CHAIRPERSON: Representative Catherine Abercrombie

SENATORS: Moore, Logan, Maroney, Haskell

REPRESENTATIVES: Case, Wilson Pheanious, Butler, Cook, Dathan, Hughes, McGee, Santiago, Stallworth, D'Amelio, Mastrofrancesco, Sredzinski

REP. ABERCROMBIE (83RD): I'd like to thank you all for being here. Just for clarification, we will start the first hour with the agencies and elected official. If we run over the hour then we will be rotating between the elected officials and the public, and with that, we will call up our first speaker which is Deputy Commissioner Kathleen Brennan from DSS. Good morning. Just please introduce yourself, but your microphone on, and then we will begin.

KATHLEEN BRENNAN: Good morning Representative Abercrombie and distinguished members of the Human Services Committee. My name is Kathy Brennan, and I'm the Deputy Commissioner at the Department of Social Services. I'm pleased to be here before you today to offer remarks on several of the bills on today's agenda. I will start on Senate Bill 818, AN ACT ALLOWING FOR THE DEDUCTION OF COURT-APPROVED CONSERVATOR AND FIDUCIARY EXPENSES FOR MEDICAID APPLIED INCOME. This bill proposes to exempt conservator and fiduciary fees for Medicaid income eligibility and asset transfer determination.
A state Medicaid agency is required to reduce cost to the state by using a member's income or applied income for payment for institutional services. A Medicaid member's gross income is reduced by all allowable deductions in a specific order defined by the post eligibility treatment of income rules. This process results in a patient liability amount paid directly by the member to the long-term services support provider, thereby reducing the amount that the state pays to the provider each month.

Currently, allowable deductions consist of personal needs allowance, established by state law, the community spouse allowance, a community family allowance, Medicare, and other health insurance premiums. Section 1A of the bill proposes to add conservator expenses including conservator compensation, probate court filing fees and expenses, and premiums for any probate court bond as additional allowable deductions. Each expense that is not that did from the patient liability would increase the percentage of cost the state would be liable to pay for institutional services.

In addition, implementing a change to the department patient liability calculation will require numerous systematic changes, system enhancements, as the current eligibility system is not programmed to include conservator and fiduciary fees as an allowable patient liability deduction. Further, the requirement to track and calculate expenses related to conservatorship would impact the long-term services and support eligibility determination process requiring additional human resources to ensure compliance with timeliness standards.
The bill also requires the department on an annual basis to calculate uniform the probate court administrator the total amount deducted from applied income, and the probate court administrator to then return half of that the department. While we welcome the partial reimbursement, the task and cost of tracking the data, making necessary system changes, and maintaining processing workload, would fall exclusively on the department.

Section 2 of the bill also establishes a minimum baseline conservator compensation of $125 dollars per month, but it doesn't require the conservator to provide documentation to demonstrate that the actual services were provided. Current probate regulations do require the submission of invoices for time expended, documentation pertaining to who is performing those services, and a summary of each entry. Further, 45A-594A of the Connecticut General statutes governs payments to conservators of individuals who receive benefits through the state, therefore this proposed bill is in conflict with both state law and regulation.

Section 3 of the bill states that the department may not consider probate court approved conservator fee paid for services rendered as an improper transfer for the purpose of establishing Medicaid eligibility. The department is the single state agency that determines Medicaid eligibility and must retain the discretion to consider whether it has been a transfer of assets for fair market value. If the department concludes that an individual has paid conservator fees that are excessive and are not consistent with services provided by the conservator, the department must have the ability to
impose a transfer of assets penalty that is consistent with both state and federal law.

Because these portions of the bill are inconsistent state and federal law and would have a negative fiscal impact on the state budget, the department must oppose this bill. However, we acknowledge the need to work on this very important issue of adequately compensating conservators who are pointing to individuals with limited resources, but welcome the opportunity to work with, actually continue working with the probate courts, to analyze the long-term fiscal impacts and develop a long-term solution to this issue.

The next bill is Senate Bill 820, AN ACT WAIVING PRIOR MEDICAID AUTHORIZATION REQUIREMENTS FOR CERTAIN PHARMACOGENOMICS TESTS. It took me a while to get that phrase right, just saying [laughter]. You know if you Google it you press it will tell you how to say it, so, it worked for me. So, this proposal requires Medicaid coverage for pharmacogenomic test without prior authorization when medically necessarily. Currently the department provides Medicaid coverage for over 200 types of genetic test including these types of test, the overwhelming majority of which require prior authorization to determine medical necessity. As drafted, the bill requires DSS to provide Medicaid coverage for these tests when medically necessarily and without PA for certain condition.

We do have significant concerns with this language. The pre-A process protects the safety of HUSKYG members by certifying that the test is appropriate for their medical condition and ensures that the department continues to be responsible stewards of state and federal funding by confirming that
Medicaid is only paying for those tests that are determined to be medically necessary. Inhibiting the department from implementing PA also impairs the department's ability to adapt to changing circumstances and clinical practices, while increasing the risk of performing and paying for unnecessary and repeat testing.

In addition, the science of genetic testing is changing rapidly with new tests and diagnostic methodologies coming online almost daily. To etch one diagnostic modality into statute, threatens to prevent HUSKY members from being able to access newer, potentially better, and more accurate modalities in the future. The statutory definition of medical necessity allows and in fact requires HUSKY coverage to grow and evolve as medical science grows and evolves.

Finally, lines 14 through 18 of this bill allows the department to give preference to any Medicaid enrolled laboratory provider that offers a discount for such tests. As we mentioned, the department already provides Medicaid coverage for genetic testing, and for those tests that are performed as part of an inpatient hospital service, payment for the test is bundled within the diagnosis related group or DRG structure. For those test that are performed through a laboratory provider, reimbursement is made in accordance with the laboratory fee federal, and if there is a test that is considered medically necessary, but not covered within a DRG or public fee schedule, we would manually price the tests, but for these reasons the department must oppose the bill.

Senate Bill 821, AN ACT CONCERNING EQUITABLE MEDICAID REIMBURSEMENT FOR FQHC PRACTITIONERS. This
bill will require the department to equalize Medicaid reimbursement rates for E-consults is a Federally Qualified Health Centers, FQHCs, with the Medicaid rate for E-consults in addition to a fixed the per patient visit. The department supports and recognizes the importance, effectiveness, and efficiency of the use of E-consults. Through E-consults a patient can receive the benefit of a specialist consult without having to wait for a face-to-face appointment.

We recognize and applaud the leadership of Connecticut's FQHCs in supporting the use of E-consults on a national level. Connecticut's FQHCs are at the forefront of this movement and deserves both our gratitude and our congratulations. We have been paying for E-consults originating from FQHCs since July 1, 2015 through a supplemental payment methodology. This methodology required the FQHCs to pay the-consulting specialist and for DSS to intern pay the FQHC for their cause and the-consulting specialist fees. CMS approved this payment methodology but only for a period of one year. They refuse to approve and a permanent extension of these payments because the payment arrangement excluded non-FQHCs affiliated primary care providers and consulting specialist from participating.

So, to maintain compliance with the Medicaid requirement for comparability of services, CMS requires that E-consults be available to all clinicians or to none. As a result, to continue to allow the use of E-consults, the department was required to implement a new payment methodology, which we did July 1, 2017. We now use the physician fee schedule. The-consulting specialist and the PCP are paid directly by the department unlike the
original arrangement where the FQHC paid the consultant and the department paid the FQHC.

The reimbursement method that is proposing this bill would establish two billing methodologies for the consulting specialist, one billing DSS directly, and the other billing DSS indirectly through the FQHC. This went on prevent the department from double billing in this context, because it would receive billing information, billing claims, under a separate category and with different billing provider information. Further, the proposed language, which appears to reestablish the former supplemental payment methodology would likely not receive federal approval. We do however understand and agree that FQHCs should be paid for their cost to generate an E-consult, we just don't agree with the mechanism of the proposed payment and this bill.

Right now, the FQHCs are paid on a prospective payment methodology that was established in 1998 and is set in federal law and Connecticut regulations. The methodology created an FQHC- specific cost based bundled payment for patient encounters for all services. Each FQHC has a special encounter rate for every medical, dental, and behavioral health visit that they provide, originally based on their cost reports in 1998. The encounter rate has been and continues to increase on an annual basis by the federally set medical inflation rate. As such, FQHCs are the only category of Medicaid enrolled providers that guaranteed an annual federal increase in the law.

The prospective payment methodology also includes a process to recognize cost associated with new services provided by an FQHC. The encounter rate can be recalculated by the addition of new services to
the costs in the already established encounter rate. This is called the scope of service change in the process through which FQHCs should pursue the department to recognize the new cost from the E-consults. We believe that the bill is unnecessary as each FQHC has the ability to account for these additional costs for providing E-consults through the scope of service change, and for these reasons we oppose the bill.

Senate Bill 822, AN ACT CONCERNING CONVEYANCES OF PROPERTY OWNED BY A RECIPIENT OF PUBLIC ASSISTANCE. A recipient of financial or medical assistance or their legally liable relatives, are required to obtain consult from the department before they sell, transfer, or dispose of real property. This proposes to limit the requirement for the recipients of assistance to obtain such consent. We're concerned that the proposed language would open the state to increase litigation on priority liens and will compromise the department's ability to accurately determine eligibility for assistance and limit the state's ability to recoup on improperly disposed assets, all resulting in financial losses to the state.

The revisions to this bill seek to add also requirement that the department issue a decision on the consent no later than 10 business days after receiving the request. There are number of factors that could impact the timeliness of our ability to make such a decision, including the complex nature of the case, the existing workflow, priorities of the staff. Further, we are unaware of any existing concerns or problems with the time that it currently takes for the department to issue such a decision. Therefore, we would welcome the opportunity to
address concerns related to the timeliness of the process prior to legislating a standard for timeliness.

The proposed language also states that the commissioner shall not treat as inferior the state's interest in property, prior recorded sale, assignment, transfer, encumbrance for which consent was sought pursuant to this section. The use of the word prior is ambiguous as it fails to specify prior to what, and also appears to cancel out the prohibition of selling, transferring, or disposing, without the commissioners consent. The current statute requires a recipient to obtain the commissioner's approval before doing so. The proposed language implies that if consent is sought but not given, the recipient can proceed. Currently improper transfers expose recipients to penalties. These proposed changes would limit our recourse and eligibility when assets are disposed of improperly. By requiring a consent of the DSS Commissioner, the Department of Administrative Services has the ability to recoup improperly disposed property and reduce the amount of assistance that is paid out. For this reason, the department opposes this bill.

House Bill 7090, AN ACT CONCERNING AN EQUITABLE METHADONE MAINTENANCE REIMBURSEMENT RATES UNDER THE MEDICAID PROGRAM. This bill seeks to require the commissioner to provide equitable weekly reimbursement rates under the Medicaid program for all methadone maintenance programs. Historically methadone maintenance was paid using a bundled weekly rate regardless of the number of services that have been provided in accordance with section 1902A30A of the Social Security act, the methodologies and procedures related to payments for
services are required to be both economic and efficient. Generally, under CMS rules, bundled payments are not considered economic and efficient, as the payment can be made for services that may or may not have been actually rendered to the member or for services that may not be covered by Medicaid. So, in order to comply with CMS rules, the department submitted it State Plan Amendment, SPA, to CMS that made several technical changes to the reimbursement methodology, specifically we prorated the weekly rate to account for weeks in which services are provided fewer than seven days a week. We specified in detail the services that are included in the rate, and we provided for specific types of documentation requiring that services are provided. We also remove references to locations, establish provisions for merchant clinics and newly licensed clinics, and authorize payment for take-home doses in compliance with federal regulation.

We received approval of that SPA on July 18, 2018. These changes are not intended to standardize methadone maintenance rate or to provide a rate increase. It did not fundamentally change the provider-specific rate in place. If you didn't have the authority to unilaterally increase or implement significant reductions in reimbursement for some providers. However, to better understand the cost structure of a methadone maintenance provider, as it relates to their reimbursement, we have implemented an annual cost report requirement. We have received six reports thus far, we expect to receive the final three by February 20, and we're going to finalize the rate after we see analysis at that time. This proposed bill would result in two additional cost for the state, absent the availability of
appropriations, the department is unable to support this bill.

House Bill 7094, AN ACT CONCERNING TEMPORARY FAMILY ASSISTANCE. The intent of this bill would increase TFA payments to parents with children under the age of three find additional $30 per month per child under the age of three in order to purchase diapers. In calendar year 2018, there was a monthly average of approximately 3800 children under the age of three and families who received TFA cash assistance. The department applauds the efforts of the bill to elevate the importance of diaper availability to children of low-income families.

In our work over the last five years with the New Haven Moms Partnership, we've also learned of the effect of diaper scarcity in the mental health of young mothers. While the data is not yet available, we have reason to believe that fathers would be similarly affected by the lack of diapers for their young children. The research of Megan Smith [phonetic] and others at Yale University suggest that low income women who mother in poverty experience additional stressors, pointing to the need for innovative public health promotion efforts to reduce mental illness. Simple innovations like making diapers more available and affordable may represent an effective method of addressing this problem. We also know that not having a reliable supply of clean diapers can disrupt the physical attachment of children and their caregivers. We estimate that some 1.37 million dollars would be needed to address the intent of the bill. We respectfully request to sponsor this bill, support the creation of a workgroup, met by the leaders of
the national diaper banks to develop an alternative method in assisting families with these funds.

These funds may serve to leverage additional funding to increase the availability of diapers for low income families. The department would work with the bill sponsors to ensure the inclusions of organizations like the Moms Partnership, our FQHCs, and community action agencies in this workgroup effort to design a method to disseminate diapers with linkages to other needed services and supports. The department will continue to monitor and support national efforts to secure funding for diapers as a Medicaid reimbursable service similar to the support Medicare provides for older adults with incontinent devices.

While we support the bill in concept, it will result in additional expenditures, therefore, absent the availability of appropriations, we are unable to fully commit to this bill.

House Bill 7122, AN ACT CONCERNING MOBILE DENTAL CLINICS. This bill seeks to allow mobile dental clinics to submit claims for Medicaid reimbursement for coverage services provided not more than 50 miles from the dentist fixed location. Currently, they are authorized to submit claims for services not more than 20 miles. We oppose this bill for the reasons detailed below.

The Connecticut dental health partnership has developed and maintained a robust provider network as reported to the MAPOC Council on February 8th, 100 percent of HUSKY health members have access to a dental home within 20 miles of their residence, and 98.8 percent have access to a dental home within 10 miles of the residence. Over the past seven years
Connecticut has been recognized as one of the top two states in the nation for the delivery of appropriate dental care for our members.

While the CTPHP currently recognizes the use of mobile dental clinics, we are confident that our provider network as it currently is configured meets the needs of our HUSKY health members. Further, there are benefits to a dental home that are not afforded to a mobile clinic, specifically dental homes provide comprehensive dental care, both preventative and restorative during standard business hours as well as after hours in emergencies. For these reasons, the department does not see the benefit of the expansion and opposes this bill.

House Bill 834, AN ACT CONCERNING SERVICES WITH SMITH-MAGENIS SYNDROME. The department appreciates the opportunity to address this legislation. Smith-Magenis syndrome is a genetically based disorder leading to moderate to severe intellectual disability in addition to changes in facial appearance, sleep, and behavior. The statutory definition of medical necessity governing Connecticut's Medicaid program and the Children's Health Insurance Program, CHIP, requires that every member received an assessment of their individual needs. Not only related to their specific diagnoses, but also to their life circumstances. Although the HUSKY Health Program does not provide specific services for specific diseases or illnesses, HUSKY Health does provide a wide array of services and supports when medically necessary that are intended to adequately meet the needs of individuals with any illness or condition including Smith-Magenis syndrome. These include but are not limited to care.
from a primary care provider, developmental behavioral health specialists, dentist, medical and surgical specialists, occupational, physical and speech therapist. When necessary, HUSKY Health provides all manner of durable medical equipment and medical supplies as well. We are unsure of the unmet need or needs of the children with Smith-Magenis syndrome that would prompt this legislation. We will, however, cooperate with the commissioner of developmental services with their efforts on behalf of patients with Smith-Magenis syndrome, and we will make ourselves available to the families or individuals with Smith-Magenis syndrome or any other diagnosis if the unmet need is for a HUSKY health member.

Finally, house Bill 7092, AN ACT EXPANDING THE KATIE BECKETT WAIVER PROGRAM. This bill proposes to increase the capacity for and reduce the waiting list of the Katie Beckett Medicaid waiver program. The program provides service and access to Medicaid for children and adolescents until they reach the age of 22. Currently there are 303 children on the waiver, and a waiting list of 265. There have been five children that have been granted waiver slot, but are still waiting final approval, and the current waiting list is approximately four years.

The waiver was originally a 200-slot model waiver that was expanded in 2014 that was expanded to 300 slot plus reserve slots for children that are transitioning out of institutions under Money Follows Person. The average Medicaid cost per Katie Beckett participant is approximately $33,340 dollars per year. As an expansion in this program would result in additional expenditures, absent the availability of appropriations, the department is
unable to support this bill. Thank you very much I am here with members of my team to answer any questions.

REP. ABERCROMBIE (83RD): Good job! [laughter]. Can we go back to the beginning? [Laughter]

KATHLEEN BRENNAN: What was that middle thing?


SENATOR MOORE (22ND): You had quite a few time twisters in there today--

KATHLEEN BRENNAN: A little bit. [Laughter]

SENATOR MOORE (22ND): Thank you. I want to go to Senate Bill 820. You don't need to say the word again [laughter]. So, I heard you say you can offer these services, how would someone get the services now?

KATHLEEN BRENNAN: So, they could get the services now, they could have this test done, but it would be prior authorized.

SENATOR MOORE (22ND): And then--prior authorized before they get the services--

KATHLEEN BRENNAN: That's correct. So, right now the bill is just saying not to prior authorize.

SENATOR MOORE (22ND): All right, that was clarification. Thank you.

REP. ABERCROMBIE (83RD): That's it? Questions?

KATHLEEN BRENNAN: Wow.

REP. ABERCROMBIE (83RD): No, no, no, no, my turn. I would let my colleagues go first [laughter] my turn. Okay, so, let's see--methadone--
KATHLEEN BRENNAN: Methadone.

REP. ABERCROMBIE (83RD): Clinics, 7090, so, I it seems like from your testimony that there's different rates depending on the area, is that your understanding?

KATHLEEN BRENNAN: Yes, it's my understanding that different methadone maintenance clinics pay different rates. It's not a base rate-- Chris you want to come up? I'll bring up my expert if that's okay.

REP. ABERCROMBIE (83RD): We always liked experts in the room [laughter]. Chris, just introduce yourself.

CHRIS LEVINE: Chris Levine, DSF. The current methadone maintenance rates vary a bit from about 75 two maybe just over $100, I'll have to look it up. They were established many years ago, like two decades ago about, yeah about two decades ago, so, their historical. They were based on probably cause that the time or negotiated rate at the time. The changes we made in the state plan last year were technical so, we were CS compliant, but we didn't feel we had authority to and start changing people's rates, especially reductions to make it cost neutral.

REP. ABERCROMBIE (83RD): And how many clinics are there?

CHRIS LEVINE: Bill, number? [background conversation] eight or nine.

REP. ABERCROMBIE (83RD): And so, from your testimony, Deputy Commissioner, it sounds like what you were saying was that you're looking at what the current rates are for each of them, and then are you
saying that you're going to come up with the universal rate, or are you just going to keep to the same system that you're using and adjust the rate if possible?

CHRI S LEVINE: Often when we have rates that are out of balance, like we don't really know the cost structure as well were looking at them, you know, there's a dialogue about what's-- how the cost or bucketed and what the costs are, so, we're in that review process now, and in that will give us an idea of their cost, which costs are allowable in reasonable, and then the variance between facilities to see if a differential in rate is warranted. Because of this cost structure if the volume, volume is a big driver, location, so, we're evaluating that now, and we can report back on what we see.

REP. ABERCROMBIE (83RD): Yeah, that will be helpful if after you've done your research on this and collected the data, just let us know if there are going to be any changes to the reimbursement rate, and then what is the methodology that you're going to use to try to adjust it. I'm still unsure why we would have different rates for the clinics, so, that would be helpful if you could kind of--and I understand it's probably one of those beings--exactly, it's how we've done it in the past, we're going to continue to do it. I get that, so, thank you. Chris, you may not want to go anyplace next question is Katie Beckett waiver, right. So, you know, I'm just going to save for the public, best bang for about. It's not--you guys, you guys get it. I think the time has, as we shuffle the deck with dollars that we really look at this waiver and see if there's a possibility to increase the amount of slots. I'll say it again, it's where we
get our best bang for the family that we represent, and I know that you agree and you can't, you know, it's all budget stuff, but I think it's worth us having a conversation about it.

For the diaper bank, right, so, it was really interesting because I met with the diaper bank people a couple of weeks ago, and I didn't realize how much of a hardship--God bless you, I'm gonna say how old I really am, but my oldest is 32, so, I haven't had to have diapers for a long time, but I didn't realize, you know, the impact of this on families. Even just the mother being able to go to work, right because she had to supply the diapers. So, that's where we thought that maybe through the TANF dollars we could do some shifting in those dollars to be able to give under cash assistance a little bit of an enhancement, and that's what we're looking at.

So, I know that you testified that at this point you wouldn't be in favor of it, but I think it's important to know for people that are sitting around this table, when we met with the diaper bank, if we fully funded what it would cost for these families, it was about $15 million. $15 million, like it was incredible to think that something like, I'll use myself as the example, took for granted, you know, really impairs these young families. So, I would like you--I know you testified, you know, that at this point you didn't see is having dollars, but I really like you to look at the TANF dollars and see if there's some flexibility in there to be able to do some kind of an increase enhancement for families, because I think at the end of the day it would be so, beneficial for these families.
The dental clinics, where did you come up with the 20 miles?

KATHLEEN BRENNAN: How we got to that?

REP. ABERCROMBIE (83RD): Yeah.

