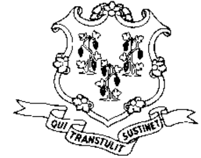

Testimony before the Human Services Committee
Commissioner Andrea Barton Reeves
Department of Social Services
March 16, 2023

Good morning, Senator Lesser, Representative Gilchrest, Ranking Member Seminara, Ranking Member Case, and distinguished members of the Human Services Committee. On behalf of Commissioner Andrea Barton Reeves, my name is William Gui Woolston, and I am the director of Medicaid and the Division of Health Services at the Department of Social Services (DSS).

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

SB 1202 AN ACT CONCERNING PRESCRIPTION DRUG AFFORDABILITY.

Section 4 of this bill establishes a Prescription Drug Payment Evaluation Committee to provide recommendations to the Office of Health Strategy on upper payment limits on at least eight prescription drugs using other states or foreign jurisdictions as a guide. The Department of Social Services is named as a participant on the Committee. While DSS appreciates the intent of this bill, setting an upper payment limit is a resource intensive process that requires economic and clinical analysis that have not been funded in the Governor's budget. Additionally, since other states are just beginning the process of implementing similar evaluation committees, we would recommend that we partner with other states on any such initiative once best practices have been clearly established.

SB 1203 AN ACT CONCERNING MEDICAL DEBT.

The Department of Social Services broadly supports the goals of section 1, which is targeted at reducing the burdens of medical debt for low-income individuals. Although DSS supports efforts to address the crushing impact of medical debt, the Department wishes to better understand the proposed framework in section 1 and explore how to achieve those goals while also maximizing opportunities to connect individuals with Medicaid coverage. DSS looks forward to continued conversations and collaboration on how best to address these issues while maintaining a hospital's ability to assist patients in obtaining valuable Medicaid coverage and get compensated for services, as restricting applications for Medicaid could result in a lost opportunity for both the patient and the hospital.

SB 1205 AN ACT CONCERNING MEDICAID REIMBURSEMENT FOR PEER RECOVERY SUPPORT SERVICES.

This bill requires DSS to provide reimbursement to certified peer recovery support providers enrolled in Medicaid. Recovery coaches are part of the larger service delivery category of certified peers. Many certified peers, including recovery coaches, are state or grant-funded through the Department of Mental Health and Addiction Services (DMHAS). As part of the Substance Use Disorder (SUD) demonstration waiver approved by CMS in April of 2022, Medicaid now reimburses for services provided by certified peers, inclusive of recovery coaches, within SUD residential treatment settings and some ambulatory settings. Additionally, peer support services are available to Medicaid members who receive supports under the Mental Health waiver. Given the recent expansion in coverage through the SUD waiver and the other mechanisms in place for reimbursement, DSS does not support this bill, which would require the Department to amend the Medicaid state plan.

DSS will continue to work collaboratively with our sister state agencies, DMHAS and the Department of Children and Families, to explore additional opportunities to include individuals with lived experience as part of a treatment or support team for Medicaid members.

HB 6885 AN ACT CONCERNING MEDICAID PAYMENT RATES.

Sections 1 through 3 of this bill require rate and service coverage changes, while section 4 requires a rate study for specific coverage areas.

DSS currently lacks a systematic approach to assess rates across provider types on a consolidated or summarized document. As a managed fee-for-service state, Connecticut sets rates and fees for all its Medicaid providers. Often changes to the rates or fee schedules are reactive or situational in nature and rely upon appropriation or legislative changes enacted by the General Assembly, subject to stakeholder input and feedback received. The result is an uneven rate setting process that leads to inequities between similarly situated providers and services. It is essential that DSS establish a framework for a more comprehensive and well-informed approach to provider rates and fee schedules.

The Governor’s recommended budget allocates $1.0 million in ARPA funding to enable DSS to contract with a vendor to undertake a comprehensive Medicaid rate study. The consultant will also develop recommendations on payment reform methodologies and assist with prioritizing rate setting policies that are likely to reduce future costs and improve member outcomes. This is essential to comprehensively study this issue. There are roughly 430 separate provider types in the Medicaid program. Collecting and studying the rates across each of those provider types is a massive undertaking. For the above reasons and given the lack of funding for any of these sections in the Governor’s budget, DSS must oppose. However, we strongly encourage approval of the $1.0 million recommended in the Governor’s budget to do a systematic rate study. More detailed comments on each of the sections of the bill are provided below.

