House of Representatives

General Assembly

File No. 509

January Session, 2009

Substitute House Bill No. 6402

House of Representatives, April 6, 2009

The Committee on Human Services reported through REP. WALKER of the 93rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING HUSKY REFORM.

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

Section 1. (NEW) (*Effective July 1, 2009*) (a) Not later than January 1, 2010, the Commissioner of Social Services shall seek federal reimbursement under the HUSKY program for the following services: (1) Screening of pregnant women and mothers of infants for behavioral health needs, including prenatal and postpartum depression, stress and anxiety; (2) medical services for a child under the age of five who is determined to be at high risk for a developmental disability due to a physical or mental condition of the child's mother, including, but not limited to, depression and substance abuse; (3) medical services for in-home therapy to a mother of an infant or a young child when the mother is diagnosed with depression and participates in a program certified by the Department of Social Services or the Department of Children and Families, including, but not limited to, the Child First program; (4) screening of new mothers for symptoms of postpartum depression during each visit to a licensed health care professional

during the first six months after the birth of the child; and (5) mental health services provided by practitioners who participate in evidence-based models and are certified by the Department of Social Services or the Department of Children and Families.

(b) The Commissioner of Social Services shall study the results of the screening services described in subsection (a) of this section. Not later than July 1, 2010, and annually thereafter, the commissioner shall submit a report on the results of such studies to the advisory council on Medicaid managed care, established pursuant to section 17b-28 of the general statutes.

Sec. 2. Section 17a-22i of the general statutes is amended by adding subsection (c) as follows (*Effective July 1, 2009*):

(NEW) (c) The Behavioral Health Partnership, in coordination with the administrative services organization, shall: (1) Develop HUSKY managed care organizations and professional associations that include providers of pediatric, obstetrics and gynecology services and family practitioners; (2) develop practitioner training for screening of prenatal and postpartum depression; and (3) provide referrals for services that are provided through the Behavioral Health Partnership.

Sec. 3. (NEW) (*Effective July 1, 2009*) (a) Any licensed health care professional who provides prenatal care to a patient shall provide such patient with information concerning postpartum depression.

(b) Any licensed health care professional that provides postnatal care to a patient shall screen such patient for symptoms of postpartum depression during each visit during the first six months after the patient gives birth to the child.

Sec. 4. (NEW) (*Effective July 1, 2009*) Not later than January 1, 2010, the Commissioner of Social Services shall develop and implement a provider-directed care coordination program for HUSKY recipients. The program shall provide payment to primary care providers for care coordination services provided to persons who require care beyond

that offered by a primary care physician. To be eligible for such payment, a provider shall: (1) Develop written care plans that include evidence of family participation; (2) have staff members dedicated to care coordination; (3) maintain documentation of care plans; (4) be designated as the patient's provider by patient selection or by assignment, if the patient does not make any selection; (5) provide services twenty-four hours per day, seven days per week; (6) arrange for the patient's comprehensive health care needs; and (7) provide integration, coordination and continuity of care with referrals for specialty care and other necessary health care services.

Sec. 5. Section 17b-260c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

[The**]** Not later than September 1, 2009, the Commissioner of Social Services shall apply for a Medicaid waiver, pursuant to Section 1115 of the Social Security Act, for the purpose of providing coverage for family planning services to adults in households with income that does not exceed one hundred eighty-five per cent of the federal poverty level and who are not otherwise eligible for Medicaid services. If the commissioner fails to apply for such waiver by said date, the commissioner shall, not later than September 15, 2009, submit a written report in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to human services explaining the reasons for such failure.

