



Testimony before the Human Services Committee
Roderick L. Bremby, Commissioner
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Good morning Senator Markley, Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. The Department of Social Services (DSS) is pleased to appear before you today to respectfully request your support on the Governor's Implementer bill and four agency bills:

**H.B. No. 5038 AN ACT CONCERNING THE GOVERNOR'S BUDGET
RECOMMENDATIONS FOR HUMAN SERVICES**

Sections 1 through 34 of this bill transfer the responsibilities of the State Unit on Aging from the Department of Social Services to the Department of Rehabilitation Services (DORS). This consolidation aligns with the federal Administration for Community Living, which serves as a model for placing services for older adults and people with disabilities together. As DORS was already providing administrative support to the State Department on Aging, merging its responsibilities promotes efficient and effective agency management and aligns with the current memorandum of agreement.

Section 35 continues to freeze Category 1 intake under the state-funded Connecticut Home Care Program. Category 1 is a state-funded component of the program for elders in need of limited home care, with the lowest risk of hospitalization or short-term nursing home placement. Public Act 15-5 (June Special Session) closed intake to Category 1 for FY 2016 and FY 2017. To achieve savings targets associated with the 2018 budgeted lapses, intake for the program remains closed for FY 2018. This proposal will not impact existing enrollees nor will it impact the enrollment of individuals residing in affordable housing under the assisted living demonstration project. Savings of \$2.2 million in FY 2019 are anticipated.

Section 36 eliminates payments for Graduate Medical Education. While Medicare is the primary payer of graduate medical education (GME), many states voluntarily support these costs through their Medicaid programs. Unlike Medicare, the federal government has no explicit guidelines for states as to whether they should or how they could make GME payments under Medicaid.

Based on a survey by the Association of American Medical Colleges, 42 states made GME payments under their Medicaid programs in 2015. The eight states that reported not making GME payments were Alaska, California, Massachusetts, New Hampshire, North Carolina, North Dakota, Rhode Island and Wyoming. In addition, three states (Alabama, Michigan, and Tennessee) reported in 2015 that they had recently considered ending Medicaid GME payments due to budget shortfalls or cost controls.

In Connecticut, hospitals are slated to receive \$21.1 million in Medicaid GME payments in FY 2018. Nearly 70 percent of the state's hospitals will receive funding under the program, with FY 2018 payments ranging from \$6,816 to Rockville Hospital to \$7.97 million to Yale New Haven Hospital. In addition, it is of note that five Connecticut hospitals receive close to three-quarters of the \$21.1 million.

Payments for direct graduate medical education under Medicaid are supported by state and federal funding at the standard Connecticut cost share of 50% federal and 50% state. The total payments made to hospitals, including state and federal shares, are issued as a prospective quarterly pass through payment. This payment for a given state fiscal year is based on the Medicaid inpatient percentage of full-time equivalent (FTE) residents multiplied by the approved amount for resident costs, using the hospital's Medicare cost report, inflated by the inpatient hospital market basket published by CMS. The Medicare cost report for the period two years prior to the current state fiscal year, submitted to the Office of Health Care Access, will be used in the calculations.

The added direct costs of GME incurred by teaching hospitals include: stipends and fringe benefits of residents; salaries and fringe benefits of faculty who supervise the residents; other direct costs; and allocated institutional overhead costs, such as maintenance and electricity. Other direct costs include, for example, the cost of clerical personnel who work exclusively in the GME administrative office.

In addition to the direct GME payments noted above, hospitals also receive payments, as part of their existing inpatient rate, for indirect medical education (IME) costs. Similar to direct GME payments, the Medicaid payments are reliant upon the accepted Medicare IME payment methodology. This methodology considers the ratio of a hospital's residents to beds and uses a federally established multiplier. This method uses Medicare cost reports as filed with the Office of Health Care Access.

The application of this factor is expected to contribute approximately \$90 million in total hospital Medicaid payments in SFY 2019. The Governor's recommended budget continues to support indirect medical education; funding is not reduced in this area.

The Department respectfully requests that the Committee take favorable action on HB 5038, An Act Implementing the Governor's Budget Recommendations for Human Services Programs.

S.B. No. 245 (RAISED) AN ACT AUTHORIZING THE DEPARTMENT OF SOCIAL SERVICES TO CONTRACT WITH OTHER STATES

This bill would provide the necessary legislative authority to allow DSS to contract with another state.

