



STATE OF CONNECTICUT
OFFICE OF POLICY AND MANAGEMENT

*TESTIMONY PRESENTED TO THE HUMAN SERVICES COMMITTEE
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Testimony Supporting Senate Bill No. 843

AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING
SOCIAL SERVICES

Senator Doyle, Representative Walker and distinguished members of the Human Services Committee, thank you for the opportunity to offer written testimony on Senate Bill No. 843, AA Implementing the Governor's Budget Recommendations Concerning Social Services.

In general, the initiatives in this bill will result in: (1) savings of \$354.0 million in FY 10 and \$408.1 million in FY 11; (2) additional revenue of \$2.0 million in FY 10 and \$2.2 million in FY 11; and (3) annual debt service savings of \$3 million. But I would ask you to look closely at all of the initiatives contained in this bill. Many of the initiatives are those that we would recommend whether there was a budget surplus or a budget deficit - because they are good ideas that deserve your consideration.

This bill makes the following changes:

Sections 1 and 8. Eliminate State-Funded Non-Emergency Medical Assistance to Non-Citizens. Under federal rules, non-citizens who have been in the country for more than five years are eligible for Medicaid and Title XXI and their costs are federally reimbursable. States have the option of providing coverage to non-citizens who have been in the country for less than five years, but the costs are 100% state funded. Connecticut is one of only fourteen states providing coverage for non-citizens through state-only funds, and at least two of those states have proposed cutting these services. Under this bill, DSS will only provide non-citizens under Medicaid and HUSKY B with emergency health care services allowable under the Medicaid and Title XXI programs, which are federally reimbursed. Savings of \$23.6 million in FY 10 and \$24.5 million in FY 11 are anticipated.

Section 2. Reduce Debt Service Contract Assistance for Supportive Housing Program. This section eliminates the expansion of the state's contract assistance to provide debt service on Connecticut Housing Finance Authority (CHFA) bonds for the Next Steps Supportive Housing Program, which was passed

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during the 2008 legislative session. PA 08-123 raised the state's contract assistance commitment to provide debt service on \$70 million in CHFA bonds to a total of \$105 million in CHFA bonds for the Next Steps Supportive Housing Program. The \$35 million expansion in the program would have provided an additional 150 housing units. The funding for the increase in state support was provided starting in FY 09 via FY 07 surplus in the amount of \$3.0 million. The Governor's proposed budget eliminates the expansion of the program for an annual debt service savings of \$3 million and for a total program savings of \$60 million over the next 20 years in debt service costs.

Section 3. Close Department of Children and Families' High Meadows Facility. This section deletes the name of High Meadows as a DCF facility effective July 1, 2010. The Governor's budget assumes the closure of the facility by February 2010, with a phased attrition of clients into other settings. Savings in DCF of \$1.4 million in FY 10 and \$6.0 million in FY 11 are anticipated.

Sections 4 - 7 and 9 - 12. Create a Community and Social Services Block Grant and an Employment Services Block Grant. This bill requires DSS to create two new block grants. The Community and Social Services Block Grant will respond to the health and social needs of communities. The Employment Services Block Grant will address employment needs throughout the state. DSS will define regions and identify regional planning councils, which may include existing regional planning organizations. The regional planning councils will receive input from community providers and local citizenry on the respective needs for their region. Each regional planning council will develop an area services allocation plan, which will include a description of programs and services to be funded and a budget allocation. The Department of Social Services and the Office of Policy and Management will review, modify and approve. The final allocation plan will be submitted by OPM to the legislative committees of cognizance for approval or denial. The goal of this initiative is to distribute funding equitably throughout the state and allow local organizations to identify the most critical social, community and employment programs and initiatives for their region. Savings of \$3.0 million in each year of the biennium are anticipated.