KATHLEEN BRENNAN: Because that's what we do now, and I--

REP. ABERCROMBIE (83RD): Right.

KATHLEEN BRENNAN: I don't know that answer. Do you [background comment] historic, historically.

REP. ABERCROMBIE (83RD): Okay.

KATHLEEN BRENNAN: So, I can try to find a little bit more information of why 20 miles.

REP. ABERCROMBIE (83RD): Yeah, because I think in the--I think the reason why the proponents brought this forward was in the rural areas. They think the time has come for us to expand the amount of miles back there are under state statute I believe, that it's only 20 miles. So, if you guys could take a look at that and say, has the time come for us to expand on that. When not asking to add any new facilities, but just give them the ability to serve more people, and you know, I'll state it for the record, as co-chair of MAPOC, I get it. We do a great job when it comes to our dental, but that doesn't mean that we have to stop being outside the box, and are there more people we can serve, right so, I think I think that's why the proponents of this legislation brought it for, so, if you could take a look at why, and have the time come to just to expand and what that would look like.

Moving on to Senate Bill 818, which is allowing that the ducks in a court approved conservator and
fiduciary expenses. What's the average cost that a person pays out for these, do we know?

KATHLEEN BRENNAN: That's a great question, and no I don't. My assumption is, because they're looking at a conservator being $125 bucks, that's what they baselined it, that must have some, they must've looked at what the cost were, but I don't know. I can go back and certainly get that information for you.

REP. ABERCROMBIE (83RD): I think we have an expert behind you that may have some information, so, when he comes up to testify our last cam the same question, but I just didn't know if you knew, and then Senate Bill 821, which is the pharmacogenomics tests. Has the price--the reason why we put this on the agenda again--because I have to tell you, I was just amazed that we have a test that can help so, many individuals with mental health issues, right, and I know you guys testified on this last year, my question is has the cost of this test come down since we first talked about it last year or the year before?

KATHLEEN BRENNAN: No, it has not. Come on up Dr. Zavoski. You can smile [laughter].

DOCTOR ROBERT ZAVOSKI: Good morning representative, Rob Zavoski with the Department of Social Services. The answer is that some tests have come down, some tests have gone up. The amount of research in this area is just exploding, and the challenge that we have is that we base our fees based on Medicare fees. Medicare has thousands of people to look at test and services and actuaries to set rates, etc., and the Department of Social Services has me. So, we base our rates based upon what Medicare does.
Medicare bases their rate when they think—when they have enough data to be able to support what the test should cost, what it should pay, and frankly whether they think the test is going to stick around or be supplanted by a new test next year.

So, where the test are reasonably inexpensive and there is a price, we tend to take prior authorization off, but most of the time for most of these tests there is no Medicare fee, so, what where left with is called a process called manually pricing where we received a request, we set a price based upon what's being asked for, and it has to be done manually by a person, so, we have to put prior authorization on it. As time goes on, and these tests become more broadly available and it's clear which tests are going to be used, and the price comes down hopefully--there's something in my throat--we will remove PA.

REP. ABERCROMBIE (83RD): So, what is the current fee that--

DOCTOR ROBERT ZAVOSKI: They're all over the place.

REP. ABERCROMBIE (83RD): For this particular test?

DOCTOR ROBERT ZAVOSKI: This is a family of test, there's a whole bunch of them, and the fees vary.

REP. ABERCROMBIE (83RD): So, this-- so, let me just regroup for one second, so, this isn't one test, there's a series that they take under this will, and each level or each test has a different fee schedule?

DOCTOR ROBERT ZAVOSKI: Essentially what these tests are, is there will be a test for a drug, and to see if someone has the receptor on their cell that will allow the drug to be--do its thing, and so, there is
a whole range of tests for each drug that comes along. There are more tests as more markers are found. It's a fascinating and amazing science. When I train back in the Stone Age, when we started someone on a medication, we would put them on the medication, wait to see if there was an effect, if there was no effect we would increase the dose and keep increasing the dose until you got to a therapeutic effect or you started having side effects, and then you would stop that one or wean them off and start a new medication, and it was just--it was nuts.

These tests do allow you to be more scientific in which medications you prescribe don't prescribe, and so, yes, they are a huge step forward, and it is in our interest to make them available, and as soon as there are fees for them, we will fee them, or as soon as Medicare recognizes a fee, we will go that route. The purpose--our policy has always been to make the Medicaid program as simple as possible when we can.

REP. ABERCROMBIE (83RD): No, and I agree, and I think, you know, when we heard the testimony it's definitely fascinating how many individuals this could help, right, because we know under mental health issues you could go many years before you find, especially bipolar, you know, let's take about our young people, you know, before they find something that works for them, right. So, I totally agree. Do we know how many prior authorizations have been asked in the last year and how many we've granted? Kate is smiling over there because she always knows what the next question is going to be.

DOCTOR ROBERT ZAVOSKI: Yes ma'am. Overall, we had 1147 request for this family of test, not all of
them were for behavioral health conditions. The behavioral conditions added that thousand was 10 percent or about hundred.

REP. ABERCROMBIE (83RD): So, how many did you--so, you authorize, out of 1147--

DOCTOR ROBERT ZAVOSKI: We authorize almost all of them.

REP. ABERCROMBIE (83RD): Oh, you did.

DOCTOR ROBERT ZAVOSKI: Unless it has been done before, so, we just try to get them to get the results.

REP. ABERCROMBIE (83RD): Okay, great thank you.

DOCTOR ROBERT ZAVOSKI: And before you ask, our average turnaround time, since we chase people around to get this, is eight days in 2017 and nine days in 2018.

REP. ABERCROMBIE (83RD): Wow. Keep that system, let's see if we can do in other areas, no offense. That's great, no thank you--listen, come on Dr. Z, we can go into details but we were not going to. Moving on to Senate Bill 821, which is the reimbursement for E-consults with the FQHCs. So, I guess my question is, right, and I don't know on your end of the table but on our end of the table when we do an analysis of a program for appropriations we never take into account if we don't do--what the flip side of it is, I write? So, it's like preventative care, right. What does it cost the state if we don't give people preventative care? Do we know by doing these how much we save the state? What's the reimbursement compared to what we pay for the face-to-face?
DOCTOR ROBERT ZAVOSKI: I don't have that in front of me. We did that analysis and set the rates to basically spend the savings. So, we increase the rates as high as we thought we could. Over time were going to plot--track utilization, both face-to-face and the E-consults to see if the rates need to be adjusted. I can get you that information. I don't have it right here today.

REP. ABERCROMBIE (83RD): Because you know that the providers are asking for this, you know, not just for the FQHCs, but, you know, the providers would like this across the spectrum and because it is something that is covered under Medicaid, you know, we're trying to figure out on this side, especially, and I'll speak for my colleague Representative Case [laughter] I love the look when he knows what is before them, but if were looking at Medicaid dollars, you know, where can we adjust and if this is a place that we could really save some dollars, you know, we need to start moving in that direction and maybe one of the things, and I don't know if CMS would allow us to do it, but maybe the time has come that we look at a pilot, right. So, that if you're looking at being able to validate the savings, you know, maybe that's the direction we need to go, because we do have the data from the FQHCs but maybe from the private sector, just a thought because it's the way of the future, and I think as a state we need to really start thinking about that. So, whatever your thoughts are on that I would appreciate at some point. I will turn it over to my cochair who has a couple of more follow-up questions and then will open it up.

SENATOR MOORE (22ND): I do, and it's really about the diaper. I can predate-- we used cloth diapers
when my kids were babies, that's how far I go back. Very proud to say that [laughter] Pampers were luxury when I had children. So, who punted right now, the diaper bank?

KATHLEEN BRENNAN: The Moms Project. So, it's a chargeable organization for the New Haven's Moms Project.

SENATOR MOORE (22ND): So, has there ever been money in any bills to appropriate funds for the diaper bank ever?

KATHLEEN BRENNAN: Not that I'm aware.

SENATOR MOORE (22ND): So, it has always been an outside nonprofit that's been able to do this?

KATHLEEN BRENNAN: Yes.

SENATOR MOORE (22ND): Okay. That was just for my own information. I had not realized that so, many people were accessing it, and I just didn't realize it wasn't funded by the state.

KATHLEEN BRENNAN: I think, and if I remember correctly when--remover when we had hurricane Sandy and there were federal dollars that we were allowed to utilize for certain areas of the state that were hit harder than others, we did end up entering through a contract, I think those were SSBG dollars that went to Yale University to help fund the New Haven's MOMS Partnership, and that's where I first started hearing about the diaper bank because that was part of the work that they were doing. Literally making--or being in like Stop & Shop and having folks come in there. So, I think we've had our hand in it may be indirectly through those dollars, but that's going back a couple of years already.
REP. ABERCROMBIE (83RD): Yeah, and just for full disclosure, this is coming from, I think California is the first state to use TANF dollars to help these families through their cash assistance and that's where the idea came from, and that's why we thought we'd take a look at it. Representative Case.

REP. CASE (63RD): Just to continue on that really quick, you say that's out of New Haven, but we also have a diaper bank up in Torrington and it's very active, and maybe there's some people that don't know that it's there and available, but I go and donate diapers that my child doesn't fit into anymore, and it's amazing the amount of people that don't know that it's there, but it is utilized.

REP. ABERCROMBIE (83RD): Representative.

REP. DATHAN (142ND): Thank you very much Madam Chairman and thank you very much for your testimony today. Carrying on from the diapers, you know, I'm a mom of three kids I've gone through, and I thought diapers were outrageous, even on the cloth side, and I would love to figure out if there's any other states apart from--it sounds like California is using TANF dollars, but is there any other state in the country that are funding diaper programs? I mean it just seems to me that where funding incontinence products for older generations, it just seems like it should be done because it is--I even think $30 a month probably wouldn't come close to probably quarter of it, so,--any thoughts? Thanks.

KATHLEEN BRENNAN: Yeah, right now, you know, the only thing I do know for certain is that is not a Medicaid reimbursable expense. So, whether or not other states are funding it through other
mechanisms, I'm not sure, but we can certainly take a look at that.

REP. DATHAN (142ND): Just curious.

KATHLEEN BRENNAN: Sure.

REP. ABERCROMBIE (83RD): Questions? Representative Hughes? Yes? No?

REP. HUGHES (135TH): I just was wondering if the TANF dollars, it needs to be established as a basic need, like if there's that criteria for TANF dollars if we use that, does anybody know? Because SNAP benefits would have to be for consumables, but I wasn't sure where the criteria was for--

KATHLEEN BRENNAN: So, these are TANF cash assistance, so, I think they meet the eligibility requirements. I think we're just trying to womp it in as part of the cash assistance. That's how I read the bill.

REP. HUGHES (135TH): So, it's different from the SNAP benefits correct?

KATHLEEN BRENNAN: Yes.

REP. HUGHES (135TH): Again, I think it's a basic need, so, we have to figure out a way to support that.

REP. ABERCROMBIE (83RD): And just so, you know we have reached out to our congressional delegation, Representative Rosa DeLauro is on the children's and she's on the human services appropriations, so, we've been talking to her to see if they can become an allowable expense under SNAP. So, we're actually thinking the same thing as you are, you know, where can we take some of these federal dollars and be able to use them more wisely, so, no I agree with
you. Further questions? Seeing none. Thank you very much Debbie Commissioner and have a great day. Moving on to Steve Hernandez for the Commission of Women, Seniors, and Children. Good morning.

STEVE HERNANDEZ: Good morning. I was gonna say not necessarily in that order. My name is Steve Hernandez I'm the executive director of the legislatures commission on Women Children and Seniors and Equity and Opportunity. I'm here today to testify in favor of House Bill 7092, AN ACT EXPANDING THE KATIE BECKETT WAIVER PROGRAM. I think it's important to start by telling Katie Beckett's story because sometimes we forget the underlying story that really drives a lot of the work that we do both on a federal level in here in the state.

So, Katie Beckett was a three-year-old girl who contracted encephalitis, of viral brain infection what she was just five months old. Katie was in the hospital when she had her first seizure and went into severe respiratory distress. Another seizure five hours later sent her into a coma and onto life support. At this point, the encephalitis attacked Katie's central nervous system and paralyzed her diaphragm, permanently affecting her ability to breathe and swallow without medical support. In the beginning, the Beckett's private insurance covered Katie medical expenses, but during her extended hospitalization, she became eligible for SSI, or Supplemental Security Income, which meant she also became eligible for Medicaid coverage. When the Beckett's reached their $1 million-dollar private insurance cap, Medicaid began covering Katie in full. After nearly 3 years in the hospital her condition improved to the point where she was ready to go home with her parents.
The Katie Beckett Waiver Program is a program that allows the State of Connecticut and the Department of Social Services to provide Medicaid services to individuals 21 years of age and younger who have a permanent disability and may or may not have a co-occurring developmental disability who would not normally qualify, financially, for Medicaid due to family income. The State of Connecticut should amend the state plan to adopt--our only recommendation would be in addition to the convention, to adopt state regulations that clarify that Autism Spectrum Disorder is a covered benefit when medically necessary and provided by qualified medical professional, should be included as part of the Katie Beckett waiver program. It's a clarification that I think is necessary in our law. We appreciate the committee's work in extending human services and support needed by all of our residents, especially those among us with Autism Spectrum Disorder.

I would just add on House Bill--I wasn't going to testify on this, but I want to add on House Bill 7093, AN ACT ESTABLISHING A TASK FORCE TO INCREASE EMPLOYMENT OPPORTUNITIES FOR PERSONS WITH DISABILITIES. You know, Representative you and I and others in this legislature have done a lot of work on trying to figure out how we can best serve our population with Autism Spectrum Disorder, so, many of whom are at various levels of independence and want to contribute in a workforce environment where they can thrive.

So, many of our young people on the spectrum are able to access training and opportunities through internships, but often times that doesn't translate to meaningful workplace opportunities into adult head. So, I think that having a study that looks at
ways of not only engaging that transition, but really having a multigenerational approach at workforce that covers all of our kids is important, and as the agency that--together with Senator Moore, are really championed by Senator Moore, the Two-Generational Initiative for the State of Connecticut, this is one of those subcomponents of that Two-Generational Initiative, which ensures that all of our families drive together in the State of Connecticut. So, that is our testimony, I welcome any questions, and I appreciate your work.

REP. ABERCROMBIE (83RD): Thank you and thank you for your leadership. Were very lucky to have you under the commission. Questions? Yes.

REP. SREDZINSKI (112TH): Thank you Mr. Hernandez for being here. You are rolling your testimony that the State of Connecticut should amend its plan that clarifies that Autism Spectrum Disorder should be a covered benefit under Medicaid. In your experience, do you know if it is being covered and it's just not widely covered and needs clarification, or are you certain that it is not being covered right now?

STEVE HERNANDEZ: in our experience with families that we've been working with, it's not being covered from what we understand.

REP. ABERCROMBIE (83RD): So, just for clarification. So, under Medicaid autism services are included, right, we do a payment for them under the ACA, right, that came about their. What we're talking about is adding these individuals to the waivers that they're currently not allowed to get more benefits under that, that's a clarification we are trying to make.
REP. SREDZINSKI (112TH): Thank you very much for your answers and thanks for the clarification Madam chair, and I have nothing else, thank you.

REP. ABERCROMBIE (83RD): Questions? Any further questions? Jay [phonetic] you have a question? No? Okay, thank you very much for your time. We appreciate it.

STEVE HERNANDEZ: Thank you so, much, and thank you all for your leadership.

REP. ABERCROMBIE (83RD): Senator Formica? I didn't see him in here, but if he does come in, we will just call him up as soon as he gets here. Representative Petit, you're up.

REP. PETIT (22ND): Thank you Madam chairwoman, Representative Abercrombie-- I turned it off, sorry. I William Petit, the state representative for the 22nd district. Thank you for allowing us to testify. I'm going to secede my time to Mr. Zuckerman to talk about an issue of fairness that's affecting the treatment of one of the biggest issues we face in society today, that is the treatment of people with opioid addiction.

STEVEN ZUCKERMAN: Good morning. Senator Moore, Representative Abercrombie, Senator Logan, Senator Case, and members of the Human Services Committee, The Root Center for Advanced Recovery appreciate the opportunity to offer testimony and strong support for house Bill 7090, AN ACT CONCERNING INEQUITABLE METHADONE MAINTENANCE REIMBURSEMENT RATES UNDER THE MEDICAID PROGRAM. My name is Steven Zuckerman and I'm the president and CEO of The Root Center for Advanced Recovery, previous referred to as the Hartford dispensary.
The Root Center is the largest provider of methadone maintenance in Connecticut. We've been treating clients in the State of Connecticut with opioid addiction since 1970 and opened our first outpatient medical clinic in December 1884, becoming the first such outpatient clinic in the State of Connecticut. We currently have 250 employees with nine locations across the state and we serve close to 6000 clients a day. Despite this, we receive the lowest state Medicaid rate for methadone maintenance at $75.80 per week. I believe the rate is the consequence of previous historical rate, which were establish at a time when DMHAS provided state grant dollars for such services will. These grant dollars as well as federal grant dollars have all but disappeared. Despite that, all providers, regardless of their weekly rate, must comply with the same federal, state, and accreditation requirements. The standards do not change based upon your weekly rate.

Since that time treatment continues to change and evolve especially when you navigate through what has been an opioid epidemic. New opportunities for treatment of it approved and exhibiting success of the opioid-dependent client, but are services we cannot currently offer. These alternative forms of medication assisted treatment require more resources to manage and oversee, but are weekly rate is already below the cost for our Medicaid clients. Despite this, The Root Center is committed to this population and expanding our services. We continue to make investments in our locations, serving the state's most vulnerable communities. There are often complementary forms of substance abuse treatment services, not dependent upon a bundle weekly methadone treatment. However, at a time when the largest methadone treatment organization in the
State of Connecticut should be expanding locations to have a greater methadone treatment impact and more communities, we have been financially reluctant to do, so.

I've attached to my testimony with the list of reimbursement rates for methadone maintenance providers in the state. The current rate structures inequitable needs to be modernized. A new provider could come into Connecticut and receive a rate of $88.52, brand-new provider. This is almost $13 higher than our rate. The fact is that these rates are inequitable and cost prohibitive for organizations like The Root Center. Although the draft language may be unclear, it has never been our intention to reduce other providers rates.

In our most recent cost report, we have shown a cost per medicate client of approximately $129 dollars a week, again, are weekly rate is $75.80. Approximately 80 percent of current clients served on Medicaid, 15 percent are self-pay, these are clients who are not on insurance and pay is on average of $60 a week, a dollar figure that we would be hard-pressed to maintain going forward, which can potentially inhibit their care. The remaining clients are on commercial insurance. It is important to note here that almost two-thirds are on HUSKY D, which is reimbursable by the federal government at 90 percent. So, a very sizable portion of any Medicaid increase will be borne by the federal government.

Additional monies would also not only provide the opportunity for greater treatment options, many of which the same clients would already be able to receive it they reside in other parts of the state or with the different methadone treatment provider,
but it would also allow is to invest monies in the indirect care of our clients, like building renovations, training and education of our staff, and information technology infrastructure just to name a few. I'm available to answer any questions or meet to discuss our services further and the need to modernize reimbursement rates and methadone maintenance. Thank you for your attention to this matter.

REP. ABERCROMBIE (83RD): Thank you. Thank you for your testimony. Representative Petit, did you want to add anything to that sir?

REP. PETIT (22ND): I think Mr. Zuckerman did a great job. I think it's sort of historical vagaries that lead to this issue, and I think if we really want to be leaders of the state and the legislatures pass a number of laws in the last several years to try to help with the opioid epidemic, you don't want to be underpaying, not paying a fair rate to the organization that has been around the longest and provides a significant number of visits throughout the state. So, I think it's something that should be corrected so, that we can improve services that are provided, and provide services to more people, although the epidemic may show signs of cresting at this point, we still have a lot of work to do.

REP. ABERCROMBIE (83RD): I couldn't agree more. So, two quick questions for you sir, what percentage did you say are your clients on Medicaid?

STEVEN ZUCKERMAN: 80 percent.

REP. ABERCROMBIE (83RD): And where you eligible to get any of the grant that came in through DMHAS, and about how much was that to your clinic?
STEVEN ZUCKERMAN: Yes, we were eligible we apply for those grants. The issue that I have found with grants over the years is the fact that your expenses continue to go up and the grant stay the same. Or the grants wind up ending are disappearing in your last two hold the financial burden. So, we did not go for any of those specific grants.

REP. ABERCROMBIE (83RD): Really.

STEVEN ZUCKERMAN: That has nothing to do with our--that would have not impacted our methadone treatment rate.

REP. ABERCROMBIE (83RD): No, I understand that, but okay. That's interesting, okay.

STEVEN ZUCKERMAN: There were grants for all sorts of things, Narcan, other tight areas, but not necessarily for methadone treatment services.


REP. CASE (63RD): Thank you Madam chair. Good morning Representative Petit. Quick question, how many do we know are on methadone and the State of Connecticut right now?

STEVEN ZUCKERMAN: That I don't know. So, again we serve about 6000 clients a day. I'd say about 4400 of them are on methadone that we serve, which again is about 80 percent or so, so, it's a large number, and what's happening now is that there other types of medication assisted treatment that have become pretty prevalent, suboxone and Vivitrol to name a few. So, if your client and another portion of the state who might be attached to a methadone treatment provider with the much higher reimbursement rate, there's more ancillary services as a result of their
increased rate that they could likely provide those clients.

We are at nine sites across Connecticut, New London, Willimantic, Norwich, Bristol, Manchester, two sites in Hartford, Torrington, and our client should be able to get the same amount of services with us as they would in other parts of the state.

REP. CASE (63RD): Your success rate on the methadone, what are you seeing? Because I hear a lot of things on the methadone clinics. You know I'm happy that it's people who are tracked to help themselves, but I also hear from personal people who are on it that--have swayed a different way where they take the drug that they have, and they can go out and swap it out for something else in the parking lot.

