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March 3, 2009

Testimony before the Human Services Committee

Members of the Human Services Committee:

I am Randi Faith Mezzy, an attorney with Connecticut Legal Services, one of four legal aid organizations working to enforce the rights of Connecticut's poor people. I am here to highlight dangerous threats to our Medicaid recipients that would occur if the Governor's budgetary cuts are enacted through SB 843.

The Governor proposes to cut \$273 million from health care programs at a time when the federal government has recognized the need to respond to the state's most vulnerable residents by increasing the federal Medicaid reimbursement and infusing \$1.3 billion back to the state for health care expenditures. Not only would the Governor's cuts mean denials of critical health care for our neediest residents but it would also mean that we will actually turn away over a billion dollars in federal funds to which we now have access. That makes no sense. The proposals that will greatly harm CT's low-income residents include the following:

Gutting the Definition of "Medically Necessary Services"

I want to address the subtle and seemingly innocuous change in wording that the Department of Social Services (DSS) proposes in its long-standing definitions of "medically appropriate services" and "medically necessary services."

The Governor claims that these changes will save millions of dollars for the state of Connecticut. That is not entirely true. What these changes will do is nothing less than to cut out the heart and soul of our state's Medicaid program:

This so-called "modernization" of the MN definition is simply a way for DSS and its subcontractors to issue MORE DENIALS OF ESSENTIAL MEDICAL SERVICES. There will be no benefit whatsoever to Connecticut's Medicaid recipients. In the long run, there is no benefit to Connecticut's taxpayers either, if necessary preventive and treatment services are denied. Eventually, we all end up



paying for those untreated health conditions, after they have worsened and become critical.

I know that over the years, many members of this committee have heard Medicaid horror stories about kids being denied needed medications or being kicked out of the hospital before they were really well. I know that no one here wants to be a party to allowing that to happen.

The Managed Care Organizations are once again running Medicaid for children and families in Connecticut, and most of the so-called savings will benefit them. When they deny needed treatment by using a new definition of medical necessity, the MCOs - not DSS, not the taxpayers -- get to keep more money. They have an incentive to deny care anyway, which has been built into the Medicaid Managed Care program from its inception back in the 90s when it was created as a capitated risk-based system. This proposed change simply gives them a bigger, wider, more profit-driven "DENIED" stamp.

It's important to remember that Medicaid Managed Care was supposed to save us, the taxpayers, money. The plan was for Connecticut to sign a contract for a fixed amount of money for the HMOs to administer Medicaid, and then we would have a fixed budget line item with no surprises. What has happened in reality is that the HMOs come back to the till every year with their hands out, asking for more money to run Medicaid, because - guess what - it costs a lot to run it! Last year, HMOs were given a 25% rate increase! This year, despite the fact that most of us are taking pay cuts, the HMOs got another increase.

The Governor's proposal serves to give the HMOs yet a third income increase, disguised as a change in the definition of "Medical Necessity." The line item should read *"Change the definition of "medical necessity" to allow HMOs to fatten their profits by denying kids their needed treatment."* That is what the Governor's proposal will do. It will not save taxpayers money.

Even for the disabled and elderly people in Medicaid fee-for-service, which DSS still runs, the savings are a mirage. Sick people, particularly frail ones, do not just go away; they get sicker. So denying treatment when a problem is somewhat small and treatable is a false economy. Later, when that untreated person ends up in the hospital for 3 weeks with pneumonia because her antibiotic was denied, it will cost the taxpayers far more.

The Imposition of Co-Pays and Premiums (Cost Sharing) on HUSKY Families

The imposition of co-pays and premiums for HUSKY A is a recycled proposal that has been unsuccessfully tried at least twice in the past. Both times that

cost sharing was imposed in the past, the legislature repealed the practices because of the significant barrier co-pays and premiums presented to those needing health care or medications.