Sections 13 and 65. Require Medicare Part D Recipients to Enroll in Benchmark Plans. Currently, persons dually eligible for Medicare and Medicaid and ConnPACE recipients in Medicare Part D may enroll in any Part D prescription drug plan of their choice. CMS pays the monthly benchmark premium (\$31.74 in calendar year 2009) for those individuals receiving the federal Part D low-income subsidy, but when clients enroll in a plan costing more than the benchmark amount, DSS pays the difference. Of the 47 prescription drug plans available to enrollees in program year 2009, 26 are enhanced plans, with premiums ranging as high as \$111.30. With aggressive marketing on the part of prescription drug plans, clients are increasingly enrolling in enhanced plans, although generally there are no substantive benefits to the higher costing plans. Under this bill, all dually eligible and ConnPACE recipients participating in Medicare Part D will be required to enroll in one of the 12 benchmark plans. Limiting enrollment to benchmark plans will simplify the coordination of benefits and premium payment and plan reconciliation. This proposal is in line with the vast majority

of states, which do not cover costs beyond the benchmark amount. Savings of \$900,000 in FY 10 and \$1.8 million in FY 11 are anticipated.

Section 14. Study Impact of Medicaid Waiver. This bill requires DSS to study the impact of implementing a waiver to extend Medicaid coverage to individuals with income up to 100% of the federal poverty level who would otherwise qualify for medical assistance under SAGA. This study is needed to determine the cost-effectiveness (to both the state and the federal government) of expanding eligibility under a federal entitlement program beyond the existing SAGA population.

Section 15. Cap Medicare Part D Co-payment Coverage for Dually Eligible Clients. When Medicare Part D was instituted in January 2006, the state began covering the Part D co-pays for persons dually eligible for Medicare and Medicaid at 100% state cost. As of 2007, Connecticut was one of only eight states covering the costs of these co-pays for dually eligible clients. (The co-pays for 2009 range from \$1.10 to \$6.00.) Under this section, dually eligible clients will be responsible for paying up to \$20 per month in Medicare co-pays for Part D-covered drugs. By capping the monthly costs for dually eligible clients, this bill protects those individuals with a high number of prescriptions. Savings of \$3.7 million in FY 10 and \$4.0 million in FY 11 are anticipated.

Section 16. Maintain Current Rates for Nursing Homes. Under current statute, DSS is required to rebase nursing home rates no more than once every two years and no less than once every four years. Since nursing home rates were last rebased in FY 06, the Current Services budget includes a rate increase of 9.64% in FY 10 to reflect the rebasing of rates at a cost of \$113.7 million in FY 10 and \$127.6 million in FY 11. To comply with DSS' regulations, the Current Services budget also includes a 3% inflationary adjustment in FY 11 based on the anticipated increase in the Data Resources Incorporated (DRI) consumer price index, which tracks inflation specific to the nursing home industry. In addition, under current statute, DSS incorporates an adjustment to accommodate improvements to real property (referred to as a "fair rent adjustment") when setting annual nursing home rates. This bill maintains existing nursing home reimbursement levels by eliminating these increases over the biennium. Even with this bill, Connecticut's rates will remain one of the highest in the country - the state's rates are currently in the top five in terms of highest Medicaid reimbursement. Savings of \$115.3 million in FY 10 and \$166.4 million in FY 11 are anticipated.

Section 17. Restructure ConnPACE. This section of the bill implements four provisions included in the Governor's budget:

1. **Apply the Federal Low-Income Subsidy Asset Test for Medicare Part D.** Under this provision, the asset test used for determining eligibility for the low-income subsidy under Medicare Part D will be applied to ConnPACE enrollees (i.e., \$12,510 for individuals and \$25,010 for married couples for 2009). These asset levels will be indexed each year in accordance with the federal Medicare Part D program. Savings of \$23.9 million in FY 10 and \$24.9 million in FY 11 are anticipated.
2. **Increase the Annual Enrollment Fee.** Currently, ConnPACE enrollees are

required to pay an annual enrollment fee of \$30 at the point of application or redetermination. The enrollment fee was last updated in 2003, when it was increased from \$25 to \$30. Under this provision, the annual fee will be increased to \$45 for all clients. Savings of \$260,000 in FY 10 and \$250,000 in FY 11 are anticipated.

