 2, 3, & 4)

DSS Requirements. The bill requires DSS, in consultation with the Children's Health Council (defunct), the Medicaid Managed Care Council, and 2-1-1 Infoline, to develop mechanisms to increase outreach and maximize enrollment of children and adults in HUSKY. The mechanisms must include, at a minimum, developing and implementing an on-line application. Under current law, DSS must develop outreach mechanisms, including only a mail-in application.

The bill adds the departments of Education, Mental Health and Addiction Services, Mental Retardation, and Motor Vehicles to the list of agencies through which DSS must disseminate outreach material. It eliminates a requirement that the commissioner include in the outreach efforts information on the Medicaid program for purposes of maximizing the enrollment of eligible children and the use of federal funds.

By law, the DSS commissioner, within available appropriations, must contract with severe-need schools and community-based organizations for purposes of public education, outreach, and recruitment of HUSKY-eligible children. The bill extends this to include HUSKY-eligible adults.

Current law requires DSS to report annually to the governor on its community-based outreach program. Starting January 1, 2008, this report must also go to the Appropriations, Human Services, and Public Health committees, and it must be on all outreach efforts, not just community-based ones.

School District Requirements. The bill requires each local or

regional board of education or similar body governing a nonpublic school to provide HUKSY outreach material to parents and guardians of students at the beginning of each school year. DSS must develop the material and disseminate it to the schools.

Multi-Year, Statewide Information Campaign. The bill requires DSS, in consultation with the Department of Public Health (DPH), to establish a joint program between public and private entities to develop and implement a multi-year, statewide public information campaign to promote HUSKY enrollment.

The bill requires DSS to consult with DPH and solicit bids from private organizations to design and operate the campaign, regardless of any contrary provision in the personal service agreement (PSA) law (see BACKGROUND). The bids must be solicited by sending notice to prospective organizations and by posting notice on public bulletin boards within the departments. They must be opened publicly at the time that the soliciting notice states. The departments' acceptance of a bid must be based on standard specifications that they adopt. The bill allows DSS to accept gifts, donations, bequests, grants, or funds from public or private agencies for the campaign.

Beginning January 1, 2008, the DSS commissioner must report annually to the Appropriations, Human Services, and Public Health, committees on the campaign's status.

Central Unit in DSS to Assist in Processing and Marketing HUSKY Applications (§ 6)

The bill requires DSS, in consultation with the servicer with which it contracts (i.e., enrollment broker, currently ACS, Inc.) to establish a centralized unit responsible for processing all HUSKY applications. DSS, through its contract, must ensure that a child determined eligible for HUSKY has uninterrupted coverage for as long as the parent or guardian elects to enroll or re-enroll the child.

The bill requires DSS, in consultation with the servicer, instead of the servicer alone, to (1) jointly market the HUSKY A and B as one

program and (2) develop and implement public information and outreach activities with community programs. It requires the servicer to electronically send HUSKY A, as well as HUSKY B, enrollment and disenrollment data to DSS. And it requires the servicer to send all applications and supporting documentation, not just those for children in families with income below 185% of the FPL, to DSS for eligibility determinations.

MEDICAID—MEDICALLY NEEDY (§ 1(J))

The bill requires the DSS commissioner to file a Medicaid state plan amendment that will allow DSS, when making income eligibility determinations for individuals who are aged, blind, or disabled (commonly referred to as medically needy), to establish and maintain the income level at the same level used for HUSKY A caretaker relatives (currently 150% of the FPL, under the bill 185% of FPL). The bill permits him to do this by establishing a special income disregard that DSS applies only to this group.

Under federal law, the Medicaid medically needy income limit is tied to a state's family cash welfare benefit, which in Connecticut has been the same for over 15 years. Although states may not raise the income limit, federal law allows them to establish separate disregards or deductions which, when applied, have the effect of raising the amount of gross income these individuals can have without having to spend down any excess income on medical bills.

SAGA MEDICAL ASSISTANCE (§ 7)

The bill requires the DSS commissioner to increase the income limit for SAGA medical assistance recipients from the Medicaid medically needy income limit (currently \$476 per month for a single resident living in most parts of the state) to 100% of the FPL (\$850 per month). It extends, from March 1, 2004 to January 1, 2008, the deadline for DSS to seek a federal Medicaid waiver to get Medicaid coverage for the SAGA medical assistance program.

The bill eliminates the deadline (August 20, 2003) by which

federally qualified health centers participating in the SAGA medical assistance program must enroll in the federal Office of Pharmacy Affairs Section 340B drug discount program. Enrollment enables the centers' pharmacies to purchase drugs at a substantial discount.

Finally, the bill removes obsolete language pertaining to town-administered General Assistance (GA). The state took over the GA program in 2004.

INTERPRETERS IN MEDICAID (§ 12)

The bill requires the DSS commissioner to amend the Medicaid state plan to include foreign language interpreter services provided to any Medicaid beneficiary with limited English proficiency.

BACKGROUND

Personal Service Agreements (PSA)

In general, whenever a state agency wishes to hire a person, firm, or corporation to provide services on a contractual basis, a PSA must be executed, which defines the services the contractor must perform. For PSAs costing up to \$20,000, the contract should, but does not have to, be competitively bid. PSAs costing more than \$20,000 must be competitively bid, unless the agency purchasing the services (1) determines that a sole source is necessary, (2) applies to the Office of Policy and Management (OPM) secretary for a waiver, and (3) the secretary grants it. PSAs costing more than \$50,000 must always receive the secretary's approval, regardless of whether a waiver is requested (CGS § 4-212, et. seq.).

Reimbursement

MCO pediatric dental fees apparently fall well below the 70th percentile. For example, a recent DSS analysis shows that the HUSKY MCOs paid, on average, \$24 for an initial exam, compared with the NDAS 70th percentile rate of \$65. For cleanings, the rates were \$22 and \$52, respectively. (It should be noted that DSS pays the MCOs a capitated rate, which is based, in part, on a fee schedule DSS maintains for the Medicaid program. The schedule generally has not been update

for inflation.)

Because Medicare and Medicaid, particularly HUSKY A, serve different populations (elderly and disabled vs. children and parents), their services may not be comparable and there may not be a Medicare fee available for each Medicaid service. Nevertheless, a recent DSS analysis found that Medicaid fee-for-service (non-HUSKY) fees were 48.7% of Medicare fees for medical procedures, and 57% for surgery.

Related Bills

Several committees have favorably reported bills broadly addressing health care access that contain provisions similar to those in sSB3. They are:

<i>Bill Number</i>	<i>Committee</i>
SB 1	Public Health
SB 70	Insurance
SB 1127	Human Services
SB 1371	Insurance
HB 6158	Children
HB 6652	Insurance
HB 7314	Labor
HB 7375	Human Services

sSB 1181, reported favorably by the GAE committee, changes the PSA reporting requirements.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute

Yea 19 Nay 0 (03/22/2007)