



Testimony Before the Human Services Committee

S. B. No. 53 AN ACT CONCERNING INCREASED ACCESS TO THE CONNPAGE PROGRAM.

S. B. No. 137 AN ACT CONCERNING THE ESTABLISHMENT OF A CLOTHING ALLOWANCE FOR CHILDREN UNDER THE TEMPORARY FAMILY ASSISTANCE PROGRAM.

S. B. No. 147 (COMM) AN ACT CONCERNING THE USE OF PREFERRED DRUG LISTS AND PRIOR AUTHORIZATION REQUIREMENTS BY THE DEPARTMENT OF SOCIAL SERVICES IN THE ADMINISTRATION OF THE DEPARTMENT'S PRESCRIPTION DRUG PROGRAMS.

S. B. No. 201 (COMM) AN ACT CONCERNING ADEQUATE REIMBURSEMENT TO PROVIDERS OF VISION CARE SERVICES UNDER THE STATE-ADMINISTERED GENERAL ASSISTANCE PROGRAM.

S. B. No. 203 (COMM) AN ACT CONCERNING FULL PAYMENT TO MEDICAL ASSISTANCE PROVIDERS FOR SERVICES PROVIDED TO DUALY ELIGIBLE PATIENTS.

S. B. No. 247 AN ACT CONCERNING THE ESTABLISHMENT OF A CENTRALIZED CALL CENTER FOR MEDICAID BENEFICIARIES.

S. B. No. 373 AN ACT CONCERNING RELOCATION OF A MEDICAID CERTIFIED NURSING FACILITY.

S. B. No. 379 AN ACT CONCERNING NURSING FACILITY RELOCATION.

S. B. No. 386 AN ACT CONCERNING RELOCATION OF A NURSING FACILITY WITHIN THE SAME GEOGRAPHIC AREA.

H. B. No. 5484 AN ACT CONCERNING ELIGIBILITY FOR THE QUALIFIED MEDICARE BENEFICIARY AND SPECIFIED LOW-INCOME BENEFICIARY PROGRAMS.

H. B. No. 5632 AN ACT CONCERNING EXPANDED ELIGIBILITY FOR THE CONNPAGE PROGRAM.

H. B. No. 5646 AN ACT CONCERNING INCREASED ENROLLMENT IN THE CONNPAGE PROGRAM.

H. B. No. 5659 AN ACT CONCERNING MEDICAL COVERAGE FOR VETERANS UNDER THE STATE-ADMINISTERED GENERAL ASSISTANCE PROGRAM.

H. B. No. 6035 (COMM) AN ACT CONCERNING THE ASSET TEST USED TO DETERMINE ELIGIBILITY FOR THE STATE-ADMINISTERED GENERAL ASSISTANCE PROGRAM.

Michael P. Starkowski
Commissioner Designee
February 6, 2007

Testimony

Good morning, Senator Harris, Representative Villano and members of the Human Services Committee. My name is Michael P. Starkowski. I am the Commissioner Designee of the Connecticut Department of Social Services (DSS). Thank you for this opportunity to testify on several bills on today's public hearing agenda addressing important issues in a range of DSS programs, such as State Administered General Assistance (SAGA), ConnPACE, Prescriptions Drugs, Nursing Facilities, and Temporary Family Assistance (TFA).

At the outset, I wanted to remark broadly on several bills where my agency has an understanding and appreciation of the underlying issues that are addressed in the proposed bills. However, there remain important issues related to the costs of implementation that would need to be addressed if these bills move forward. In this regard, I would be happy to employ the resources of my department in assisting the committee and its staff offices with the financial and programmatic information needed to fully assess the legislation. The following bills fall into this category:

Proposed S. B. No. 137 AN ACT CONCERNING THE ESTABLISHMENT OF A CLOTHING ALLOWANCE FOR CHILDREN UNDER THE TEMPORARY FAMILY ASSISTANCE PROGRAM;

S. B. No. 203 (COMM) AN ACT CONCERNING FULL PAYMENT TO MEDICAL ASSISTANCE PROVIDERS FOR SERVICES PROVIDED TO DUALY ELIGIBLE PATIENTS.

