



*Testimony before the Human Services Committee  
Kathleen Brennan, Deputy Commissioner  
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Good morning, Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Kathleen Brennan, and I am the Deputy Commissioner of the Department of Social Services.

I am pleased to appear before you to offer remarks on several of the bills on today's agenda.

**SB 818 - AN ACT ALLOWING FOR THE DEDUCTION OF COURT-APPROVED CONSERVATOR AND FIDUCIARY EXPENSES FROM MEDICAID APPLIED INCOME**

This bill proposes to exempt conservator and fiduciary fees from Medicaid income eligibility and asset transfer determinations.

A state Medicaid agency is required to reduce costs to the state by using the member's income (applied income) for payment of 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 support services provider, thereby reducing the amount that the state pays to the provider each month. Currently, allowable deductions consist of a personal needs allowance established by state law, a community spouse allowance, a community family allowance, Medicare and other health insurance premiums, costs for medical treatment approved by a physician when incurred subsequent to the effective date of eligibility, and expenses for services provided by a licensed medical provider in the six-month period immediately preceding the first month of eligibility.

Section 1(a) of this bill proposes to add conservator expenses, including conservator compensation, probate court filing fees and expenses, and premiums for any probate court bonds as additional allowable deductions. Each expense that is deducted from the patient liability will increase the percentage of costs the state will be liable to pay for institutional services provided to a Medicaid member.

In addition to an increase to the Medicaid budget, implementing a change to the Department's patient liability calculation will require numerous system enhancements, as the current eligibility

system is not programmed to include conservator and fiduciary fees as an allowable patient liability deduction.

In addition to the need for system enhancements, the requirement to track and calculate expenses related to conservatorship would impact the long-term services and supports eligibility determination process, requiring additional human resources to ensure compliance with timeliness standards.

Section 1(c) requires the Department, on an annual basis, to calculate and inform the Probate Court Administrator of the total amount deducted from applied income under section 1(a), and requires the Probate Court Administrator to transfer one-half of this amount to the Department. While the Department would welcome partial reimbursement of the amounts deducted from individuals' applied income, the task and cost of tracking such data, making necessary system changes, and maintaining the processing workload would fall exclusively on the Department.

Section 2 of the bill establishes a minimum baseline conservator compensation of \$125 per month. The bill does not require the conservator to provide documentation to demonstrate that actual services were provided. Section 16 of the Probate Court Regulations however, requires the submission of invoices for time expended in increments of one-tenth of an hour; documentation relating to who is performing services; and a summary of the activity for each entry. In addition, for individuals who are already on Medicaid, this language also conflicts with section 45a-594(a) of the Connecticut General Statutes, which governs payment 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 a Probate Court-approved conservator fee paid for services rendered as an improper transfer for purposes of establishing Medicaid eligibility. It is important to note that the Department is the single state agency that determines Medicaid eligibility and must retain discretion to consider whether there has been a transfer of assets for fair market value. Currently, if the Department determines that payment of a conservator fee was made in exchange for the fair market value of the services performed, the payment will not be considered an improper transfer. If, however, the Department concludes that an individual has paid a conservator fee that is excessive and not consistent with the services provided by the conservator, the Department must have the ability to impose a transfer of asset penalty, consistent with state and federal law.

Because portions of this bill are inconsistent with state and federal law and would have a negative fiscal impact on the state budget, the Department must oppose this bill.

The Department also acknowledges the need for work on this very important issue of adequately compensating conservators who are appointed to individuals with limited resources. The Department welcomes the opportunity to work with the Probate Courts to analyze the long-term fiscal impacts and develop a long-term solution to the issue.

## **SB 820 - AN ACT WAIVING PRIOR MEDICAID AUTHORIZATION REQUIREMENTS FOR CERTAIN PHARMACOGENOMICS TESTS**

This proposal requires Medicaid coverage of pharmacogenomics tests without prior authorization (PA) when determined medically necessary.

