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TESTIMONY OF SHELDON TOUBMAN BEFORE THE APPROPRIATIONS COMMITTEE CONCERING THE DSS BUDGET AND PROPOSED CHANGES TO DSS LEGISLATIVE REVIEW PROCESSEES

Senator Bye, Representative Walker and Members of the Appropriations Committee:

My name is Sheldon Toubman and I am an attorney with New Haven Legal Assistance Association. I am here to testify in opposition to specific proposed cuts in the Governor's budget as concerns the Department of Social Services and other harmful changes in the Governor's bill, SB 17.

Opposition to proposal to eliminate all legislative committee review and approval of Medicaid waivers prior to submission to the federal Medicaid agency, CMS.

Section 32 of SB 17 would takes away a critical protection for Medicaid enrollees and applicants, and would remove the long-standing role of this committee (and of the Human Services Committee) to ensure that a waiver or waiver amendment is in the public interest, before it is submitted to the Centers for Medicare and Medicaid Services for approval. Several harmful waiver provisions have been wisely blocked by the legislature because of this careful review process, set forth at Conn. Gen. Stat. § 17b-8, and there is no reason to change it. Indeed, this statute provides for legislative committee review of other kinds of federal waivers as well, and there is no justification for removing the legislative review process in these areas either.

Opposition to proposal to leave it to all state agencies, including DSS, to decide how to cut their budgets, without line-item legislative review.

This proposal by the Governor would remove this critical role of the legislature and deny a public airing of any specific proposed cuts to those agency budgets. Many cuts to benefits for individuals served by DSS have been stopped by the public coming forward to this Committee and the General Assembly and explaining why these cuts should not be made. This combined public and legislative role would be entirely supplanted without an individual line item review process. But, beyond this, we might not even know about a cut until after it was already made. This is a concern not just with this administration's proposals but with those of all future administrations.

Opposition to Governor's proposal to cut 1,000 or more state jobs to the extent it would effect the number of line jobs at DSS.

DSS is already suffering from a severe shortage of staff and an antiquated eligibility management computer system which will not be replaced until at least 2017 and probably later. (The argument that this new system, called "IMPACT", was "around the corner" has been used as an argument for not bringing on necessary additional staff, but it was just announced that another substantial delay in its implementation is required.) Although the Governor's initial proposal is not to cut DSS jobs specifically, the problems with untimely processing of applications and redeterminations resulting in eligible individuals going without various benefits and services will only get worse if the staffing at DSS processing centers and regional offices is in any way reduced due to either layoffs or attrition.

Here is a very recent case handled by a legal services attorney which demonstrates the consequences of having too few people to timely process all of the millions of documents which DSS must process through human engagement:

> Elderly individual on long-term care Medicaid sends in all paperwork for redetermination on time, on December 19th. On February 3rd, she received a Notice of Action dated 1/28/16 stating that she would be terminated on 1/31/16 due to "YOU DID NOT COMPLETE THE REVIEW PROCESS". The next day, her daughter called the DSS Benefits Center. The first person she reached looked up the case and said that DSS **had** the paperwork, and that she would transfer the daughter to another person. That second person (Rich) said:"Oh, the notice is misleading. We have an old computer system, and if we don't work on your paperwork, it assumes you didn't send it in. We will process it now in 24 hours."
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> Although the second DSS person told the daughter last week it would be processed within 24 hours, four days later, she **still had not been reinstated**, according to the client's DSS "My Account" – It said that her "application" was received on February 1 and is still pending. Yet, the document list in MyAccount said they actually received the documents (including the redet form) on December 22, 2015. So the bottom line is that this elderly person, though having timely submitted Medicaid redetermination papers which were received by DSS on December 22nd, was cut off on February 1st , with a notice dated January 28th, because, even then, over a month later, the DSS workers were so behind with processing documents in the queue that the system was routinely cutting off individuals who are still eligible. .

As harmful as this to our clients, we also note that there are two federal court orders requiring DSS to timely process applications, respectively, for Medicaid and SNAP. One order was entered by the court as a preliminary injunction (*Briggs*, concerning SNAP application processing); the other through a settlement memorialized in a consent decree (*Shafer*, concerning Medicaid application processing). Without adequate staff, DSS runs the very real risk of violating these court orders.

Accordingly, given the agency's current inability to keep up with the amount of work, at least until the new eligibility management computer system is actually implemented in

2017 or 2018, we should be **increasing** the number of DSS front line staff. At the very least, staffing levels should be maintained and any vacancies should be promptly filled. Even the current hiring freeze is wreaking havoc on DSS's ability to keep up with the volume, and it should be relaxed for this agency.

Opposition to Further Restrictions on Access to Orthodontia for Children on Medicaid in Section 19

We oppose Section 19 of SB 17, under which the Governor proposes to further tighten access for poor children to orthodontia services.

Under the recently created statutory scheme, a child must have a certain score on the Salzmann Assessment, an antiquated test that was created in the 1960s in order to persuade commercial insurers to cover orthodontic treatment. This test was **not** created for the purpose of determining "medical necessity," nor was it ever intended to be used in the Medicaid program[1]. There is no relationship between a Salzmann score and a child's actual need for orthodontic treatment.

