



*Testimony before the Human Services Committee*

*Michael P. Starkowski*

*Commissioner*

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Good morning, Senator Doyle, Representative Walker and Members of the Human Services Committee. I am Michael Starkowski, Commissioner of the Department of Social Services. I am pleased to be here this morning to present testimony on legislation introduced at the request of Governor Rell implementing features of the recommended mid-term budget adjustments. I am also happy to have this opportunity to testify on the merits of legislation introduced at the request of the department and would like to thank the committee for raising these bills.

As we indicated in our testimony before the Appropriations Committee in support of Governor Rell's budget recommendation for the Department of Social Services, these are extraordinary times of economic adversity. During the continuing fiscal crisis in Connecticut state government, it is inevitable that the agency with the largest General Fund budget will be under tremendous pressure to control expenditures, and, in fact, reduce expenditures where feasible. This reality is evident in the Governor's midterm adjustments, just as it was reflected in the budget adopted by the members of this General Assembly in September for the first year of the biennium.

*Legislation to Implement the Governor's Recommended Mid-term Budget Adjustments*

**S. B. No. 32 AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING SOCIAL SERVICES.**

**HUSKY A**

The HUSKY A program currently provides no-cost healthcare to low- and moderate-income children and families. In SFY 2010, the HUSKY A program has experienced substantial increases in enrollment. Over the first 7 months of SFY 2010, enrollment in the HUSKY A program has increased by approximately 14,660 clients, or an average of 2,094 clients per month for a total enrollment as of January 1, 2010, of over 357,000 clients; and a projected enrollment by the end of SFY 2010 of 368,000 clients.

The biennial budget included a full-year reduction to managed care rates of 6%, which is essentially asking the managed care organizations (MCOs) to operate at a significant loss, based upon current financial reports. The department is currently in negotiations with the MCOs pertaining to changes in program scope, contract terms and capitation rates. While the biennial budget included rate reductions to the MCOs, the mid-term budget recommends converting HUSKY to a non-risk model with the HUSKY program continuing under an administrative services organization structure. This ASO structure

would be similar to the model being developed to provide care management for the Medicaid Aged, Blind and Disabled population, which is centered around improving health outcomes, reducing unnecessary or inappropriate service, and thereby reducing overall Medicaid expenditures.

### **Pharmacy**

Upon passage of the budget, the department took aggressive steps to implement numerous pharmacy initiatives. These initiatives included changes to pharmacy reimbursements, early refills, and prior authorization requirements, representing a reduction in Medicaid expenditures of approximately \$20.2 million in SFY 2010.

The mid-term budget expands a number of these cost-savings initiatives in order to maximize savings while still providing the necessary pharmacy benefit. The Budget recommends revising MAC reimbursement under DSS' pharmacy programs from the average wholesale price (AWP) minus 45% to AWP minus 50%. This will make existing mental health prescriptions subject to the preferred drug list with prior authorization being required to receive coverage of any mental health drug that is not on the preferred drug list. The recommendation also requires dually eligible clients to be responsible for paying up to \$20 per month in Medicare co-pays for Part D-covered drugs as opposed to the \$15 per month currently. The recommendation also would remove coverage of over-the-counter drugs, with the exception of insulin and insulin syringes, under DSS' pharmacy programs. Some of the more common OTCs are Benadryl, Tylenol, Advil and Motrin, hydrocortisone cream, and various cough and cold preparations. Between August 1, 2009, and November 1, 2009, the department covered 178,970 over-the-counter prescriptions at a total cost of \$5.32 million.

The overall savings that will result from the above are \$10.9 million.

### **Other Medical Initiatives**

The biennial budget included supplemental funds to cover Federally Qualified Health Centers (FQHCs) enhancements. In addition to funds provided in Medicaid to supplement operating costs, funds were provided to cover the full cost of 16 new out-stationed eligibility workers. Of these 16 positions only seven have been filled, despite our best efforts. The mid-term budget proposes that the discretionary funding provided under Medicaid be removed, which, in turn, will require the FQHCs to contribute toward the cost of any out-stationed eligibility workers.

