

*Deficiency Testimony before the Appropriations Committee  
Roderick L. Bremby, Commissioner  
April 21, 2015*

The DSS budget deficiency is currently estimated at \$108 million, which represents approximately 3.6% of the total General Fund appropriation for the Department. This is a net deficiency shown under the Medicaid account after all other shortfalls and surplus account balances are taken into consideration. This is the standard presentation of our deficiency as the Department traditionally transfers balances through the Finance Advisory Committee prior to year end to adjust for all other surpluses and shortfalls.

The primary reasons for our deficiency are noted below:

Hospital Retroactive Settlements

While the appropriation for SFY 2015 included \$20 million for hospital retroactive settlements, we are now projecting approximately \$80 million in settlement payments. These settlements occur under the Department's hospital reimbursement structure prior to the implementation of the new hospital DRG-based reimbursement. Under the prior methodology, hospital costs and lengths of stay are estimated, and per diem payments are made based upon those estimates. To the extent that hospitals are able to manage more favorable length of stays and costs, settlement payments are made. With the change to our new DRG-based reimbursement structure, the Department is completing prior year settlements on a more rapid schedule. We will process settlements for hospital fiscal years 2012 and 2013 in the current fiscal year at a cost of approximately \$40 million each. This difference, once net funding is taken into consideration, would contribute up to \$30 million to the current shortfall projection. As these are one-time settlements, and as the state has moved away from the reimbursement methodology which required these settlements, these payments will not be required after SFY 2016. Funds for these final settlements are included in the Governor's Recommended Budget.

HUSKY D and Federal Guidelines for 100% Reimbursement

Based upon the authorizing language under the Affordable Care Act (ACA), the appropriation for SFY 2015 anticipated that all of the HUSKY D population (Medicaid Coverage for the Lowest Income Population group) would be eligible for 100% federal reimbursement. The ACA reflects the federal government's intent to fully cover the costs of Medicaid coverage for such individuals, but also requires states to substantiate that they are, in fact, newly eligible and would not have otherwise been eligible under another coverage group. Details surrounding the federal claiming process, and related adjustments to limit reimbursement to the traditional 50% for HUSKY D clients who may have been eligible under another coverage group (principally, 19- and 20-year olds), became more apparent as the fiscal year progressed. Early Department estimates

indicated that the share of clients who were not newly eligible would be in the range of 2-3%. As additional information was gathered, analyzed, and as the Centers for Medicare and Medicaid Services clarified its interpretation of federal law, this percentage is now estimated at approximately 6%. Given the \$1.24 billion estimate for total HUSKY D expenses, 6% of that amount, or approximately \$74 million, is now estimated to be subject to 50% reimbursement versus 100%. Given net Medicaid funding, this has implications for the deficiency and contributes up to \$37 million to the current shortfall projection.

#### Difficulty Achieving Certain Savings Objectives

The appropriation included savings of \$20 million for medication administration and \$15.8 million for step therapy, in total, including both federal and State shares. These were ambitious savings targets that have proven difficult to achieve. In particular, the medication administration savings figure was difficult to achieve because although statute now authorizes home health aides, under supervision of nurses, to administer identified types of medications, and the Department and DPH have collaborated on training curriculum and other means of promoting the option, home health agencies have been very slow to put this into practice. Recognizing the need for an alternative strategy, the Governor's recommended budget proposed to reduce the reimbursement rate for medication administration services, for a projected savings of \$20 million including both federal and State shares. Additionally, while the Department has implemented step therapy for several classes of drugs, savings have not been as high as were assumed in the budget.

#### New Hepatitis C Drug Costs

While first introduced last fiscal year, this fiscal year saw a significant uptick in utilization of new high cost treatments for Hepatitis C. This increase was not anticipated in the appropriation. Through March 2015, over \$93 million in additional costs have been incurred for Hepatitis C drugs this fiscal year, including both federal and State shares and before rebates. In response, the Department completed a cross-state analysis of means of balancing access to these new curative treatments with cost containment and has proposed prior authorization policies and explored opportunities to maximize drug rebates, both of which will be presented to the Pharmaceutical & Therapeutics (P&T) Committee in early May. This new cost has contributed approximately \$16 to the State deficiency once rebates and the federal share of expenses are taken into account. It is also worth noting that these medications are curative and presumably will result in a net saving from other avoided illness and care such as transplants, but that such savings accrue many years in the future.

#### Transfer by Finance Advisory Committee to CCMC

The Finance Advisory Committee transferred \$10 million in State funding from the Medicaid account to the Connecticut Children's Medical Center. This contributes to the deficiency in an equal amount.

It should be noted that the Department's recent per member per month (PMPM) cost trend for total Medicaid expenditures is still very favorable. Attached are the most recent data points in

regard to the total Medicaid PMPM trends, inclusive of both the federal and State shares of the program. As you can see, they continue to exhibit a very stable per client cost trend. This contrasts markedly to historical trends, which involved significant year over year increases. It is also a very favorable experience when compared with national benchmarks. It is important to note that this has been achieved concurrent with across-the-board improvements in both health outcomes and also care experience for Medicaid beneficiaries under the State's Administrative Services Organization (ASO) model.

In terms of additional costs that may have resulted had not this PMPM trend been so constant, our total Medicaid spending, including both federal and State shares, is in the range of \$6 billion. Each one percent overall cost increase therefore results in approximately a \$60 million increase in total federal and State combined expenditures.

As part of the administration's obligation to mitigate deficiencies within its existing statutory and regulatory authority, the Department has implemented additional Medicaid efficiencies to help offset our requirements for additional funding. The Department has reviewed discretionary rate and spending areas for cost reductions. A number of these are incorporated into the Governor's Deficit Mitigation Plan, while others moved forward before the Governor's Deficit Mitigation Plan and are included in the Governor's current services budget.

The following accounts are also expected to vary from the appropriation in the amounts indicated. Any necessary adjustments will be addressed through transfers under the authority of the Finance Advisory Committee.

Surplus accounts

Old Age Assistance; Aid to the Disabled; Temporary Family Assistance, Connecticut Home Care Program

Shortfall accounts

State Administered General Assistance; HUSKY B; Other Expenses

