



Testimony before the Appropriations Committee
Claudette J. Beaulieu, Deputy Commissioner for Programs
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Good morning, Senator Harp, Representative Geragosian, Senator Debicella, Representative Miner and members of the Appropriations Committee. My name is Claudette Beaulieu, and I am the Deputy Commissioner of the Department of Social Services. I am accompanied today by senior staff who are prepared to address detailed questions relevant to their areas of expertise. Thank you for allowing me the opportunity to review with the committee the current status of the Department of Social Services budget.

Based upon the most recent estimates, the potential deficiency for SFY 2011 at the department is approximately \$182.9 million, which represents 3.5% of the department’s \$5.185 billion General Fund appropriation.

Our most significant deficiencies and surpluses by account are summarized below.

Estimated Deficiencies (In Millions)		Offsetting Surpluses (In Millions)	
OE	(20.7)	Charter Oak	3.3
Medicaid	(197.7)	TFA	10.8
Old Age Assistance	(0.6)	ConnPACE	2.2
Aid to Disabled	(0.8)	CT Home Care	14.8
		Child Care	3.8
		Other	2.0
Total Deficiencies	\$(219.8)	Total Surpluses	\$ 36.9
		Net Deficiency	\$(182.9)

A major economic factor that continues to drive our caseload and costs is the unemployment rate. Although October’s employment report showed faster private sector employment growth, there

remains a high backlog of unemployed workers. The unemployment rate in Connecticut is holding steady at 9.1%, compared to January 2010 when the rate was 9.0%, 7.1% a year earlier and 4.9% in January of 2008.

The last time I was before you, I talked about how the biennial budget implementation legislation that was passed in October of 2009 included a number of savings initiatives that were based on 12 months of savings, yet we were already three months into the state fiscal year. Many of these same initiatives contained aggressive annualized and ongoing savings estimates. Even with the changes made in the mid-term budget adjustments, our projected savings for these initiatives in the second year are lower due to changes in annualization, a continued economic downturn, and recognition of the actual trends we are seeing going forward.

MEDICAID OVERVIEW

The largest appropriation, \$4 billion, is for the Medicaid account. The projected deficiency in Medicaid of \$197.7 million is clearly the most significant deficiency that the department has, representing somewhat less than 5% of the Medicaid appropriation. As you know, Medicaid is a federal/state entitlement program that provides comprehensive health care benefits for eligible clients within our state. The department continues to experience significant increases in expenditures due to caseloads that are higher than what was contained in the budget in several key areas of the Medicaid program. HUSKY A caseloads continue to grow. HUSKY A served 385,300 individuals in October 2010, up from 357,500 in January 2010, or a 7.8% increase in the last 9 months alone.

Medicaid for Low-Income Adults (Medicaid LIA)

Pursuant to the federal Affordable Care Act, the medical services portion of the State-Administered General Assistance (SAGA) program was discontinued retroactive to April 1, 2010. Connecticut was the first state to receive federal approval to expand Medicaid under the Act. Former SAGA recipients are now covered under the new Medicaid population referred to as “Medicaid for Low-Income Adults” or “Medicaid LIA.” Medicaid LIA is open to Connecticut residents aged 19 through 64 with an income-eligibility limit for single adults and married couples that is approximately 56% of the federal poverty level (68% of the federal poverty level in southwestern Connecticut due to an additional disregard for higher shelter costs). Similar to HUSKY A, there is no asset test in determining eligibility.

As mentioned, Connecticut was the first state in the nation to expand Medicaid to include low-income adults. This was approved by the federal Centers for Medicare & Medicaid Services (CMS) on June 21, 2010, retroactive to April 1, 2010.

Since the CMS approval of the expansion, enrollments continue to increase. The April 2010 enrollment of 44,752 has grown 27.5% through October, with a current enrollment of 57,079. Six hundred and thirty-three former Charter Oak enrollees who qualified were moved to Medicaid LIA in October, and an additional 600 are expected to move in November. There are 3,138 enrollments in the new age group of 19- and 20 year-olds who were not covered under the former SAGA medical program, representing 5.5% of the total Medicaid for Low-Income Adults population.

The Medicaid for Low-Income Adults expansion required the addition of benefits not previously covered under the former SAGA program, including home health care, hospice, nursing home care, and expanded non-emergency medical transportation.