In an effort to improve access to health care for Medicaid clients with limited English proficiency, the legislature mandated that DSS amend the Medicaid state plan to include foreign language interpreter services provided to any beneficiary with limited English proficiency as a covered service under the Medicaid program. The biennial budget includes partial year funding in FY 2010-11 of \$2.5 million for this initiative, with annualized costs projected at \$6 million. The mid-term budget recommends obtaining these services from one centralized vendor. We believe this is a more cost-efficient, streamlined model than one where providers would need to submit claims for reimbursement of medical interpreter costs. This latter model would require a Medicaid

state plan amendment. Providing services from one centralized vendor is expected to result in annualized costs of \$1.7 million, significantly less than the \$6 million projected under a state plan amendment.

Consistent with federal rules, the budget recommends requiring co-pays of up to \$3 per service on allowable medical services (excluding hospital inpatient, emergency room, home health, laboratory and transportation services), not to exceed 5% of family income. Co-payments for pharmacy services will be capped at \$20 per month. These co-pay requirements would not apply to any children under 18 years of age, individuals at or below 100% of the federal poverty level, Supplemental Security Income recipients, pregnant women, women being treated for breast and cervical cancer and persons in institutional settings. It should be noted that 45 states require co-payments under their Medicaid programs.

The budget proposes to expand transportation options under Medicaid to include stretcher van service for those individuals who are medically stable but must lie flat during transport. The new stretcher van rate will be significantly less than the non-emergency ambulance rate, which has a base rate of \$218 plus \$2.88 per mile (approximately \$275 for a 20-mile one-way trip). This change is consistent with a number of other states that have recognized the economic value of stretcher vans.

Eyeglasses, contact lenses and services provided by opticians are considered optional under federal Medicaid rules. The budget recommendation continues coverage for services by optometrists and ophthalmologists but does not continue coverage for vision hardware (eyeglasses, contact lenses). To comply with federal rules, the current benefits, including hardware, will continue to be provided to all individuals under the age 21.

### **HUSKY B**

The mid-term budget includes an increase in premium cost-sharing for HUSKY B members in 'band 2,' those with incomes between 236% to 300% of the federal poverty level (FPL). Under this proposal, the monthly premium payment for families with one child will increase from \$30 to \$50, and will increase from \$50 to \$75 for families with more than one child. Those clients in 'band 1,' from 185% to 236% of FPL, would continue to be exempt from premium cost-sharing. It is important to note that the premium cost share for HUSKY B members has not been raised since the inception of the program 1998, despite sizable medical cost increases incurred by the state over that time period.

Additionally, HUSKY B co-pay requirements will be structured to align with those of state employee health plans. Consistent with the federal rules, the family obligation, including premium payments and co-pays, cannot exceed 5% of the family's gross income.

### **Charter Oak Health Plan**

The monthly subsidies paid for Charter Oak clients are now limited to between \$50 and \$175 per month, depending on income. The proposed budget contains costs by

suspending the state subsidy of premium for one year. Any enrollees coming on to Charter Oak after July 1, 2010 will be responsible for the full premium costs.

### **Other Medical Programs**

#### **SAGA**

The budget includes several cost-saving initiatives in the State-Administered General Assistance (SAGA) program.

The administration of care management for SAGA clients will be modified to mirror the approach currently being developed for the Medicaid fee-for-service program. This change will not affect the clients' ability to receive necessary medical care.

Payments to Federally Qualified Health Centers (FQHCs), which are currently made at the Medicaid rate, will be reduced to 90% of that rate. This rate is still considerably higher than that paid to private physicians and hospital clinics for the same services and therefore should have a negligible impact on access to care for SAGA clients.