3. Suspend COLA Increase Provided for the Purposes of Determining Income Eligibility. Income limits for the ConnPACE program are adjusted each January based on the cost-of-living adjustment provided by the Social Security Administration. Under this provision, income limits will not be increased by the 2010 and 2011 cost-of-living adjustments. Savings of \$130,000 in FY 10 and \$880,000 in FY 11 are anticipated.
4. Establish an Open Enrollment Period. Under this provision, an open enrollment period will be established under ConnPACE effective January 1, 2010. Individuals will be eligible to enroll in the ConnPACE program during the open enrollment period or within 31 days of turning age 65 or becoming eligible for disability benefits under the Social Security Disability Income (SSDI) or Supplemental Security Income (SSI) programs. The open enrollment period will coincide with the open enrollment period for the Medicare Part D program - November 15 through December 31. Savings of \$240,000 in FY 10 and \$600,000 in FY 11 are anticipated.

Section 18. Restructure Pharmacy Coverage. This section of the bill implements three changes included in the Governor's budget:

1. Eliminate Coverage of Most Over-the-Counter Drugs. This provision eliminates coverage of over-the-counter drugs, with the exception of insulin and insulin syringes, under the department's pharmacy programs. This change is consistent with the current policy under the ConnPACE program. To comply with federal rules, Connecticut will continue to provide coverage of over-the-counter drugs to all children under the age of 21 under the HUSKY A program. Savings of \$7.0 million in FY 10 and \$7.7 million in FY 11 are anticipated. Note: A technical correction to the bill is required: line 511 should be amended by inserting the word "and" before "as required under federal law."
2. Eliminate Automatic 30-Day Fill for New Prescriptions Requiring Prior Authorization. Currently when a recipient presents at the pharmacy with a new prescription that requires prior authorization (PA), the pharmacist can immediately (at the point of sale) dispense a 30 day supply without going through the PA process. On subsequent fills of the same medication, if no PA is requested and obtained, the claim will deny because the prescriber must be contacted to request and receive prior authorization. Under this section, this first 30 day fill without prior authorization will be eliminated. This is consistent with the department's policy prior to the pharmacy carve-out and is supported by DSS' Medical Director. The 5 day "emergency" supply will continue to be provided when the prescriber cannot be contacted or DSS' contractor cannot complete the prior authorization within the required timeframes. Savings of \$1.2 million in FY 10 and \$1.3 million in FY 11 are anticipated.

3. Require Prior Authorization for High Cost Drugs. Prior authorization is required when a drug is within one of the classes included on the preferred drug list, but the drug being requested is not on the PDL. Under this section, DSS will require prior authorization for certain high cost classes of drugs to ensure medical necessity. To ensure appropriate prescribing, DSS will conduct evidence-based educational outreach to physicians to reduce the use of off-label anti-psychotics in children and other areas of high cost prescribing that present high clinical risk and/or limited effectiveness beginning July 1, 2009. These efforts will be further strengthened by requiring prior authorization for certain drugs, including the use of off-label anti-psychotic drugs in children, regardless of whether the drug is on the PDL beginning July 1, 2010. Net savings of \$1.3 million in FY 10 and \$1.5 million in FY 11 are anticipated.