STEVEN ZUCKERMAN: Yeah, there's illicit behavior no matter what type of environment you're working in. The medication assisted treatment, which is what methadone is, allows the client to be stable medically so, they can more aptly participate in counseling, be with their family, hold a job, so, it's a medication assisted treatment. That being said, that in of itself is not going to be the final product to create vast and long-term recovery.

REP. CASE (63RD): Okay--

STEVEN ZUCKERMAN: You need more than just that medication assistance--

REP. CASE (63RD): One last question, and I think maybe Doctor Pettit can help me later on understand this more, but when you have a patient coming, and they're coming on an ongoing basis, are they tested to see if the methadone is in their system or are
they--and if it's not, is there question on where that's going? Because my concern is the version of actually going to the parking lot and swapping out the product they got for the drug that got them there.

STEVEN ZUCKERMAN: Yeah, so, there's regulars--part of what we have to do is part of our bundled rate. We do urine toxicology screening, it's actually part of that $75.80 a week, that's part of that process. Were able to bill for eight toxicology screenings.

REP. CASE (63RD): Okay, thank you. Thank you, Madam chair.

REP. ABERCROMBIE (83RD): Yes representative.

REP. MASTROFRANCESCO (80TH): Thank you Madam Chair. Just a quick question, you had mentioned--how much do you get per week per patient?

STEVEN ZUCKERMAN: $75.80 per week, and again attached to the testimony you should be able to see the list of the providers and all of the weekly rates that everyone receives.

REP. MASTROFRANCESCO (80TH): So, do they come in on a daily basis?

STEVEN ZUCKERMAN: Yes--

REP. MASTROFRANCESCO (80TH): So, is that like $10 a day?

STEVEN ZUCKERMAN: You got it, so, divided by seven, so, $10 and change. So, yes, depending upon where you are in treatment you might be eligible for what is called take-home bottles. So, there are some who are getting an actual surface, but they are not coming in that day to take the methadone, they are taking it at home, but if you are a newly admitted
client who maybe just overdosed yesterday and you're starting to get treatment, you're becoming every single day for quite a period of time before you advance in your treatment.

REP. MASTROFRANCESCO (80TH): And what is the actual cost?

STEVEN ZUCKERMAN: Great question. So, like I mentioned, we just submitted our cost report, as the deputy commissioner stated earlier, we just submitted our cost report in the past week. So, our cost, with administrative cost as well, was $129 a week. So, we're getting $75.80 per week, and our cost were showing $129 dollars a week.

[Unintelligible speaker 01:02:47]

STEVEN ZUCKERMAN: Where do we make of that money? We make up that money in working through other services that are not part of this methadone bundle treatment.

REP. MASTROFRANCESCO (80TH): Is the cost the same for someone using private insurance?

STEVEN ZUCKERMAN: Private insurance, no. For private insurance the rate is much higher as far as what we're getting reimbursed.

REP. MASTROFRANCESCO (80TH): What is the rate?

STEVEN ZUCKERMAN: Anthem is reimbursing us either $159 or $169 a week.

REP. MASTROFRANCESCO (80TH): I thought it was $129 a week was your cost.

STEVEN ZUCKERMAN: Our cost is $129 week--
REP. MASTROFRANCESCO (80TH): I guess my question is what do you charge a patient or somebody who comes in that has private insurance to be on methadone?

STEVEN ZUCKERMAN: It's what the negotiated contract is with that commercial insurance company.

REP. MASTROFRANCESCO (80TH): Okay.

STEVEN ZUCKERMAN: So, where we might get $159 or $169 a week from anthem for methadone treatment, another provider based upon other services they have that uses Anthem, they may get an entirely different rate.

REP. MASTROFRANCESCO (80TH): I got you, okay--

STEVEN ZUCKERMAN: Yes, and we do sliding scale. I mentioned earlier that we have self-pay clients who are not on commercial and who don't have Medicaid. To fill in those cracks were having them pay $60 a week. My guess is that none of these other providers have a self-pay rate of $60 per week, and we're gonna be hard-pressed to continue that.

REP. MASTROFRANCESCO (80TH): What is the percent--you mentioned you serve 6000 people a day, which is a lot and that is very sad, it's sad that we have that many people a day. You do not provide the other services they are like the Vivitrol, suboxone, Subutex, so, forth, you do not?

STEVEN ZUCKERMAN: We're not doing that right now. You know, we were doing some math, if, you know, the providers range in rate from $75, $80, all the way up to $99.49, if we have 4400 Medicaid clients, and just the difference between the lowest provider and the highest provider, rounded out to $25 per week. You times that by 4400, and you're talking about a little bit more than 5 million a year we would be
getting an additional money. So, with those additional monies, we are not for profit, it goes right back to services, so, it could be more doctors for Vivitrol, for suboxone, other ancillary services that's the--again, based upon the inequity. So, if you're someone in another part of the state at another methadone treatment provider, you might be more apt to be able to get those services.

REP. MASTROFRANCESCO (80TH): Okay, and then just one more question, out of the approximately 6000 people that you serve per day, what is the percentage or the number and a yearly basis that they would start weaning somebody off of methadone so, they can live a productive life without being dependent on it, and how long does that take?

STEVEN ZUCKERMAN: Yeah, I do want to be careful because I'm not a physician, so, you're getting into some medical questions, and right now I'm sort of reluctant to go in that direction. If our medical director was here I would have him answer that, but in my experience, there are clients over time who do get Wayne down of methadone. Many times, it is their choice to start getting weaned off, and are quite successful, but I couldn't give you numbers, and I want to be careful not to speak for my medical director.

REP. MASTROFRANCESCO (80TH): Is that a goal?

STEVEN ZUCKERMAN: Is that a goal--

REP. MASTROFRANCESCO (80TH): Is that always a goal for--

STEVEN ZUCKERMAN: I do-- I think for some it's a goal. You know, again, this is a disease, not unlike diabetes or high blood pressure, and I think there
are some people who are on insulin their whole lives, and there are some people who are on high blood pressure medication for the whole life. So, I really think it depends upon the individual.

REP. MASTROFRANCESCO (80TH): Okay. Thank you very much I appreciate it.

REP. ABERCROMBIE (83RD): Representative Hughes.

REP. HUGHES (135TH): Hi, thank you chairwoman, and thank you Doctor, and I'm sorry I forgot your name.

STEVEN ZUCKERMAN: Steven.

REP. HUGHES (135TH): Steven, yeah. Can you tell the committee what time of the day do these methadone clinics open up?

STEVEN ZUCKERMAN: So, early--

REP. HUGHES (135TH): Like 4:30?

STEVEN ZUCKERMAN: They're typically open at 5:30 a.m.

REP. HUGHES (135TH): Right, so, your staffing them from 5:30 a.m. until?

STEVEN ZUCKERMAN: Well, again it depends—if you're just talking about the methadone treatment services, there from 5:30 a.m. until about 1:30 p.m., but we have since expanded to other service lines, so, we're there until 5 or 6 o'clock with other service lines--

REP. HUGHES (135TH): Right.

STEVEN ZUCKERMAN: And eventually we will be adding more service lines that would take us through the evening.
REP. HUGHES (135TH): Right, so, so, for $75 a week, with talking way beyond the scope of business hours. I just want to make that point. Thank you.

STEVEN ZUCKERMAN: And also keep in mind that with that $75.80 per week that could be 50 counseling sessions in a given week, that could be one, that could be 10 sessions with the doctor, that could be one with the nurse, it's all the same rate. It's a bundled rate, so, the amount of services does not change the weekly rate.

REP. ABERCROMBIE (83RD): Have you submitted your cost reports to DSS?

STEVEN ZUCKERMAN: I submitted them over the summer when we initially asked for rate increase, we were rejected for that rate increase, even though our cost clearly showed that we were--it was costing us more than our weekly rate, and I recently submitted in the past week again.

REP. ABERCROMBIE (83RD): Okay, so, were you here sir when DSS gave their testimony that they are looking at it to see if the time has come for them to reevaluate what the rate structure is?

STEVEN ZUCKERMAN: Yes, I will remain curious because again, we did submit over the summer, and we were rejected, and part of the premise of the rejection was is that if your organization showed even a dollar of a surplus, you shown that you don't need a Medicaid rate increase, and that's a significant problem as an organization that we have.

REP. ABERCROMBIE (83RD): Well, I think it's a little deeper than that. I think that we are in a tight budget time, and when we only have so, many Medicaid dollars, and I think the agency has to look
at where is the best place to spend them, and I'm not saying that what you do is an important, I'm just saying that there are only so, many dollars to go around, and I will tell you that, and I said it last year and I'll say it again, the tsunami is here right now for rate across the board, for providers across the board, and it is something that we as a state have to wrap our hands around, so, I totally agree with you, I'm not disagreeing with that.

STEVEN ZUCKERMAN: Yeah, and again where in the middle of an opioid epidemic.

REP. ABERCROMBIE (83RD): I totally agree. Further questions or comments? Seeing none, thank you both for your testimony. We do appreciate it.

STEVEN ZUCKERMAN: Thank you.

REP. ABERCROMBIE (83RD): We have gone past are our for public officials and agencies, so, we're gonna go to the public, and just so, the public knows, you are given three minutes. We would appreciate if you would adhere to the three minutes. There will be a bus or that will go off, and we will ask you to wrap up. So, starting with Carl Mitchell as our first, and then we'll go back to the elected officials and Senator Kelly will be the first one after. Good morning sir.

CARL MITCHELL: Good morning. Honorary members, good morning. How y'all doing? My name is Carl Mitchell, I'm a resident of Cromwell, Connecticut, and I'm here to support House Bill 7093, AN ACT TO ESTABLISH A TASK FORCE TO INCREASE EMPLOYMENT OPPORTUNITIES FOR INDIVIDUALS WITH DISABILITIES. Basically, as a registered Republican, I grew up with the philosophy of self-responsibility, and that seem to work for me fine throughout high school. I was nominated to the
Air Force Academy, I scored an 1160 on my SATs, had a 3.7 GPA, and things just went great. Unfortunately, I never made it to the Air Force Academy. My father had cancer, so, I was going out to Colorado, and during my junior year in college they discovered a pilocytic astrocytoma, that's a tumor in the brainstem. They gave me six months to live. Fortunate for me that was 19 years ago. Unfortunate for me I've been on SSDI for 19 years. Since SSDI works on the amount that you put in through work, and I was only 19 at the time, I'm on the minimum amount of SSDI receive, so, I get like $800 a month now. When I started it was like $700.

Fortunately, I went back to college and graduated as an engineer from Massachusetts Maritime Academy, and the median salary for an engineer from Mass Maritime is like the $65000 a year, I'm getting $700 or $800 per month, so, nowhere near the same ballpark. Needless to say, when I was reading this bill I just wanted to give you--and express my total support for. It's obviously needed because the amount of excuses I get from employers on why they do not hire me it's unbelievable. First it was, oh you didn't graduate with the 3.0 or higher, it's like sorry I've got six holes in my head. Again--there's the buzzer so, I guess I gotta go, but--

REP. ABERCROMBIE (83RD): You can finish your thoughts.

CARL MITCHELL: Sure, thank you Madam. Final my opinion is that the private sector companies don't really care about social responsibility and giving people work. It's going to need to come from government our federal government and state government. Private companies don't really care, they're all about money, that's just the nature of
the beast, but at the end of the day I recommend that we pass this bill.

REP. ABERCROMBIE (83RD): Thank you for your testimony we do appreciate it. Just one moment before you leave. Anybody have any questions? Representative Case.

REP. CASE (63RD): I don't really Madam chair have any questions, but I just want to thank you for coming forward. We work very hard, not only--one of my co-chairs for the IDD caucuses behind us, and you know we need adequate ability, and you seem like a very intelligent bright person, and this is exactly what we need to care, and I just wanted to thank you for coming forward and putting a face to the light of why these bills come to us. Thank you, Madam Chair.

CARL MITCHELL: Thank you very much.

REP. ABERCROMBIE (83RD): Thank you. Have a great day. Thank you for coming up. We're going to go back to the elected officials. Senator Kelly, would it be okay if Senator Formica goes? He was higher up on the list and now that he's here, is that okay? Thank you. Senator Formica. [Laughter]

SENATOR FORMICA (20TH): Good morning chairman, ranking members, I'm kind of curious as to what list I'm higher up on [laughter]. It kind of makes me a little nervous that I'm not--that I'm the same list as Senator Kelly, however, good morning. I will be brief because of the folks before me testified in detail on this. I'm here to support 7090 on the methadone balancing act, and I appreciate that the people are looking at these rates, but I think it's important that we look and take Mister Zuckerman's
approach that we have to be fair and balanced everywhere.

So, I look forward to having everybody do that, and I know there's further testimony behind me, you have a busy day, and also on the pharmacogenomics testing, you know, this seems to be something that many other states are doing and doing successfully. We seem to be nibbling around the edge at it, and I think it might be time, you know, for us to do what we can. Like you, I understand the budget implications that we have, but we have to eventually get to a point where we have to spend a little bit to save a little bit long time. We can always just think of the moment, and we have to begin those initiatives. I know you have an expert come up and talk to you a little bit about that, and I want to be mindful of the committee's time, so, thank you very much for the opportunity to address you this morning.

REP. ABERCROMBIE (83RD): Thank you and thank you for your testimony. So, if I'm not putting words in your mouth, you feel that the prior authorization is not necessary for the testing? Because that's--they are--so, if you heard DSS's testimony, there's about 1100 prior authorizations that have been granted over the last year. So, what this bill would do would say that we're automatically paying for the services and not to have to have a prior authorization. So, you're in favor of that?

SENATOR FORMICA (20TH): So, they would have to be some indication that there is a need for that, right #and we want to make sure that that happens, so, I would be in favor of moving it forward if there's a way to save money, guess.
REP. ABERCROMBIE (83RD): Okay, thank you. Questions from committee members? Seeing none. Thank you for your testimony we appreciate it. Were gonna hop back to the public. Second person up is Janet Alfano. Janet? No, so, then to go back to the elected officials. Senator Kelly. Good morning sir.

SENATOR KELLY (21ST): Good morning Chairwoman Moore, Chairwoman Abercrombie, Senators Maroney, Logan, and Representative Case as well as members of the committee. It's certainly good to be back in front of and with the Human Services Committee. I do miss you this year [laughter]. It was a pleasure to serve with all of you in the last term, but I would like to thank you for the good work that I know you all do with regards to what are very, very difficult and complex issues. So, thank you for your service with regards to human services.

You have my testimony regarding three bills, Senate Bills 818, 819, and 822, and what I'd really like to talk about is the Senate Bill 818. That bill talks and deals with allowing an applied income deduction for court approved conservator and fiduciary fees, and we've seen this in the past, but this is a real common sense bill that will actually help to leverage federal dollars, and actually bring money into the General assembly--the general fund, while also increasing and improving human services in the area of probate court.

What you have or individuals who would be on Medicaid, in an institution, and in this instance would have to have somebody to help manage their affairs, and right now the State of Connecticut pays 100 percent of that. So, by using an applied income deduction, we can get a 50 percent match from Washington to provide the same services. So, the
question I have in this tough financial climate, is why are we doing more to try to get extra revenue into the general fund? I understand the department will indicate that there is an investment that has to be made. Based on last year's fiscal note it was $600,000, but we know that the baby boomers are moving into retirement, as the number of individuals increase, so, will that number.

The estimate for the cost of this program to make the computer tweak was $500,000 of which the federal government reimburses 75 percent. So, you're looking at, based on last year's numbers, a $125,000 appropriation to get a $600,000 benefit. Who wouldn't take that? Besides DSS, I mean I think it makes common sense the first year you're only going to have to 475, every year thereafter you get 600. As to working out the eligibility issues that has to deal with that, let me remind everybody on the committee that Medicaid is a very complex program. I'm certain that the quality staff that we have a DSS is more than capable of handling one more deduction and handling the applied income that is done on every single one of these files, and within an amendment to the computer program it would be very easy for them to process.

So, I think it makes sense and benefits not only the people in need on Medicaid, it helps the probate court, it also helps taxpayers. Questions?

REP. ABERCROMBIE (83RD): Could you, before we going to questions, can you comment a little bit about-- and I'm reading your testimony Senate Bill 819, which is the third-party contract?

SENATOR KELLY (21ST): Sure, with regards to the third-party guarantors a payment, whether it's in
the skilled nursing facility or even the assisted living facility, we're looking at a chronic care continuum when dealing with seniors and aging in place initiatives. What this is looking at is that whenever vendors contract with, I'm gonna say individuals in need, it's many times they don't necessarily always deal with that person that's receiving the services. They go to the care provider, and in the process of working with the care provider say I need you to sign mom or dad in, I need you to be a responsible party in case something happens, like mom or dad has a stroke and has to go to the hospital, or mom and dad, worse, passed away—we just want to get somebody that has some information we can contact, somebody who is responsible.

Really what they're trying to get isn't somebody to be responsible in that nature, it's somebody to get responsible for a financial obligation that may have accrued because of that individual being in its facility, and what I want to do with this is to make sure that those types of third-party guarantee repayment are not allowed. I mean think of it differently, if I went into the local car dealership and purchased a car or—let me change it, you went into the local car dealership and purchased the car, but told them Kevin Kelly is going to sign for that, you'd look at that and say, well no, that's not the way it's going to be, but that's really what happens here.

The person in need is the person who's receiving the services, they should be signing the contract unless courts have deemed the person incompetent, in which case a conservator could handle conservator could handle that transaction, but in the absence of that
court adjudication, that the person is incapable of handling their affairs, their free to contact, and that's really who the vendor should be working with, not some third-party who quite frankly as a caregiver dealing with a loved one in a very difficult position and just trying to help that person get the services that they need.

Being a caregiver is a daunting task, and it's one that many people have not been in before and not knowing the landscape it's very difficult and stressful when somebody just comes in puts this in front of them and says hey signs here so, we can take care of your mom or dad is in a tough spot. They're gonna sign it because they want to get the care, but then after the fact they realize, wait a minute, I think I'm on the hook for contract that I knew nothing about.

REP. ABERCROMBIE (83RD): And so, this is just addressing assisted-living facilities?

SENATOR KELLY (21ST): Correct.

REP. ABERCROMBIE (83RD): And do we do this in nursing homes?

SENATOR KELLY (21ST): There is--

REP. ABERCROMBIE (83RD): Don't get complicated on me Attorney Kelly please [laughter]--

SENATOR KELLY (21ST): It's not done--there is some legislation that has been passed in the years to address this issue. I don't think it goes far enough but will leave that on the shelf for today.

REP. ABERCROMBIE (83RD): So, yes or no, do we do this? I'm just trying to figure out this is a practice we use across the board for different types
of facilities or is this unique to assisted-living, I guess that's my question?

SENATOR KELLY (21ST): No, there's a prohibition and skilled nursing facilities from third-party guarantee or a payment upon admission, so, we'd be applying that rule to the assisted living facility also.


REP. CASE (63RD): Thank you Madam chair. Good morning Senator. So, basically what we're talking about that, is there any language--because, you know, when you're signing those papers you're under duress and you want to get the person into the facility, is there anything delineated in the paperwork that you're just signing the paperwork saying that, or could we put something so, that you're just signing the paperwork for the reason of a caregiver, not financial. Is that what you're looking for or get rid of the third-party altogether?

SENATOR KELLY (21ST): Well, I mean you don't want to detach caregivers from their loved ones, okay, so, you want to try to keep them as attached as possible. What I'm looking for is protection for that caregiver from becoming a third-party guarantor for paying it based on the admission process.

REP. CASE (63RD): Okay, I think we have a little bit to go with it with how we drafted or how it's put together. I agree with you 100 percent because we really don't know sometimes what your sign when you're doing that, and I just had a question on 822, can you do a brief description of the conveyance of
properties owned by the recipient of public assistance?

SENATOR KELLY (21ST): Sure, there's two issues here. One is to get a timely response from the department when a request is made for consent, because under statute the commissioner either needs to consent or not to the conveyance of property, so, that would put it ten-day requirement on the department if you've asked for this then they need to get back to you. The second is with regards to, I'm going to say the way title and conveyance law in the State of Connecticut is handled, right now basically first in time, it's first and right. When you file something on land records, a lien or an encumbrance, however, when you deal with DSS they don't accept that law and many times disregard it and come back to this statute if somebody has not been on assistance to say, well you didn't ask for the commissioner's consent, so, now we can disregard the fact that there is an encumbrance in the chain of title, which is contrary to real estate long Connecticut. So, I'm just trying to clarify that practice and make sure that what we call grace notice is adhered to in Connecticut.

REP. CASE (63RD): Senator Kelly, as always, I think you. As a lawyer you bring a good perspective to the human services, and I think Senator Logan has done a good job of trying to represent and bring the bills to us, but with that Madam chair thank you.

REP. ABERCROMBIE (83RD): So, just a quick follow-up question, so, you're saying that--is it in statute that DSS has to respond within 10 days and they're not doing that or is it just practice that it's 10 days they're supposed to be responding?
SENATOR KELLY (21ST): I believe in statute it was a reasonable time, and I think in the proposed bill I put 10, I mean I'm not wedded to 10. If there's 30--whatever works for the department, but I think there has to be a deadline as to when a response would be necessary rather than just say, we could never get to it and that was reasonable.

REP. ABERCROMBIE (83RD): So, what is the longest period of time that DSS has taken to get back on an issue, on this particular?

SENATOR KELLY (21ST): I think I've been told there are some instances where they haven't, or it's been like months.

REP. ABERCROMBIE (83RD): Okay, that's fair. Thank you. Further questions or comments? Yes.

REP. MASTROFRANCESCO (80TH): Thank you Madam chair. Question for you on Senate Bill 819, is it--I spent about three years working in an assisted living, and I know when a new resident moves in their very thorough with their, you know, with their paperwork, having them sign it and clearly reading every line for like a third-party guarantor. Is it your experience as an attorney that people are doing that? I mean is it, did you get a lot of complaints? Have you--as an attorney do you cover elderly or things like that? I'm just curious.