It is estimated that Medicaid LIA costs alone are contributing \$21.7 million to the overall DSS Medicaid deficit. Considering the 7% increase in caseload for the last month alone, we will also need to reassess our projection going forward as increases may ensue. While we continue to analyze the influx of Medicaid LIA clients to determine how to best structure the program to manage growth, we are instituting measures to ensure we do everything possible to manage and control these costs. We are also working with DMHAS on the behavioral health portion of the program.

As both DSS and DMHAS have been analyzing the unexpected increases in expenditures resulting from the Medicaid expansion, several cost containment measures are under review:

- The department is working with DMHAS to implement behavioral health managed care for the Medicaid LIA population. This managed care program is expected to be up and running during the third quarter of SFY 2011.
- We intend to **limit the nursing home benefit** to 90 days under Medicaid LIA, effective January 1, 2011. The current benefit is unlimited. Additional nursing home coverage will be available under the Medicaid aged, blind and disabled (ABD) coverage groups. In doing so, they will be subject to the asset test and the transfer of asset 'look back' during eligibility determination.
- **Prescription drug savings** are expected to be achieved from the TOP\$ (The Optimal Preferred Drug List Solution) initiative. This multi-state pool we have joined is designed to achieve quality pharmaceutical care for clients served by the department's medical assistance programs while providing state savings.
- Also, **dental savings** are anticipated with the implementation of Dental Clinic Prior Authorization and, as of January 1, FQHC Dental Clinic Prior Authorization. The savings will result from applying the identical limitations for frequency of services defined in the Medical Assistance Policy regulations, for example the placement of crowns or replacement of dentures, that currently exist for all private and group dental providers.

During the next legislative session we will be working with the new administration and the legislature on additional measures to contain costs.

Managed Health Care

The state budget included a number of significant savings initiatives and assumptions, many of which have been recognized as optimistic and, in some cases, not feasible. A savings of \$76.7 million was budgeted for HUSKY managed care, the majority of which was a one-time savings of \$65 million related to a change in the timing of capitation payments. We believe that this savings objective was rendered unattainable given the decision by the Legislature to delay the June 2010 MCO payments by an additional month. To assume a further delay in cash flow beyond that would not be possible given the current fee-for-service payment structure. Therefore, \$65 million of the \$76.7 million in budgeted savings was unachievable at the outset.

While structural changes themselves in managed care for HUSKY and Charter Oak were permitted, not required, in legislation, a significant savings initiative that the Legislature required was management of medical care for our ABD clients. We will be working with the new administration to explore alternatives for managing medical care for the ABD population. We are currently working in conjunction with DMHAS to achieve savings through the Behavioral Health Recovery Plan, but it is unlikely that the savings in SFY 2011 will be close to the \$60 million included in the budget.

Non-Citizens

The state budget also contained a provision to eliminate state medical coverage for certain non-citizens who do not qualify for federal Medicaid. In accordance with the budget directive, effective December 1, 2009, State Medical Assistance for Non-Citizens (SMANC) was discontinued. In January, 2010, the state Superior Court issued a permanent injunction that enjoined the state from proceeding with this action, pending appeal. Accordingly, the department promptly reinstated medical benefits for affected clients retroactively. As a result of the court's ruling, the department was unable to realize any of the \$9.3 million savings that was budgeted for SFY 2010 and the department is not anticipating any of the \$9.75 million savings budgeted for SFY 2011.

OTHER EXPENSES

We are currently projecting a \$20.7 million deficiency in the Other Expenses account. I would note, however, that our end of year OE projection is comparable to last year's actual costs. It should also be noted that \$18.6 million of the \$20.7 million is a result of OE holdbacks. In addition, our deficiency reflects changes that were not contemplated previously when the budget was passed, including an expansion of the Money Follows the Person (MFP) program. The department has received supplemental federal grant awards for MFP, including funding for administrative costs. These costs are gross-funded and paid out of our OE appropriation; while requiring additional Other Expense funding, they are eligible for 100% federal reimbursement.