Section 19. Impose Cost-Sharing Requirements on Individuals Receiving Medicaid Services. A total of 44 states impose co-payments under their Medicaid programs. Under this bill, DSS will require co-pays not to exceed 5% of family income on allowable medical services (excluding hospital inpatient, emergency room, home health, laboratory and transportation services). Under federal rules, co-pays for FFY 09 can range from \$0.50 to \$5.70, depending on monthly family income and size, and are indexed annually based on inflation. Co-pays for pharmacy services will be capped at \$20 per month. Consistent with federal rules, certain children under age 18, individuals at or below 100% of the federal poverty level, SSI recipients, pregnant women, women being treated for breast or cervical cancer and persons in institutional settings are exempt from the cost sharing requirement. Savings of \$8.5 million in FY 10 and \$10.5 million in FY 11 are anticipated.

Section 20. Establish Premiums for HUSKY A Adults. Under this bill, DSS will require a monthly premium not to exceed federal maximum levels - total cost-sharing (co-pays and premiums) cannot exceed 5% of the family income. Premium amounts will be determined on a sliding scale, up to 10% or 20% of the monthly cost of services, depending on the individual's family income. Consistent with federal rules, certain children under age 18, individuals with income at or below 100% of the federal poverty level, pregnant women and individuals in hospice are exempt from paying premiums. Savings of \$8.8 million in FY 10 and \$9.3 million in FY 11 are anticipated.

Section 21. Mirror Medicare's Non-Payment Policy for Certain Hospital Acquired Conditions. The federal Centers for Medicare & Medicaid Services (CMS) has started to address ways that Medicare can help to reduce or eliminate the occurrence of "never events" - serious and costly errors in the provision of health care services that should never happen (e.g., surgery on the wrong body part or a mismatched blood transfusion). Beginning in October 2008, Medicare payment will be denied for six costly and sometimes deadly, preventable hospital-acquired conditions. Under this bill, DSS will implement similar provisions under Medicaid and SAGA. According to CMS, at least twenty states are currently considering the same policy for Medicaid patients with about a dozen states having already implemented such efforts. Savings of \$1.7 million in FY 10 and \$1.8 million in FY 11 are anticipated.

Sections 22, 52 and 53. Maintain Current Rates for Boarding Homes, Residential Care Homes and Community Living Arrangements. Under current statute, DSS is required to annually determine rates for various boarding homes. Per DSS regulations, boarding home rate increases are based on actual cost reports submitted by facilities, barring any legislation to remove rate increases for a particular fiscal year. Under the normal rate calculation structure, these homes would have received increases of up to 5%. This bill maintains existing reimbursement levels over the biennium by eliminating these rate increases that have been included in the Current Services budget. Savings of \$4.5 million in FY 10 and \$9.3 million in FY 11 are anticipated.

Sections 23 - 39. Implement Provisions under the Federal False Claims Act. The federal Deficit Reduction Act (DRA) of 2005 authorizes the state to bring a civil action against any individual or entity who engages in fraud against the state of Connecticut. This proposal includes 'qui tam' provisions allowing individuals to initiate claims and allowing the Attorney General to substitute the state of Connecticut for such individual's civil action. The federal government will provide financial incentives to states that adopt this qui tam law for purposes of recovering Medicaid funds in such actions. Savings of \$500,000 million in FY 10 and \$1.0 million in FY 11 are anticipated. Note that the language in these sections is consistent with House Bill No. 6299, AAC Fraud Against the State.

Section 40. Eliminate Funding for Interpreters under Medicaid. Under Title VI of the Civil Rights Act of 1964, all health care providers who receive federal funding are required to ensure "meaningful" services for individuals with limited English proficiency. Thus providers must ensure meaningful access to programs and services by ensuring effective communication, including the provision of interpreter services. As a result, it is the provider's responsibility to arrange and pay for interpreter services. Although the legislature added \$4.7 million in FY 09 to cover the costs of including foreign language interpreter services as a covered service under the Medicaid fee-for-service program, costs are expected to be at least \$6.0 million once fully annualized. By removing the requirement that interpreter services be a covered service under Medicaid, this bill will require providers to continue to cover the cost of interpreters. This is consistent with the majority of states; according to the Connecticut Health Foundation, only 12 states (HI, ID, KS, ME, MN, MT, NH, TX, UT, VT, WA and WY) and the District of Columbia had a fully operational program as of April 2007. It is anticipated that providers will continue to provide interpreter services for individuals with limited English proficiency. Savings of \$5.5 million in FY 10 and \$6.0 million in FY 11 are anticipated.