SENATOR KELLY (21ST): Yes, as a practitioner my primary focus of the practiced elder law. Ideal with elder law probate estate planning. Are you referring to third-party guarantee of payment?

REP. MASTROFRANCESCO (80TH): Yes, yes. I was just curious. Do you see that often misleading I guess in the industry with family members?
SENATOR KELLY (21ST): Generally speaking the assisted living has a much healthier client population and skilled nursing facilities, so, a skilled nursing facility obviously sees people that are either incapacitated or near incapacitated much more frequently than you see in the assisted living arena. So, from that perspective we don't see the issue arise is often as you may think, but it does happen, not so, much in my area, the greater Bridgeport area, but I have heard that this is happened, you know, in other facilities throughout the state, so, it's an issue that's out there, and when a third-party child get stuck in this you certainly hear about it and it's unfortunate because they didn't understand that on admission, and it wasn't really laid out clearly that they were actually getting on the liability hook.

REP. MASTROFRANCESCO (80TH): Okay thank you. I was just curious how--

SENATOR KELLY (21ST): Not as much as in the skilled area.

REP. MASTROFRANCESCO (80TH): Okay, thank you I appreciate it.

REP. ABERCROMBIE (83RD): Further questions or comments? Seeing none. Thank you, Senator Kelly, we appreciate it.

SENATOR KELLY (21ST): Thank you very much.

REP. ABERCROMBIE (83RD): We're going to go back to the public portion, and I just want to remind people the minutes. Next up is Lynn Comer and then we will go back to the elected officials, and it will be Representative Lavielle. Good afternoon.
LYNN COMER: Good day Senator Moore and Senator Abercrombie, and members of the committee. My name is Lynn Comer, and I'm the policy coordinator with the National Diaper Bank Network. I appreciate the opportunity to testify before you today in support of House Bill 7094, AN ACT CONCERNING TEMPORARY FAMILY ASSISTANCE. The bill will help thousands of Connecticut babies and toddlers whose families to go with diaper need.

One in three families in the United States experiences diaper need. Parents experiencing diapering need frequently stretch diaper supplies resulting in frequent changes in the reuse of soiled diapers. Diaper need causes severe but preventable health consequences for infants and toddlers. Diaper need poses a significant health and economic cost to the state. Diaper need creates barriers to childcare, employment, and the pursuit of education that affects the entire family.

While diapers are basic necessity, equitable access to diapers is not universal. For mother who is working full time at Connecticut's minimum-wage, this expense alone can represent almost 5 percent of her gross income. Nonprofit diaper banks are experienced at getting clean diapers to families and to those who need them. In fact, the nine Connecticut diaper banks that are part of the National Diaper Bank Network distributed more than 2.3 million diapers in 2017, but that's not nearly enough to end diaper need for the 30,000 infants and toddlers under age 3 and poor and low-income families in Connecticut.

Nonprofits alone cannot solve diaper need. Connecticut families need House Bill 7094. In 2017 the National Diaper Bank Network probably supported
a similar bill in California that was signed into law making California the first state to give parents with children under age 3 and enrolled in the state welfare program $30 a month to buy diapers. By funding and passing House Bill 7094, Connecticut can further its leadership role in supporting innovative legislation, plus Connecticut took his home to the diaper bank of Connecticut, among the oldest and most prominent diaper programs in the country.

Last year, the nonprofit issued a joint study with the Connecticut Center for economic analysis that revealed the impact of distributing diapers to low income families experiencing diaper need. The recipient families personal income increases, medical expenses are prevented, and the state's tax revenues go up. According to the study 50 percent of parents who rely on childcare who go to work have missed work due to a lack of diapers. Most childcare centers in the state require parents to provide a daily supply of diapers for their children, without diapers parents cannot go to work.

In addition, a study by Yale researchers published in the Journal of Pediatrics concluded that an insufficient supply of diapers is not only a risk factor for poor infant health and child health, but also for maternal mental health.

A simple solution to end diaper need does exist, provide families with access to the diapers required for their children to thrive. I ask each of you support House Bill 7094 because all babies deserve clean diapers. I also have copies of the economic analysis if anybody is interested in taking a look at that. Thank you.
REP. ABERCROMBIE (83RD): Yeah, if you could give it to our clerk, she could send it out to the whole committee, that would be great. Questions? Do you have any other thoughts? You know the bill looks at TANF dollars and giving and enhance cash assistance, do you have any thoughts, any other areas, any other money that we get from the Fed that we might be able to use for this particular service?

LYNN COMER: I don't right now, but I can go back to organization and talk to them about it.

REP. ABERCROMBIE (83RD): That'd be great. If you have any ideas, please send it on, and I don't know if you were in the room when we talked about—we've reached out to our congressional delegation and talked about having it as an add in under SNAP, so, we're looking at that also. Questions?

LYNN COMER: I think typically they stayed away from putting it under SNAP because it's already not enough money to provide a family, you know, the food that they need for the month, so, we typically stayed away from putting it there.

REP. ABERCROMBIE (83RD): Yeah, but with the—right, so, it goes to, so, where else do we get it, right? So, it's—yeah, I agree. Thank you for your testimony, we appreciate it. We'll go back to elected officials, Representative Lavielle, and then judge you're next.

REP. LAVILLE (143RD): Good afternoon Senator Moore, Representative Abercrombie, Representative Case, and members of the committee. I'm Representative Gail Lavielle from 143rd District. We are here to testify in support of Senate Bill 834, which is the one that deals with services for people with Smith-Magenis Syndrome. All I will say about it
before I yield my time to my constituent is that this disorder causes medical, and intellectual, and cognitive problems in people, but what it universally causes are very profound and serious behavior disorders which don't always fit the parameters that are generally used to evaluate people for services. My constituent, Jennifer Iannuzzi, I want to introduce to you. Since her daughter was diagnosed with SMS she has devoted the time she has, which isn't much, to an incredible effort of raising awareness about this disorder, and the founder, copresident of the Smith-Magenis Research Foundation. So, I will turn it over to Jen.

JENNIFER IANNUZZI: Thank you for having me. I really appreciate it. Good afternoon everyone. I'm here today thanks to Ms. Lavielle, to get me this opportunity to speak to you and to the magnitude, the profound impact that this rare genetic syndrome has on not only the individual affected by it, but also its family members. I'm gonna speak for my own personal experience in terms of services and supports, and how complicated they are to get despite the symptoms you might read in a textbook, so, to speak, and I'm also going to jump on the bandwagon a little bit of the Katie Beckett waiver and use that as an example.

So, my daughter was diagnosed back in 2007. It took me well over three years to even get on the list for the Katie Beckett waiver because that, at the time, is determined by medical needs. Now while Smith-Magenis Syndrome can have a whole host of medical conditions, not everyone is affected by those the same, however, there are neurobehavioral deficits, which are genetically driven are universal due to
the RAI1 deletion in this particular syndrome, which makes it a profound and complicated syndrome.

With those behavioral issues comes self-injurious behaviors of an enormous magnitude, headbutting, picking of skin, frequent, constant, chronic behavioral meltdown regardless of whether you're in the home, in the community, it can relate to police intervention if people aren't aware of what this child has.

So, when I had Katie Beckett come in to evaluate I was the night three times because there was not a medical need for it. I wasn't granted access to some of the Medicaid benefits that would help me with respite care, which would have greatly help alleviate numerous problems in the home as well as the caregiver, myself, mental health issues. I am 24/7, 365 caregiver for my daughter. To even come here I needed to arrange three separate caregivers because one couldn't manage it all. You know, I am lucky and fortunate enough to be able to do that on my own. There are many people out there that I'm advocating for today that can't do that on their own, that are homebound and stuck with the child to this degree.

While I agree earlier today, this morning, I forgot her name, but from DSS mentioned that they evaluate on an individual basis, which is correct. One of the issues with that is that it is a rare syndrome. Nobody really knows much about it yet. It takes a lot to explain it to an evaluator who cannot really appreciate the magnitude of what these behavioral characteristics can do to a family. So, for instance these children have an inverted circadian rhythm, they are up all night. My daughter sleeps in an enclosed bed that cost close to $5000. It's
difficult to explain the need for that when it isn't necessarily a medical need, it is not due to some medical condition, it is due to a behavioral condition. It's very difficult to explain to an evaluator who is never heard of the syndrome.

You might go about trying to liken it to autism or to other syndromes, but I'm here today to have it stand on its own as its own severe, debilitating syndrome. Many testimonies were cemented today from people from different states. Several states recognize SMS as its own syndrome, eligible for services, Connecticut does not. Prader-Willi and Down Syndrome are recognized syndromes, where family doesn't necessarily have to explain the ins and outs. Again, I am an educated, and I hope I take you at individual that is able to do that, but there are many, many people that are not, and again I'm here are not only my own self but also to move this syndrome along and get the recognition and the support it needs at the state level.

REP. ABERCROMBIE (83RD): Thank you, thank you for your testimony. So, a few questions, how many individuals would you say there are in Connecticut with this disability?

JENNIFER IANNUZZI: I would say probably anywhere between 50 to 75, no more than that, I will go on the lower end conservatively speaking.

REP. ABERCROMBIE (83RD): And so, you're here today to kind of get this as a recognizable disability so, that you can get services, so, my question is, so, we talk about autism part of the challenges that it's a spectrum, right, so, there isn't one test that dictates, like Down syndrome and IQ test, right, which makes it very difficult in the private
sector to not cover the services. Is that the same case with this particular disability? There isn't one test that dictates that this is that disability?

JENNIFER IANNUZZI: Well, yes, a genetic screening would tell you for certain if you have Smith-Magenis Syndrome. It is a deletion on chromosome 17, every individual with SMS is deleted of a very important protein called the RAI1 protein that is responsible for those neurobehavioral issues that these children face, and yet, despite that, despite the severe behavioral deficits that they have, some could land in the mild IQ range, and those of individuals that scare me the most, the I'm afraid for the most because even with a mild IQ that could show up on some subjective testing, they will forever be limited by these behavioral issues that they have.

They have no emotional regulation regardless of an IQ. They have no ability to manage their executive functioning. Regardless of the IQ level they will never live an independent life. Now I'm, again, the cofounder and president of the SMS Research Foundation, for over a decade I've been very involved in this relatively small community at a global level, and I have yet to meet one individual that can live independently regardless of, let's use IQ as the marker, and that has been what has always concerned me quite a bit about this syndrome, and when I entered into the arena of getting involved with the state services, that IQ level concerned me quite a bit, because what if she happened to be in the mild range, we would be--I would have a lot harder time getting services, and even with the IQ, and my daughter's case I guess it's severe low, she is, you know, 52, I don't know where that falls, I still had to appeal Katie Beckett three times
because I get—I don't know how to say it right, but I guess it really applies to medically needy individuals, which, you know, my daughter may not fall under that, but behaviorally I needed tremendous amount of support, and with SMS some of the medical needs, as the years go on. So, for instance, one individual, I know it's one, but I'll just give it to you as an example, medically sound for the most part, 13, 14 got diagnosed with the horrific kid need condition. Because kidneys are part of the genetic makeup of this, and now at this point, you know, this child is on dialysis and will likely pass away from problems with her kidney, and because it's a rare syndrome it's hard to know what the trajectory of this is going to be.

If you do some research on the history, I would say it's a 20-year-old known genetic syndrome, not much more than that. It's very hard to definitively say that these are definitely the medical issues. I think they come up as the years go on, but again the hallmark of it is this behavioral component that it—it's hard to explain how devastating it is to family, it really is.

REP. ABERCROMBIE (83RD): Yes, and I don't think anybody up here—as little as I know about this, this is the first time ever heard of it, I'm not saying that it isn't devastating. What I will say is if children do have a dual diagnosis, and I don't mean it disrespectfully in all, sometimes they are in a better place because of the fact that they get more services. That's what we found over the autism community. So, you know, the IQ does matter because of that. How older kids when they are usually diagnosed with this? Is this something—because if you're missing a chromosome, I would think that—
JENNIFER IANNUZZI: Well you're not--you're deleted a protein. There's microdeletion on a chromosome. So, for instance you'll have all of your chromosomes, but there is a tiny piece on the long arm of chromosome 17 that is deleted, and in that microdeletion is that RAI1 protein. So, for instance, I had amnio, this was not picked up. My daughter was not diagnosed until 20 months due to an aggressive neurologist and the microarray, but it is not an easy syndrome to pick up.

The facial features don't really begin to present themselves until about 10 or 11. So, for years and years a child could receive no services because nobody really understands what's going on, and with the behavioral issues this could just get pushed aside as a behavioral disorder and treated horrifically, which is why spend a tremendous amount of time advocating to explain what the syndrome and because with ample behavioral support, a lot of support in the home, parent education, we could mitigate a lot of the, what's the word, shortcomings or devastating effects of this syndrome. So--and when you say dual diagnosis, you mean IQ as well as SMS?

REP. ABERCROMBIE (83RD): Same in the autism world, right--

JENNIFER IANNUZZI: I mean I prayed for low IQ because, you know, and I was worried about that. An IQ is a very arbitrary number. I'm also a licensed clinical social worker and I have been for years. 20 years ago, in the field the number was 72 to pass now at 69, it flip-flops and that concerns me as well because of the changes. Again, in the future, based on whatever reason that arbitrary number changes, what happens to these individuals if we're
basing it on IQ who also happen to be severely troubled.

REP. ABERCROMBIE (83RD): Yeah, and I'm not saying it's a fair system. I'm just saying that what I've learned in my years up here and have advocated on behalf of individuals on the spectrum is that when you talk about private insurance, and when you talk about the medical fields they want something that they can hold onto to be able to say yes this is a disorder, these are the symptoms, yes we want to pay for, and that's where we've had a lot of challenges in the autism community, and I'm not, you know, I'm not saying--

JENNIFER IANNUZZI: The difference between autism and SMS though whereas SMS falls along the lines of the category of Prader-Willi, which is chromosome 15 and Down syndrome, which is an extra chromosome, SMS is a micro deletion on a chromosome. You can test for it, you can prove it. Autism is a much more difficult syndrome to--

REP. ABERCROMBIE (83RD): And I agree. This private insurance pay for services?

JENNIFER IANNUZZI: Not all some, it depends on what the issue is. So, it will not reimburse me necessarily always for physical therapy, occupational therapy and that degree, but obviously medical it will. It's not to provide any respite care or anything like that.

REP. ABERCROMBIE (83RD): So, SMS is recognized as a disability--

JENNIFER IANNUZZI: No.

REP. ABERCROMBIE (83RD): So, it isn't, so, that's where it's--
JENNIFER IANNUZZI: In my insurance company, I don't think so, no.

REP. ABERCROMBIE (83RD): Okay, so, that's where your challenging, okay.

JENNIFER IANNUZZI: I think the symptoms of it, you know, what comes from it are, but I don't think if we just wrote down SMS I would get coverage based on that, based on what the child is presenting with.

REP. ABERCROMBIE (83RD): Okay, thank you so, much for your testimony. This is really informative.

Questions from committee members? Senator Moore—did you say yes, okay. Senator Moore followed by Representative Case.

SENATOR MOORE (22ND): Thank you for your testimony, you are so, knowledgeable about this in such a champion. I had not heard of this before. I said to my co-chair, I wish we had done an informational on this so, that more people would become aware of it and have other experts up here and other families to ask questions, so, if this doesn't move this time, perhaps we could use something like that. But I think you brought a lot of awareness to this and that you've been a real advocate. I'm wondering if you have a medical background. Do you have a medical background?

JENNIFER IANNUZZI: no, I do not. My husband is the head of our scientific advisory panel. He is a physician at St. Vincent's and Bridgeport Connecticut. He's a radiation oncologist but has quickly learned quite a bit about it in over the past 10 years I've learned from him, and he heads up our scientific advisory panel who determines what research we fund, so, I've learned a lot through that.
SENATOR MOORE (22ND): So, is it the facial disorder that really calls attention to--

JENNIFER IANNUZZI: It's the behaviors that--

SENATOR MOORE (22ND): The behaviors also?

JENNIFER IANNUZZI: Yeah, the behaviors that really will be the hallmark. So, for instance when my daughter was quite young, she was a big head banger and it didn't feel right, and extremely self-injurious, and no sense of self-preservation in any way.

You would have to put her in a helmet you have to put her in a padded room, like there is no ability when that meltdown or tantrum comes, that in the drive to self-preserve is not there and SMS, and it is manageable and a two-year-old, and a five-year-old, but as you begin to go up in the years it is quite dangerous. I've had some people submit written testimony of how this can happen out in public, and it becomes quite dangerous because they are not only a threat to themselves, they are a threat to others to because it is completely not controllable, and almost an out of body experience for individuals with SMS.

SENATOR MOORE (22ND): So, I thought I heard the expert from the DSS say there is a series of test, no?

JENNIFER IANNUZZI: No, two different things.

SENATOR MOORE (22ND): Okay, all right, well thank you so, much.

JENNIFER IANNUZZI: Thank you.

SENATOR HASKELL (26TH): Thank you Madam chair and thank you Representative Lavielle for bringing this
forward to us. Living with a family with a disabled, with SMS, what is it like in the family life for you will, and there are so, few in the state but obviously we need to take care of all, I'm very passionate towards that, and what are the biggest barriers that you face?

JENNIFER IANNUZZI: In terms of family life the biggest barrier that we face, and I think is one of the most difficult services to get is respite care by not only people familiar with it, but also trained to manage it. I think that to take care of an individual with SMS requires one-on-one supervision and a very stress-free calm home. They do not assimilate themselves into the larger family life. That creates a tremendous divide in families, and I'll speak from my own experience. We split up. I usually take my daughter and my husband takes my sons, and we go our separate ways. It's very difficult to be a family unit, and that creates a tremendous amount of stress on the caregiver, myself, it could lead to social isolation, family isolation, depression, panic attacks, anxiety attacks, you are with this person on your own. It can get to the point where you don't want to leave the home.

Respite services are crucial to be able to maintain as much of a normal family life for the other children in the home and know that the SMS individual is safe. So, regardless of whether there to, four, 24, 34, they will always require one-on-one. For instance, my daughter, 13 years old, attends a special school, only 40 kids in the school, one teacher to seven kids, she requires the use of 28. She cannot be managed without to aids in that setting, and that is a setting that has some of
the most profoundly impaired special needs kids with diagnoses you've all heard of, yet mine is the only one with a two to one due to the severity of the behaviors.

I'm just gonna share one other example, just how difficult it is to explain to the evaluators that come to your home what it's all about. I had--three times from the Community First Choice Program, I was denied twice for the services because I could not really do justice to someone who did not understand the syndrome, how severe the behaviors were. They made the--they rejected my desire for the program because there were no medical issues, and the need for ADL, someone to come in and take care of the ADL, that is not Smith-Magenis Syndrome, I mean it can be, and that's where the spectrum comes in. You can have a completely incapacitated individual with Smith-Magenis Syndrome, and you can have a completely able-bodied person, but at the end of the day regardless of the spectrum you will be impacted by significant behavioral challenges that will create a situation where you are isolated in your home and cannot go into the community and require more help to keep that individual safe.

REP. CASE (63RD): So, I just want to say thank you. There are so, many things that we learn about, and it's quite interesting that three of our top people in appropriations have testified today, so, we can get that across that these are programs because we all don't know all the disabilities that are out there and how it affects people and how to fix their lives.

You know, I know Representative Abercrombie has always worked very diligently to educate people on certain aspects of a disability as well as I have on
different avenues, and it's a lot different from my perspective when you live with it, and it's getting other people engaged, and I really appreciate you coming up today. I honestly until this bill came forward didn't understand what it was at all. I appreciate it. I'm sure Representative Lavielle and I will be having more conversations on this, but I just wanted to thank you very much.

JENNIFER IANNUZZI: Thank you very much for having me. I appreciate it.

REP. ABERCROMBIE (83RD): Don't go anyplace. Senator?

SENATOR HASKELL (26TH): Thank you very much Madam chair, and thank you so, much for your testimony. To echo what Representative Case said, I have learned so, much about Smith-Magenis Syndrome as you spoke today. To follow-up on Senator Moore's question, you do have such tremendous knowledge of the medical background, the terminology that goes with this syndrome. I'm wondering if in your advocacy experience you've encountered families who don't have a physician in the immediate family and have struggled to either obtain the necessary services from the state or even learn to diagnose and cope with their daily realities. Can you speak a little bit about those families?

JENNIFER IANNUZZI: I certainly can because those bright me the most. You know, I'm lucky that I can sit here, and Smith-Magenis Syndrome is my biggest problem, but for many, many families it's not, and the ability to care correctly and provide support for those children, or individuals are young adults or adults is not good at all. Several individuals that I know personally have ended up in either gel
because the caregiver cannot explain well to the people that get involved out in the community what they're dealing with.

There was a case in Massachusetts in particular, I'm not to mention the name, maybe I can, but I don't want to at this time, that happened to and resulted in that state, Massachusetts, recognizing Massachusetts as a legitimate syndrome in and of itself because of what happened. That individual ended up in jail and then somehow that parents had to relinquish their rights in order to get for their services for this child and it took them five years to get that child back in their care. There're numerous stories were these individuals and up and emergency, ER psych hospitalization, where they do not belong, overly medicated.

The staff that are treating them don't understand what they're looking at all because it could look like a psychiatric disorder, it could look like a psychotic episode or bipolar mania episode, and yet you're actually talking--you're trying to do mental health intervention with an individual that has the cognitive capacity of a three-year-old, and yet it could be taken as either oppositional until you finally figure out what's right in front of you.

So, for many reasons I taken this to the next level because I'm frightened of what it looks like out in the community, because it is such a unique disorder that can present one way, but yet behind-the-scenes has is very dysfunctional, primitive behavioral action decisions being, and the deficits that are involved are just sometimes naked to the eye because you take executive functioning for granite, which kind of guides you through your day. SMS individuals have no ability to do that. They truly need to be
handheld through their day, and when pushed too far, this very primitive reaction comes up.