Section 1 of this bill requires DSS to incrementally increase Medicaid rates for services provided by individual fee-for-service health care providers until they are fully aligned with Medicare rates for the same services beginning in FY 2028. While many providers are paid fee-for-service, there are many providers that are paid through other methodologies. Passing this bill would result in a significant cost to the state without a nuanced understanding of rate disparities amongst providers and it could further rate inequities for providers paid under a different payment methodology. To avoid this, a comprehensive rate study as outlined above is necessary. Additionally, on a national level, states' Medicaid rates are, on average, well below Medicare fee-for-service rates so tying Connecticut's rates to Medicare would make Connecticut an outlier.

Section 2 of the bill requires Medicaid reimbursement for school-based health services to the extent allowed under federal law. The Department would like to seek clarity as to whether the intent for coverage is through the school based child health (SBCH) program or school based health centers (SBHCs). Additionally, this bill focuses on certain services, the majority of which are already available for coverage under Medicaid, and specifies coverage of services through legislation when DSS has an established process to review for inclusion of clinically appropriate services, within federal permissibility, to applicable fee schedules or payment methodologies.

Under Connecticut's Medicaid program, the school based child health program is the mechanism by which a school district may seek Medicaid reimbursement for Medicaid-covered services provided to an eligible student pursuant to the student's individualized education plan (IEP) or 504 Plan. The districts can bill DSS for services provided for students who have parental consent to bill Medicaid for their services. Services include assessment, audiology, clinical diagnostic laboratory, medical, mental health, nursing, occupational therapy, physical therapy, respiratory care, speech/language, and optometric services. Services must be provided in the schools by district qualified staff or qualified providers contracted with by the school. Services are provided to students regardless of the district's involvement in the Medicaid SBCH program. For those school districts that are enrolled in Medicaid, DSS bills the federal government on their behalf and, of the revenue received, half goes back to the district, thereby reimbursing the school district for 25% of their gross claims. Claimable services can be updated as part of the Medicaid state plan process.

DSS also covers school based health center services. School based health centers are enrolled in Medicaid as either a clinic (medical or dental) or, for those operated by a federally qualified health center (FQHC), as part of an FQHC site. Coverage for medical services include evaluation and management services that would be inclusive of psycho-educational/informational services, preventive counseling services, standardized and validated screenings, including mental health screens, routine childhood vaccinations, biopsychosocial assessment and interventions, vision screenings, and individual, group and family psychotherapy. The services billed by a school based health center enrolled as a medical clinic are reimbursed based on a set fee schedule that is currently set at approximately 80% of the 2007 Medicare physician fee schedule, except for physician administered drugs, which are updated annually to 100% of the January current year Medicare drug average sales price file. School based health centers operated by FQHCs are reimbursed for services as part of their applicable encounter rate. School based health centers enrolled as dental clinics can bill for medically necessary services on the dental fee schedule and

are reimbursed accordingly. For clinics where there is a dentist on-site, dental screening is inclusive of the examination performed by the dentist. When the clinic does not have a dentist on-site, the dental hygienist can bill a screening code which designates the degree of dental disease/risk by assessment.

Given that the Department already covers or can add coverage for clinically appropriate services without the need for legislation, the Department does not support section 2 of this bill but welcomes the opportunity to work directly with the provider community to understand gaps in current coverage.

Section 3 of this bill requires DSS to increase rates for emergency medical transportation services by 10% each year until rates equal Medicare rates and provides for annual rate increases thereafter. In 2015, there was an emergency medical transportation rate increase due to a change in DSS methodology to mirror Medicare. Again, in 2021, there was a 10% increase in ambulance rates that impacted both emergency and non-emergency rates – and the mileage rate was increased by 104%, resulting in a mileage rate that exceeds neighboring states. Please note, the emergency ambulance procedure codes (A0427 & A0429) which would be directly impacted by this section are already higher compared to the current Medicare base rate. Thus, a further increase is not supported without a more comprehensive review of Medicaid rates as proposed by the Governor.

Section 4 of this bill requires DSS to perform a rate study for long-term acute care hospitals and methadone providers and produce a report by 10/1/2023. As outlined at the top of the testimony, a comprehensive rate study is needed for all HUSKY Health providers to better understand rate disparities and funding for that study is included in the Governor's budget.