Sec. 6. Section 17b-278a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

The Commissioner of Social Services shall amend the Medicaid state plan to provide coverage for treatment for smoking cessation ordered by a licensed health care professional who possesses valid and current state licensure to prescribe such drugs. **[**in accordance with a plan developed by the commissioner to provide smoking cessation services. The commissioner shall present such plan to the joint standing committees of the General Assembly having cognizance of matters

relating to human services and appropriations by January 1, 2003, and, if such plan is approved by said committees and funding is provided in the budget for the fiscal year ending June 30, 2004, such plan shall be implemented on July 1, 2003. If the initial treatment provided to the patient for smoking cessation, as allowed by the plan, is not successful as determined by a licensed health care professional, all prescriptive options for smoking cessation shall be available to the patient.**]**

Sec. 7. (NEW) (*Effective from passage*) (a) Not later than January 1, 2010, the Commissioner of Social Services shall apply for a waiver of federal law under the Health Insurance Flexibility and Accountability demonstration initiative for the purpose of extending health insurance coverage under Medicaid to persons qualifying for medical assistance under (1) the state-administered general assistance program, and (2) the Charter Oak Health Plan, established pursuant to section 17b-311 of the general statutes. The commissioner shall submit, in accordance with the provisions of section 11-4a of the general statutes, the application for the waiver to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations prior to submitting the application to the federal government in accordance with section 17b-8 of the general statutes.

(b) If the commissioner fails to submit the application for the waiver to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations by January 1, 2010, the commissioner shall submit a written report to said committees not later than January 2, 2010. The report shall include, but not be limited to: (1) An explanation of the reasons for failing to seek the waiver; and (2) an estimate of the cost savings that would result from the approval of the waiver in one calendar year.

Sec. 8. Section 17b-257a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2009*):

(a) Qualified aliens, as defined in **[**section**]** Section 431 of Public Law 104-193, admitted into the United States prior to August 22, 1996, shall

be eligible for Medicaid provided other conditions of eligibility are met. Qualified aliens admitted into the United States on or after August 22, 1996, shall be eligible for Medicaid subsequent to five years from the date admitted, except if the individual is otherwise qualified for the purposes of state receipt of federal financial participation under Title IV of Public Law 104-193, such individual shall be eligible for Medicaid regardless of the date admitted.

(b) Not later than January 1, 2010, the Commissioner of Social Services shall seek federal funds to provide medical assistance to qualified alien children and pregnant women whose date of admission into the United States is less than five years before the date services are provided.

Sec. 9. (NEW) (*Effective July 1, 2009*) Not later than January 1, 2010, the Commissioner of Social Services shall apply for a waiver from the State Children's Health Insurance Program (SCHIP), under Section 1115 of the Social Security Act, 42 USC 1315, as amended from time to time, to provide funding for supports and services to children with special health care needs in home and community settings. The commissioner shall seek such waiver to expand services available under the HUSKY Plus supplemental benefits package and to extend HUSKY Plus supplemental benefits regardless of income through a buy-in premium based option.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2009*	New section
Sec. 2	*July 1, 2009*	17a-22i
Sec. 3	*July 1, 2009*	New section
Sec. 4	*July 1, 2009*	New section
Sec. 5	*July 1, 2009*	17b-260c
Sec. 6	*July 1, 2009*	17b-278a
Sec. 7	*from passage*	New section
Sec. 8	*July 1, 2009*	17b-257a
Sec. 9	*July 1, 2009*	New section

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 House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 10 $	FY 11 $
Department of Social Services	GF - Cost	Significant	Significant

Municipal Impact: None

Explanation

Section 1 of the bill requires the Department of Social Services (DSS) to seek federal reimbursement under the HUSKY program for a variety of mental health services. It is assumed that this requirement would lead to additional costs that would be reflected in future negotiated rates with the HUSKY managed care organizations. The extent of these costs is unknown, but presumed to be significant.

Section 2 requires the Behavioral Health Partnership (BHP) to add additional components to the behavioral health services provided to HUSKY recipients. It is assumed that this requirement would lead to additional costs that would be reflected in future negotiated rates with the BHP administrative service organizations. The extent of these costs is unknown, but presumed to be significant.

Section 3 adds informational and screening requirements concerning postpartum depression for all licensed health care professionals. To the extent that any costs associated with this requirement are passed on to the state under medical assistance programs or state employee health costs, additional state costs may result.