Just a further answer your question, and other parts of the country, we happen to be very lucky in the State of Connecticut with the school systems and what the autism community has done for individuals with disabilities in general, that is not the case everywhere, these kids are locked in closets, you know, because nobody knows what they're dealing with, and if you don't have an aggressive medical team, you don't have a diagnosis, right. No one is spending thousands of dollars for microarray to find this deletion, and they're looking at it at face value as a behavioral disorder with severe oppositional defiance, and you're overmedicated in your isolated.

So, it's very difficult for a parent who can even advocate for themselves for their own basic needs in some parts of this country, let alone for a child with such a complicated syndrome that to some could be deemed--where the parents could be judged for poor parenting because this child is on the floor kicking and screaming, and it just adds insult to injury.

SENATOR HASKELL (26TH): Well, so, much for your testimony, for your advocacy for all SMS individuals and families, and thank you Representative Lavielle as well.

REP. ABERCROMBIE (83RD): Further questions? I just have to real quick ones. One, can you send my office what the daily activities look like for you? I just want to understand a little bit more, and then secondly, what kind of services--your daughter right--what kind of services does your daughter get?
So, that she does OT, PT, does she have a BCBA, like who are the providers who do the services and what kind of services that she received. If you could send not--

JENNIFER IANNUZZI: I'll send that to you.

REP. ABERCROMBIE (83RD): Yeah, and I'll send it out to the committee. Because I think that were all trying to educate ourselves on this, but I do want to take this opportunity to thank you for being here really bringing this to our attention, and you've got a great advocate--

JENNIFER IANNUZZI: You have no idea how wonderful this is, so, thank you very much. SMS is still never heard, and when the community at large found out we had the opportunity, it really ignited a lot of hope and momentum for them. So, regardless of whatever comes from today so, thank you, I really appreciate it.

REP. ABERCROMBIE (83RD): Representative.

REP. LAVIELLE (143RD): I want to thank you all on the committee as well for your really sincere attention to this. It's the--Jen is--and I really want to thank Jen for coming forward to discuss this because it's been a while since she has begun sharing her experiences with others and particularly in our town, which has about 18,000 people it's small, sometimes these episodes happened in public. She writes about them, she talks about them, people sometimes know who it is when it's happening, and they understand because she is so, courageous and sharing information, but it is--when you read some of these things, it's hard to imagine how it's possible to from day-to-day. I have, you know, really not myself read or seen anything so,
profoundly disturbing in the way of the behavior disorder as I have in discovering these types of episodes. So, thank you to you all, thank you to Jen, and I hope that will be able to work on something that will help everyone in Connecticut with SMS and their families. Thank you.

REP. ABERCROMBIE (83RD): Thank you both. Thank you for your testimony. We're going to go back to the public portion. Just a reminder, three minutes. Lucy Potter, I thought I saw her. There she is, and then we'll go back to the elected officials and it will be the Honorable Paul Knierim.

LUCY POTTER: Good afternoon. I am Lucy Potter, an attorney at Greater Hartford Legal Aid. I'm here to testify about 7094, which is paying for diapers for women who get temporary family assistance. I've been representing women in the TFA program since it was started 23 years ago, and before that the previous AFDC program, and the thing that I think I can bring to this conversation that wasn't raised earlier concerning where should this money come from. The temporary assistance for needy family funding, this is what this money is for. So, in 1996 before the TFA program was started, $400 million a year was being spent for families on Aid To Families With Dependent Children. The amount that a family of three in Hartford now gets is $597. In 1989, in the AFDC Program, it was $581, that's $16 less 30 years later.

So, I think you can see there's been no cost-of-living adjustment in the Temporary Family Assistance Program. The program has away downsized to the time limits and work requirements and everything else. This is a fundamental need that should be paid for out of the TANF grant. It's just really important.
Obviously, you know, the people on the temporary family assistance program are required to work, and order to do that the childcare. In order to have childcare--you know, maybe there are few people who can figure out how to do it with cloth diapers, you really--in there's no daycare provider was going to take a child without disposable diapers.

So, I think it's just a really important, basic benefit that's needed, and the other benchmark I think is the talk of SNAP paying for this. SNAP is not going to pay for this, and an interesting comparison, SNAP, which is adjusted for cost-of-living, this year it passed the grant for a family of six to get $908 and TFA for all your needs, housing, everything, clothing, and food, but the supplemental nutritional assistance program you get 913 for six kids. So, I'm just underline the fact that the TFA benefit is really, really too low, and it is supposed to be paid for out of TANF, and at this point less than 25 percent of the TANF and MOE funding is going towards these families, so, it doesn't make sense to me that that money isn't there in the TANF benefit. That's all I have to say.

REP. CASE (63RD): Thank you for coming forward. I know we've heard a few other people on this, and having some experience with an 11-week-old at home, we tried those, you know, the natural diapers and many other things--

LUCY POTTER: It's hard, especially with the little baby. I tried it for a while.

REP. CASE (63RD): Yeah, disposable ones once I get home one, that's when they go on, but does anybody have any questions on the committee here? Representative Hughes.
REP. HUGHES (135TH): Thank you Chairman. So, you're feeling is that the TANF funds should be used for this, and in fact diapers qualify--

LUCY POTTER: Absolutely, yes, they're part of--

REP. HUGHES (135TH): And yet we haven't, or the federal dollars or the federal hasn't raised the cost of living?

LUCY POTTER: It's not only that, it's that we get--the funding is block granted, so, it uses TANF funding, and as the state meets an effort, it's the same amount of money about 400 million, which it was in 1986. Increasingly we divert that money to other things. It goes to the state Department of Education, DCF, many, many other things, important things, but this is really important, and there's nothing else that goes to basic needs for--

REP. HUGHES (135TH): Babies. Okay all right I think I'm clear.

REP. CASE (63RD): Anyone else? Thank you very much for coming forward today. Up next the Honorable. If you want to shut one of those microphones off easier for us to hear, that would be great. Perfect, thank you.

HONORABLE PAUL KNIERIM: Good afternoon Representative Case, members of the committee. I'm Paul Knierim, and probate court administrator here to testify in support of raised bill 818 concerning the expenses of conservators being reimbursed from federal Medicaid funds. I do want to, because I always try to take the opportunity when I can, to emphasize the importance of conservatorship the states safety social net, safety net I should say. About 22,000 individuals in Connecticut have a
conservator. They are seniors with dementia and other serious illnesses. They are adults with illness and intellectual disability, and numerous other categories.

Conservators have an absolutely fundamental role in all of the needs of those individuals food, clothing, shelter, personal safety. Conservators also say the state an enormous amount of money in the services that they provide. As an example, conservators provide the structures necessary for an individual with mental illness to be able to live in the community and avoid inpatient hospitalization, the same is true for seniors who are able to age in place at home rather than print requiring institutional care because conservators arrange for all the support that are necessary.

The conservatorship system imposes a great deal of strain on the finances of probate courts, and you've heard me say that before here at this committee, but I always need to emphasize that point. Connecticut looks to the probate courts to find conservators for individuals who don't have close family or friends who can serve in that role. It also looks to the probate court to pay for the services of the conservators when the individual is indigent, that aspect of our safety net represents 10 percent of the probate court systems budget. Last year we spent $4.6 million compensating conservators for indigent individuals. So, that's the framework I need to understand, how important conservatorship is in the lives of so, many Connecticut residents, how Connecticut takes the unusual posture of relying on the probate courts to pay for it, and then the solution part of this legislation, which is by changing our state Medicaid plan, and mending it as
other states have done, we could recover half of the expense I've just described to you for conservator compensation, making it Medicaid eligible.

We've worked on this subject for a little over two years now. There are some administrative challenges associated with it, but they are not insurmountable. Rhode Island, Vermont, Massachusetts, our neighbors have all accomplish this, and the savings for the state would be about $800,000 per year. It may be small dollars in comparison to many of the things that this committee works with, I understand, but a significant chunk from the standpoint of the probate court system budget.

I need to correct one thing in my written testimony, I had indicated in the written testimony that the benefit of the Medicaid reimbursement dollars would redound to the general fund, as drafted, it actually would have that benefit go to the probate court system, that seems entirely suitable to me. Over the last two years we discussed different frameworks on that, but I misspoken my written testimony, and I wanted to be clear about that.

REP. CASE (63RD): Well thank you, thank you for coming forward. You talk about probate working with indigent, but there's also an expense with DDS, correct? With disabled? I was a conservator for my brother, I have to go through the probate court in order for that conservatorship to happen. So, the 10 percent that you talk about for indigent, it doesn't have to do--that doesn't include what you do for the disabled population, does it?

HONORABLE PAUL KNIERIM: That's correct. That figure would not include that.
REP. CASE (63RD): So, you figure of your cost for the state for somebody who is title 19, so, that even goes up and exasperates even more the cost that your absorbing as the probate court?

HONORABLE PAUL KNIERIM: It does. One thing that you might be very well aware of, then I think it's important for the committee to know, while we have a framework for compensating conservators for indigent conservative persons, do not have a framework for compensating guardians or adults with intellectual disabilities. Now you are referring to a conservatorship, so, those two different statutory frameworks have a different set up with respect to whether someone serving on behalf of a disabled individual can be compensated for those services. Guardianship, there is no provision for it, where there is conservatorship.

REP. CASE (63RD): Yeah, I think mom was a conservator, my sister and I were the other. I think you for coming for. There is always been an issue with the great work that you guys do and the budget usually doesn't affect that for all the work you do. Does anybody have any questions? Yes, Representative Hughes.

REP. HUGHES (135TH): Thank you Chairman. Hi Judge.

HONORABLE PAUL KNIERIM: Good afternoon
Representative. Nice to see you.

REP. HUGHES (135TH): Can you speak to the newly online training system to help conservators both family and professionals really understand their parameters, which is a great bang for their buck when we think about using Medicaid applied income?
HONORABLE PAUL KNIERIM: Thank you representative, I'd be very happy to--and I appreciate your assistance on making that happen. To put it in context, we been working very hard to improve our support and oversight of conservators. Given the work they do, nothing could be more important that we have a strong very professional system in place to help people with this role. So, over the course of about a year we've developed an online free training program for conservators. There are actually two different modules, one for the family member who will probably only do this once and everything is new to that person, a separate module is for professional conservators who work in the field and help more than one individual.

It's a comprehensive four-hour program. It covers all the aspects of the responsibilities of conservators, ethical issues, criterion for decision-making, resources that they can avail to help the conserved person, and we tried just to structure it in a way that is very accessible, online, so, people can take it any time from the comfort of their home if it if that's appropriate, and they can also do it in installments, they don't have to sit down for four hours straight to do it.


SENATOR MOORE (22ND): Thank you for your testimony. Is that course free?

HONORABLE PAUL KNIERIM: Yes Senator, it is free, and I should have also that for attorneys who have an annual 12 our continuing education requirement, it is eligible for credit for continuing it, and that's probably true for other professional
disciplines as well, but I can't say that for certain.

REP. CASE (63RD): Anybody else--

REP. HUGHES (135TH): It's offered in Spanish too.

REP. CASE (63RD): Thank you very much. Representative Hughes is very involved in this project, so, she knows as much as I do, and I appreciate her asking. Anybody else? Thank you for coming forward.

HONORABLE PAUL KNIERIM: Thank you very much.

REP. CASE (63RD): Yes, Senator Osten, we have one more and then you. Lucy Potter? No. Senator Osten, you're up. Good afternoon.

SENATOR OSTEN (19TH): Is it afternoon? I'm not even certain anymore. What time is it? It is [laughter]. Thank you very much chairs of the Human Services Committee and members, I'm here today in support of House Bill number 7090. You have my written testimony in front of you. A this is essentially about The Root Center which has a Norwich location, and has the lowest, as I have found out, the lowest reimbursement rates in the state. I did here earlier when I was traveling in and out, and I know how busy you are, Representative Abercrombie said a that we always have to pick and choose how we're paying for different services, and I agree wholeheartedly with her on that, but I would say that in my review all summer of the rates that were paying in Eastern Connecticut, they are significantly different in a lot of different areas, whether it is the Homeless Hospitality Ctr., United Services, and then root, all representing people that are in Eastern Connecticut.
Roots happens to travel through many different cities and towns, and I just cannot accept any longer the DSS nation that they are providing the rates that they see fit, that fit into the services that are being presented. The Roots can expand services into the behavioral health and mental health population and often are unable to treat the underlying cause of the substance abuse problems that are leading to the methanol maintenance program. Many of you know that I worked in the Department of Corrections for 21 years, and I saw the long-term consequences of us not dealing with this issue that was in the urban areas and we ignored. So, now that it's traveling through other suburban and rural areas, we consider it a crisis, but it was clearly a crisis that was causing an increase in our population and the Department of Corrections, and I just really think that we should pay programs on a commensurate basis that is fair for every program that is out there and not--I believe that it's based on historical payments to different programs, and I think that we need to review all rates and making sure that we're providing the correct payment.

I could talk for very long time on our last payment for mental health areas. One I think that that need significant reform, but this, today, is about this particular program that is the lowest paid in the state, and it should not be the lowest paid in the state. We need to do rate reform and make sure that everyone is being paid fairly and in an even fashion. I'll be happy to answer any questions.

REP. CASE (63RD): Thank you Senator Osten. It's so, nice to have you in front of us. And I agree with you, the eastern part of the state I'm a but also
you talk about--I always listen to you, in the northwestern corner we have the same issue because we have one dispensary that covers 1100 mi.$^2$, and, you know, I guess it's something that was going to have to look at. DSS was here and said they're gonna bring some more rate schedules. I guess there's a big rate schedule bill that will be looking at. I don't have any specific questions, but I think you for coming forward and testifying on it, and, you know, we bring it before appropriations will have a good year on it.

SENATOR OSTEN (19TH): Right.

REP. CASE (63RD): Anybody else have any questions on the committee? After all that wait, no questions.

SENATOR OSTEN (19TH): I don't mind waiting. I was just trying to hop between meeting after meeting to make sure--because I had a lot of very good pieces of legislation that were being discussed in a lot of different committees, so, I just didn't want to miss my turn so, I kept popping in and out, so, I wasn't putting any pressure on anybody, I just wanted to make sure that I--

REP. CASE (63RD): Now Senator Moore has a question for you.

SENATOR MOORE (22ND): I don't have a question, I have a comment that the gentleman from the organization represented did a really good job of explaining in-depth how many people he serves in a day, 6000, and he talked about the different locations where they are. So, I think he gave a really great overview of what it is, but I did hear people say sometimes we have to spend a little bit more to get better assistance and have long-term outcomes, and I think as we look at some of the
things on the rate you have to balance. I heard what Representative Abercrombie said, but I think we need to figure out where the balance is on some of the things because there's a long-term impact, we don't take care of the people who run these methadone--and there are opportunities. I know many people have weaned themselves off of methadone to be totally clean, and there's not enough access many times to these places that serve that. When you mentioned, I had not thought about--I know you said it you work in the prison system for 20+ years, but I, you know, when we talk about the opioid addiction, when it was my community, and you hear it over and over again, when it was in the urban center and they were bringing the drugs and, nobody really cared, nobody--they thought, it's our problem and now it has spread out to the urban and suburban and all of these different areas, it is a problem.

Now the prison population I had not thought about, because it's disproportionately people of color in the prison system, right. So, this should be also about racial justice. That people are able to access the services, and that they are given the right amount of money and what they need or reimbursement for more people to be treated. I heard them say that they--some places you have private money you if you have by private insurance can get $150 because their coupling the services and what you can get. I don't know what happens when you're on Medicaid and you're getting these services and how they reimburse, but I think it is a much more serious issue when you start to look at it. Though I do thank you for taking the time--and if you use that one piece of information, that I don't think anybody else thought of.
SENATOR OSTEN (19TH): So, I would just like to say, on the prison population, I've been doing a lot of research on the prison population, I actually started testifying on mental health issues in the prison population before, while I was still a correctional lieutenant working in the system, working for justice, the one area that is seeing a significant increase, that I wish we would start talking about is the issue of mental illness, which is oftentimes the underlying cause, although not the only cause of addiction or addiction behaviors. When I first started working in the Department of Corrections, the numbers of those that were chronically mentally ill that were in the Department of Corrections were single digits, around 6 percent or 7 percent. They are now up to 35 to 40 percent of the inmate population is diagnosis chronically mentally ill.

I would clause it, quite frankly, is that all we did, when we thought we were doing a great job of closing our state hospitals, is that we changed geography, and we made it far worse for the people that are mentally ill. I tried to get up here when we were doing a press conference on that under the Senate Democrats, to talk about the issues, so, I'm gonna take this time because I couldn't make it up here for that particular minute, and I have said while we were working through the prison reform that we've been working for, and I am fully in support of that, that we are leaving out one set of the population, that is those people that are mentally ill, that have chronic mental illness, and we decide that someone who is chronically mentally a with mental illness, that they are going to get better in six weeks.
We give them a diagnosis, and we say, if you had a broken bone you could be better in six weeks, and this is not a broken bone, this is something that is long-term, and I also think that we don't do enough with the trauma that young people have that result in mental illness, and I, actually have been waiting for an answer, I'm gonna start pushing for the answer because I have had it.

You know, we close the state hospital in Norwich, people stay, because there are rental properties there that they can stay in, and I'm happy, I like renters, I think we should rent as many places as possible. I invite anybody to come into Norwich, but we did not to what we promise to do. The keep the promise coalition always said we did not provide supportive housing, and we did not provide wraparand services. We let people out of our institutions and we said good luck, we hope we can get a job, we hope you can find a place to live, we hope that the doctors will still keep servicing you, and that is not the case, and so, now we have a prison population that is verging on close to 50 percent of the inmate population that is diagnosis chronically mentally ill, and I think that we need to start dealing with that, and I think that that is a social justice issue. I think if you look at it, it would be a racial justice issue also but I know it's a social justice issue that we need to start remembering that mental illness should be treated with parity with medical illnesses and we need to stop separating the two, and recognizing that this is a significant problem for us, and if you look at the number of people who are chronically mentally ill who can't get a bad in a group home because nobody wants them because they are more expensive to care for, so, they do almost their whole sentence.
We deposit them in homeless shelters, and we say good luck. We give them two weeks' worth of medication, and doctors don't like to see people without an address. So, they finished those two weeks' worth of medication and then they don't get their medication and they decompensate, and then they end up back in the prison system.

I put ability to the dictionary committee as a task force to look at the overall issue of chronically mentally ill that are going through our prison system and where there ending up, and how many of them received revised, and I think the numbers are very high, so, I think you forgive me the opportunity to spout about something that I'm completely passionate about, and I just don't think we do enough for.

REP. ABERCROMBIE (83RD): Thank you, and we couldn't agree more.

SENATOR OSTEN (19TH): Thanks for all your hard work ladies and gentlemen.

REP. ABERCROMBIE (83RD): Thank you. Matthew my friend, good afternoon.

MATT BARRETT: Good afternoon. My name is Matt Barrett, I'm the CEO of the Connecticut Association of Healthcare Facilities. I think you for this opportunity to testify at today's public hearing. I want to begin by supporting, with a recommended revision, Senate Bill 818, AN ACT ALLOWING FOR THE DEDUCTION OF COURT APPROVED CONSERVATOR AND FIDUCIARY EXPENSES FOR MEDICAID APPLIED INCOME. This is important legislation designed to encourage greater participation of conservators, and in doing so, maximizing federal Medicaid revenue and reimbursement.
The bill requires the Department of Social Services to amend Medicaid and permit a deduction of certain conservator expenses when calculating a Medicaid eligible nursing home resident applied income. In general, nursing home residents must be any income they have on their care. This contribution is referred to as the applied income amount, and it is most commonly the revenue of Social Security.

The bill alters the applied income arrangement by requiring that a deduction of the enumerated conservator expenses be reduced from the applied income amount, and the practical effect of those deductions will be to reduce the amount of applied income going to the cost of nursing home care for the Medicaid recipient to the nursing facility. Consequently, the Medicaid portion of the payment would otherwise increase as the applied income is reduced, otherwise the nursing home would be uncompensated for the cost when such conservator expenses are deducted from the applied income.

To ensure that the Medicaid payments to the nursing home is increased as applied income is reduced, which is the apparent at intention of the bill, our association request that the language of the bill be amended as follows:

On line 12, after the sentence "are permissible under federal law" we ask that you insert, "whenever such conservator fees and other expenses are deducted from the applied income, the Medicaid payment to the nursing home should be equal in an amount equal to the reduced applied income," and with that I'm pleased to offer my support for the bill, and with the chairman's permission if I could just very briefly mention a second bill on the agenda, which is Senate Bill 819, and we're urging
no action on an act prohibiting assisted-living services, agencies, and continuing care providers offering assisted-living services from requiring a third-party contract guarantor.

We believe that requiring or prohibiting this commonplace arrangement would impede access to assisted-living services, and the community what not be well served by doing so, with that, thank you again for having the opportunity to testify, and I'm happy to answer any questions you might have.

REP. ABERCROMBIE (83RD): Thank you Matt. Can you send up that language?

MATT BARRETT: Yes, it's actually-- I put it in the body of my testimony, and I submitted it to the committee.

REP. ABERCROMBIE (83RD): Okay, all right, because that's online. Were only getting hard copies from elected officials at this point.

MATT BARRETT: I'd be happy to get a copy to the legislative commissioner's office right now.


MATT BARRETT: Thank you.

REP. ABERCROMBIE (83RD): Moving on to Mag Morelli.

MAG MORELLI: Good afternoon Senator Moore, Representative Abercrombie and members of the committee. My name is Mag Morelli, and I'm president of Leading Age Connecticut, a member of Association of 130 not-for-profit and mission driven organizations representing the entire field of aging services and senior housing. On behalf of Leading
Age Connecticut, I'm here today to testify against Senate Bill 819, AN ACT PROHIBITING ASSISTED-LIVING SERVICE AGENCIES AND CONTINUING CARE PROVIDERS OFFERING ASSISTED-LIVING SERVICES FROM REQUIRING A THIRD-PARTY CONTRACT GUARANTOR.