Sections 41 and 42. Defer Cost of Living Adjustments for AABD Clients. Current statute provides recipients and applicants of Temporary Family Assistance, State Administered General Assistance (SAGA) and the Aid to the Aged, Blind and Disabled (AABD) programs a state-funded cost of living adjustment based on the percentage increase in the Consumer Price Index - Urban on July 1 of each year. This bill maintains the existing assistance levels and does not provide the cost of living adjustment estimated at 3.8% in FY 10 and 0.9% in FY 11. It should be noted that Connecticut is one of the few states

that allows TFA recipients to keep their earnings up to the federal poverty level. Savings of \$9.1 million in FY 10 and \$14.9 million in FY 11 are anticipated.

Section 42. Defer Increase in the State Supplement Disregard for AABD Clients. In past years, any cost of living adjustments (COLA) received as part of an AABD client's Social Security benefit were considered an increase in income and applied to the client's cost of care. Recent legislation, however, allows AABD clients to retain their Social Security COLA (by increasing the unearned income disregard) without a concurrent reduction in their state benefit. This bill reinstates the previous policy of applying any federal COLA to offset the cost per case. Savings of \$830,000 in FY 10 and \$3.0 million in FY 11 are anticipated.

Section 43. Increase Child Support Pass-through Disregard. This bill increases from \$50 to \$100 the amount of the current child support payment that is disregarded and passed through to families receiving Temporary Family Assistance (TFA). Increasing the disregard provides families with additional financial support and 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 at least \$100, rather than \$50, above the payment standard before losing eligibility. Effective 10/1/08, the Deficit Reduction Act no longer requires states to "share" 50% of child support payments collected and disregarded. As a result of this change in federal law, the child support pass-through can be increased to \$100 at no cost to the state.

Sections 44 and 45. Limit Dental Services Benefit for Adults to Emergencies. This bill scales back dental services for adults under Medicaid and SAGA. DSS will continue to provide emergency dental services, including dentures, x-ray, limited oral evaluation, emergency treatment of dental pain, and extractions. In the last few years, many states have reduced or eliminated adult dental benefits offered through Medicaid. According to a study conducted in 2004, only eight states, including Connecticut, provided full dental benefits for adults under their Medicaid programs. The Governor's budget includes \$1.0 million under the Department of Developmental Services to fund full dental coverage through an existing federal waiver. Net savings of \$21.7 million in FY 10 and \$27.0 million in FY 11 are anticipated.

Section 45. Eliminate Limited Vision and Non-Emergency Medical Transportation Benefits. Coverage of non-emergency medical transportation and vision under SAGA had been eliminated in FY 02 and FY 03, respectively. The legislature partially restored these benefits in FY 07 by providing funding for limited benefits. Under this bill, these expanded benefits are eliminated. It is anticipated that DSS will continue to provide transportation for dialysis and cancer treatments under SAGA. Savings of \$1.1 million in FY 10 and \$1.2 million in FY 11 are anticipated.

Section 46. Include Mental Health Related Drugs under the Preferred Drug List. Although mental health related drugs are one of the highest cost categories of drugs, they are currently exempt from DSS' preferred drug list (PDL). Under this bill, mental health related drugs will be added to the PDL in order to receive supplemental rebates on these drugs. For coverage of drugs that are not on the

PDL, the extra step of receiving prior authorization will be required. Thus clients will continue to receive their necessary medications. Savings of \$1.9 million in FY 10 and \$2.1 million in FY 11 are anticipated.