Nevertheless, DSS has, for years, used a regulation that employs this arbitrary[2] scale to determine eligibility for orthodontic treatment. Last year, the administration successfully lobbied to turn the regulation into a statute which changed the standard from 24 points to a higher standard of 26. As a result, many more children in need of orthodontia have been denied access to these medically necessary services..

Now the Governor proposes to make this test even harder for Connecticut's needy children to meet, by increasing the required number of points needed to qualify for medically necessary orthodontic treatment, with the sole purpose of denying services to more children.

Orthodontia corrects medically determinable oral deviations. These may cause a negative impact on speech or on a child's ability to eat food, and often cause pain for the child. It is not simply cosmetic treatment. It is necessary medical/dental treatment, just like every other medical treatment covered by Medicaid.

[1] J.A. Salzmann, D.D.S., F.A.P.H.A., Orthodontics in Public Health and Prepayment Programs in Orthodontics in Daily Practice 628 (1974)

[2] Two examples of the arbitrariness of this test:

- Under the Assessment's instructions, a crowded tooth receives a score of one point, recognizing that it is a condition which is not normal and needs correcting. A rotated tooth receives a score of one point, recognizing that it, too, is a condition which is not normal and needs correcting. But a tooth which is both crowded and rotated receives not two points, but only one point. **The assessment deliberately ignores one of the two oral deviations which require correction.**

- The Assessment assigns **no points at all** for tooth pain or excessive pressure.

In 2010, the legislature adopted C.G.S. Sec. 17b-259b, which defines "medical necessity" specifically for the Medicaid program. This definition was the product of a select committee of knowledgeable providers and others authorized by the legislature to create an updated, legally sufficient definition of "medical necessity" for the Department of Social Services to use in administering the Medicaid program, for **all** categories of medical services. DSS staff, including its then-medical director, participated in crafting this definition.

The resulting statutory standard provides:

> (a) …. "medically necessary" and "medical necessity" **mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition**, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease." (emphasis added).

As a further set of protections against payment for inappropriate services, the statutory standard also requires that the treatment be:

> (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) **based on an assessment of the individual and his or her medical condition.** (emphasis added).

Significantly, cosmetic services were **NOT** intended to be covered under this detailed statutory standard, Equally significantly, the medical necessity determination was intended to be based on an assessment of **each individual** and his or her medical condition, not on an arbitrary test assigning points to some, but not all, orthodontic problems.

The 2015 law[3] that provides for the Salzmann assessment as a measure of medical necessity directly conflicts with the standard of medical necessity in 17b-259b, which applies to **every other category of services under Medicaid**. There is no justification for such a heightened standard for this one category of services needed by poor children.

Accordingly, we strongly oppose the increase in the numerical requirement for receiving orthodontia under the statute from 26 to 29 points. We further request that the

[3] C.G.S. § 17b-282e.

legislature change C.G.S. § 17b-282e.so that it is in harmony with the broader medical necessity statute passed by the legislature and in 2010[4].

The need for a separate, stricter test for one category of medical treatment has no basis in Medicaid law or in common sense statutory interpretation. It creates confusion in the Medicaid program, but, more importantly, it denies medically necessary treatment to poor children whose conditions would qualify under the medical necessity definition in C.G.S. Sec. 17b-259b.

Support for Undoing a Cut Affecting Drug Access for Medicaid Enrollees Made Last Year

As stated above, we oppose the Governor's proposed cuts to the DSS budgets and changes to the legislative review process. But we also urge the committee to undo a very small, but harmful cut you already made last year, and that was the elimination of the protection against high copays for prescription drugs for dually eligible Medicare/Medicaid individuals who must get their prescription drugs under the Medicare Part D benefit. Until July of last year, the state covered all of those copays in excess of $15 per month. But, at the Governor's urging last year, this protection was eliminated, in order to save what was projected to be only $90,000 per year.

Since then, we have heard several stories of individuals who now must choose between filling prescriptions or paying for food or utility bills. And the fact that they are low income and receive the federal "Low Income Subsidy" for purchasing drugs still leaves them with copayments that can exceed $7 per name brand drug. For individuals on several medications, the removal of the protection for copays in excess of $15 per month is an extreme burden. Accordingly, we ask that you restore this protection at a cost which, while *de minimus* for the state budget, can make the critical difference between keeping an elderly or severely disabled individual's medical condition under control or their ending up in a hospital for treatment because a medication went unfilled. Indeed, just two people ending up in hospitals because needed prescriptions go unfilled could more than wipe out the $90,000 per year which is being saved by ending this protection.

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[4] The easiest method of achieving statutory harmony is to repeal C.G.S. § 17b-282e so that C.G.S. Sec. 17b-259b applies to all categories of Medicaid services, as it was designed to do.
In the alternative, the legislature should add the following language, which references the Medicaid medical necessity statute, to C.G.S. § 17b-282e:

> If a recipient's score on the Salzmann Handicapping Malocclusion Index is less than twenty-six [or twenty-nine] points, the Department of Social Services shall consider additional substantive information when determining the need for orthodontic services, based on the definition of medical necessity applicable to all Medicaid services in Conn. Gen. Stat. Section 17b-259b.