



*Testimony before the Human Services Committee
Roderick L. Bremby, Commissioner
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Good afternoon, Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services. I am pleased to be before you today to testify on one bill raised on behalf of the Department. In addition, I offer remarks on several other bills on today's agenda that impact the Department.

Bill Raised on Behalf of DSS:

H.B. No. 6770 (RAISED) AN ACT CONCERNING MEDICAID COVERAGE FOR OVER-THE-COUNTER DRUGS

This proposal allows payment for over-the-counter medications for adults over the age of 21 in situations which are medically necessary and cost effective. Of late, there has been a marked rise in the number of products switching from federal legend (prescription only) to over-the-counter (OTC) status. This bill will allow the Department to continue coverage of an OTC product if it is deemed to be a safe, efficacious and cost-effective alternative, as the Department currently does for the 0-20 year old population.

We wish to draw the Committee's attention to clarifying language to the bill as written. The Department requests a technical correction to Section 1 (5), that reads, "over-the-counter medications determined by the Commissioner of Social Services to be medically necessary or cost effective." The updated subsection 5 would read as "(5) additional over-the-counter medications and products if the Commissioner of Social Services determines that such medications and products are clinically efficacious, safe, and will be a cost-effective alternative to other drugs or services covered by the medical assistance programs."

There are OTC products which the Department wishes to cover due to their unique formulation for adults, especially the growing geriatric population. Many of these products are also more cost-effective because of their OTC status.

For example, the proton pump inhibitors Nexium and Prevacid recently both became available over-the-counter. The Department would pay \$25.62 for 30 Prevacid 15mg OTC and \$137.06 for its prescription counterpart. For 30 Nexium 20mg OTC, the Department would pay \$19.46. In comparison, for the 30 Nexium 20mg prescription counterpart, the Department would pay \$238.64.

The Pharmacy Unit at the Department oversees drug coverage for all Medicaid programs. This unit ensures that all drugs, both prescription and OTC, are added to the drug file with appropriate coverage rules, in a timely manner, to ensure that they are available to clients when prescribed by an enrolled provider.

This bill and its proposed modifications will afford the Department latitude to provide these types of medications in a cost-effective manner and without delay. It is important to note that a physician must still prescribe the OTC medication in the same manner as a legend drug to be covered by Medicaid.

We ask for your support of this proposal.

Other Legislation Impacting the Department:

S.B. No. 899 (RAISED) AN ACT CONCERNING VOLUNTARY BED REDUCTIONS AT NURSING HOME FACILITIES

This bill increases a nursing facility's Medicaid rate if it temporarily reduces licensed beds from service.

Assuming beds would be reduced to 90% of the current total licensed capacity, nursing facilities would receive a per-day as an add-on to their current rate related to fixed costs. This would result in an increase in nursing home expenditures totaling approximately \$13 million annually.

It is also important for the Department to note that this proposal takes a position in stark contrast to the state's Strategic Rebalancing Plan. In particular the Department's rebalancing efforts address supply and demand trends for nursing home and community based services, ensuring that our investments in services and infrastructure are aligned with the preferences of the people we serve. The plan is guided by the principles of person-centeredness protecting the values of dignity, autonomy and choice for those who seek long-term services and supports. Several federally funded grants including Money Follows the Person, serve as foundational initiatives within the plan.

Because of the substantial fiscal impact attached to this bill, along with its contrasting view on the state's rebalancing initiatives, the Department must oppose this bill.

S.B. No. 915 (RAISED) AN ACT CONCERNING THE TREATMENT OF ASSETS IN MEDICAID ELIGIBILITY DETERMINATIONS

This bill proposes that an institutionalized individual cannot be denied Medicaid based on an undisclosed or unliquidated asset. The exclusion of a disqualifying asset would effectively allow institutionalized individuals to have assets in excess of the Medicaid asset limit, yet qualify for assistance.

This bill would not allow institutionalized individuals to be denied Medicaid solely on the basis of a single unliquidated asset providing the individual can show evidence that the asset is inaccessible. This bill also would not allow institutionalized individuals to be denied Medicaid solely on the basis of an asset discovered in the month of application, providing the individual reports the discovery, takes steps to liquidate the asset and spends-down the proceeds in accordance with Medicaid policy. Both proposed changes pertain to a single disqualifying asset that causes the institutionalized individual's total assets to exceed the Medicaid limit.

Federal regulations define a countable asset as cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and can convert to cash to be used for his or her support and maintenance. If the individual has the right, authority or power to liquidate the asset it is countable towards the Medicaid limit.

The exclusion of a single disqualifying asset would effectively allow institutionalized individuals to have assets in excess of the Medicaid asset limit, yet qualify for assistance. This would remove any incentive for individuals or their representatives to reduce their assets in a timely manner by paying nursing facilities, which would increase Medicaid expenditures.

The Department does not support this proposed bill as it will result in additional expenses in the Medicaid account in an already challenging budget environment.

S.B. No. 978 (RAISED) AN ACT CONCERNING RESIDENTIAL CARE HOMES

This proposal would increase the minimum fair rent reimbursement for real property from \$3.10 per resident per day to \$5.10 per resident per day.