This bill would prohibit assisted-living service agencies and continuing care facilities that provide assisted-living services from requiring third-party guarantee is on their agreement. The stated purpose is to apply to them the same prohibition on third-party guarantor contracts that are currently applied to nursing homes. It's unclear to us while such a wide prohibition is necessary in the assisted living or continuing care setting. We represent many of these communities, and we are not aware of any issues that have arisen in the settings concerning the use or enforcement a third-party guarantee.

Most importantly, such a broad prohibition is simply not workable and can even be detrimental given the nature of assisted-living services and continuing care contracts in the models of contracting for the services. In addition, the bills for is far broader than the third-party guarantor provisions under federal and state requirements governing nursing homes.

Connecticut does not license facilities where assisted-living services are provided, and only licenses the assisted-living service agency. Assisted-living services and fees for those services are often incorporated into the residency agreement, which also covers housing, meals, and related amenities. In the assisted living facility setting, that agreement must comply with landlord-tenant law, and residents have the rights afforded to tenants under landlord-tenant law. Also assisted-living
services with you exceptions are provided on a private pay basis in Connecticut.

Assisted-living facility should have the right to ensure that payment will be available for the residential accommodation and for any assisted-living services provided. Requiring a ban on third-party guarantee it equally unnecessary and untenable for continuing care facilities that provide the services. It is a practical matter that would extend to all the continuing care retirement facilities all, because they offer assisted-living services.

Continuing care facilities are registered with the Department of Social Services and subject to particular requirements under the law and that are set forth in the Connecticut General statute 17b-520. Continuing care facilities necessarily establish financial criteria for admission because the model involves payment of a substantial interest fee upfront as well as monthly fees in exchange for housing, amenities, and certain services that could include, when needed, assisted-living services, some even offer life care options, where the resident pays the entrance fee and a monthly fee in exchange for housing and services for the remainder of his or her life.

Due to the financial criteria for admission, the typical continuing care facility resident is one who has Artie been determined to be able to afford the required payment, and so, it is highly unusual that a third-party guarantee will be involved there are some cases, however, were third-party guarantee might be necessary or appropriate. While the stated purpose of the bill, finally, is to impose a third-party guarantee prohibition that is consistent with the prohibitions in place for nursing homes, the
proposed language is far broader and more restrictive than those provisions.

So, in summary, we just want to reiterate that it is unclear why this broad prohibition is necessary, more importantly such a broad prohibition is simply not workable and could even be detrimental given the nature of assisted-living services and continuing care contracts, and the models of contracting for these services. We strongly urge the committee to not move forward with this proposal. Thank you for consideration of this testimony. There is more—there's additional information in the testimony. I'd be happy to answer any questions.

REP. ABERCROMBIE (83RD): You're like speed dating [laughter], that's all I could say Ms. Mag.

MAG MORELLI: I have to get all in, in three minutes.

REP. ABERCROMBIE (83RD): Thank you so, much for your testimony, and yeah--and I-- I'll be honest with you, I'm not sure where this is coming from, so, we actually have some homework to do on our side, but I have not, through the industry, heard any complaints with the process that we have in place at this point, so, I'm not exactly sure what we're trying to get at with this legislation. Questions? Comments? Jay, nothing? Got nothing? Okay. Thanks Mag.

MAG MORELLI: No problem. If there's anything you need from us, please just let us know.

REP. ABERCROMBIE (83RD): Thank you I appreciate it. Chris Carter. Good afternoon nice to see you again.

CHRIS CARTER: Good afternoon. How are you? [background conversation] pretty well, thank you.
Good afternoon, my name is Chris Carter, and I'm president of the Connecticut Assisted-Living Association. I'm pleased to provide testimony regarding raised bill 819 from the Connecticut Assisted-Living Association.

CAL is a statewide organization that represents not-for-profit and proprietary owners and operators of some 150 managed residential communities offering assisted living and life plan services to Connecticut's older adults and senior citizens. CAL respectfully reminds committee members that assisted-living communities are governed by the landlord-tenant law and are in predominantly private pay settings. As such, in the absence of a third-party guarantor, the only recourse for provider is to pursue eviction through housing court. We can all agree that the fiction process is traumatic for resident, time-consuming, and prohibitively expensive for both consumers and providers. Preventing providers from obtaining a third-party guarantee will make admission more difficult for those residents who may not be able to clearly demonstrate the financial resources to provide for their care in that setting for next ended. Of time.

Prohibiting providers from requesting a guarantor as part of the moving process create a future obstacle for the quality and continuity of care that a resident may need once he is her resources become limited. Not having a guarantor to ensure that caring services continue to be provided to a senior, will result in a providers need to terminate the residency agreement and potentially engage in filing an eviction. This in turn would result in the senior being required to seek alternative living arrangements, thereby disrupting their lifestyle and
the excellent housing and care they have become accustomed to.

CAL opposes the bill on the basis that the added increase in cost to protect payment will be passed on to assisted-living consumers and harm the industry as a whole. With added cost to market, screen, and evict a resident if assets are depleted without a guarantor. CAL encourages legislators to reconsider the proposals raised in this bill both for how they will ultimately impact consumers with increased cost, and the significant added cause for assisted-living and senior living providers at a time when the industry is growing.

Finally, I would add, regarding Senator Kelly's comments, that cosigners are used commonly in numerous other types of transaction, whether it's car loans, student loans, etc. I'll entertain questions. CAL remains available to serve as a resource to committee members in the future and thank you for your consideration.

REP. ABERCROMBIE (83RD): Thank you Chris.
Representative Case.

REP. CASE (63RD): Thank you Madam chair. Just one of your last sentences I think it is for me to, so, you are looking for a guarantor when the patient or the resident runs out of funds? Because your statement was unique to have a guarantor if there are no other assets available.

CHRIS CARTER: It's used primarily in cases where a resident is--has higher acuity or dementia, and the question asked of their resources is a concern.

REP. CASE (63RD): So, what is the third-party does not sign? You won't--the resident is not--
CHRIS CARTER: So, what I would say is that, you know, in the statement of purpose it mentions comparing it to what's done in the skilled nursing world, and the reason it's done that way is because you wouldn't attach, or you wouldn't pursue Medicaid or Medicare for payment after someone's passing. So, in our case no one wants to have to chase in a state, and generally the move to an assisted living is episode driven. So, this is really why our model is different skilled nursing world.

REP. CASE (63RD): Okay. I think we'll have a lot to discuss because that concerns me that if the finances run out you need that third-party so, you can get paid, so, it could be a family member that would have to keep utilizing their assets to keep the person in there. Fortunately, my mother took out long-term care insurance, so, that covers her, they don't offer those policies anymore, but are there cases where that's happening now, were an extended family your son or daughter is paying for the care because they run out of funds for their mother other father?

CHRIS CARTER: Sometimes-- I believe it's a stopgap measure, so, that if someone has to leave assisted-living because of their acuity and/or their resources, then the family would be in place to step in until Medicaid eligibility is in place. So, you know, --and the skilled nursing facility will not take a resident until the Medicaid eligibility is in place. So--

REP. CASE (63RD): And there's no what you can take from that third-party?

CHRIS CARTER: Not to my knowledge, no.

REP. CASE (63RD): Thank you Madam chair.
REP. MASTROFRANCESCO (80TH): Thank you Madam chair. Just a clarification for Representative Chase and thank you for your testimony. As I mentioned before I worked for a few years and assisted-living, and I'm very familiar with the process when somebody comes in and they are to sign a lease, and they do have that third-party guarantor for a number of reasons. A lot of times family members want to keep their parents in assisted-living, the cost is very reasonable, they provide family service for them at probably half the cost if you were to pay privately, saying a nursing home, so, it's important for them to collect those funds will, but the residents that are moving in and the adult child who is signing the paperwork is fully aware that when money runs out, you are going to be responsible for it.

If they feel the adult child does not want to sign that, that's an agreement that they can make privately with the assisted-living facility point. So, anyway at that point, you know, they have to move out if they run out of money or wait until they're on Medicaid, and they would have ample time to find another location, but you know, they can't do the service for free, right, providing care, room, and board, so, the third-party guarantor is, I believe, very important to them, and honestly the families are very much aware of that third-party guarantor, and if one they don't want to deal with them, that's fine.

No assisted-living, in my opinion, is going to deny that person access to come in, but they will tell them, look you're running out of funds on. Let's start working with you to find another facility or get you going on the Medicaid process so, we can
find housing for you. Thank you. Thank you, Madam chair.

REP. CASE (63RD): Thank you and I-- you know, and I think the good representative. I think what Senator Kelly, when he spoke, because he's an attorney and had a case in front of him, it was a family that was unaware. So, I don't know if there's a document that you have to sign off that saying that you are made notified of the third-party. I think the only reason why he brought it forward is because there were some things that were going on where it was a family that was unaware that they sign that third-party guarantor, and they were going after their finances. I just want to make sure that we make everybody whole and everybody safe, that they know what they're signing sometimes under duress just because they want to get the person in, so.

CHRIS CARTER: Again, as with student loans, I cosigned for my child's student loan, and I know that I cosigned for my child's student loan, so, those documents are all pretty clear, and folks are aware of everything that they're executing and attesting to.

REP. ABERCROMBIE (83RD): Representative Hughes.

REP. HUGHES (135TH): Thank you chairwoman, and thank you for your testimony, and I wanted to add to Representative Mastrofancesco's experience. I'm a social worker in the field, and my experience is that a lot of genuine care communities are moving away from the third-party guarantor because just a barrier, it's prohibitive. So, a lot of my clients, geriatric clients that are looking to assisted-living facilities, are just looking for a year a contract, a year-to-year kind of contract, and prove
that they have the funds to pay for their living for an X number of time, just because it's more flexible are the client's needs, and you're right, a lot of that has to be around working together to help inform a client ahead of time that they are either running out or going to need a higher level of care and how are we going to do that. So, it's not just like you either's line of third-party guarantee or not, you know, you represent Watermark?

CHRIS CARTER: Yes.

REP. HUGHES (135TH): Yeah, so, there one of the ones that certainly do, and have a robust continuing care community contract--lifetime contract with that, but they also go through a rigorous financial disclosure kind of review before accepting clients into that contract.

CHRIS CARTER: Yes, and as my colleague at Leading Age, Mag, indicated in the CCRC for life plan communities, generally speaking the entrance fee is in place so, that this bill is really, you know, doesn't pertain in those instances.

REP. ABERCROMBIE (83RD): And just for clarification, these contracts are yearly?

CHRIS CARTER: The residency agreements are yearly, or annual, yes.

REP. ABERCROMBIE (83RD): Okay, but the continuing care contract is lifetime?

CHRIS CARTER: Yes.

REP. ABERCROMBIE (83RD): So, that's what you're talking about the third-party guarantee for.

CHRIS CARTER: Right, right.
REP. ABERCROMBIE (83RD): Thank you. Thank you for that clarification. Any questions or comments? I love when she gives me the look, not yet at least. Thank you very much Chris nice seeing you.

CHRIS CARTER: Thank you very much, and nice to see you.

REP. ABERCROMBIE (83RD): Next up, and I so, apologize, I can't read your last name, is it A-h

SUNEETA AHUJA: Ahuja.

REP. ABERCROMBIE (83RD): Ahuja? Thank you. If you both want to come up together you can. Good afternoon.

SUNEETA AHUJA: Good afternoon. Thank you so, much Representative Abercrombie and Senator Moore and the rest of the committee members. I am here to support Senate Bill 820, AN ACT WAITING PRIOR MEDICAID AUTHORIZATION REQUIREMENTS FOR CERTAIN PHARMACOGENOMIC TESTING. The reason we are here to support this is because we are local genetic testing lab, and this test, as everyone the doctor, including yourself, agreed that it is very beneficial to the behavioral health community because it tells the doctors what to prescribe for the patient based on their genes. So, there is absolutely no doubt that the test is very necessary, but in our experience, we have requested prior authorization for so, many patients and 90 percent of them get denied for medical necessity.

We provide all the medical records and everything that they request, and still we get denied. So, we started--we work with Connecticut behavioral health, and we work with optimist health providers from those organizations have requested DSS for prior
authorizations, and they get denied. Sometimes in a very rare case they authorize the one patient, and then the doctor goes back and ask, okay you authorize this one and you didn't authorize where this patient was more severely ill, what is the basis, and they say, oh we should not have authorized for the first one.

So, in our experience 90 percent of the cases get denied, and they are all behavioral health and mental health and we would like to request the committee to look further into this, who is getting approvals, why are they getting approvals, because in our experience we are getting denied all the time, and then, as the doctor who testified said, that they are reimbursing according to the Medicaid schedule. They are reimbursing to the Medicaid schedule, and there are a number of genes that get tested, and they get reimbursed for each single one of them, so, the reimburse it is around $1200-$700. We are local lab, and if there's any provision to sign up a contract with the local lab, we are willing to do all those--like we have 17 genes and our panel, which covers about 350 drugs. We are willing to do all those 17 tests for $500 for the local community to benefit the mental health.

So, if you can look into how much they are reimbursing for each test, if they're reimbursing thousands of these tests, how much they are reimbursing. If the state can benefit from working with the local lab, we are here located in Oakdell, Connecticut, and we employ locally all the graduates from Yukon. So, if you can save money working with us, please look into it, and we are willing--initially we had a requested $900 dollars, but we have further refined our processes, and we can go
down to $500 dollars for these tests when HUSKY Medicaid--if they're paying for thousands of tests, they are paying $1200-$1700 dollars, but we are getting rejected, and I would really appreciate if the committee can tell us if we have to go through this approval process of getting prior authorization, and other people are getting approved, then tell us what we should do to get approval.

If there any--like we have--we follow all the medical necessary requirements. The patients have bipolar disorder, depression, anxiety, ADHD, schizophrenic, every one of them has been rejected, like he can testify to some of the patients, how much they have benefited from the test. We have done the test with them, but we have not got paid for them. So, sometimes it becomes very hard because these people, you are dealing with the human being, and you see them suffer so, much, and you see that your test can really benefit them, and we do the test for free for them, but we don't get paid by HUSKY.

REP. ABERCROMBIE (83RD): So, let's talk a little bit about process here. So, you're the lab, right?

SUNEETA AHUJA: We're the lab.

REP. ABERCROMBIE (83RD): So, you request the prior authorization from the DSS? I thought it would be the doctor that would request the prior authorization to have those procedures done.

SUNEETA AHUJA: So, the doctor requested, and they get denied. So, they tell us, this is required test, can you request it? Usually the labs requested, and for this type of lab testing, because they say the lab is doing the test so, you don't request--you're
not provider—you're not providing the service, the lab is providing the service, the lab requested, so, we requested when the doctor, but always a doctor authorizes the test.

REP. ABERCROMBIE (83RD): So, let's just follow up with that. So, I'm Dr. X, I requested prior authorization from DSS to have this procedure done, which is genetic testing, right?

SUNEETA AHUJA: Yes.

REP. ABERCROMBIE (83RD): DSS says no, this candidate doesn't qualify under our medical necessity rules, then you guys go back to DSS and reapply for it?

SUNEETA AHUJA: No, so, the doctor applies and they request authorization, and then they refuse the doctor, they come to us, here at the lab providing this test, provide us with these documents, so, we go back to the doctor, get all of the medical records, and provide all of the medical records to DSS, and they involve both of us, like the provider as well as the lab, and we provide all the documents to them, and then the provider, we get a letter, and the patient gets a letter rejecting.

REP. ABERCROMBIE (83RD): So, can you give us documentation on individuals that have been denied, prior authorization, because that would be really helpful to us to send over to DSS, and then the other thing I just want to comment on, you made a comment about if they doctors were using your lab would be able to give a discounted rate. Just for clarification, we have very, very strict contracting laws here in Connecticut, especially around human services, and we would not be at the liberty of giving just a contract to you, because you're giving
a discounted rate, it would have to go through the RFP process, so, I just want, for clarification that people don't start paying, you know, where we not using this one lab, you know, we're very strict. We do RFPs for everything because we don't want it to come back that were picking one provider over another.

So, if you--if DSS is doing an RFP to try and save money, and you guys come in at the lowest bid and they decide they want to go with ABB that's up to them, but we don't--in legislation or statute dictate, you know, how that works, and we don't want to go--personally I don't want go down that road. I don't believe that's part of our job to do that, just for clarification, but if you can send, you know, that--some of the individuals that have been denied, we would be more than happy to talk to DSS about it.

SUNEETA AHUJA: Okay, we can send you examples.


SUNEETA AHUJA: Thank you.

SENATOR MOORE (22ND): [Background conversation] so, we'll move on to Deb Polun.

DEB POLUN: Good afternoon members of the Human Services Committee. For the record, my name is Deb Polun and I'm here representing the community Health Center Association of Connecticut, and we work with the states Federally Qualified Health Center on helping them provide services to 400,000 people across the state every year. I'm here to speak in favor of Senate Bill 821, which is the E-consult
bill you heard about earlier when DSS was testifying. Simply put, E-consult our win, win, win for our state. What they do is that they increase access to specialty services for people who are on HUSKY.

As you may know people who are HUSKY enrollees to have difficulty accessing specialty services including cardiology, dermatology, rheumatology, and the like. They may have to wait months for an appointment. What we can do with E-consult, and this is really innovative, and we've been doing it, is we can have a primary care provider and information through a secure messaging portal to ask dissipating specialist who examines the information and the test that are said, and then sends the information back to the primary care provider who then connects back with the patient. We've done this as a pilot, I know Representative Abercrombie asked about potentially doing a private program pilot program for E-consults so, we've done that pilot. We did a pilot with five Health Centers over the course of six months. We were able to avoid, I think, about 1000 specialist visits, people who really didn't really need to see a specialist but were able to be treated by the primary care provider with specialist advice, and we were able to save the state $3 million dollars in six months I, and that's with only five Health Centers participating.

So, we can see that it helps improve access for people on HUSKY and it saves the state money. This really is a no-brainer in my opinion. So, the issue is in order to make E-consult work appropriately and correctly, they need to be reimbursed. This is a situation where using a primary care providers' time, and where using a secure messaging system that
cost money, so, the appropriate thing is to reimburse the primary care provider as well as reimbursing the specialist. Unfortunately, without reimbursement, providers are not going to be incented to utilize E-consult. They will, unfortunately, revert back to writing a note, a referral to a specialist, and saying, go see this person when you have the time, when you can get time off from work, and when the person can see you.

For us, this bill is an issue of equity. Health Centers see about 240,000 HUSKY enrollees every year. These 240,000 enrollees are now, because of DSS decision, unfortunately not able to access the E-consult care. They can access E-consults if they choose a primary care provider who is not a Health Center, but they cannot access E-consults if they go to a Federally Qualified Health Center for their primary care.

I'm a little bit confused about DSS's testimony, we have tried to work with DSS over the past couple of years to resolve this issue. They asked us to correct some data on our pilot. They told us what data they wanted, we got them the data. So, I'm a little confused about what their concerns are around this equitable reimbursement. We're not married to this language though, so, if there's a way that we can get this done using alternate language, we would be thrilled to do that. What we don't think would work is DSS's recommendation around each Health Center going forward and asking for rate increase. That has not typically worked for providers in the past, and we have no confidence that it will work this time.

So, where asking for your assistance. We would have preferred to do this without legislative
intervention, but we are at the point, after working for a couple of years and now demonstrating the data that we have, that we've been able to save the state money and improve patient engagement and satisfaction with the process, and provide access to specialty care, that were asking to help us get this done to benefit all HUSKY enrollees in our state, and there other people who will speak after me and can provide extra data for you. Thank you.

REP. ABERCROMBIE (83RD): Are there any questions?
Representative Case.

REP. CASE (63RD): Thank you Madam chair. So, when you talk about the E-consults, we're moving a lot towards that with a lot of different aspects in the state. The FQHCs they have federal controls over them, correct?

DEB POLUN: There are many, many different rules that the Health Centers have to meet--

REP. CASE (63RD): What do the federal control say about this?

DEB POLUN: Yeah, so, there are Health Centers across the country who are utilizing E-consults. Many states allow E-consults in their Medicaid program for Health Centers and not for Health Centers.

REP. CASE (63RD): So, when you say primary care, could that also be an APRN?

DEB POLUN: Yes, it could.

REP. CASE (63RD): So, with an E-consult if you APRN, would it be a different rate than talking with the primary care or is it just the primary care's office?
DEB POLUN: So, for Health Centers--thank you for asking a question, the way that Health Centers are paid for Medicaid medical visit is they get one bundled rate regardless of what care is provided and what services are provided during that visit. So, if somebody comes in for full wellness checkup and gets vaccine and does a little vision screening, a little hearing screening, they are going to get the medical rate, which averages about $150 dollars. If somebody comes in for a brief visit to see they have an ear infection, they get the same rate. So, is supposed to average out that the Health Centers are on average paid about what their cost is. We know that it's in the probably 78 percent range that the rate covers the past.

What we're asking for under E-consults, is simply the same treatment that DSS is willing to provide to private providers, and that is under their policy bulletin that was published in December, they're willing to pay a primary care provider, whether it's a physician or an APRN, about $17 to facilitate that exchange of information with the specialist and then back to the patient on top of the regular visit rate, and we're asking for that same consideration for Health Centers, that they get the regular visit rate and then if they do an E-consult, which again we know saves the state money and is preferable to providing access to specialty care, then they would get that same add-on rate that the private practitioners would get.

REP. CASE (63RD): So, just help me out for a second here, so, what are some of the types of things that an E-consult to consult over the--

DEB POLUN: Sure. There are tons of specialties that we use E-consults for including orthopedics,
dermatology, rheumatology, cardiology. One example might be, and I put this in my testimony, but so the record can reflect as well, let's say an otherwise healthy patient says to his or her primary care provider, you know, recently when I exercise, I have these heart palpitations, is it something I need to be concerned about. Under the traditional model the primary care provider might do an EKG in the office and then probably will write a referral to a cardiologist. Now the patient has to find the cardiologist, get an appointment three or four months out, maybe if they're lucky, take another day off of work, get to the cardiologist, right, so, there's all these extra barriers that are put up.