Section 4 requires DSS to implement a provider directed care coordination program for HUSKY recipients. This provision implements current practice as the primary care case management

system currently being implemented by DSS appears to meet the bill's requirements. As such, no additional cost to the state is anticipated.

Section 5 requires DSS to apply for a Medicaid family planning waiver by September 1, 2009. It is anticipated the DSS will incur an administrative cost of up to $200,000 to develop this waiver. The cost of this waiver would be dependent upon what services are allowed under the plan, which cannot be known in advance. Experience in other states has shown that family planning expenditures can result in significant savings through reduced Medicaid funded deliveries. The FY 10-11 biennial budget (as approved by the Appropriations Committee) contains $2 million in each year to provide family planning services, and assumes a savings of $6 million in FY 11. Services provided under a family planning waiver are reimbursed at 90% by the Federal Medicaid program.

DSS will also incur additional administrative costs (likely between $100,000 and $200,000) for staff and contractual obligations necessary to develop and submit such a waiver.

Section 6 requires Medicaid coverage of smoking cessation treatment. Depending on the plan developed, the annual cost is estimated to be between $1,175,000 and $3,948,000.

POPULATION

There are approximately 188,000 adults receiving health services through Medicaid (80,000 in fee for service and 108,000 in HUSKY). It is unknown how many in this population smokes and would attempt to quit. Assuming that 20% of this population smokes, and that 25% of these smokers will attempt to quit, the Office of Fiscal Analysis assumes that smoking cessation services would be provided to 9,400 people annually.

COST ESTIMATE

The total cost of this service extension will depend upon the Medicaid amendment to be developed by DSS. Such plan could

include a wide range of services with varying costs, from nicotine chewing gum to pharmaceuticals to psychiatric counseling. It is expected that DSS will include measures within this plan to manage services and contain costs. Therefore, until the department develops such a plan, the total cost of this bill can only be estimated.

The table below details two potential cost scenarios, both of which assume certain cost containment measures. The first is based on a plan that covers two quit attempts of up to 90 days per year, which has been implemented in other states. The estimated annual cost per case for this coverage is $125, which results in an annual cost of $1.175 million. Extrapolating the first scenario to more expansive coverage, as may be necessary under the Medicaid program results in a per person cost of $420, illustrated as scenario two below.

Scenario	Participants	Cost per Person	Annual Cost
One	9,400	$125	$1,175,000
Two	9,400	$420	$3,948,000

As stated above, the final cost will depend upon the plan implemented by DSS. The costs illustrated in the table represent a likely range of costs.

Section 7 requires the Department of Social Services to enroll State Administered General Assistance (SAGA) and Charter Oak Health Plan clients in Medicaid via a federal Health Insurance Flexibility and Accountability (HIFA) waiver. The bill also repeals a section of statute that previously required SAGA to be expanded and included in Medicaid. This section was never implemented, and therefore has no fiscal impact.

Currently, the state only receives federal reimbursement (via the Disproportionate Share Hospital grant) for the hospital inpatient and outpatient portions of the SAGA program. The following table illustrates the FY 10 current services estimated costs for SAGA:

	FY 10
Hospital Payments	$ 61,322,400
Other Medical Payments	$ 121,393,055
GA Managed Care (DMHAS)	$ 83,281,389
TOTAL	**$ 265,996,844**
Fed Revenue - DSS	$ (30,661,200)
Fed Revenue - DMHAS	$ (7,495,325)
Net State Program Costs	**$ 227,840,319**

As indicated by the table, there are approximately $190 million in non-hospital SAGA costs (including behavioral health care) that are not currently eligible for federal reimbursement. The state receives no federal reimbursement for Charter Oak expenditures, estimated in FY 10 to be $20.8 million.

It cannot be anticipated what the structure of the HIFA waiver submitted by the department will be, nor what the federal government may require prior to final approval of federal financial participation. (For the purposes of this analysis, it is assumed that any such waiver is specific only to the SAGA and Charter Oak programs, and does not alter the structure of the current state Medicaid program.)

