



Senate

General Assembly

File No. 913

January Session, 2009

Substitute Senate Bill No. 988

Senate, May 7, 2009

The Committee on Appropriations reported through SEN. HARP of the 10th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING MEDICAID FUNDING FOR SAGA AND CHARTER OAK.

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

1 Section 1. (NEW) (*Effective from passage*) (a) Not later than January 1,
2 2010, the Commissioner of Social Services shall apply for a Medicaid
3 Research and Demonstration Waiver under Section 1115 of the Social
4 Security Act for the purpose of extending health insurance coverage
5 under Medicaid to persons qualifying for medical assistance under (1)
6 the state-administered general assistance program, and (2) the Charter
7 Oak Health Plan, established pursuant to section 17b-311 of the general
8 statutes. The commissioner shall submit the application for the waiver
9 to the joint standing committees of the General Assembly having
10 cognizance of matters relating to human services and appropriations
11 prior to submitting the application to the federal government in
12 accordance with section 17b-8 of the general statutes.

13 (b) If the commissioner fails to submit the application for the waiver
14 to the joint standing committees of the General Assembly having

15 cognizance of matters relating to human services and appropriations
16 by January 1, 2010, the commissioner shall submit a written report to
17 said committees not later than January 2, 2010. The report shall
18 include, but not be limited to: (1) An explanation of the reasons for
19 failing to seek the waiver; and (2) an estimate of the cost savings that
20 would result from the approval of the waiver in one calendar year.

21 Sec. 2. Section 17b-192 of the general statutes is repealed and the
22 following is substituted in lieu thereof (*Effective from passage*):

23 (a) The Commissioner of Social Services shall implement a state
24 medical assistance component of the state-administered general
25 assistance program for persons ineligible for Medicaid. Eligibility
26 criteria concerning income shall be the same as the medically needy
27 component of the Medicaid program, except that earned monthly
28 gross income of up to one hundred fifty dollars shall be disregarded.
29 Unearned income shall not be disregarded. No person who has family
30 assets exceeding one thousand dollars shall be eligible. No person shall
31 be eligible for assistance under this section if such person made,
32 during the three months prior to the month of application, an
33 assignment or transfer or other disposition of property for less than
34 fair market value. The number of months of ineligibility due to such
35 disposition shall be determined by dividing the fair market value of
36 such property, less any consideration received in exchange for its
37 disposition, by five hundred dollars. Such period of ineligibility shall
38 commence in the month in which the person is otherwise eligible for
39 benefits. Any assignment, transfer or other disposition of property, on
40 the part of the transferor, shall be presumed to have been made for the
41 purpose of establishing eligibility for benefits or services unless such
42 person provides convincing evidence to establish that the transaction
43 was exclusively for some other purpose.

44 (b) Each person eligible for state-administered general assistance
45 shall be entitled to receive medical care through a federally qualified
46 health center or other primary care provider as determined by the
47 commissioner. The Commissioner of Social Services shall determine

48 appropriate service areas and shall, in the commissioner's discretion,
49 contract with community health centers, other similar clinics, and
50 other primary care providers, if necessary, to assure access to primary
51 care services for recipients who live farther than a reasonable distance
52 from a federally qualified health center. The commissioner shall assign
53 and enroll eligible persons in federally qualified health centers and
54 with any other providers contracted for the program because of access
55 needs. Each person eligible for state-administered general assistance
56 shall be entitled to receive hospital services. Medical services under the
57 program shall be limited to the services provided by a federally
58 qualified health center, hospital, or other provider contracted for the
59 program at the commissioner's discretion because of access needs. The
60 commissioner shall ensure that ancillary services and specialty services
61 are provided by a federally qualified health center, hospital, or other
62 providers contracted for the program at the commissioner's discretion.
63 Ancillary services include, but are not limited to, radiology, laboratory,
64 and other diagnostic services not available from a recipient's assigned
65 primary-care provider, and durable medical equipment. Specialty
66 services are services provided by a physician with a specialty that are
67 not included in ancillary services. Ancillary or specialty services
68 provided under the program shall not exceed such services provided
69 under the state-administered general assistance program on July 1,
70 2003, except for nonemergency medical transportation and vision care
71 services which may be provided on a limited basis within available
72 appropriations. Notwithstanding any provision of this subsection, the
73 commissioner may, when determined cost effective, provide or require
74 a contractor to provide home health services or skilled nursing facility
75 coverage for state-administered general assistance recipients being
76 discharged from a chronic disease hospital.

77 (c) Pharmacy services shall be provided to recipients of state-
78 administered general assistance through the federally qualified health
79 center to which they are assigned or through a pharmacy with which
80 the health center contracts. Recipients who are assigned to a
81 community health center or similar clinic or primary care provider
82 other than a federally qualified health center or to a federally qualified

83 health center that does not have a contract for pharmacy services shall
84 receive pharmacy services at pharmacies designated by the
85 commissioner. The Commissioner of Social Services or the managed
86 care organization or other entity performing administrative functions
87 for the program as permitted in subsection (d) of this section, shall
88 require prior authorization for coverage of drugs for the treatment of
89 erectile dysfunction. The commissioner or the managed care
90 organization or other entity performing administrative functions for
91 the program may limit or exclude coverage for drugs for the treatment
92 of erectile dysfunction for persons who have been convicted of a sexual
93 offense who are required to register with the Commissioner of Public
94 Safety pursuant to chapter 969.