The Department of Social Services provides Medicaid coverage for over 200 types of genetic tests, including pharmacogenomics tests, the overwhelming majority of which require prior authorization to determine medical necessity.

As drafted, SB 820 requires DSS to provide Medicaid coverage for pharmacogenomics tests when medically necessary, and without PA for certain conditions. The Department has significant concerns with this language. The PA process protects the safety of HUSKY members by certifying that the test is appropriate for each person's 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.

Prohibiting the Department from implementing PA impairs the Department's ability to adapt to changing circumstances and clinical practices and increases 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 allow the Department to give preference to any Medicaid-enrolled laboratory provider that offers a discount to such tests. As previously mentioned, the Department already provides Medicaid coverage for genetic testing, including pharmacogenomics. For tests performed as part of an inpatient hospital service, payment for the test is bundled within the diagnosis-related group (DRG) structure. For tests performed through a laboratory provider, reimbursement is made in accordance with the laboratory fee schedule. Finally, the Department will manually price any test that is considered medically necessary and not covered through a DRG or within a published fee schedule.

For these reasons, the Department must oppose this bill.

## **SB 821 - AN ACT CONCERNING EQUITABLE MEDICAID REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTER PRACTITIONERS**

This bill would require the Department to equalize Medicaid reimbursement rates for e-consults at federally qualified health centers with the Medicaid rate for e-consults in addition to a fixed fee 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.

The Department also recognizes and applauds the leadership of Connecticut's federally qualified health centers (FQHCs) in supporting the use of e-consults on a national level. Connecticut's FQHCs are at the forefront of this movement and deserve our gratitude and our congratulations.

The Department of Social Services began paying for e-consults originating from FQHCs beginning July 1, 2015, through a supplemental payment methodology. This methodology required the FQHC to pay the consulting specialist and for DSS to, in turn, pay the FQHC for their costs and the consulting specialist's fees. The Centers for Medicare and Medicaid Services (CMS) approved this payment methodology for a period of one year. CMS refused to approve a permanent extension of these payments because the payment arrangement excluded non-FQHC affiliated primary care providers (PCPs) and consulting specialists from participating. To maintain compliance with the federal Medicaid requirement for comparability of services, CMS requires e-consults to be available to all clinicians or to none. As a result, to continue the use of e-consults, the Department was required to implement a new payment methodology.

Effective July 1, 2017, DSS implemented e-consults for all PCPs and consulting specialists using 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 DSS paid the FQHC.

The reimbursement method proposed in section 1(b) of the bill would establish two billing methodologies for the consulting specialists, one billing DSS directly and the other billing DSS indirectly through the FQHC. DSS would not be able to prevent double billing in this context because it would receive each billing claim under a separate category and with different billing provider information. Further, the proposed language, which appears to re-establish the former supplemental payment methodology, would not receive federal approval.

The Department understands and agrees with the FQHCs that they, too, should be paid for their costs to generate an e-consult. The Department, however, does not agree with the mechanism of

payment proposed in this bill and maintains that the established payment methodology for FQHCs includes a process to recognize additional costs for e-consults.

The FQHC prospective payment methodology was established in 1998 and is set in federal law and established in Connecticut regulations. The methodology created an FQHC specific; cost-based bundled payment for patient encounters for ALL services. Each FQHC has a specific encounter rate for every medical, dental and behavioral visit they provide, originally based upon their reported costs in 1998. The encounter rate has been and is increased on an annual basis by the federally set medical inflation rate. As such, FQHCs are the only category of Medicaid-enrolled provider guaranteed an annual fee increase under federal law.

The prospective payment methodology also includes a process to recognize costs associated with new services provided by an FQHC. The encounter rate is recalculated by the addition of new services to the costs in the already established encounter rate. This is called a scope of service change and the process through which the FQHCs should pursue with the Department to recognize the new costs from e-consults.

This bill is unnecessary as each FQHC has the ability to account for the additional costs for providing e-consults through the scope of services change process.