HIFA waivers allow states great flexibility in structuring benefits. Both the SAGA and Charter Oak program have substantially different benefit plans and payment mechanisms as compared to the Medicaid program. Should the federal government simply allow these program structures to be maintained while providing federal reimbursement (which is unlikely), the state would realize a net revenue gain of $95 million.

It is more likely that the federal government would require substantial changes in these programs prior to waiver approval. These changes would likely increase the overall cost of the program, thereby reducing the net state gain. Although the changes required cannot be anticipated, the state would likely see a net gain even with substantial

increases (up to 70%) in the overall programmatic costs.

DSS will also incur additional administrative costs (likely between $100,000 and $200,000) for staff and contractual obligations necessary to develop and submit such a waiver.

Section 8 requires DSS to seek federal funds for eligible children and pregnant women who are legal immigrants. The recent federal State Children's Health Insurance program (SCHIP) reauthorization allows states to receive the enhanced match (65% for Connecticut) for this population. DSS currently expends $23.6 million annually on medical services for legal immigrants with no federal reimbursement. Assuming that roughly half these costs are for pregnant women and children, the state would realize a revenue gain of $7.67 million annually from this provision.

Section 9 requires DSS to pursue a federal SCHIP waiver for children with special health care needs. It is assumed that this requirement would lead to additional costs that would be reflected in future negotiated rates with the HUSKY managed care organizations. The additional cost will be dependent upon the extent of the service expansion, which cannot be known prior to the development of the waiver. DSS will also incur additional administrative costs (likely between $100,000 and $200,000) for staff and contractual obligations necessary to develop and submit such a waiver.

The Out Years

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

Sources: DSS cost and caseload data, FY 10-11 biennial budget recommendations, outside research

OLR Bill Analysis
sHB 6402

AN ACT CONCERNING HUSKY REFORM.

SUMMARY:

This bill requires licensed health care professionals who provide pre- and postnatal care to women to provide them with information about, and screen them for, postpartum depression. It also requires the Department of Social Services (DSS) to cover specific mental health screenings and related services for HUSKY recipients. And it requires the Behavioral Health Partnership (BHP) to play a role in the provision of these services.

The bill also requires DSS to (1) extend medical assistance to certain legal aliens and (2) apply for federal waivers to (a) enable more children with special health care needs to get services, (b) provide family planning services to more women, and (c) obtain federal Medicaid matching funds for two state-funded medical assistance programs.

The bill requires the DSS commissioner to develop and implement a provider-directed care coordination program for HUSKY recipients.

And it revises the law that directs DSS to provide Medicaid coverage for smoking cessation treatment.

EFFECTIVE DATE: July 1, 2009, except the provision requiring the waiver for Medicaid coverage of State Administered General Assistance (SAGA) and Charter Oak is effective upon passage.

SCREENINGS FOR POSTPARTUM DEPRESSION

The bill requires licensed health care professionals who provide prenatal care to provide a patient with information about postpartum

depression. It also requires such professionals providing postnatal care to women to screen them for postpartum depression symptoms during each visit in the first six months after they give birth.

MENTAL HEALTH SCREENINGS IN HUSKY

The bill requires HUSKY coverage for certain mental health services. These include:

1. screenings of pregnant women and mothers of infants for behavioral health needs, including prenatal and postpartum depression, stress, and anxiety;

2. medical services for a child under age five determined to be at high risk for a developmental disability due to the mother's physical or mental condition, which could include depression or substance abuse;

3. medical services for in-home therapy to a mother of an infant or young child when the mother is diagnosed as depressed and participates in a program certified by DSS or the Department of Children and Families, including the Child First program;

4. screening of new mothers for postpartum depression symptoms during each visit to a licensed health care professional during the fist six months after the child's birth; and

5. mental health services provided by practitioners who (a) participate in evidence-based models and (b) are DSS- or DCF-certified.

The bill requires the DSS commissioner to study the results of the screenings and report on them annually to the Medicaid Managed Care Council, with the first report due by July 1, 2010.

