



STATE OF CONNECTICUT  
OFFICE OF POLICY AND MANAGEMENT

**TESTIMONY PRESENTED TO THE HUMAN SERVICES COMMITTEE**  
**February 26, 2008**

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Testimony Supporting

Senate Bill No. 32, AN ACT CONCERNING THE FINANCIAL CONDITION OF NURSING HOMES,

Senate Bill 33, AN ACT IMPLEMENTING THE GOVERNOR'S RECOMMENDATIONS WITH RESPECT TO SOCIAL SERVICES PHARMACY PROGRAMS, AND

Senate Bill 34, AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS WITH RESPECT TO SOCIAL SERVICES PROGRAMS;

And Opposing

Raised Bill 5617, AN ACT DELAYING IMPLEMENTATION OF AND MAKING REVISIONS TO THE CHARTER OAK HEALTH PLAN, AND

Raised Bill 5618, AN ACT CONCERNING REVISIONS TO THE HUSKY PLAN.

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Senator Harris, Representative Villano and distinguished members of the Human Services Committee, thank you for the opportunity to offer testimony in support of the Governor's nursing home bill and two human services implementer bills, as well as in opposition to two other bills that are before you today.

Senate Bill 32, AAC THE FINANCIAL CONDITION OF NURSING HOMES, enhances the Department of Social Services' ability to conduct reviews of nursing facilities planning a change in ownership or control, expands requirements for nursing homes in receivership, reinvigorates the Nursing Home Financial Advisory Committee, and stiffens the financial reporting requirements for nursing homes. All of these actions will provide greatly enhanced oversight by DSS of nursing homes, with a goal of early identification of financial stress that could potentially lead to quality of care issues. With this sort of language in place, DSS will be better positioned to identify and address fiscal deterioration of the sort that led to the Haven Healthcare situation in November, and will provide greatly enhanced accountability for the nearly \$1.3 billion the state spends on nursing home care each year.

Senate Bill 33, AA IMPLEMENTING THE GOVERNOR'S RECOMMENDATIONS WITH RESPECT TO SOCIAL SERVICES PHARMACY PROGRAMS, ensures that DSS can continue to take advantage of Medicare Part D rebates as well as ensure that rebates can continue to be obtained with the recent carve-out of pharmacy services from HUSKY and SAGA.

Sections 1 and 2 of the bill provide for continuation of Medicare Part D rebates. The federal Centers for Medicare and Medicaid Services (CMS) recently clarified that the Department of Social Services cannot require pharmaceutical manufacturers to provide rebates on non-formulary drugs under Medicare Part D based on existing federal Medicaid rebates agreements. This determination was made on the basis that the dually eligible clients (i.e., clients eligible for both Medicare and Medicaid services) are, in this case, receiving prescription benefits under Medicare not Medicaid. As a result, the department was forced to return approximately \$3 million in non-formulary rebates. This bill allows for the continuation of the previous rebate policy but rather than relying on the federal Medicaid rebate agreement, separate provider agreements will be established with manufacturers similar to the agreements in place under ConnPACE that requires rebates from the manufacturers if they wish to participate in the program. This language is critical and should be expedited if we are to ensure that DSS can continue to obtain manufacturers' rebates estimated in the amount of \$6 million annually.

Section 3 of the bill will ensure continuation of rebates under DSS' pharmacy carve-out. Effective February 1, 2008, DSS carved-out the pharmacy benefit from the HUSKY A, HUSKY B and State Administered General Assistance (SAGA) programs and assumed responsibility for administering the program within the agency. Net savings are assumed in the budget based on the expectation that DSS will be able to maximize the level of rebates received from the pharmaceutical manufacturers. For the pharmacy carve-out to be successful, it is critical that this legislation be in place to ensure that manufacturers be required to pay rebates at levels that mirror Medicaid (similar to ConnPACE) for claims beginning February 1, 2008, the date of the pharmacy carve-out.

Note that without passage of this bill, over \$17 million would need to be added to DSS' budget for FY09. Early passage of this bill will ensure at least \$4 million of this amount can be collected.

Senate Bill 34, AA IMPLEMENTING THE GOVERNOR'S RECOMMENDATIONS WITH RESPECT TO SOCIAL SERVICES PROGRAMS, makes a variety of changes to implement the Governor's budget.