Pursuant to the 1981 formal opinion of Honorable Henry E. Parker, State Treasurer, Attorney General, State of Connecticut (1981 WL 157392), all state agencies are required to have explicit

legislative authority to contract with other states. This proposal updates the Department's contracting statutes to ensure proper compliance.

As with all DSS contracts, these contracts would comply with the state's standard contract language and review process.

The Department asks for your support of this bill.

S.B. No. 246 (RAISED) AN ACT LIMITING AUTO REFILLS OF PRESCRIPTION DRUGS COVERED UNDER THE MEDICAID PROGRAM

This proposal seeks to reduce the ability of Connecticut pharmacies to offer a prescription automatic refill program to Medicaid beneficiaries for certain drugs. Recognizing that some drugs may be appropriate to automatically refill, the proposal also provides the Commissioner of Social Services with the discretion to allow certain drugs or classes of drugs to be included in an automatic refill program. The proposal allows the Pharmaceutical & Therapeutic Committee to review and provide the Commissioner with recommendations on such drugs.

This bill makes no changes to the coverage of prescriptions under Medicaid or the DSS preferred drug list. The Department also recently increased the period prescriptions will be covered from 6 months to one year to ensure greater access.

Currently, pharmacies in CT are allowed to enroll Medicaid beneficiaries in a program to "auto refill" their prescriptions. Subsequent filling of these prescriptions can therefore be done without any patient action or request to refill.

The Department has found that many of the automatic refills for Medicaid beneficiaries are unnecessary, but Medicaid is still left liable to pay for the prescription. Specifically, DSS has seen instances where a beneficiary's prescription has changed or has been discontinued (either through a provider request or post-hospitalization) but the pharmacy has not been notified of such change. The prescription for a drug which is no longer needed is then automatically refilled, the pharmacy notifies the beneficiary (without detailing which prescription is ready for pickup) and the beneficiary retrieves the prescription. In this situation, DSS is still required to pay the pharmacy in full for the prescription. Once a prescription leaves the pharmacy premises, it cannot be returned.

Prescribers are generally not aware that members receive automatic refills and these medications continue to be picked up or delivered despite the prescriber having discontinued the medication, either because the medication is no longer needed, is not having a therapeutic benefit, or there is a contraindication either by a side effect or addition of another medication. Further, prescribers make further therapeutic interventions under the assumption that the medication was stopped.

When an unnecessary medication is picked up and consumed by a beneficiary, it may have serious clinical consequences including duplicative medications, hospitalization or even death. Additionally, auto refills of unnecessary prescriptions can lead to stockpiling of medications for

improper purposes. As the health and safety of our Medicaid members is a priority for the Department, it is important to stress that this legislation facilitates accurate medication usage and protects our members from the serious adverse effects that come from prescription mismanagement, even if unintentional.

Many other states have limited auto refills under Medicaid as a health and safety, cost savings and fraud prevention measure (FL, AZ, IL, MS, MA, NY etc.). In July of 2015, the US Government Accountability Office published a report to review program integrity efforts related to pharmacy practices in select state Medicaid programs. The document details that, “automatic refill programs may result in Medicaid beneficiaries obtaining medications far in excess of what was utilized or needed, resulting in wasted Medicaid resources.” (GAO 15-390 Medicaid Pharmacy Fraud, page 30)

For these reasons, the Department is requesting your support for this bill.

H.B. No. 5253 (RAISED) AN ACT EXPANDING ACCESS TO THE MONEY FOLLOWS THE PERSON DEMONSTRATION PROJECT AND REPEALING OBSOLETE STATUTES

This proposal repeals the statutory cap that requires the Department of Social Services to serve no more than 5,000 persons under the Money Follows the Person (MFP) Demonstration Project. In addition, this proposal repeals various obsolete statutes that are described in more detail below.

In January of 2013, the state released its Strategic Plan to rebalance long-term services and supports (LTSS). This plan detailed diverse elements of a broad agenda, designed to support older adults, people with disabilities and caregivers in a choice of their preferred means, mode and place to receive such supports. Rebalancing LTSS reduces the reliance on institutional care and expands access to community LTSS.

MFP has been one of the leading initiatives working toward rebalancing LTSS across the state. Specifically, MFP allows residents transitioning from institutional care back into the community to access a full range of high quality, long-term care options that maximize autonomy, choice and dignity.