Under the E-consult model, the primary care provider to go to the secure messaging system, write a note, include the results of the EKG, that note goes securely to a participating cardiologist who within 48 hours and usually much sooner than that, usually within a few hours, will send a message back to the primary care provider. This patient does not need to be seen yet, try a course of XYZ, and have the patient come back to you in two weeks and see if they are doing any better. Then the primary care provider calls the patient and says, try this and come see me in two weeks. So, what we've done is, is we avoided the specialist visit. The primary care provider has received education now that that patient can carry forward to the next person that he or she sees, and the patient gets to try getting better right away instead of waiting the three or four months to get the appointment with the specialist.

REP. CASE (63RD): Thank you for-- you know, it's a way that were going towards, not only in the state
but across the country with all this E stuff. It's interesting because I had something with my son, you know, we want to E-consult with the physician because you can take pictures these days is something and send it, and our insurance here doesn't allow for that, so, we had to make an appointment and go visit, but I can see where the E-consults for the FQHCs, I mean, our FQHC in the northwest corner in Torrington covers 1100 square miles. It can't be the easiest thing to get an appointment and get into see somebody or get a ride because we don't have transportation out that way. So, will look at it very heavily. I'm sure there'll be a lot of discussion on this.

I appreciate you coming forward, and if I have other questions--I'm intrigued by it, but it's--there are some cases where somebody has to get in physically to see a doctor, but there are other cases where they don't. I mean, we put heart monitors in people's houses so, that they can--the doctor can call in daily, or if there's a trigger that goes on because the cost says that their rate is such a level, then they have to get to a physical person to see them. So, there so, much technology out there today, and we need to utilize it so, that not only in our budgetary problems we have, you know, we can grow on what the electronic stuff can do today, and you know make that happen, and make people feel comfortable and safe so, that they can get some medical treatment.

DEB POLUN: Yeah, I really appreciate you highlighting that Representative Case. I mean there is technology for the sake of technology, this is not that. This is truly technology applied to increase access to healthcare that people need, and
that's simply what it is, and this bill is just a way to provide that technology in an equitable fashion regardless of who your primary care provider is in the HUSKY Program. Thank you.

REP. CASE (63RD): Well, I thank you for coming forward. Thank you, Madam chair.

SENATOR MOORE (22ND): Representative Butler.

REP. BUTLER (72ND): Thank you Madam chair. Inc. you for your testimony. Certainly, any time we can extend the healthcare possibilities to people in this kind of fashion, I think that it really -- healthcare accessible to more people that otherwise might not, you know, have it. My question is around your pilot, you mention your five centers and you had a real life-saving estimate of a route $3 million. My question is whether any reimbursements associated with that, if so, how much and do you also have an estimate if there weren't any reimbursements of how much that would have cost during that pilot process?

DEB POLUN: Thank you for asking that, and with the committee's indulgence, would it be okay if I brought up my colleague who has more information about the pilot program?

[Unidentified speaker 03:10:53]

DEB POLUN: Come on up. Introduce yourself.

ROB RIOUX: Good afternoon. I'm Rob Rioux, Community Health Center Association of Connecticut. To your point, there was no reimbursement mechanism in place for the pilot period. It was a six-month pilot with five community Health Centers. During that time, we performed 1268 E-consults resulting in about 740 specialist visits avoided.
REP. BUTLER (72ND): Okay and can you kind of, you know, extrapolate how much that might have cost, estimate mind you because the rates may have buried a little bit here and there, it could you kind of estimate what the reimbursement process would've been over that period of time? What I'm trying to get to the net benefit. If you're talking about savings of $3 million yes if there were no reimbursement process, but if there were reimbursements process, how much would actually be a savings.

ROB RIOUX: Yeah, so, the total cost for a primary care physician to institute an E-consult is approximately $85, give or take a few. That includes the cost for workflow adjustments access to the technology and payment to the specialist at the market rate, all in about $85 per E-consult. The pilot that we instituted we had grant funding to pay for that six-month period, so, it's not a true assessment of what the cost would've been. We use the funds to access the technology and provide the number of E-consults that we had, but it's about on average between $80 and $85 in cost to do an E-consult.

DEB POLUN: And I'll just chime in and say that under the DSS reimbursement proposal, the reimbursement would be way less than $85. So, what we're asking for is just equitable treatment, and I think that some of the folks after us have additional data on the cost and the savings as well, and just as a reminder, this was only five community Health Centers, there are 17 community Health Centers, and this did not include any private providers either.
REP. BUTLER (72ND): Yes because—well if there are other people that could speak to that, that would be helpful because if we're talking about rolling this out on the whole community, or in the larger community, it really would help to know, you know, the dollars and cents. I certainly applaud your efforts and what you're providing, I just would like to know the dollars associated with it, I do anyways, so. Thank you for your testimony.

REP. HUGHES (135TH): Thank you Chairman Moore. I appreciate your testimony, and I just want to know from the pilot what the position feedback, the primary care physician feedback? I mean, you sort of anecdotally said it, but also if there was any data around patient outcomes?

ROB RIOUX: The provided feedback was all very positive. The opportunity for the providers to, certainly from the chief medical officer perspective, to be able to use the feedback they received an E-consult as a learning opportunity for their staff. They--many of them did grand rounds around some of the feedback on particular issues that were presented, and then the long going educational aspect of an E-consult is as providers get accustomed to seeing conditions, having feedback from a specialist on how to treat the condition, and then the next time someone else enters the room with that same issue, they are little bit more informed, and that just progresses over time.

The question around patient outcomes, so, we did have a third-party group look at the data from our pilot, an independent third-party, matrix public health solutions was the entity that looked at our data, and they found correlation between the E-consult practice and reduction in certain disease
states mostly around diabetes and other metabolic issues, and I can for that data as well if you'd like.

REP. HUGHES (135TH): Yeah, those are the long-term cost that we're not aware of saving because, you know, like-- so, that's helpful in terms of costing out the cost efficiency--

ROB RIOUX: And there are many downstream costs that we didn't capture, pacifically I can think of 740 and some odd patients who didn't have to get on a bus or train to get to a specialist, who may not be, you know, in their true graphic proximity, or utilize the state funded transportation system for medical transportation, those costs were avoided as well.

REP. HUGHES (135TH): Yeah, that's an equity and access issue that we really don't look enough that, so, I appreciate that. Thank you.

REP. MASTROFRANCESCO (80TH): Thank you Madam chair, and thank you for your testimony, very educational, very interesting topic. We've been given to the age of e-commerce and everything that were doing on the Internet, and it's also scary in a way. I'm just curious, on the pilot that you did, where there certain questions? Is that basically how it worked? They would email or talk to somebody live, is that basically how it works? Like a live chat when we say and asking medical questions for the existing patient, is that basically how it works?

DEB POLUN: So, for the e-consult model it's actually called the store and forward method, and what that means is you put all the information into an email, essentially an email portal and then it goes to the provider who looks at it on his or her
own time within a couple of hours usually. So, it's not a live chat, that would be a different subcategory of telehealth.

REP. MASTROFRANCESCO (80TH): So, the physician would look at the symptoms or the information that the patient is sending over and determining what they should do or what the outcome could possibly be?

ROB RIOUX: So, the process would be for the primary care provider in the room with the patient uncovers an issue that they may not have a lot of comfort around for understanding of, and they would like the opinions or guidance of a specialist. They'll create a record, the type of some information and send it to that specialist over a secure mechanism, the technology provides the security of that, and then the specialist will respond within 24 hours. In our pilot the response time was four hours. So, the primary care provider within get that feedback back from the specialist and then they would then take that information, make a determination as to whether or not to see the patient again, or just medication, whatever the guidance was from that specialist and that's how that process works.

REP. MASTROFRANCESCO (80TH): So, this is just basically for specialists, the physician has already seen the patient they come to an agreement, you need a specialist, that's when this will come into play?

ROB RIOUX: It will come into play as an alternative to sending that patient to a specialist.

REP. MASTROFRANCESCO (80TH): Correct.

ROB RIOUX: So, if I'm Doctor Smith and I see my patient, Mrs. Jones, and I have concerns over her--
maybe there's an issue with her heart, instead of sending her to a cardiologist I might pose my question to a specialist, get the feedback, and the feedback might be as simple as adjusting medication or some other treatment.

REP. MASTROFRANCESCO (80TH): Okay, so, it's not a substitute for the patient just going in to visit with the doctor for their initial visit, or maybe they're not feeling well and there have some symptoms, it's not a replacement for that?

ROB RIOUX: No, this is purely provider-to-provider correspondence and guidance so, that patient can be treated in a more effective manner.

REP. MASTROFRANCESCO (80TH): Normally when someone goes to see a specialist there's a provider and a provider, is there a cost involved there that the insurance companies are billed for the provider getting information for the patient and talking to another physician?

DEB POLUN: No but how that normally works is, it is just like a handoff, like here, here's a patient for you. In this case we actually achieve another old which is providers are speaking with each other, so, it's more integrated care and that is certainly one of the goals of our HUSKY Program in any healthcare system really, is that the primary care provider and specialists are talking together about the same patient, and working together to find a solution, on top of the initial visit.

REP. MASTROFRANCESCO (80TH): Do they not do that if--

DEB POLUN: Not necessarily, no.
REP. MASTROFRANCESCO (80TH): They just kind of hand it off.

DEB POLUN: Yep.

REP. MASTROFRANCESCO (80TH): And the other physician wouldn't ask--

DEB POLUN: Unless they're in the same network, you know, it's possible if they're in the same network of care that they may speak with each other, and that does happen more often in Health Centers because they are under the same roof, but typically, no. I mean, if you get a referral to a specialist provider, that person may or may not ever communicate back with your primary care provider.

REP. MASTROFRANCESCO (80TH): And-- so, in a normal situation they handoff and there's no fee, right?

ROB RIOUX: Right.

REP. MASTROFRANCESCO (80TH): The fee would come into play now because two physicians are communicating with each other?

DEB POLUN: Through a secure system.

REP. MASTROFRANCESCO (80TH): Through a secure system, but that's basically what--

DEB POLUN: And then the primary care provider, and this is key, gets back in touch with the patient to say this is what you need to do, so, the patient has that ongoing relationship with his or her primary care provider and that's the person who is communicating information back.

REP. MASTROFRANCESCO (80TH): And is the patient, person who is billing the insurance company, is it coming out of the patient's insurance plan?
DEB POLUN: Well in this case, the patient is on HUSKY, so, the providers are billing HUSKY?

REP. MASTROFRANCESCO (80TH): And with this be available for private insurance as well?

DEB POLUN: It is available, and in fact many commercial plans do use E-consults already.

REP. MASTROFRANCESCO (80TH): They do, and is there big cost difference between what they charge, whether you're on HUSKY or on private insurance?

DEB POLUN: I don't think so. I don't know actually. The commercial insurance rates are really publicly available as far as what they're paying their providers, so.

REP. MASTROFRANCESCO (80TH): The only reason why ask is because I often hear that HUSKY, so, they'll be reimbursed as much for Medicaid, but they charge more for private insurance to try to make up the difference, you know what I mean, so, if a service is a service, why is one charging more and one charging less that's--I'm just curious on that.

DEB POLUN: I think that's a different public hearing [laughter].

REP. MASTROFRANCESCO (80TH): That's why I was wondering, what is the cost for your E-consult for a private insurance company as opposed to someone being on Medicaid.

ROB RIOUX: I can tell you that many of the insurance companies or managed-care companies who have a stake in the outcomes that are taking on risk, are implementing E-consult as a way to reduce costs overall. They understand that there's a
financial benefit to doing it, and so, that's why they're doing it.

DEB POLUN: If I could just add, there's another benefit that we actually have a mention yet, which is we know we have a shortage of specialists in the HUSKY program, one of the things that this does is that it leaves those specialist spots available for people who really do need a specialist so, you're taking people way, you know--you're not restricting access to care, your providing care in a different way to people who might not actually need to see the specialists in his or her office, and that leaves open those appointment slots for people who truly need to see the specialist, so, it improves access to everybody.

REP. MASTROFRANCESCO (80TH): Thank you. I appreciate it. It will be interesting to hear the cost factors that Representative Butler was mentioning. I'm interested to hear about it.

DEB POLUN: For one thing, we know its way less than it will cost to send that patient to a specialist, so, I can say that. At least, you know, probably 50 percent of the cost or less.

ROB RIOUX: Actually, we do know those numbers. So, with the supported DSS we were able to look at actual Connecticut claims data and discover that for a patient who accesses specialty care service for the first time it was about $625 of downstream costs over that this month. For that patient versus the cost of a primary care visit, probably averaging about $150. You can see the difference in that.

REP. MASTROFRANCESCO (80TH): Thank you very much. I appreciate it. Thank you, Madam chair.
SENATOR MOORE (22ND): So, have you seen a change in the response time to care because of this?

ROB RIOUX: Well, naturally there would be for that patient who comes in and has--is suitable for an E-consult. They have a condition that requires that then the responses is within 24 hours from the specialist, and the primary care provider can get back to that patient a lot sooner. The average wait time for a normal face-to-face visit for Medicaid patient exceeds several months and, in some cases, up to nine months to a year depending on a specialty. So, we definitely think that E-consult has a direct impact on access to care and the timeliness of it.

SENATOR MOORE (22ND): Which should be the most important. So, the pilot was done from what time to what time, was the time span on that?


SENATOR MOORE (22ND): Did you say five or six?

ROB RIOUX: Five Health Centers.

SENATOR MOORE (22ND): Five Health Centers.

ROB RIOUX: Right.

SENATOR MOORE (22ND): And so, you'd disseminated the information of the pilot to who?

ROB RIOUX: We've shared that internally amongst our membership, we also shared it with key stakeholders with the state DSS, OPM--

SENATOR MOORE (22ND): And do we have it?

ROB RIOUX: I'm sorry?
SENATOR MOORE (22ND): Do we have it, does this committee have it?

DEB POLUN: We'll send it over.

SENATOR MOORE (22ND): Thank you, that'd be very helpful. Representative Abercrombie if you--

REP. ABERCROMBIE (83RD): Yes, thank you very much. So, let's stroll down a little bit as to what we're talking about and this bill here. So, my understanding is, there was a pilot done, the FQHC got a fee for the E-consult, and the specialist also got a fee, right?

DEB POLUN: So, there were two actually, and correct me if I'm wrong about this, I may have the details a little off, but there were two instances of e-consults being piloted per se. One is that we had a temporary approval from CMS to have reimbursement through HUSKY for E-consults, and under that model the Health Centers received, I think, $85 dollars, and they were to share that money with the specialist who participated in the E-consult, that program ended through DSS. The second pilot was privately funded through a grant that our office had, and under that model we offered the Health Centers--how much do we offer them per E-consult?

ROB RIOUX: Well we actually--we pay for the entire system, and so, the Health Centers implemented E-consult using our technology at no cost to them other than their own cost on workflow and so, forth, but we gave them access to the specialist and to the technology.

REP. ABERCROMBIE (83RD): So, are you here today to ask--so, I'm a little confused here because if you look at DSS's testimony, that's not what they're
saying, okay. So, what you're asking for today is to have E-consults brought back with two payment systems, one to you guys and one to the specialist, that's what you're asking for?

DEB POLUN: Correct.

REP. ABERCROMBIE (83RD): Okay.

DEB POLUN: But DSS is willing to offer that to physicians and other providers in private practice, we are simply explaining don't exclude the others.

REP. ABERCROMBIE (83RD): So, the way I read this though is that they are not implementing it through the private from the testimony because CMS--let me finish--CMS is saying, if you're going to do this program you got to do it across the board for everybody. DSS is saying we don't have the dollars to do this at this point that's why we're not gonna do it with anybody. It's not that there picking winners and losers, my understanding from what I'm reading in the testimony, is that they don't have the funds to do it across the board, and what you're saying is, if I understand, is that you believe that there are savings that can be done, so you think we should be able to implement this across the board to everyone?

DEB POLUN: Yes, and I will say their testimony also confused me because it didn't appear to be consistent with the policy bulletin that came out from DSS in December 2018, that was only two months ago. DSS put out a policy bulletin indicating that they would be paying specialist $34 and private primary care physicians $17 per E-consult, and that policy bulletin specifically says, essentially, other than Federally Qualified Health Centers. So, they willing to do it for the providers who are in
private practice, we don't understand why they wouldn't be willing to do it for us as well.

REP. ABERCROMBIE (83RD): Can you send us that bulletin? Send it to my office--

DEB POLUN: It's actually linked to my testimony.

REP. ABERCROMBIE (83RD): It is, okay. We'll take a look at that. Thank you, Madam chair.

SENATOR MOORE (22ND): Do you have any other questions? You also have a testimony on another bill, do you want to do it while you're there?

DEB POLUN: I'm willing to wait to allow the other folks who want to testify on E-consult to do that in a row, if that's convenient for the committee.

SENATOR MOORE (22ND): Okay.

DEB POLUN: I don't mind waiting around.

REP. ABERCROMBIE (83RD): You just love us, we know how it is.

DEB POLUN: I do. Thank you very much.

REP. ABERCROMBIE (83RD): Thank you very much. I will call you if we have follow-up questions on this. Suzanne you're up next, I see. Actually, you're the only one--no, he's not on here. You're Rich? I'm sorry, I thought Rich was--I'm sorry, I misunderstood my thought, my fault. Rich you're up next I apologize. I thought the gentleman was--because I came in late. I apologize.

RICHARD ALBRECHT: Good afternoon. How is that? Better. Chairpersons Abercrombie and Moore, Cinder Logan, Representative Case, and members of the Human Services Committee, thank you for this opportunity to provide testimony today in support of Senate Bill
821. My name is Richard Albrecht. I have worked as an executive in primary care organizations here in Connecticut since 2013. I presently serve as the telehealth network director for Community Health Network of Connecticut Holdings Inc., an association of seven Federally Qualified Health Centers in the state. Collectively, these centers serve about 190,000 patients, 80 percent of which are either a Medicaid or are uninsured.

I'm here to explain the importance of including FQHCs in any Medicaid e-consult reimbursement policy. Over the past two years a member of my centers have been evaluating a system to improve access to specialty care with the process called e-consults. We've already discussed what e-cons are, but essentially it is involving having a PCP request a consult from a specialist by describing the patient condition and providing relevant clinic information to that specialist using a secure Internet platform. The specialist typically returns a rendition to the PCP within 48 hours, often much sooner. So, the results of this evaluation within my centers, part of which includes the pilot that you heard testimony of just a few minutes ago, have been notable. Over 1000 unnecessary specialist visits have been eliminated with PCPs being able to administer the recommendations of the specialist without having to refer the patient's for the specialist care.

They are getting the specialist information and administering that by the PCP, typically at a lower cost. The centers that are still involved in this evaluation, and there's a phase two of this pilot ongoing now, report that approximately 80 percent of their e-consult request now eliminate the need for
that patient to see a specialist. This improves the overall efficiency of the state's health system by reducing the number of unnecessary specialists appointments and enables primary care to be more fully utilized to its potential.

The real cost savings opportunity of this program was presented to DSS last year when at their request we analyzed actual Connecticut Medicaid specialty care clinics to determine the financial impact of a widespread adoption of e-consults for eight of the most commonly used medical specialties.

I led the work on that analysis, and we found that with reasonable reimbursement to PCPs and specialist for their time and effort associated with e-consults, the state could realize a net annual savings of over $6 million. Simultaneously, access to the expertise of medical specialists would be dramatically improved for thousands of Medicaid patients. Simply stated, with good broad adoption, e-consults result in significant cost savings and far better access to care for those who most need it. Today, Connecticut Health Center serve almost 400,000 state residents and 30 percent of the Medicaid population. Failure to include FQHCs in a Medicaid e-consult reimbursement policy, would effectively exclude that 30 percent of the Medicaid population from the benefits of e-consults, and would significantly reduce the opportunity to achieve any material cost savings for the state.

So, in closing, I urge you to consider that a policy that fairly and equitably reimburses specialist and all PCPs, including those in Health Centers, is critical in realizing the proven value of e-consults. Thank you.
REP. ABERCROMBIE (83RD): Thank you. So, quick question for you, so, in DSS's testimony, right, they talked about the bundled rate, which FQHCs get, which they believe includes this service. Was a bundled rate in place when you guys were getting a separate fee for this service?

RICHARD ALBRECHT: I believe the bundle rate has always been in place, bundle rate methodology for payment has always been in place.

REP. ABERCROMBIE (83RD): So, they had--so, back in 15 they were giving you a separate rate to do this service?

RICHARD ALBRECHT: That is correct.

REP. ABERCROMBIE (83RD): Thank you. Any questions? Seeing none. Thank you for your testimony. I think we have more questions than answers at this point on this one. DSS is going to have some questions, or maybe Suzanne can, you know, but that button on, talk us through this, just make out that this is MAPOC, okay.

SUZANNE LAGARDE: I sure will. So, Chairman Moore and Abercrombie, Senator Logan, Representative Case and members of the Human Services Committee, obviously I'm here speaking in favor of Senate Bill 821. I've practiced in Connecticut for 30 years. For the past six years I've been the CEO of Fairhaven Community Health Care. Obtaining specialty care for our patient population is extremely challenging. I know that I'm telling you stuff that you already know. It's not unusual for it to take three to six months or even longer to get a consult, but there's an easy fix to this problem, and it will save Connecticut millions of dollars, and that solution is e-consult. Now I've been pushing this for five
years and I'm pulling my hair out because I just--
I'm so frustrated that we have not been able to do
this.

Let me share with you a few facts, large Medicaid
systems such as those in LA County, Cook County, New
York City, have been doing this for years, and they
are improving access, and they are saving money, why
can't Connecticut do it?

Two I want to go to little bit more—and I'm sorry
that gentleman is not here because there's a little
confusion about the cost of it, if you don't spend a
little bit of money, you're not gonna save a lot of
money, but I'm telling you if you do spend a little
bit of money the potential for savings is huge, and
we say this based on DSS's own data.