Section 1 eliminates FY 09 funding for interpreters under Medicaid. As the DSS commissioner testified last Thursday, an RFP for the interpretation services is anticipated with implementation by January 1, 2009. The Governor is supportive, subject to the agreement of the legislature, of carrying forward the approximately \$1.2 million appropriated for FY 08 into FY 09 to permit these services to move ahead. It's important to note that with all of the initiatives on DSS's plate, it is unlikely that anything could be in place sooner than January 1,

2009, so the \$4.7 million originally appropriated for this effort in FY 09 is not needed.

Section 2 of the bill updates the definition of medically necessary services under Medicaid to mirror the definition in use under the SAGA program since January 2005. The bill would change the definition of medical necessity to be consistent with generally accepted standards of medical practice and determined to be clinically appropriate, as opposed to the current definition under Medicaid which sets the benchmark at attaining or maintaining an "optimal level of health". In addition to being consistent with the SAGA standard, the proposed definition is consistent with the definition used by most commercial plans, as well as many states under their Medicaid programs. Savings of \$4.5 million in FY 09 are included in the budget for this change.

Section 3 of the bill limits rate increases for Residential Care Homes. Last year, the Governor proposed statutory language to limit rate increases for residential care homes to 2% in each year of the biennium. This language was removed during the implementer discussions based on an understanding at the time that the FY 08 and FY 09 appropriation could absorb increases greater than 2%. Based on expenditure trends, however, these uncapped rate increases are expected to generate deficiencies in the Aid to the Aged, Blind and Disabled accounts, which support residential care homes. To address this, this bill limits rate increases for residential care homes to 2% in FY 09 consistent with the rate increase provided for community living arrangements. Without this cap, expenditures are anticipated to be \$1.9 million in excess of the FY 09 appropriation.

Section 4 of the bill requires certification for medication administration. Current statute allows for personnel to obtain certification for the administration of medication from the Department of Public Health. This bill requires that residential care homes and boarding homes have an appropriate number of staff certified to administer medication to their residents, similar to the process used by the Department of Developmental Services. In general, nurses will still be required to administer all injections. While the Medicaid program will realize savings due to reduced reliance on nurse administration of medications, funds are provided to residential care homes to meet their costs associated with their staff administering the medications. Net savings of \$1.5 million in FY 09 are anticipated.

Section 5 of the bill increases from \$50 to \$100 the amount of current child support payments that is disregarded and passed through to families receiving Temporary Family Assistance (TFA). This is a real positive for TFA families. By increasing the disregard, families have a greater incentive to cooperate in securing child support for their children. Increasing the disregard will also result in fewer families being discontinued from TFA each month because of child support income as they will now have to have child support more than \$100, rather than \$50, above the payment standard before losing eligibility. This proposal is expected to result in a reduction in revenue of \$650,000. Note that we have identified a required change to the proposed effective date from July 1, 2008, to October 1, 2008.

Section 6 requires DSS to add hospice services as a coverage group under Medicaid. Prior to implementing the benefit, the bill requires consultation regarding the various service components to be considered in establishing a viable rate structure before moving forward. It is expected that this initiative will be cost neutral and in fact, at this point, it appears that Connecticut may be one of only two states that does not explicitly cover hospice services under Medicaid.

Sections 7 and 8 expand Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS). Until January 1, 2008, the Court Support Services Division (CSSD) within the Judicial Department provided intensive community services for children with serious psychiatric problems through its Adolescent Community Treatment (ACT) programs. These services included a mix of day programs and home-based services that were duplicative of services provided under DSS' Behavioral Health Partnership (BHP). Effective January 1, 2008, all CSSD children who are HUSKY A, HUSKY B or DCF involved will receive their services through the CT BHP. The costs of serving HUSKY children will be borne by DSS while the costs of serving non-HUSKY DCF involved children will be borne by DCF. All non-HUSKY/non-DCF involved children will continue to have their services paid for by CSSD. The conversion of CSSD services to IICAPS under BHP will enable the state to claim federal revenue for these services under Medicaid, to the extent that they are provided to children enrolled in HUSKY. Additional costs of nearly \$730,000 are anticipated in CSSD to serve the increased number of children receiving services as ordered by the court.