We have mentioned in past hearings before the Committee, yet it bears repeating, that the vast majority of expenses under the department's Other Expenses account are not commodity-type expenditures, as is commonly assumed, but represent contractual obligations required to support the array of medical programs provided by the department. Approximately 80% of the total funding available for Other Expenses is utilized for administrative contracts. We claim these costs through our federal reporting and receive federal financial reimbursement (i.e., revenue for the state). The largest contracts are required to operate our medical programs, such as claims processing; these medical program contracts alone are estimated at \$41.9 million this year. In addition, we have contracts for client eligibility and enrollment processing, premium collections, and mandatory quality reviews. We also fund contracts totaling approximately \$5.26 million for child support collections processing of child support payments and maintenance of the state's automated child support system, for which we also get federal reimbursement.

OLD AGE ASSISTANCE

We are projecting a \$638,000 deficiency in the Old Age Assistance account. While there was a midterm adjustment of \$3.1 million to reflect decreasing trends, these trends are not being fully

recognized currently. For example, caseloads have increased by 1% since September 2009. Additional funds are now required to ensure adequate funding to cover client benefits through the end of SFY 2011.

AID TO THE DISABLED

We are projecting an \$800,000 deficiency in the Aid to the Disabled account. . While there was a midterm adjustment of \$1.1 million to reflect decreasing trends, these trends are not being fully recognized currently. For example, caseloads have increased by 2% since September 2009. Additional funds are now required to ensure adequate funding to cover client benefits through the end of SFY 2011.

Surplus Accounts

Offsetting the anticipated shortfalls just discussed are surpluses in accounts which will mitigate some of our deficiencies. These are:

CONNECTICUT HOME CARE PROGRAM FOR ELDERS

The state-funded Connecticut Home Care Program for Elders is anticipated to have a surplus of \$14.8 million in SFY 2011, based on current projected costs of \$60 million and an average enrollment for SFY 2011 of approximately 5,000 per month. This estimate is preliminary as enrollment numbers have fluctuated during the last year, presumed to be associated with implementation of cost-sharing requirements and subsequent changes in the amount, from 15% to 6% effective July 1, 2010. There is also expected to be some cost shifting in services due to the addition of Personal Care Assistant (PCA) services under the program.

CONNPACE

The department is estimating that the ConnPACE program will end the year with a surplus of approximately \$2.2 million. This surplus is assumed to be primarily due to continued enrollment of ConnPACE clients in the federally-funded Medicare Part D Low-Income Subsidy. Eligibility for this program has been granted to many ConnPACE clients as a result of the expansion of eligibility for the Medicare Savings Programs. Additional savings may also be realized from pharmacy initiatives implemented over the past year.

CHARTER OAK HEALTH PLAN

The department is currently projecting a surplus of \$3.2 million in the Charter Oak Health Plan. Caseloads in the program have decreased for the last five consecutive months, from 14,579 in May to 11,097 in October, an overall 24% drop in those five months. That reduction includes Charter Oak Health Plan enrollees who transferred to the Medicaid for Low-Income Adults program. Increases in client premiums contribute to the current projected surplus. We are experiencing a decline in caseloads, which we believe is related to the premium adjustments implemented in February, 2010, and the change to a uniform premium of \$307, regardless of income, effective June 1, 2010. The change to a \$307 premium was pursuant to the elimination of state premium assistance for new enrollees through this fiscal year, as directed by Public Act 10-3.

TEMPORARY FAMILY ASSISTANCE

We are projecting a \$10.8 million surplus in the Temporary Family Assistance account due to smaller than expected caseload increases in this account. The department had expected an average caseload of 24,069 for SFY 2011. This estimate has been revised to 20,900 for SFY 2011, or a decrease of 13%. It is assumed that the extensions to Unemployment Insurance to a total of 99 weeks of benefits have decreased the need for this program. Please note that although the extension in unemployment benefits does affect eligibility for this program, which provides cash assistance; the demand for medical assistance and the overall enrollments in the department's medical programs continues to increase.

CHILD CARE SERVICES

To address the \$4.5 million shortfall projected earlier in the year in the Child Care Services account, the Department closed intake to Priority Group 6, which serves households with income up to 75% of the state median income (\$76,232 for a family of 4) in November 2010. While we have restricted access for new applicants for Priority Group 6, people whose income rises while they are on the program will be able to shift into Priority Group 6 and continue receiving child care services.

CONCLUSION

The department continues to look for every opportunity to mitigate our deficiency and plan on working effectively with the transition team to make sure all savings initiatives move forward in an expedited way.

Once again, thank you for the opportunity to come before you to address this issue. I appreciate your continued support of our efforts.