BEHAVIORAL HEALTH PARTNERSHIP (BHP)

The bill requires the BHP, in coordination with the administrative services organization (Value Options, Inc.) with which it contracts, to provide behavioral health services to HUSKY recipients to:

1. develop HUSKY managed care organizations and professional associations that include providers of pediatric, obstetrics and gynecology services, and family practitioners;

2. develop practitioner training for screening of prenatal and postpartum depression; and

3. provide referrals for BHP services.

DSS and DCF formed the BHP to plan and implement an integrated behavioral health service system for children and families. BHP's primary goal is to provide enhanced access to, and coordination of, a more complete and effective system of community-based behavioral health services and supports and to improve member outcomes.

MEDICAL ASSISTANCE FOR PREGNANT WOMEN AND CHILDREN WHO ARE QUALIFIED ALIENS

The bill requires the DSS commissioner, by January 1, 2010, to seek federal funds to provide medical assistance to qualified alien children and pregnant women who were admitted into the U.S. less than five years before the "date services are provided."

The recently passed federal Children's Health Insurance Program Reauthorization Act (CHIPRA, PL 111-3) permits states to claim federal Medicaid (HUSKY A in Connecticut) and State Children's Health Insurance Program (SCHIP, HUSKY B) funds to provide health care coverage to pregnant women and children who are recent (within five years) immigrants.

Federal 1996 welfare reform law generally bars legal immigrants who have been in the U.S. for fewer than five years from receiving federally funded assistance. States can provide this assistance with state-only funds, which Connecticut has done since 1997.

WAIVER FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The bill requires this waiver to provide funding for supports and services in home and community settings to children with special health care needs. The waiver must also (1) expand services available

under the HUSKY Plus program and (2) extend HUSKY Plus to individuals regardless of income through a "buy-in premium-based option."

The state uses its SCHIP block grant primarily to fund the HUSKY B and HUSKY Plus programs, the latter of which provides supplemental services to children with severe physical disabilities. To qualify for HUSKY Plus, a family must be eligible for HUSKY B, the income limit for which is 300% of the federal poverty level (FPL). Families with higher incomes can buy into HUSKY B, but their children are not eligible for HUSKY Plus benefits.

FAMILY PLANNING WAIVER

PA 05-120 directed DSS to seek a federal Medicaid 1115 waiver to provide family planning coverage to adults in households with income up to 185% of the FPL. (These are individuals who would not otherwise qualify for HUSKY A.) DSS never requested the waiver.

The bill requires the commissioner to (1) apply for this waiver by September 1, 2009 or (2) if he fails to do so, report to the Human Services Committee by September 15, 2009 explaining the reasons why.

WAIVER FOR MEDICAID COVERAGE OF SAGA AND CHARTER OAK HEALTH PLAN

The bill requires the DSS commissioner, by January 1, 2010, to apply for a federal Health Insurance and Flexibility and Accountability (HIFA) demonstration waiver to provide Medicaid coverage to individuals qualifying for either the SAGA medical assistance program or the Charter Oak Health Plan (see BACKGROUND). Currently, state funds are used to pay for the SAGA program and the subsidized portion of the Charter Oak Health Plan. Medicaid coverage would provide a federal match for these state expenditures.

The bill requires the commissioner to submit the application to the Human Services and Appropriations committees before sending it to the federal Medicaid agency, in accordance with state law. If he fails to

do so by the above date, he must report to both committees explaining (1) why he has not done so and (2) an estimate of the cost savings that such a waiver would provide in a single calendar year. This report must be submitted by January 2, 2010.

Current law requires the DSS commissioner, by January 1, 2008, to seek a waiver to cover SAGA recipients with income up to 100% of the federal poverty level. He never sought the waiver.

PROVIDER-DIRECTED CARE COORDINATION FOR HUSKY RECIPIENTS

The bill's provider-directed care coordination program must pay primary care providers (PCP) for care coordination services they provide to individuals who need care beyond what the PCP offers.