The cost savings from co-pays is dubious at best. The state will not be saving money because of the additional income provided by the co-pays but instead, the savings will come from the sudden drop in services provided. Studies have shown that even minimal co-pays deter Medicaid recipients from accessing health care. (See the Connecticut Health Foundation website for their Families at Risk series, 2004, www.cthealth.org.) Although the proposal caps prescription co-pays at \$20 a month and all co-pays are limited to 5% of a family's income, these caps are meaningless to a family who is living at 100% of the federal poverty level which equates to \$1525 a month for a family of three (\$18,310 annually) and would be hard-pressed to come up with even the minimum amounts. Despite the caps, prescriptions and doctors visits become an unaffordable expense.

Additionally, for the state to actually realize any savings through these co-pays, DSS would have to make corollary reductions in the per member/per month fees currently paid to the Medicaid Managed Care Organizations administering the HUSKY program. If that does not happen, only the MCOs will realize the windfall from these co-pays, not the State of Connecticut. They will receive the same capitated payments for providing less services, as recipients will stop seeking medical attention because they can't afford the co-pays. Why is it that all of the Governor's suggested ways of gutting the Medicaid program seem to end up fattening the coffers of the MCOs instead saving money for the state?

The imposition of premiums has proved to be a significant barrier to program participation for families who are eligible for HUSKY services but unable to pay the monthly fee. Imposing a premium for HUSKY A Adults and raising the premium for HUSKY B children will result in families simply dropping out of the program. Again, this is a recycled proposal that was wisely reversed by this legislature once the destructive impact on our poorest citizens was realized.

Elimination of SAGA Vision and Non-Emergency Medical Transportation

The SAGA Medical Program currently provides critical health care services to approximately 35,000 of CT's neediest residents. Although prior to 2001, SAGA Medical mirrored Medicaid coverage, it now does NOT cover home health care, durable medical equipment, podiatry, chiropractic, naturopathy or physical, occupational or speech therapy. All non-emergency medical transportation and vision care had been eliminated but were restored in a limited way in the 2006 legislative session.

SAGA Medical clients are now able to get routine vision care consisting of one full exam and one pair of glasses per year. Non-emergency medical transportation was also restored in the form of a private cab or taxi available to recipients in wheelchairs and post-op patients being discharged from the hospital or going to post-op follow-up appointments. A shared ride or livery service is available to oncology, cardiology, stroke-related, HIV related and outpatient rehab patients. Most SAGA medical patients are still without transportation for basic medical needs.

SAGA Medical has literally become a lifeline for its recipients. But if they cannot get to their health care providers, there is no lifeline. If they can't see, SAGA recipients will never be able to fully function independently.

SAGA Medical recipients are usually unable to work because of disabilities, but their applications for a federal SSI disability determination typically take months and sometimes years until a final disposition is reached. In the interim, because they are not elderly and don't have dependents, SAGA recipients are NOT eligible for Medicaid or any other health-care assistance program. There is a bill requiring DSS to apply for a federal waiver to allow SAGA Medical recipients to receive Medicaid coverage. This would mean that the cost to Connecticut would be halved while the scope of coverage would be broader, thereby helping SAGA recipients to have a chance to get back into the workforce or to qualify for SSI so Connecticut no longer supports them with cash benefits. Please vote in favor of this waiver proposal, but make sure that DSS does not try to access this new benefit by cutting existing benefits. We cannot afford to choose among impoverished, ill residents or decide who is most worthy of decent medical care. It is a "Sophie's Choice" dilemma that Connecticut should not and does not have to make.

Elimination of Medical Assistance to Recent Legal Immigrants

The Governor's proposal to eliminate state-funded health care (except for emergency care) for all non-citizens legally in this country for less than five years is especially curious given the federal government's recent expansion of coverage for legal immigrants. States are now eligible, under the recently enacted expansion of the CHIP program, for a federal match for a large portion of the cost of providing health care for legal immigrants. Prior to this expansion of CHIP, CT covered legal immigrants under a state-funded program without federal reimbursements. So now that an enlightened new administration that recognizes non-citizens are people too, the Governor wants to take a giant step backwards by marginalizing people who are here legally. It makes no sense.

Thank you for the opportunity to present this information to you today. I would be happy to answer any questions you may have.

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