Proposed H. B. No. 5659 AN ACT CONCERNING MEDICAL COVERAGE FOR VETERANS UNDER THE STATE-ADMINISTERED GENERAL ASSISTANCE PROGRAM .

H. B. No. 6035 (COMM) AN ACT CONCERNING THE ASSET TEST USED TO DETERMINE ELIGIBILITY FOR THE STATE-ADMINISTERED GENERAL ASSISTANCE PROGRAM.

Again, I would be happy to provide the committee with anything that is needed to assess these bills. Next,

Proposed S. B. No. 53 AN ACT CONCERNING INCREASED ACCESS TO THE CONNPACE PROGRAM, Proposed H. B. No. 5632 AN ACT CONCERNING EXPANDED ELIGIBILITY FOR THE CONNPACE PROGRAM, Proposed H. B. No. 5646 AN ACT CONCERNING INCREASED ENROLLMENT IN THE CONNPACE PROGRAM.

Current ConnPACE eligibility requirements are \$23,100 single/\$31,100 couple. With ConnPACE now providing wraparound benefits with the new Medicare Part D program, ConnPACE has become more complex than it was in the past. I am very concerned that

these bills will ill-serve ConnPACE recipients by adding to the program's complexity too soon into the Medicare Rx experience. As members of the committee know, ConnPACE coordinates benefits with 51 individual Medicare Part D benefit plans. Some 96% of our ConnPACE population qualify and are enrolled in one of these plans. Moreover, the approach recommended here would add an additional level of complexity and costs as secondary payor when trying to wrap around the benefits of the Part D plans. Additionally, making this program any more complex than it currently is, would be frustrating to the enrollee and add confusion to the enrollee when trying to understand their level of benefit.

S. B. No. 147 (COMM) AN ACT CONCERNING THE USE OF PREFERRED DRUG LISTS AND PRIOR AUTHORIZATION REQUIREMENTS BY THE DEPARTMENT OF SOCIAL SERVICES IN THE ADMINISTRATION OF THE DEPARTMENT'S PRESCRIPTION DRUG PROGRAMS.

I am concerned that many of the provisions in this bill will undermine the prior authorization components of DSS pharmacy programs by adding complexity and costs when there is evidence that PA is working with minimal disruption. When developing prior authorization policies, the Department established a number of safeguards to ensure beneficiaries were not harmed. The prior authorization call center is open 24/7. Additionally, where most states and the federal government require that prior authorizations be determined within 24 hours, DSS requires that a prior authorization decision be made within 2 hours. If the prior authorization is not acted upon within the 2 hour time-frame, a 5-day temporary supply is granted to the beneficiary. If a prior authorization is denied and the beneficiary appeals the decision, the beneficiary would continue to receive the medication prescribed pending the appeal decision.

S. B. No. 201 (COMM) AN ACT CONCERNING ADEQUATE REIMBURSEMENT TO PROVIDERS OF VISION CARE SERVICES UNDER THE STATE-ADMINISTERED GENERAL ASSISTANCE PROGRAM.

In accordance with last session's budget agreement, on January 1, 2007, my agency implemented a limited reinstatement of vision care benefits and non-emergency medical transportation benefits for SAGA recipients. A full service benefit package was not included given the capped \$2.8 million amount in the adopted budget available for this purpose. The appropriated dollars, as intended by the state legislature, have been split between the vision care and transportation initiatives. I believe we were fortunate that our existing SAGA medical assistance contractor, Community Health Network (CHN) was able to secure vision care services from their HUSKY vision care vendor and their network of providers at \$35 per eye exam. I appreciate that this amount is considerably less than the encounter rate that a Federally Qualified Health Center (FQHC) may receive for other SAGA patient visits, however, I am unable to authorize a higher payment for the FQHCs because to do so would either cause my department to exceed the appropriated amounts or otherwise limit a vision care benefit which is already pared down given the constrained appropriation.