For these reasons, the Department must oppose this bill.

## **SB 822 - AN ACT CONCERNING CONVEYANCES OF PROPERTY OWNED BY A RECIPIENT OF PUBLIC ASSISTANCE**

A recipient of financial and/or medical assistance, or their legally liable relatives, are required to obtain consent from the Department before the transfer, sale or disposal of property. This bill proposes to limit the requirement for recipients of assistance to obtain such consent. The Department is concerned that the proposed language would open the Department to increased litigation, compromise the Department's ability to accurately determine eligibility for assistance and limit the state's ability to recoup on improperly disposed property, all resulting in financial losses to the state.

The revisions to 17b-85 proposed by this bill seek first to add a requirement that the commissioner issue a decision on consent no later than ten (10) business days after receiving the request for consent. There are a number of factors that impact the time it takes to thoroughly examine whether it is appropriate for the Department to consent to the sale, assignment, encumbrance or disposal of property by a recipient of public assistance. Such factors include the timely receipt of any and all requested information, the complex nature of certain cases or

requests and the existing workload and priorities of staff. The Department is unaware of any concerns or complaints regarding the timeliness of the current process and we are therefore, uncertain of the problem that this provision seeks to address. The Department would welcome the opportunity to discuss and address concerns related to the timeliness of this process prior to legislating a standard for timeliness.

Next, the proposed language states "the commissioner shall not ... (2) treat as inferior to the state's interest in property any prior recorded sale, assignment, transfer or encumbrance for which consent was sought pursuant to this section". The use of "prior" is ambiguous as it fails to specify "prior to what" and appears to cancel out the prohibition of selling, transferring, or disposing of property without the commissioner's consent.

The current statute requires a recipient of public assistance to obtain the Commissioner's approval before selling, transferring, assigning or encumbering property. The proposed language implies that if consent is sought but not given, the recipient can proceed. Currently, improper transfers expose recipients and their legally liable relatives to penalties. The proposed change would limit the Department's recourse on eligibility when an asset is disposed of improperly. By requiring the consent of the DSS Commissioner the Department of Administrative Services has the ability to recoup the improperly disposed of property and reduce the amount of assistance paid out.

For these reasons, the Department opposes this bill.

## **HB 7090 - AN ACT CONCERNING INEQUITABLE METHADONE MAINTENANCE REIMBURSEMENT RATES UNDER THE MEDICAID PROGRAM**

This proposed bill seeks to require the Commissioner of Social Services to provide equitable weekly reimbursement rates under the Medicaid program for all methadone maintenance programs.

Historically, methadone maintenance was paid utilizing a bundled weekly rate regardless of the number of services rendered during the week. In accordance with Section 1902(a)(30)(A) of the Social Security Act, the methodology 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 actually be rendered to the member or for services that may not be covered by Medicaid.

In order to comply with CMS rules, the Department submitted a state plan amendment (SPA) to CMS making several technical changes to the reimbursement methodology for methadone maintenance. Specifically, the SPA: (1) pro-rated the weekly rate to account for weeks in which

services are provided on fewer than seven days in the week; (2) specified in detail the services that are included in the rate; and (3) provided for specific types of documentation regarding the services that are provided. The SPA also removed references to specific provider locations, established provisions for merged clinics and newly licensed clinics, and authorized payment for take-home doses in compliance with federal guidelines.

On July 18, 2018, the Department received CMS approval of SPA 18-016, bringing the methodology into compliance with CMS requirements.

The technical changes implemented through SPA 18-016 were not intended to standardize methadone maintenance rates or to provide a rate increase. SPA 18-016 did not fundamentally change the provider specific rate structure in place. The Department did not have the authority to unilaterally increase costs or implement significant reductions in reimbursement for some providers.

However, to better understand the cost structure of methadone maintenance providers, as it relates to the cost structure, the Department has also implemented an annual cost report requirement. The Department has received and reviewed the six (6) cost reports received thus far concluding that all six providers maintained significant profitability margins. The Department expects to receive the final 3 cost reports by February 20, 2019, and will finalize the rate adequacy analysis at that time.