Connecticut’s MFP Demonstration has documented savings to both Medicaid and Medicare for people who move to the community compared to costs incurred for care the year prior to discharge from the institution. For example, Medicaid costs associated with older adults who moved to the community were \$2,578 per member per month less compared to their costs in the nursing home while Medicare costs for the same population were \$571 per member per month less.

Since inception of the program in 2007 (with the first transition occurring in 2008), MFP has successfully transitioned approximately 4,950 participants back into the community. In the next fiscal year, MFP projects the program will transition an additional 716 participants.

Currently, state statute caps service to 5,000 participants. As upcoming projections will surpass this cap, the Department is recommending repeal. It is imperative that residents in need of MFP services have the ability to access them.

Regarding the Department's request to repeal obsolete statutes, below provides additional information on each statute.

CGS 17b-241b- This statute implemented a one-time rate increase for psychiatric residential treatment facilities in 2014. This rate increase was implemented within available appropriations through State Plan Amendment 14-029. The statute is now obsolete and should be repealed.

CGS 17b-242b- This statute implemented a pilot program for ventilator-dependent Medicaid recipients receiving medical care at home, that was subject to available appropriations in 2012. No funds were appropriated for this pilot and the statute is now out of date. If implemented, this pilot would result in an unbudgeted cost to the state. The Department is requesting repeal.

CGS 17b-258- This statute, which was enacted during the May 1992 special session, established a discretionary "two-year pilot program to provide health insurance assistance for unemployed persons." The Department is requesting repeal of this statute as it is no longer relevant and is outdated.

CGS 17b-260c- This statute required DSS to apply for a Medicaid waiver by February 1, 2010, to provide coverage for family planning services for adults who are not eligible for Medicaid. This provision is now obsolete as DSS has established a family planning coverage group as part of the state plan under CT Medicaid, as permitted by the Affordable Care Act.

CGS 17b-263a- This statute required DSS to amend the Medicaid state plan on or before December 31, 2006, "to include assertive community treatment teams and community support services within the definition of optional adult rehabilitation services" that would "provide intensive, integrated, multidisciplinary services to adults with severe psychiatric disabilities" DSS was never able to dedicate the funds necessary to implement these services, and the state plan was therefore never amended to add the services. Amending the state plan to add these services through Medicaid would likely expand the population served and result in an unbudgeted cost to the state. Moreover, as part of the Behavioral Health Partnership, which is a collaboration among DSS, DCF, and DMHAS, a wide variety of behavioral health services are available for individuals with behavioral health conditions who receive Medicaid. Accordingly, this statute is no longer necessary and should be repealed.

CGS 17b-600a- This statute, which was enacted during the June 2000 special session, directed DSS to establish a pilot program to benefit severely disabled persons receiving state supplement benefits who cannot transfer from one surface (such as a bed) to another (such as a wheelchair) without assistance. Subsection (b) of the statute required DSS to promulgate regulations to implement the program. The pilot program was implemented, but enrollment was so low that the program was not pursued on a more long-term basis, and no regulations were ever completed. At this point, the statute is no longer relevant and should be repealed.

The Department asks for your support of this bill.

H.B. No. 5254 (RAISED) AN ACT CONCERNING CHILD SUPPORT COLLECTION FEES

In accordance with federal law, this proposal would increase the annual fees associated with child support services offered through the Office of Child Support Services within the Department of Social Services.

Section 53117 of the federal Bipartisan Budget Act of 2018, House Resolution 1892, was enacted on February 9, 2018, and requires states to increase the annual fee for child support services from \$25 to \$35. Under existing law, this fee must be collected and paid to the federal government for individuals receiving support payments who have not previously received Temporary Assistance for Needy Families and for whom the state has collected at least \$500 of child support. The federal Act also requires states to increase this threshold for collection from \$500 to \$550.

In 2017, the Department collected and provided the federal government a total of \$438,797.73 in child support fees.

The mission of the Office of Child Support Services is to improve the well-being of children, promote the self-sufficiency of families and delivery of quality child support services, with recognition that to grow and thrive, children require the financial, medical and emotional support of both parents, regardless of their living situation or relationship. Child Support Services through DSS are available to all residents of the State of Connecticut.

The Department asks for your support of this bill.