#### **Public Assistance**

Caseloads in the Public Assistance and Supplemental Nutrition Assistance Programs have increased dramatically since SFY 2009. In SNAP, we have seen an increase of 17% in the number of families receiving this assistance between June and December 2009. To assist our families during this recession, Governor Rell recommended, and the department implemented, an increase in the income limit from 130% to 185% of the FPL, thus allowing more families to receive these federally funded benefits. In Temporary Family Assistance, caseloads have risen 7% in this same time period. Recognizing the critical nature of these services, other than the elimination of the cost-of-living adjustment that was included in the biennial budget last year, no changes were recommended in the mid-term adjustments.

#### ***Legislation Introduced at the Request of the Department***

#### **S. B. No. 66 (RAISED) AN ACT CONCERNING EXPANSION OF THE LIVERY LICENSE EXEMPTION TO INCLUDE COMMUNITY-BASED REGIONAL TRANSPORTATION SERVICES FOR THE VISUALLY IMPAIRED.**

The Independent Transportation Network (ITN) was introduced to the state through legislation in 2006. ITN is designed to provide community based regional transportation services to people over 60 and to the visually impaired. Since then two ITN affiliates have been developed to provide transportation regardless of destination or time of day.

In 2008 legislation was passed to exempt these transportation services from the need of a livery license from the CT Department of Transportation. Public Act 08-101 was effective on October 1, 2008; however it only defined community-based regional transportation systems as "...a transportation system for the elderly." In doing so, it

implied that services for the visually impaired could not be provided without a livery license.

This change is needed to clarify Section 13b-101(4) of the General Statutes to have the exemption of “community based regional transportation services for the elderly” from the need of a livery license to specifically include those services for the visually impaired.

By changing the statute to include “the visually impaired,” transportation will be made available to a significant population in need of these services. If this change is not made, a gap in services to the state’s visually impaired residents will continue, denying people access to employment, social, and religious opportunities.

**S. B. No. 68 (RAISED) AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES' AND RECOMMENDED CHANGES TO THE MEDICAL ASSISTANCE AND PHARMACY STATUTES.**

Section 1 amends § 17b – 221b to conform with §10-76d (3) of the General Statutes. There remains an inconsistency in the social services statutes regarding the percentage federal match for special-education-related services DSS is to share with municipalities. Legislative intent specified 50% which is the department’s current practice. This correction would make the statutes consistent.

Sections 2 through 4 and 6 through 9 replace a string cite, which appears throughout DSS statutes and references various pharmacy programs administered by DSS, with a consistent phrase which encompasses all pharmacy programs that exist today and may exist in the future. This change also reflects current DSS practice with regard to uniform administration of pharmacy programs.

Section 5 adds two members to the Pharmaceutical and Therapeutics (P&T) Committee, increasing the total members from 14 to 16. The new members are a child and adolescent psychiatrist and a clinician representing the Department of Children and Families. As this committee is aware, there are special issues associated with mental health drugs and their use by children that need to be considered by the P&T when adding these drugs to the preferred drug list.

***Other Legislation Impacting the Department***

**S. B. No. 67 (RAISED) AN ACT CONCERNING ANNUAL BENEFITS**

This bill would permit participants in the Charter Oak Health Plan to exceed established annual benefit limits to obtain coverage for treatment that is medically necessary. While the department appreciates the concern for covering individual with complex and costly medical needs, members of the legislature should understand that completely removing the annual cap could have a number of implications for the state and Charter Oak members. Removing the annual cap would increase the cost of the program. These additional costs would either have to be absorbed by the state or absorbed by Charter Oak

members through a premium increase. While those individuals receiving a subsidy will already experience increases in their premium share additional significant premium increases could force members to leave the program.

Charter Oak members are a very medically vulnerable population. The leading diagnoses among Charter Oak members include cancer, congestive heart failure and other cardiovascular diseases. It is the department's concern that raising Charter Oak premiums further will force many members without chronic diseases to drop off, leading to greater adverse selection and instability of the program. It is our recommendation that a complete actuarial analysis be undertaken to review the possible impact of this legislation on state expenditures and/or Charter Oak enrollees.

