CHA CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
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CONNECTICUT HOSPITAL ASSOCIATION
BEFORE THE
HUMAN SERVICES COMMITTEE
Tuesday, March 11, 2008

HB 659, An Act Replacing Expedited Eligibility For Pregnant Women With Presumptive Eligibility Under The Social Security Act
HB 662, An Act Concerning Medicaid Eligibility And Reimbursement
HB 5905, An Act Modifying The Definition Of Preferred Provider Network And Clarifying Certain Provisions Of The Charter Oak Health Plan
HB 5910, An Act Concerning Legislative Oversight Of The Department Of Social Services
HB 5911, An Act Limiting Eligibility For The State-Administered Medical Assistance Program To Individuals Not Categorically Eligible For Medicaid

My name is Stephen Frayne and I am Senior Vice President, Health Policy of the Connecticut Hospital Association (CHA). I appreciate the opportunity to testify on behalf of CHA and its members on **HB 659, An Act Replacing Expedited Eligibility For Pregnant Women With Presumptive Eligibility Under The Social Security Act; HB 662, An Act Concerning Medicaid Eligibility And Reimbursement; HB 5905, An Act Modifying The Definition Of Preferred Provider Network And Clarifying Certain Provisions Of The Charter Oak Health Plan; HB 5910, An Act Concerning Legislative Oversight Of The Department Of Social Services;** and **HB 5911, An Act Limiting Eligibility For The State-Administered Medical Assistance Program To Individuals Not Categorically Eligible For Medicaid.**

SB 659, An Act Replacing Expedited Eligibility For Pregnant Women With Presumptive Eligibility Under The Social Security Act, as drafted, would replace the existing expedited eligibility process for pregnant women with presumptive eligibility. The apparent reason for this change is to allow Qualified Entities (QE's) to make the eligibility determination and speed up enrollment into the program. The downside of this change is that presumptive eligibility only covers "ambulatory pre-natal services" and thus excludes inpatient hospital services, services pregnant women clearly need. The irony is that hospitals as QE's would be part of the process that would make inpatient hospital care a noncovered service. Speeding up eligibility, while maintaining coverage for inpatient hospital services, can and should be accomplished together; to do so, the bill should be modified to require the Department of Social Services (DSS) to cover all available Medicaid services regardless of whether the cost of those services are matched by the federal government. The same modification would be required to section 1 of **SB 662, An Act Concerning Medicaid Eligibility And Reimbursement.**

HB 5905, An Act Modifying The Definition Of Preferred Provider Network And Clarifying Certain Provisions Of The Charter Oak Health Plan is intended to clarify certain provisions of the Charter Oak plan. Our understanding of the Charter Oak plan, based on DSS' description, is that Charter Oak is not Medicaid, but rather a commercial insurance product that offers affordable health

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insurance with a premium assistance mechanism for low-income enrollees. However, in the rollout of the Charter Oak plan, it appears the plan is beginning to morph into Medicaid. The clearest instance where the lines are being blurred is in the handling of mental health services. The Charter Oak request for proposal (RFP) declares that mental health services, to the extent covered, will be accessed through the Behavioral Health Partnership (BHP) and presumably reimbursed at the BHP rates. In order for this to occur, Charter Oak would have to be a Medicaid product, but it is not. This kind of blurring, if not corrected and left unchecked, will undermine the very progress we are all hoping will be achieved, i.e., to offer the uninsured who are not eligible for Medicaid or SAGA affordable access to commercial insurance products. We ask that you work with us to help clarify that Charter Oak is not a Medicaid product.

HB 5910, An Act Concerning Legislative Oversight Of The Department Of Social Services would require DSS to report quarterly on the implementation of new initiatives to committees of the legislature and the Office of Fiscal Analysis. It also requires review and comment on proposed regulations by the Human Services Committee, the Medicaid Managed Care Council, and the Behavioral Health Partnership Oversight Council. CHA supports these changes. Of concern, however, is changing the date in section 2 of the bill from May 23, 1984, to December 31, 2008, as the starting date when regulations had to be promulgated. Changing the date would deem actions taken in the intervening 24 years to be regulations, even if they were not adopted as regulations, as required effective May 23, 1984, effectively grandfathering all actions taken and not properly adopted. The date should remain unchanged and the bills should be amended to require DSS to report on how it has complied with this section in the intervening years. Finally, we ask that you add to the quarterly reporting requirement a report by healthcare providers, by year, of the Medicaid cost reports that remain unresolved and DSS' plans to close those years.

HB 5911, An Act Limiting Eligibility For The State-Administered Medical Assistance Program To Individuals Not Categorically Eligible For Medicaid, is intended to clarify the eligibility criteria for the SAGA program to ensure persons who would be categorically eligible for Medicaid are not excluded from the SAGA program. This proposal seems to run at cross-purposes of the current requirements of Section 17b-192 and, therefore, should be rejected. Since 2004, Section 17b-192 has required DSS to seek a waiver so that individuals enrolled in SAGA can be enrolled in Medicaid. The movement of SAGA individuals into Medicaid is essential for hospitals to be able to claim Medicare dollars they are otherwise entitled to receive. Every year that goes without a waiver, hospitals and the state forfeit $30 million dollars in federal reimbursement, reimbursement hospitals can ill afford to forego.

Thank you for considering our comments.