As this proposed bill would result in additional costs to the State, absent the availability of appropriations, the Department is unable to support this bill.

## **HB 7094 - AN ACT CONCERNING TEMPORARY FAMILY ASSISTANCE**

The intent of the bill would increase Temporary Family Assistance (TFA) payments to families with children under age 3 by an additional thirty dollars per month per child under the age of 3, in order to purchase diapers. In calendar year 2018, there was a monthly average of approximately 3,800 children under the age of 3 in families who received TFA cash benefits.

The Department applauds the effort of the bill's sponsors to elevate the importance of diaper availability to children of low-income families. In our work over the last 5 years with the New Haven Moms Partnership, we have also learned of the affect of diaper scarcity on 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 and others at Yale University suggests 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 would be needed to address the intent of this bill. We respectfully request that the sponsors of this bill support the creation of a workgroup, led by the leadership of the National Diaper Bank to develop an alternative method of 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 inclusion of organizations like the Moms Partnership, FQHCs, and Community Action Agencies in this workgroup effort to design a method to disseminate diapers with linkages to other needed services and supports.

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

## **HB 7122 - AN ACT CONCERNING MOBILE DENTAL CLINICS**

This bill seeks to allow mobile dental clinics to submit claims for Medicaid reimbursement for covered services provided not more than fifty (50) miles from the dentist's fixed location. Currently, mobile dental clinics are authorized to submit claims for services provided not more than twenty (20) miles from the dentist's fixed location. DSS opposes this bill for the reasons detailed below.

The Connecticut Dental Health Partnership (CTDHP) has developed and maintained a robust provider network. As reported by DSS to the Medicaid Advisory Policy Oversight Committee (MAPOC) on February 8, 2019, 100% of HUSKY Health members have access to a dental home within 20 miles of their residence and 98.8% have access to a dental home within 10 miles of their 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 to our members.

While the CTDHP currently recognizes the use of mobile dentist clinics, we are confident that the provider network, as it is currently configured, meets the needs of our HUSKY Health members. Further, there are benefits to a dental home that are not afforded through a mobile clinic. Specifically, dental homes provide comprehensive dental care, both preventative and

restorative, during standard business hours as well as after-hours and for emergencies. For these reasons, the Department does not see the benefit of this expansion and opposes the bill.

### **HB 834 - AN ACT CONCERNING SERVICES FOR PERSONS WITH SMITH-MAGENIS SYNDROME**

The Department of Social Services 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 Children's Health Insurance Program (CHIP) requires that every member receive 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 primary care providers, developmental-behavioral specialists, behavioral health specialists, dentists, and other medical and surgical specialists; occupational, physical and speech therapists, either through Birth to Three and other early interventions or through clinics and private providers; and care within inpatient and outpatient hospital settings. When necessary, HUSKY Health provides all manner of durable medical equipment and medical supplies, as well as medications and, for Medicaid, transportation to covered services.

The Department is unsure of the unmet need or needs of children with Smith-Magenis Syndrome that would prompt this legislation. We will, however, cooperate with the Commissioner of Developmental Services' efforts on behalf of patients with Smith Magenis Syndrome, and will make ourselves available to the families of individuals with Smith Magenis Syndrome or any other diagnosis if the unmet need is for a HUSKY Health member.

### **HB 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. This program provides services 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 are also 5 children who have been granted a waiver slot but are still awaiting final approval. The current waiting list is approximately 4 years.

The waiver was originally a 200 slot model waiver that was expanded in 2014 to 300 slots plus reserved slots for children transitioning out of institutions under the Money Follows the Person

Demonstration. The average Medicaid cost per Katie Beckett participant is approximately \$33,340 per year.

As an expansion of this program would result in additional expenditures, absent the availability of appropriations, the Department is unable to support this bill.