Proposed S. B. No. 247 AN ACT CONCERNING THE ESTABLISHMENT OF A CENTRALIZED CALL CENTER FOR MEDICAID BENEFICIARIES.

I believe this legislation is initiated in response to the new Medicaid citizenship requirements and the resulting case processing consequences and demands experienced in our regional offices. I acknowledge that these new requirements have contributed to the stress and strain of processing cases in our regional offices and I recognize the need to evaluate our customer service abilities in this environment of competing demands. I have discussed this and a number of ideas with the proponent of this legislation, including ideas about centralizing HUSKY case processing and calls. I hope to formulate a comprehensive plan of action to deal with these demands over the next several months and I would be happy to keep members of this committee included in these discussions.

Proposed S. B. No. 373 AN ACT CONCERNING RELOCATION OF A MEDICAID CERTIFIED NURSING FACILITY, Proposed S. B. No. 379 AN ACT CONCERNING NURSING FACILITY RELOCATION, Proposed S. B. No. 386 AN ACT CONCERNING RELOCATION OF A NURSING FACILITY WITHIN THE SAME GEOGRAPHIC AREA.

This bill would allow for the relocation of a Medicaid certified nursing facility to a site within its current municipality or a municipality within 15 miles provided there was a decrease in licensed beds, no adverse impact on bed availability and the new facility became part of a continuing care retirement facility or other alternate services including independent living.

The moratorium on new nursing facility beds that has been in effect since September 1991 will expire on June 30, 2007. While current statutory language allows for the relocation of Medicaid certified beds between facilities it does not permit facility relocation to a new site. Provided the Department retains review and approval authority with regard to the number of beds relocated and costs to be allowed for Medicaid rate setting purposes, we do not object to this proposed change. A key concern for the Department will be maintaining sufficient beds in urban and certain rural areas to serve low-income populations.

It should be pointed out that the Department recommends extension of the moratorium in legislation for an additional five years as facility occupancy rates have been decreasing despite growth in the number of elderly in Connecticut due to home care, adult day care, assisted living and other alternatives. Through facility closures and reductions in capacity by a number of homes, the number of nursing facility beds has dropped from 32,240 in 1999 to 29,681 today. Under current law, the Department has authority to approve the relocation of beds from facility to facility. This flexibility under the moratorium has worked well in addressing targeted needs and we see this legislation as another mechanism to meet needs while staying on the path of providing alternatives to nursing facility care.

Proposed H. B. No. 5484 AN ACT CONCERNING ELIGIBILITY FOR THE QUALIFIED MEDICARE BENEFICIARY AND SPECIFIED LOW-INCOME BENEFICIARY PROGRAMS.

The department is concerned about the additional costs that this bill may entail, but believes that the basic concept has merit. By setting the income limits for the Medicare Savings Plan coverage groups, including Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Beneficiary (SLMB), as well as the Qualified Individual (QI) coverage group at a level to cover all ConnPACE recipients, the Medicare RX program will cover most prescription costs for the initial deductible and the doughnut hole. In addition, because eligibility for these coverage groups qualifies the recipient for the Medicare RX Low-Income Subsidy (LIS), there would be no cost for the Medicare RX premium. The question is whether the savings to the state resulting from this would be offset by the costs of paying the Medicare B premiums for the additional individuals that would qualify for this coverage. Currently the ConnPACE income limit is approximately 235% of the federal poverty level while the highest eligibility limit for the Medicare Savings Plans is about 160% of the federal poverty level. This means there could potentially be a large group of individuals who would enroll in the Medicare Savings Plans who are not currently enrolled in ConnPACE. There would also be additional administrative costs to the department for eligibility staff to manage this increased caseload that would have to be addressed.

The bottom line is that this is an intriguing proposal worthy of further consideration and analysis. The department would be willing to work with the committee to see if a change in this area might be possible that would be at least cost neutral to the state. Should further analysis reveal that making this change would result in additional costs to the state we would not be able to support this change.

Thank you again for allowing me this opportunity to testify this morning. I would be happy to answer any questions you may have.