To qualify for these payments, a provider must:

1. develop written care plans that include evidence of family participation;
2. have staff members dedicated to care coordination;
3. maintain documentation of care plans;
4. be designated as the patient's provider by patient selection or by assignment when the patient does not choose a provider;
5. provide services 24 hours per day, seven days per week;
6. arrange for the patient's comprehensive health care needs; and
7. provide integration, coordination, and continuity of care with referrals for specialty care and other necessary health care services.

DSS is currently running a pilot primary care case management program for HUSKY recipients in two parts of the state. The program contains many of the same elements that the bill's program includes.

SMOKING CESSATION

In 1999, the legislature directed DSS to amend the Medicaid state plan to provide coverage for smoking cessation treatment. In 2002, the requirement was amended to ensure it was treatment ordered by a licensed health care professional, in accordance with a plan it submitted to the Human Services and Appropriations committees by January 1, 2003. In 2008, the legislature added a requirement that all prescriptive options had to be available to patients if the initial treatment failed. DSS has never amended the Medicaid plan.

The bill repeals all of these provisions except for the one requiring DSS to amend the plan for smoking cessation treatment.

BACKGROUND

Child First Program

This model program is designed to decrease the incidence of serious emotional disturbance, developmental and learning problems, and abuse and neglect among high-risk young children in the greater Bridgeport area. When mental health or child developmental problems first arise, the program works with pediatricians, teachers, and other community providers to identify, assess, and intervene with these children and their families.

Federal Waivers

Federal Medicaid law (Section 1115 of the Social Security Act) allows states to request "demonstration" waivers of federal rules to expand health care coverage when those rules would otherwise not allow this or to limit whom the program covers. These waivers generally run for five years but can be renewed.

The federal government introduced the HIFA waiver in 2001, which used the existing 1115 Medicaid waiver to encourage states, through their Medicaid- and State Children's Health Insurance Program-funded programs, to experiment with alternate strategies in an effort to reduce the number of uninsured residents. The federal Medicaid agency gave states broad authority under these waivers, including

limiting enrollment, modifying benefit structures, and increasing beneficiaries' cost sharing which, without the waiver, would not be allowed. At the same time, states were expected to expand coverage.

States may still request 1115 waivers, which are research and demonstration waivers that allow states to experiment with coverage. These states must be able to demonstrate that they are "budget neutral" over the life of the demonstration, meaning they cannot be expected to cost the federal government more than it would cost without the waiver.

Legislative Approval of Waivers—CGS §17b-8

State law requires the DSS commissioner, when submitting an application for a federal waiver for anything more than routine operational issues, to submit the waiver to the Human Services and Appropriations committees before sending it to the federal government. The committees have 30 days to hold a hearing and advise the commissioner of their approval, denial, or modification. If the committees deny the application, the commissioner may not submit it to the federal government. The law also sets up a process for when the committees do not agree. If the committees do not act within the 30-day period, the application is deemed approved.

Medicaid Coverage for SAGA

In 2003, the legislature directed DSS to seek a Medicaid waiver to cover SAGA medical assistance recipients by March 1, 2004 (PA 03-3, June 30 SS). In 2007, the legislature extended the deadline to January 1, 2008 and extended the waiver to individuals with incomes up to 100% of the FPL (PA 07-185). Currently, SAGA medical assistance is available to individuals with income up to about 55% of the FPL.

Charter Oak Health Plan

Since August 2008, the Charter Oak Health Plan has offered state residents another health insurance option. Individuals must be uninsured for at least six months to qualify, and benefits are provided by managed care organizations with which DSS contracts. The state

provides both premium and deductible assistance to individuals whose incomes are under 300% of the FPL.

Related Bills

sSB 988 (File 195) requires DSS to seek a HIFA waiver for SAGA and Charter Oak by January 1, 2010. sHB 6417, requires DSS, by January 1, 2010, to seek a federal waiver to cover SAGA recipients.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 13 Nay 6 (03/19/2009)