95 (d) The Commissioner of Social Services shall contract with
96 federally qualified health centers or other primary care providers as
97 necessary to provide medical services to eligible state-administered
98 general assistance recipients pursuant to this section. The
99 commissioner shall, within available appropriations, make payments
100 to such centers based on their pro rata share of the cost of services
101 provided or the number of clients served, or both. The Commissioner
102 of Social Services shall, within available appropriations, make
103 payments to other providers based on a methodology determined by
104 the commissioner. The Commissioner of Social Services may reimburse
105 for extraordinary medical services, provided such services are
106 documented to the satisfaction of the commissioner. For purposes of
107 this section, the commissioner may contract with a managed care
108 organization or other entity to perform administrative functions,
109 including a grievance process for recipients to access review of a denial
110 of coverage for a specific medical service, and to operate the program
111 in whole or in part. Provisions of a contract for medical services
112 entered into by the commissioner pursuant to this section shall
113 supersede any inconsistent provision in the regulations of Connecticut
114 state agencies. A recipient who has exhausted the grievance process
115 established through such contract and wishes to seek further review of
116 the denial of coverage for a specific medical service may request a
117 hearing in accordance with the provisions of section 17b-60.

118 (e) Each federally qualified health center participating in the
 119 program shall enroll in the federal Office of Pharmacy Affairs Section
 120 340B drug discount program established pursuant to 42 USC 256b to
 121 provide pharmacy services to recipients at Federal Supply Schedule
 122 costs. Each such health center may establish an on-site pharmacy or
 123 contract with a commercial pharmacy to provide such pharmacy
 124 services.

125 (f) The Commissioner of Social Services shall, within available
 126 appropriations, make payments to hospitals for inpatient services
 127 based on their pro rata share of the cost of services provided or the
 128 number of clients served, or both. The Commissioner of Social Services
 129 shall, within available appropriations, make payments for any
 130 ancillary or specialty services provided to state-administered general
 131 assistance recipients under this section based on a methodology
 132 determined by the commissioner.

133 [(g) On or before January 1, 2008, the Commissioner of Social
 134 Services shall seek a waiver of federal law for the purpose of extending
 135 health insurance coverage under Medicaid to persons with income not
 136 in excess of one hundred per cent of the federal poverty level who
 137 otherwise qualify for medical assistance under the state-administered
 138 general assistance program. The provisions of section 17b-8 shall apply
 139 to this section.]

140 [(h)] (g) The commissioner, pursuant to section 17b-10, may
 141 implement policies and procedures to administer the provisions of this
 142 section while in the process of adopting such policies and procedures
 143 as regulation, provided the commissioner prints notice of the intent to
 144 adopt the regulation in the Connecticut Law Journal not later than
 145 twenty days after the date of implementation. Such policy shall be
 146 valid until the time final regulations are adopted.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	New section

Sec. 2	<i>from passage</i>	17b-192
--------	---------------------	---------

APP *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect
Social Services, Dept.	GF - See Below

Note: GF=General Fund

Municipal Impact: None

Explanation

This bill requires the Department of Social Services to enroll State Administered General Assistance (SAGA) and Charter Oak Health Plan clients in Medicaid via a federal 1115 Research and Demonstration 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:

	FY10
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 1115 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.)

Medicaid 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

The Out Years

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

Sources: DSS cost and caseload data, current services budget estimates, OLR bill summary, public hearing testimony.

OLR Bill Analysis**sSB 988*****AN ACT CONCERNING MEDICAID FUNDING FOR SAGA AND CHARTER OAK.*****SUMMARY:**

This bill requires the Department of Social Services (DSS) commissioner, by January 1, 2010, to apply for a federal Medicaid 1115 demonstration waiver to provide Medicaid coverage to individuals qualifying for either the State-Administered General Assistance (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 federal matching funds 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 January 1, 2010, he must submit a written report to both committees, by January 2, 2010, 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.

Under current law, the DSS commissioner, by January 1, 2008, was to have sought a waiver to cover SAGA recipients with income up to 100% of the federal poverty level. He never sought the waiver. The bill repeals this separate provision.

EFFECTIVE DATE: Upon passage

BACKGROUND***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 such, or to limit whom the program covers. These waivers are generally good for five years unless renewed.

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 applying for a federal waiver for other than routine operational issues, to submit the application 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 of it. If they 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 from March 1, 2004 until January 1, 2008 and extended it 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. The state provides both premium and deductible assistance to individuals whose incomes are under 300% of the federal poverty level.

Legislative History

The Senate referred the bill (File 195) to Appropriations, which removed a requirement that the waiver have a certain designation.

Related Bills

SHB 6402 (File 509) requires DSS to seek a federal waiver for SAGA and Charter Oak by January 1, 2010.

COMMITTEE ACTION

Human Services Committee

Joint Favorable

Yea 12 Nay 6 (03/10/2009)

Appropriations Committee

Joint Favorable Substitute

Yea 35 Nay 14 (04/27/2009)