**S. B. No. 139 (RAISED) AN ACT CONCERNING INDEPENDENT MONITORING OF THE HUSKY PROGRAM.**

The Department opposes legislation requiring additional independent monitoring of the HUSKY program. Additional monitoring would duplicate the monitoring that already exists and that has recently been enhanced. The department has a contract with the Hartford Foundation for Public Giving, which subcontracts with Connecticut Voices for Children to conduct independent analyses of HUSKY access, utilization and quality. In addition, federal law requires that the Department contract with a certified External Quality Review Organization (EQRO) to provide independent expert evaluation and monitoring of program performance. The department's EQRO contract has been in place since the initiation of the HUSKY program and it has provided valuable information to the Department and the Medicaid Managed Care Council regarding HUSKY MCO performance. Finally, the department has recently enhanced HUSKY program reporting by requiring that the MCOs adopt a comprehensive set of Healthcare Effectiveness Data and Information Set (HEDIS) measures approved for use in Medicaid. These measures are independently audited and certified and will provide the department and the public with objective information regarding MCO performance in a broad array of areas. They will substantially improve the Department's ability to monitor overall program performance and it will support individual MCO accountability.

**H. B. No. 5068 (RAISED) AN ACT CONCERNING AMENDMENTS TO THE MEDICAID STATE PLAN.**

The department opposes this legislation. The bill would require that the department submit all state plan amendments (SPAs) to the Committees of Cognizance for review and approval, as is currently required for Medicaid waivers. This is a time consuming process. This bill would create an extraordinary burden on the department. It would create additional unfunded costs associated with such burden and it would result in delays that would in some cases prevent the department from implementing legislated and other program changes in a timely fashion, placing the state at significant risk of sacrificing federal matching funds. In medical care administration alone, the department implements dozens of SPAs each year. Many others are undertaken by the program division related to eligibility. SPA volume stands in stark contrast to waiver volume, which typically

numbers one or two each year, sometimes none. The Department implements SPAs in order to comply with federal law, implement rate changes, and to implement statutorily required programs and program changes under Medicaid.

It is critical the department maintain flexibility in the timing of the submission of state plan amendments because once an amendment is filed with the Center for Medicare and Medicaid Services (CMS), the amendment, if approved, is effective retroactive to the beginning of the quarter in which it is filed. This can mean the difference in three months of federal match, program eligibility for clients or compliance with federal or state law.

Public Act 09-05 of the September Special Session imposed the requirement that the Department notify the Appropriations and Human Services Committees of SPAs before they are filed. This requirement only just recently became effective and provides information to the committees of cognizance without presenting an impediment to the department's timely filing of SPAs. Additionally, it has been our longstanding practice to publish SPAs in the Connecticut Law Journal or in Connecticut newspapers and comments are typically received and addressed prior to submission to CMS or in the course of CMS review. There have been few if any complaints about this process from the public, which raises questions as to why additional legislative scrutiny would be required.

**H. B. No. 5145 (RAISED) AN ACT CONCERNING AN INCREASE IN THE AMOUNT OF FEDERAL FUNDS RECEIVED BY STATE AGENCIES.**

The department has already taken steps to track federal grant opportunities and notify program staff of their availability. I have designated a staff member within the Commissioner's Office to check federal grant announcements on a daily basis. When it is determined that DSS may be an eligible applicant, the announcement is sent to program staff for evaluation. Program staff are expected to determine if we are eligible and report back on actions taken or reasons why we cannot pursue. These comments are sent to the Commissioner, who makes the final decision on whether or not apply for these federal funding opportunities. The Commissioner will consult with the OPM and any other appropriate state agencies when making the final determination.

The tracking report (described above) that has been created encompasses most of the reporting requirements contemplated in this bill.

While this may place an additional administrative burden on the Department, we are anticipating that we can absorb this within our available resources.

**S. B. No. 137 (RAISED) AN ACT CONCERNING THE LEGISLATIVE COMMISSIONERS' RECOMMENDATIONS FOR TECHNICAL REVISIONS TO THE HUMAN SERVICES STATUTES.**

The provisions of the bill are purely technical and supported by the department.