The Department has estimated that this proposed increase would have an estimated fiscal impact of \$1.7 million. In these challenging fiscal times, the Department is unable to support this proposal. Additionally, this bill also proposes a cost exposure on a request retention and recruitment adjustment that the Department is unable to support.

S.B. No. 1009 (RAISED) AN ACT CONCERNING PERSONS WITH MENTAL DISABILITIES WHO HAVE COURT-APPOINTED CONSERVATORS.

This bill proposes to streamline Medicaid eligibility determinations for persons with mental disabilities who have court-appointed conservators and to study issues concerning the effective delivery of services to such persons.

Federal law requires that the Department establish time standards for determining eligibility. These standards are ninety days for applicants who apply for Medicaid on the basis of disability and forty-five days for all other applicants.

The Department is committed to serving the needs of all applicants in a timely manner, including those individuals identified in this bill. To receive services from the Department every individual

must apply. Each application received is reviewed and over 92% are processed within the standards established by federal law. While the Department prioritizes applications based on emergency situations, we do not prioritize by categories of applicants, such as those with court-appointed conservators. Prioritizing these applications as proposed is unfair to other applicants.

Federal law also requires that the Department conduct a redetermination of Medicaid eligibility once every twelve months. The Department must make a redetermination of eligibility without requiring information from the individual if able to do so. If the Department has enough information available to it to renew eligibility with respect to all eligibility criteria, a new twelve-month renewal period will begin.

The Department fulfills the time standards established by federal law for the vast majority of applicants. Federal law does not allow for an extended period of Medicaid eligibility. For these reasons, the Department must oppose this bill.

H.B. No. 6908 (RAISED) AN ACT CONCERNING FAIR HEARINGS

This bill would establish an “Office of Administrative Appeals” within the Department for which the Commissioner would appoint an administrator who would report to the Commissioner and could be removed only for cause. The proposed Office would conduct all “appeals” from decisions of the Commissioner. The bill would also require the Department to notify, in writing, each person requesting a hearing of the right to have an in-person hearing, if needed, and the need to request such in writing.

Currently, the Department has an Office of Administrative Hearings managed by an Operations Manager and housed within the Office of Legal Counsel, Regulations and Administrative Hearings. There are 19 hearing officers in the unit, who conduct hearings that clients have requested under section 17b-60 of the statutes. These requests pertain to decisions affecting eligibility for benefits or coverage for services, including eligibility for subsidies administered by Access Health CT. Staff attorneys in the Office of Legal Counsel conduct hearings requested by Medicaid providers to contest rates issued by the Commissioner or charges filed against them alleging violations of program rules.

Under section 4-8 of the statutes, department heads are authorized to organize the departments they oversee as they deem necessary for the efficient conduct of the department’s business. The Department does not see a need to appoint a new administrator, nor see a need for the head of the Office of Administrative Hearings to report directly to the Commissioner. Additionally, there is fiscal impact associated with creating a new position that is not recognized in the current budget. Moreover, this bill envisions that hearing officers would conduct all of the Department’s hearings, including those offered to Medicaid providers. Hearing officers have no experience with issues relating to rate setting or Medicaid provider requirements; they are former eligibility workers and supervisors. It would not be appropriate for the Department’s hearing officers to hold hearings for providers concerning rates and provider requirements. Department staff attorneys have expertise more suitable to preside over Medicaid provider hearings.

Section 17b-60 currently provides that an aggrieved person must appear personally, unless his or her physical or mental condition precludes appearing in person. If a person is homebound or in a nursing facility or hospital, the hearing officer will go to the client's home or the facility where the client is living. A hearing for an institutionalized client is automatically scheduled at the facility. Home-bound clients or their representatives can simply call the office to request an in-home hearing. The request does not have to be made in writing. Otherwise, hearings are typically held by video conference. The hearing officers are located in the central office and the clients connect by video in the field office closest to their homes. This is a huge efficiency. When a hearing officer has to conduct a hearing off-site for a homebound or institutionalized client, that hearing officer is largely unavailable for hearings for the rest of the day. On occasion, hearing officers travel to a field office to hold a hearing in-person when the number of people who will attend the hearing is such that the hearing cannot reasonably be conducted by video conference. This is generally a situation in which the client and the Department are represented by counsel and there are a number of witnesses expected to testify. Because the Department tries to schedule hearings as timely as possible, we do not want to encourage further requests for in-person hearings by inviting clients to request them based on undefined "specific need."

The Department is concerned that we would receive a tremendous number of requests for home hearings made for the convenience of clients and then be put in the position of determining whether and upon what basis the request should be granted. This would drain the administrative resources of the unit. The Department would require additional hearings staff to administer and hear the requests for in-person hearings. This is not a budgeted expense. Additionally, Department case workers attend hearings held in facilities and client homes. Each of these hearings takes the worker away from the work of the agency for far longer than a hearing held in the field office to which the worker is assigned to report for work each day.

Further, the term "administrative appeals" is a misnomer. The Department conducts administrative "hearings." If the final decision issued after a hearing is not favorable to the aggrieved person, that person may appeal the decision to Superior Court. An "administrative appeal" is made to Superior Court from the final decision of the agency issued following an administrative "hearing."

For these reasons the Department opposes this bill.