Section 47. Restructure Pharmacy Reimbursement. This section of the bill implements two provisions included in the Governor's budget:

1. Increase the Discount off the Average Wholesale Price Paid for Certain Drugs. This provision reduces the reimbursement level to pharmacy providers from the average wholesale price (AWP) minus 14% to AWP minus 15%. Based on surveys in a number of states, the Office of Inspector General for the federal Department of Health and Human Services reported that pharmacies tend to purchase their brand name drugs for AWP minus 22%, with generics purchased at AWP minus 66%. (In Connecticut, generic drugs are already governed by a maximum allowable cost reimbursement schedule.) Savings of \$6.5 million in FY 10 and \$7.1 million in FY 11 are anticipated.
2. Reduce Dispensing Fees Paid to Pharmacy Providers. Under this provision, the dispensing fee paid to pharmacy providers for each prescription filled under the department's pharmacy programs will be reduced from \$3.15 to \$2.15. This level is in line with the dispensing fees paid by most commercial health insurers. Savings of \$4.1 million in FY 10 and \$4.5 million in FY 11 are anticipated.

Section 48. Eliminate Self-Declaration Provisions at Application and Redetermination. In FY 02, DSS implemented new verification procedures for the HUSKY A program that allow the department to accept a client's self-declaration of income. Under this policy, DSS does not verify the information provided unless the department believes such declaration to be inaccurate. This bill eliminates the self-declaration provisions. Savings of \$2.0 million in each year of the biennium are anticipated.

Section 49. Modify Premium Payment Requirements under HUSKY B. HUSKY B offers a full health insurance package for children and teenagers up to age 19, regardless of family income. The program is divided into three income bands: the first band (185% to 235% of the federal poverty level (FPL)) pays no premiums; the second band (236% to 300% FPL) has monthly premiums of \$30 for families with one child and \$50 for families with two or more children; and the third band (over 300% FPL) is responsible for the full premium. Under this bill, monthly premiums for Band 2 will increase to \$50 for families with one child, \$75 for families with two children and \$100 for families with three or more children. Total cost-sharing (co-pays and premiums) cannot exceed 5% of the family's income. Savings of \$1.5 million in FY 10 and \$1.6 million in FY 11 are anticipated.

Section 50. Provide Half of the June Reimbursement for Nursing Homes in July. Under this bill, beginning in 2010, one-half of the June Medicaid payment to nursing homes will be deferred to the following month. This proposal will result in one-time savings and is similar to provisions that were in place from 1992 to 2007. By deferring one-half of the June Medicaid payment to July, this proposal

will have no net impact to nursing home revenues over the calendar year. Savings of \$53.1 million in FY 10 are anticipated.

Section 51. Maintain Current Rates for Intermediate Care Facilities. To comply with DSS' regulations, the Current Services budget includes a 4.7% and 4.9% increase in FY 10 and FY 11, respectively, for Intermediate Care Facilities for those with developmental disabilities based on the anticipated increase in the gross national product (GNP) deflator. This bill maintains existing reimbursement levels by eliminating these increases over the biennium. Savings of \$2.9 million in FY 10 and \$6.2 million in FY 11 are anticipated.

Sections 52 and 53. See write-up under section 22.

Section 54. Maintain Caseload for State-Funded Connecticut Home Care Program for Elders. Under this bill, the caseload under the state-funded Connecticut Home Care Program for Elders will be maintained at June 30, 2009 levels over the biennium. As clients move off the program, new clients can begin to receive services under the state-funded program. The program will re-open without restrictions beginning in July 2011. Savings of \$4.8 million in FY 10 and \$14.5 million in FY 11 are anticipated.

Sections 55 and 56. Defer Expansion of Money Follows the Person to Individuals Who Have Not Been Institutionalized for Six Months. Section 2 of P.A. 08-180 requires DSS to submit a plan to establish and administer a program similar to Money Follows the Person (MFP) for individuals who have not been institutionalized for six months, which if approved by the legislature is to be implemented on or after July 1, 2009, subject to available appropriations. The provision of community supports for individuals who have not been institutionalized for six months is expected to result in significant costs over the biennium. Because the program is to operate within available appropriations and because no such funds have been included in the Governor's budget, this bill defers the expansion of MFP. These sections will result in significant cost avoidance.