So, what Rich referred to is very graciously--Doctor
Zavoski afforded us six months of DSS claims data,
for six months in 2017, for eight of the most common
specialties, cardiology, dermatology, orthopedics.
We took the data—we know that not all consults—if
you're having crushing chest pain, we don't want an
e-consult, we want you to see a doctor, right. We
know roughly how many of each type of referral can
be successfully, safely, and efficiently translated
into an e-consult.

For instance, the number for cardiology, depending
on the source, between 25 percent and 30 percent.
Anyway, we took that data and applied it to
Connecticut claims data, and we looked at
conservative cost estimates. So, obviously, I'll
give you an example, cardiology, there were 7200 and
something visits to specialist, well downstream are
there any other costs? Will most of them will have a
follow-up visit, so, there was any claim that came
under the same TIN, the same tax ID number, as a specialist was captured as cost. So, if that cardiologist ordered a cardiac ultrasound and did it in his own office, then it would've been captured under his TIN, however, if you sent them for labs request or if they sent them him for an ultrasound to the hospital under a different tax ID number, we didn't even capture those costs.

So, our costs are significantly understated, despite that applying conservative numbers in terms of what percentage of face-to-face-consults can be translated into e-consults, the savings, for just eight specialties, and Connecticut has many more than eight specialties, the savings over one year paying $85 a consult, yes this is currently proposing to pay the private sector $51 a consult, $34 to the specialist, $17 to the non-FQHC provider, Connecticut's own data showed a conservative one year savings of $6 million, and that's taking into account paying and $85 fee because most specialist one about $50, and there is a cost in implementing this for a provider who is busy. We have to provide a workflow as Rob referred to, somebody who can gather all the data and get the EKG, get the ultrasound, uploaded to a secure system, you know make sure that if the specialist has a question, that it's answered. To make it all work smoothly, there is as cost.

I will just address this whole issue of the bundled rate, that bundle rate was established in 1999 by an act of Congress. It was based on cost from 2000 and 2001. Senators and representatives, e-consults were not even a twinkle in anyone's eye 1999 when these rates were set, and they argue that our costs have gone up, yes they go up every year by the MEI, and I
can tell you that from year-to-year that's anywhere from like 80 cents, a good year, maybe your close to $2 dollars.

So, even though every we give DSS our cost reports, which repeatedly show that this rate does not meet our cost, somehow or another everything keeps-- everything is bundled into it. So, if I sound frustrated, and I just missed my whole talk hear, it because I am. As a physician who has dedicated her life to providing better care to the underserved, we are missing an amazing opportunity, and we are doing it at a financial impact to the state, which can precious well not sustain that. I just don't get it. It just doesn't compute to me, and I'll shut up. Thank you [laughter].

REP. ABERCROMBIE (83RD): That's why we love when you come to testify. You are so, passionate about what you believe in what you believe is true. So, just one quick question, so, there's no CMS changes in the rules FQHCs that prohibits us from giving you a separate rate for this service under what the definition of bundle rate is?

SUZANNE LAGARDE: My understanding is that it would be an additional payment, and I mean I will look to my colleague, but I'm not aware of any rules that would prevent that, and in that in the pilot that Deb alluded to, we were given--we participated and actually the fee was not $85, it was $50, but we made it work, and we were able to pay the-consultant somewhere between $40 and $50, and we tried to make do with the rest, but this is sort of being penny-wise and pound-foolish. I mean if you don't invest-- I mean we have the spreadsheet, and I've attached a couple of them to my testimony, and I would love to go over them with you. When we first approached DSS
about this and we had data from other states, they thought it was interesting, but they wanted to Connecticut data. So, then we gave them Connecticut data, and it's the same thing and I just don't understand.

This occurs in Medicaid systems throughout the country successfully, and I just am flummoxed as to why we can't implement it, do it for the betterment of our patients and for the betterment of the state in terms of finances.

REP. ABERCROMBIE (83RD): So, obviously you haven't been able to have a conversation, or DSS has not been responsive to your questions about this as to why guys are being excluded from this?

SUZANNE LAGARDE: So, I'll be very honest it came as a surprise because for several months a small group of us, including Rob Rioux and Rich Albrecht, and myself and Doctor Anderson from CHC were meeting regularly with DSS and with their finance guy, and we thought we had reached an understanding of why it should be this way, and then the bulletin that Deb referred to came out and certainly totally caught me by surprise, and when I asked the question why it was, you know, it's in your rate, and it's like--it just doesn't make any sense to me because is read out--I mean our rate doesn't cover our cost. There are added costs of this. If there is not widespread adoption of e-consult, it will fail.

If you don't have all the FQHCs doing it, it will fail. The way it works is you have to have a significant volume and that's when you start to recognize the significant savings and you start to see the declotting of the bottleneck, because one of the things that I don't think was mentioned, yes
there's 24 hour 48 hour access for the patient in question, but 25 percent of cardiology consult are no longer in that queue, which you are creating that bottleneck that leads to three to six month waits for the for that person with the crushing chest pain who need to see the cardiology quickly.

So, there are so many impacts, and this is just--there are very few things that I feel so, strongly clearly makes sense. I mean there are no negatives that I see to this other than possibly the regulatory bureaucracy that's making it difficult to get from A to B. I mean again, and I want to go back, we are as a state and as a country moving to value-based payments. This is--I mean they talked to me about, well you know, you got to keep people out of the ER, that's the biggie, you have to keep people out of the ER. You know how hard it is to keep people out of the ER, it's really hard. Do you know how high can make much more savings is if I can do a widespread program of the e-consults. I can have tremendous savings from that. I could try to save some money by not letting people go to the ER, but that's hard and the mountain to be much smaller.

REP. ABERCROMBIE (83RD): Yeah, you're absolutely right there. Senator Logan.

SENATOR LOGAN (17TH): Sure. Thank you doctor. So, you covered very accurately and eloquently the savings, which is an area that I'm very, very interested in, and I do understand that sometimes you need to spend a little to save a lot, particularly if it could be quantified. I am a volunteer board member at Griffin Hospital, a small hospital out in Derby, and one of the things we've been focusing on for a number of years is patient centered care. So, I like for you to discuss the
impact of E-consult from the perspective of the patient, you know, what do patients think of E-consults, and would they prefer to see a live person?

SUZANNE LAGARDE: So, first--thank you. Patients are told that an E-consult is going to happen, so, this doesn't happen without the patient's awareness that it's taking place. Our experience is that overwhelmingly they are delighted. They know the challenges of waiting for an appointment. They know the challenges of taking two buses and waiting in the hospital's primary care center or their center to be seen.

Our experience, which I will be very honest, because of the financial issues is limited, we've done it, we did it through the first round of what DSS did, and today I'm paying out of little discretionary dollars I have for a select number, mainly dermatology, which is impossible to get. So, right now we are doing dermatology patients at Fairhaven on both our Medicaid and our uninsured patients, and I'm paying the specialists and agree upon $40 per you consult the out of, I don't know where, thin air, but otherwise these patients would never see the dermatologist, and so, our experience is limited, but with the experience we have shown that patients love it.

SENATOR LOGAN (17TH): So, you would-- there's clearly a benefit to the patient experience with the E-consults?

SUZANNE LAGARDE: That is true, and I mean if you read the literature again, not firsthand, the literature supports that as well.

SENATOR LOGAN (17TH): Thank you Madam.
REP. ABERCROMBIE (83RD): Further questions or comments? Thank you.

SUZANNE LAGARDE: Thank you very much.

REP. ABERCROMBIE (83RD): We'll figure this out.

SUZANNE LAGARDE: And I just-- and I do want to say, I wasn't here for Deputy Commissioner Brennan's comments, but I read them, and I'm very confused because I don't understand--what I'm reading does not comport with my experience, and so,--we are not necessarily saying we have to have a bundle fee to the (epic UHC's who was then distributed to the specialists, were saying that we just need to be reimbursed in a way that allows us to do this.


DEB POLUN: Thank you. Okay that's better, and I this--thank you for the encore presentation. For the record, my name is Deb Polin I'm with the Community Health Center Association of Connecticut, and now I want to talk a little bit about house Bill 7122 regarding mobile dental clinics, and you have a written testimony so, I'll quickly summarize.

This is yet another access issue that we think it really be beneficial for people across the state but particularly in rural areas. So, you heard DSS say accurately that about 99 percent of HUSKY enrollees have access to a dentist within 15 minutes of their home, this is great, and in my testimony you will see the map that the American Dental Association put together that was presented at MAPOC last week or two weeks ago that shows what they call, the mustard stain, over the state, and it covers most of the state. Where are the areas that are not covered?
It's Northwest Connecticut, a little bit on Eastern Connecticut, the rule areas of the state. So, having to fix the location is great for people who can get there. The value of a mobile dental van or portable equipment, either one, is that it helps to provide dental care where people are instead of making people get to the dentist.

So, who does this help? It helps people with transportation barriers, again, the rule areas of the state have no public transportation, and the rest of the state, although there is public transportation, we know that that does serve as a barrier even if you use the nonemergency medical transportation, this can be a barrier for some people. Providing carrot schools allows children to receive care at school and reduces the amount of time they miss in the classroom, so, this is a great opportunity for kids to get the dental care that they need in a setting that can speak it for them and their families, and it also expands access to areas of the state that might not be able to support a full-time dental office.

So, we really like mobile and. A lot of Health Centers in addition to their next in a location also have mobile than so, that they can go out and reach people where they are.

One of the keys to providing care through a mobile service is to make sure that whoever is providing that care connected with the local dental organization, in our case it's the Federally Qualified Health Centers to provide the care out in the field and then also have the fixed location available. The reason this is so, (is so, that the patient can Kate continuous care. So, if they are in the field and they have a screening for dental
cleaning and there's further work identified that is more properly done and a brick-and-mortar location, they can go to that location and have a seamless transition because the records are already there and it's the same organization and so, forth.

So, what the bill does is a sort of seeks to define what we mean by a local dental organization. We think 50 miles as proposed in the bill is probably too far. 50 miles is the distance between Bridgeport Hartford, so, if you can think about it dental organization from Bridgeport coming up to heart for, providing care in a van and then going back to Bridgeport, and think that patient you need to come to Bridgeport and get this taken care of, how many dentist office that patient would pass by along the way to get that continuous care. So, 56 seems like too much, but 15 or 20 seems like too little in certain areas of the state.

So, what we're proposing, and I've attached some alternate language to my testimony, is a 30-mile radius with the exemption for rural areas of the state. So, the role counties as defined by the Fed are Edgefield, New London, in Windham, and so, to give them a 50-mile radius and keep the rest of the state on a 30-mile radius. We fill it is a good compromise to ensuring that people have access to care both in brick-and-mortar locations and through mobile vans, whether it's for school or community center and so, forth. So, that's my testimony. Thank you.

REP. ABERCROMBIE (83RD): Thank you. We always appreciate your testimony. Senator Moore.

SENATOR MOORE (22ND): So, you know I'm used to the mobile mammography and use it all the time, and it
saves a lot of time for people to get to appointments, so, it's a way of convenience. Could you just—but I've also had to always have a doctor to anchor that person, a medical home, right. So, I can't send somebody to get on a mobile unit and if something comes back with an abnormality and I have no place to send that person, they have to be linked to a medical home. Is that the same thing with the dental?

DEB POLUN: Yes, absolutely. Particularly for the dental vans and portable equipment that are operated by the Federally Qualified Health Centers, those patients records are now part of the federally quality Federally Qualified Health Centers electronic health records. So, whoever's being seen, whether it's a school, a community center, or some other place out in the community, those records are now connected to that dental home which is the Federally Qualified Health Center.

SENATOR MOORE (22ND): Thank you, because I think I saw on the testimony that that was a concern that they didn't have a medical home, but I was thinking you are using the same thought process of having a medical home for anybody who is treated on the medical than, right. And so, that increases opportunity, trying battle for that parent who might not be in a place like Bridgeport where you can get around to get to a Health Center, don't we have three?

DEB POLUN: Two with multiple locations.

SENATOR MOORE (22ND): Multiple, so, Bridgeport your play of access to get to one, but in the rule places where Senator Austin was saying, it might be a
little bit more difficult to get them to them, correct?

DEB POLUN: Exactly, yes, and we do have a few Health Centers and rural areas of the states that utilize mobile than, and are able to get to so, many locations that wouldn't otherwise have this access to convenient dental care. One just told us last week there hoping to expand to Stafford screens. So, this is a Health Center that has brick-and-mortar sites in East Hartford, Manchester, and Vernon, it's first choice Health Centers, and they provide mobile dental care and 60 locations from Bloomfield to Hartford up through [unintelligible 03:53:40] and now they want to go up to Stafford Springs. So, the van is licensed to the East Hartford location. So, they would be able to get paid for the Stafford Springs work. If they move the license to Vernon, which would allow them to get paid the services provided in Stafford Springs, then they wouldn't be able to get paid for the services that there providing a Bloomfield. So, there thinking of moving to--moving the license to Manchester and hoping that that gets all of their sites, but this is the kind of machination that they need to do because they're trying to increase access to dental care in places that don't have easy access.

SENATOR MOORE (22ND): So, I know I have a young lady in my care a while ago who was on Medicaid, and it was very difficult to find a private pay, someone who--a regular physician to take her, and were wondering why she was misbehaving in class, come to find out she had an abscess, but we didn't have access to her Medicaid and we tried to take her to walk-ins, we tried to take her to doctors, and nobody would take her, and they actually told me if
I tried to pay out-of-pocket was against the law, and I didn't know that, I was just trying to help the child, so, I think this would be very helpful that it would increase access for people who don't have private health insurance and have a problem traveling. Thank you I appreciate it.

DEB POLUN: Please send that patient over either Optimus or Southwest Community Health Centers.

SENATOR MOORE (22ND): That's where she is now.

DEB POLUN: Great.

REP. ABERCROMBIE (83RD): So, are there any further questions? So, is there any reason why we actually have to have a distance in statute for these mobile dental vehicles?

DEB POLUN: I think you'd have to ask DSS that. I know that the goal is to ensure that we don't have out of seat providers coming in, fly-by-night, doing a dental clinic in the van, and then leaving, and leaving those patients who need the continuous care high and dry because now they don't have a dental home to go to receive that care. So, I left that, we support that goal as well. We want all of our—everybody in the Connecticut, not just HUSKY enrollees, but everyone should have a dental home where they go to receive oral healthcare on a regular basis twice a year, and then whatever follow-up care is needed. So, I think that's the original intent behind having a radius bill into the statute or into regulation, but in this case, we just want to make sure that we don't treat the whole state the same because we know that there are areas of the state that have more difficulty with access to oral healthcare than other parts of the state do.
REP. ABERCROMBIE (83RD): Sometimes we were both thinking the same thing [laughter] and it's like you can get it out of their mouth first, and it might not be your question. It my question would be, so, I think currently it's only be FQHC that do the mobile dance right now. Do we have any private programs in Connecticut that do this service?

DEB POLUN: I think several years ago we did have some organizations that were coming into the state once or twice a year and providing this mobile dental vans. I don't think that we've had that in the last couple of years.

REP. ABERCROMBIE (83RD): Okay, but--Suzanne might want to come up. Come on up Suzanne because I'm wondering if there's a way that we write the language, right, that can kind of prohibit, you know, somebody from the outside coming in just to do that service when we already have a system in place, and if that's--they have the radius, you know, I think that's kind of an easy fix, but my concern is that we always have to be careful with language because I want to make sure that if there's of that are way of doing the services that were not prohibiting it by the language we use. You guys know what I'm trying to get at, but Suzanne go ahead, just introduce yourself again in case--

SUZANNE LAGARDE: I'm sorry, Sue Lagarde from Fairhaven community health care. There's a distinction between mobile and portable, and I think it's very important that you note that. So, mobile is the van, portable you can literally Carlee. I mean it's big, but you can carry it and move it from school to school, which is where a lot of these programs take place is in the school-based Health Centers.
I think there's more of a risk particularly with the portable equipment because it's much less expensive, it's less of a commitment of the entity to go into it to engage in that and then go further than is reasonable into an area where there might be closer resources, but you just want to be careful because the language of this bill clearly defined this to be both mobile and portable, and those are two very distinct entities. I think it would be, I don't think—I don't fear sent outside entity coming in with their fan to provide dental care. I do think there is a risk with portable equipment that entities within the state can, if you will, over extend their reach and end up in areas where there are sites 5 miles away and in fact, they are 30 miles away or 50 miles away.

REP. ABERCROMBIE (83RD): Do you get an added—do you get to travel amount? So, it's a fixed rate, so, if you guys are willing to go, right, they, like you said, Stafford screens to provide a service that they are lacking in that area, you not getting any more money, you're not getting gas reimbursement, you're not getting any kind of travel reimbursement, it's a set rate. So, you're just providing a service in an area that's lacking that at this point.

SUZANNE LAGARDE: Yeah, it's challenging to make intimate—I'm sorry, is this on, okay. It's challenging to make intimate with the mobile then. So, it's really a commitment to providing the services that is the driving force.

DEB POLUN: Yeah and we have Health Centers like you CFS down in South Eastern Connecticut. They bring their portable equipment about 28 schools, each of those schools is a licensed site to receive care, so, those facilities are overseen by the Department
of Public Health, that's, you know, a very safe way to receive care, but also again that's the area of the state if you look at the map, and I included in my testimony, that's the area of the state that doesn't have good access to oral healthcare.

REP. ABERCROMBIE (83RD): Okay. Representative Hughes.

REP. HUGHES (135TH): Thank you Chairman. I'm not sure that this would apply, so, I just want to clarify. I have a lot of clients that are in assisted living setting or continuing care settings that, as you know, Medicare does not pay for any kind of oral care, and it may be difficult for them in wheelchairs or whatever to get out to a provider, even if it is within 50 miles, so, I just want to be clear that this doesn't at all impact those patients or it could like--

DEB POLUN: It could.

REP. HUGHES (135TH): It could bring them to a community, and assisted living community or continuing care community.

DED POLUN: It could, and back some of the mobile vans, I'm not sure that it's for dental, but I know him of the Health Centers are using the mobile vans for more than just dental, like one is doing podiatry for example. They could go to a senior center or in assisted living center, parked out front, and have people come out and receive their care in the van, and that is a very convenient way to receive care for anybody who has mobility issues or transportation issues.

REP. HUGHES (135TH): Right. So, I just want to reflect to the committee that we have a huge
population with both mobility issues and as you well know, Medicare does not pay for any kind of or care so.

DEB POLUN: And with the Federally Qualified Health Center, those patients would pay on a sliding scale for dental care if they don't have coverage.

REP. HUGHES (135TH): Great, thanks.

DEB POLUN: One thing I also wanted to highlight in our ultimate language we submitted is that we can add in a requirement that there be a continuum of dental care, and so, that would help protect against the fly-by-night who could be coming in and not having that connection to the local dentist.

REP. ABERCROMBIE (83RD): Thank you that's great. Further questions or comments? Senator Moore.

SENATOR MOORE (22ND): So, I-- I didn't read the bill, which is trying to determine wasn't mobile and portable in the bill?

DEB POLUN: Yes.

SENATOR MOORE (22ND): There was, okay, and I know the difference between the two because we had a mobile unit that people step onto to get a mammogram versus, they call their Sally that they roll her in to a facility to do the screening, right, so, we'll have to look at that. But then the other pieces that-- when you talk about someone coming in from out of state doing it, it was my understanding that the-- to be able to serve someone they had to be able to link them to a medical home, is that not true?

DEB POLUN: I think that's true, but again if they're linking them to a dental facility that they're not-- that they don't also own, then it's not
as seamless as a transfer as if it's the same exact organization. So, when Dr. Legarde's van goes out and provides dental care in the community, those patients know if there's follow-up they need to go to Fairhaven on grand Avenue and get that dental care.

SENATOR MOORE (22ND): So, for a mobile mammography unit, whoever provides that service has a responsibility to follow up with that client, either by registered mail or certified mail, phone call, or link them to a doctor, is that true with the dental?

DEB POLUN: I think it's a little different because with dental care you get immediate feedback versus with mammography where in usually needs to be sent off to have somebody read it and then get back to you within a couple of days. So, correct me if I'm wrong, with dental care if there is doing screenings or cleanings out in the community and they identify, all this person needs a root canal, we make it up claimant back in our brick-and-mortar site, and then you know the records are already there and the person can get connected to that service very easily.

SENATOR MOORE (22ND): So, are they also doing x-rays?

DEB POLUN: Are you doing x-rays on any of them?

SUZANNE LEGARDE: So, yes, and in fact our electronic dental record is all one, so, whether you're getting care at our fixed facility, or you're getting care on our van, it's all one electronic dental record, one x-ray system, and we actually now have handheld units thanks to a grant from TEFA this year where we--the hygienist on the van can in real time so, pictures to the tennis that at the fixed
facility and say, hey what do you think it is. Critical piece here is that connection back to headquarters, if you will, to the fixed facility. I mean you can do a lot on a van, but there's a limit to what you want to do on the van, and then the question is what's the continuity of care, and that is that link back, and that's the thing that you do not want to have to say to a kid, in particular as most of this is school-based care. Okay, well we found three cavities and you're going to need to have this drilled, and say to the mom well now--well the place that you have to go is 50 miles away, that's what this bill is trying to find what that spot as not impairing access, but similarly not allowing an entity to come in that is tied to a facility that [inaudible 04:05:42] distance.

REP. ABERCROMBIE (83RD): Further questions or comments? What thank you guys very much, that was really, really informative. I think we've got some work cut out on our part, but I think that there's a really easy solution to this and thank you for sending your thoughts and your testimony. We're going to look were going to take a look at that also and for the FQHC portion of the payment system around the E-consults, will try to figure that out also. I'm going to call the deputy commissioner and just find out what's going on once we take a look at your memo, so.

DEB POLUN: Great, and we'd be pleased to work with you throughout the session on these issues.

REP. ABERCROMBIE (83RD): Thank you guys. We appreciate it. So, that concludes everyone that is signed out for this public hearing. Is there anyone here today that did not sign up, but would like to take the opportunity to testify? Going once, going
twice, so, this concludes this public hearing. Thank you everyone.