Section 9 of the bill allows special needs trusts in the state supplement program for certain boarding home residents. The income of boarding home residents may, over time, reach levels which makes those residents ineligible for assistance under the Aid to the Aged, Blind and Disabled (AABD) program. When this occurs, they are likely to move into a higher cost nursing home setting. This bill addresses this by allowing special needs trusts to be used to reduce the countable income of those boarding home residents whose increased income would have made them ineligible for AABD in order to avoid nursing home placement. Savings of \$284,000 in FY 09 are anticipated. I should note that we have identified the need for a minor change to the language to ensure that the income transferred to a special needs trust will not be counted toward the State Supplement gross income limit. On line 377 of the bill, after "under this section." insert the following new language: Any of the individual's excess available income that is transferred to a trust, as provided in this section, shall be excluded from consideration when determining the amount of income countable toward the program's gross income limit.

Let me also offer my opposition to Raised Bill 5617, AN ACT DELAYING IMPLEMENTATION OF AND MAKING REVISIONS TO THE CHARTER OAK HEALTH PLAN. The bill proposes many costly changes to the proposed benefit package and eligibility requirements. For instance, the bill

- Eliminates the six month requirement for being uninsured;
- Caps monthly premiums at \$250;
- Revises the annual deductible from \$1,000 to \$100;

- Eliminates the 20% deductible;
- Reduces non emergency ER visit co-pays from \$150 to \$20;
- Eliminates the \$1 million life time benefit cap;
- Includes dental and vision benefits and adds comprehensive mental health coverage;
- Adds a requirement for monthly reporting to the Medicaid Managed Care Council;
- Separates the Charter Oak procurement from the HUSKY procurement; and
- Requires a medical loss ratio of at least 85%.

It is understandable that the legislature wants to make the Charter Oak package a very rich benefit. However, the intent of the Charter Oak plan was to create an affordable plan with basic coverage. The changes included in this bill would essentially create an expansion of the HUSKY program, and with substantial cost increases. Although difficult to quantify, premium costs could increase 30% to 40%, pushing the annualized cost from \$53 million to well over \$70 million.

While the fiscal implications of this bill are huge, a more discouraging point is that this bill would delay implementation by one year. We simply cannot wait longer to provide an affordable health plan to those who do not qualify for HUSKY or for other state medical assistance programs. Last year during hearings on the Charter Oak proposal, members of the legislature continually asked the question, "How will you keep the benefit affordable? Do you think \$250 is a realistic monthly premium?" I can tell you that the changes proposed in Raised Bill 5617 would with absolute certainty create a product that is unaffordable—both to the individuals who need health coverage now, and to the state.

I am also opposed to Raised Bill 5618, AN ACT CONCERNING REVISIONS TO THE HUSKY PLAN. First, this bill restores Continuous Eligibility under the HUSKY program, which is estimated to cost \$15 million for coverage of approximately 5,000 individuals. The bill also would eliminate cost-sharing under HUSKY B, at a cost estimated at over \$7 million. The bill would further eliminate a requirement that HUSKY enrollees with employer-sponsored insurance take advantage of that insurance, with HUSKY providing any wrap-around coverage to ensure no loss of benefits. Eliminating this premium assistance requirement will cost \$4.9 million. By far the biggest concern we have is that this bill would delay the HUSKY reprocurement to July 1, 2009. First, let me say that DSS does not have the capacity to provide case management to over 330,000 HUSKY clients during FY 09, so there is a real risk that the gains we have seen in areas such as childhood immunizations will be compromised. Second, there could be substantial costs to leaving the system unmanaged for such a lengthy period of time. The efforts to reprocure the state employees and retirees health plan are instructive as to the benefits of the type of reprocurement that DSS is undertaking with respect to HUSKY, so let me take a few moments to discuss that process.

The Health Care Cost Containment Committee, which is a joint union/management venture set up through negotiations with the State Employees Bargaining Agent Coalition (SEBAC) and the Office of Policy and Management in conjunction with the Retirement and Benefits Division of the Office of the State Comptroller, have been in negotiations with medical, dental and pharmacy insurance carriers providing health care services for state employees and retirees. Based on these on-going negotiations, substantial savings are expected with respect to the FY 2008-09 budgeted amounts. The contracts, which begin July 1, 2008, reflect an overall increase of 1.1% versus 6.8% assumed in the enacted budget. These negotiations allowed the Governor's Budget to be adjusted down by \$55 million to reflect the revised costs of state employee and retiree health care insurance for FY 2008-09. I should note that the negotiations are on-going.

I would like to again thank the committee for the opportunity to present this testimony. I respectfully request the Committee support Senate bills 32, 33 and 34 (with modifications as noted in my testimony), and oppose House bills 5617 and 5618. I am happy to answer any questions you may have.