Sections 57 and 58. Defer Establishment of a Long-Term Care Reinvestment Account. Section 3 of P.A. 08-180 establishes a Long-Term Care Reinvestment account, a non-lapsing account within the General Fund. The account is to be funded with the 25% enhanced federal match received under MFP in the first year of each transition to support changes in the long-term care infrastructure. Under this bill, the 25% enhanced match will be deposited into the resources of the General Fund over the biennium. Assurance has been obtained from CMS that the state does not need to deposit the enhanced match in a restricted revenue account. Instead, the state will provide detailed reporting to CMS of efforts to serve clients in the community. Additional revenue of \$1.9 million in FY 10 and \$2.1 million in FY 11 is anticipated.

Section 59. Cap the Total Number of Beds under Small House Nursing Home Projects. P.A. 08-91 requires DSS to establish, within available appropriations, a pilot program to support the development of up to ten "small house nursing home" projects with the goal of improving the quality of life for nursing home residents by providing care in a more home-like setting. While each unit can

house no more than ten individuals, each project can have multiple units. One project that is in the early stages of development will convert approximately 280 certified beds to this model. This bill restricts any further development of "small house nursing home" projects over the biennium by capping the number of beds at 280 through the biennium. To control future costs and ensure that sufficient funds will be available, the bill also requires that DSS receive the approval of the Secretary of the Office of Policy and Management before moving forward with additional proposals. Savings of \$1.5 million in FY 11 are anticipated.

Section 60. Update Definition of Medical Necessity under Medicaid. This bill replaces the current outdated medical necessity definition under Medicaid with the definition that has been in effect for the State Administered General Assistance medical program since January 2005. This new medical necessity definition combines the concepts of medical necessity and appropriateness as is done in Medicare and under public sector and commercial health care programs. The department's current Medicaid definition has a number of weaknesses: it establishes an unreasonably high standard of services necessary to achieve "optimal" functioning and fails to provide for the application of medical evidence in medical review decisions. The proposed definition incorporates the principle of providing services which are "reasonable and necessary" or "appropriate" in light of clinical standards of practice. Eliminating "maintaining an optimal level of health" will help to eliminate varying interpretations, which often result in levels of care that overly exceed the definition of medical appropriateness. The new definition will be as follows:

"Medically necessary" services means those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate a health problem or its effects, or to maintain health and functioning, provided such services are:

- a) consistent with generally accepted standards of medical practice;
- b) clinically appropriate in terms of type, frequency, timing, site and duration;
- c) demonstrated through scientific evidence to be safe and effective and the least costly among similarly effective alternatives, where adequate scientific evidence exists; and
- d) efficient in regard to the avoidance of waste and refraining from provision of services that, on the basis of the best available scientific evidence, are not likely to produce benefits.

Savings of \$4.5 million in FY 10 and \$9.0 million in FY 11 are anticipated.

Section 61. Allow Special Needs Trusts for Certain Boarding Home Residents. When recipients of AABD receive Supplemental Security Income (SSI) and/or Social Security (SSA) benefits, their income may, over time, reach levels which makes them ineligible for further AABD assistance. 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. This change will enable them to remain in a boarding home

and avoid more costly nursing home placement. Net savings of \$920,000 in FY 10 and \$1.2 million in FY 11 are anticipated.

Section 62. Require Certification for Medication Administration. Current statute permits unlicensed 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 medications to their residents, similar to the process used by the Department of Developmental Services. 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 and boarding homes for training, liability insurance, supervision and other implementation costs associated with their staff administering the medications. Net savings of \$1.4 million in FY 10 and \$2.9 million in FY 11 are anticipated.

Section 63. Increase Capacity to Execute Capias Mittimus Orders. Capias mittimus orders are issued by the court magistrate to order the arrest of a parent who personally receives notice of a court hearing and fails to appear. Although DSS' Bureau of Child Support Enforcement has enforcement officers to carry out these orders, current statute limits DSS to four sworn police officers for this purpose. From January 1, 2003 through December 31, 2008, a backlog of almost 5,000 unserved capias mittimus orders in family child support matters has accumulated. Over half of these orders are considered to be immediately "executable," meaning there is a valid Connecticut address for the non-custodial parent. This bill will increase the number of capias mittimus sworn police officers allowed under statute from four to six. This bill is expected to result in a revenue gain of \$85,000 in each year of the biennium due to increased child support collections that offset state public assistance costs.

Section 64. Expedite DSS' Ability to Implement Initiatives. This section allows DSS to implement various initiatives under this bill while in the process of developing policies and procedures in regulation. This is necessary to ensure savings are achievable over the biennium and are not delayed until final approval of regulations implementing programmatic changes.

Section 65. See write-up under section 13.

Section 66. Discontinue Payment for Non-Formulary Drugs under Medicare Part D. Connecticut is one of the few states providing state coverage of non-formulary drugs that are not paid for through Medicare Part D. The state receives no federal reimbursement on these expenditures. Under this bill, non-formulary coverage will be eliminated for dually eligible clients, who are eligible for both Medicare and Medicaid, and for ConnPACE clients. Language is retained to allow DSS to recoup amounts due the state for drugs covered prior to July 1, 2009. Under federal rules, a Medicare Part D plan's formulary must include adequate coverage of the types of drugs most commonly needed and, in those cases where a particular non-formulary drug is medically necessary, plans are required to provide coverage. As a result, it is anticipated that clients will continue to receive needed medications through Medicare Part D without state-

supported assistance. Savings of \$26.2 million in FY 10 and \$28.7 million in FY 11 are anticipated.

Section 67. Require Prior Authorization and Accountability for Dental Services. DSS implemented a dental carve-out effective September 1, 2008, with dental services under HUSKY, Medicaid fee-for-service and SAGA being managed by an administrative services organization. This section, effective on passage, requires: (1) prior authorization for non-emergency services provided under the dental carve-out; and (2) a periodic review to ensure that services billed as emergency services are indeed of an emergency nature. This section is complementary to the provisions of sections 44 and 45 of this bill. Recognizing, however, that it would not be cost effective to have all routine exams, cleanings, and sealants subject to prior authorization, it is recommended that the language be modified as indicated below. This section will result in cost avoidance and/or potential future savings by ensuring that services are appropriately billed and paid.

(NEW) (*Effective from passage*) All nonemergency dental services provided under the Department of Social Services' dental programs shall be subject to [prior authorization] concurrent or retrospective review. Nonemergency services that may be exempted from the review process include diagnostic, prevention, basic restoration procedures and non-surgical extractions. The commissioner shall periodically, but not less than quarterly, retrospectively review payments for emergency dental services for appropriateness of payment. The commissioner may recoup payments for services that are determined not to be for an emergency condition. For the purposes of this section, "emergency condition" means a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate dental attention to result in placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, cause serious impairment to body functions or cause serious dysfunction of any body organ or part.

Section 68. Eliminate Council to Advise on Implementation of Medicare Part D. P.A. 06-170 established a council in statute to advise DSS on matters relating to the administration and implementation of the Medicare Part D program. This council was to be established when Medicare Part D was in its infancy. By FY 11, Medicare Part D will have been operational for over 5 years. In light of this and the fact that the necessary appointments to the council were never made, the language establishing the council is being repealed.

I would like to again thank the committee for the opportunity to present this written testimony. I respectfully request the Committee support this bill and, as always, my staff and I are available at your convenience to answer any questions you may have.

