

PA10-072

SB281

House	4383-4386	4
Human Serv.	568-569, 606-608, 610-611, 619, 673-674, 764-765, 798- 806, 1042, 1044, 1049, 1057, 1062-1066	30
Senate	942-944, 1062-1066	8
		42

H – 1086

**CONNECTICUT
GENERAL ASSEMBLY
HOUSE**

**PROCEEDINGS
2010**

**VOL.53
PART 14
4246 – 4582**

rgd/mb/gbr
HOUSE OF REPRESENTATIVES

138
May 4, 2010

Those voting Nay 0
Those absent and not voting 1

DEPUTY SPEAKER O'CONNOR:

The bill as amended is passed.

Will the Clerk please call Calendar Number 417.

THE CLERK:

On page 19, Calendar 417, Senate Bill number 281,
AN ACT CONCERNING PUBLIC PARTICIPATION IN MEETINGS OF
THE PHARMACEUTICAL AND THERAPEUTICS COMMITTEE,
favorable report of the Committee on Human Services.

DEPUTY SPEAKER O'CONNOR:

Representative Walker.

REP. WALKER (93rd):

Good afternoon, Mr. Speaker.

DEPUTY SPEAKER O'CONNOR:

Good afternoon.

REP. WALKER (93rd):

Mr. Speaker, I move for acceptance of the joint
committee's favorable report and passage of the bill.

DEPUTY SPEAKER O'CONNOR:

The question is acceptance of the joint
committee's favorable report and passage of the bill.
Representative Walker, you have the floor.

REP. WALKER (93rd):

Thank you, Mr. Speaker.

Mr. Speaker, the underlying bill would allow members of the public to participate in meetings of the pharmaceutical and therapeutics community -- therapeutics committee. The P and T Committee makes decisions that greatly impact thousands of lives of Connecticut residents and helps makes important -- and helps members understand the importance of some of the drugs that they must -- that they are taking through the state.

Mr. Speaker, the P and T Committee advises the Department of Social Services regarding drugs that are included in the preferred drug list that the state -- for the state pharmaceutical program, which serves more than 500,000 residents receiving health coverage through the HUSKY and Medicaid program, SAGA and Charter Oak.

Changes continue to be proposed regarding prior authorization for mental health drugs, for example. And it's important that people that utilize these drugs have an opportunity to express their desires or their concerns about some of the drugs that are put on the preferred drug list. I move passage of the bill.

DEPUTY SPEAKER O'CONNOR:

rgd/mb/gbr
HOUSE OF REPRESENTATIVES

140
May 4, 2010

Will you remark further?

Representative Gibbons.

REP. GIBBONS (150th):

Thank you, Mr. Speaker.

I am in concurrence with the chairman -- the remarks of the chairman of the Human Services Committee. We heard testimony from several people who try to attend these meetings and there wasn't always ample opportunity for public comment. And it's really the people who use the drugs, who are prescribing the drugs who should be able to speak at these meetings and give their input.

So I urge passage of the bill. Thank you, Mr. Speaker.

DEPUTY SPEAKER O'CONNOR:

Thank you, madam.

Will you remark further? Will you remark further on this bill?

If not, will staff and guests please come to the well of the House. Will the members take their seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by roll call. Members to the chamber. The House is voting by

rgd/mb/gbr
HOUSE OF REPRESENTATIVES

141
May 4, 2010

roll call. Members to the chamber, please.

DEPUTY SPEAKER O'CONNOR:

Have all the members voted? Have all the members voted? Well the members please check the board to determine if your vote has been properly cast.

If all the members have voted, the machine will be locked and the Clerk will take a tally.

Will the Clerk please announce the tally.

THE CLERK:

Senate Bill 281 in concurrence with the Senate.

Total number voting 150

Necessary for adoption 76

Those voting Yea 150

Those voting Nay 0

Those absent and not voting 1

DEPUTY SPEAKER O'CONNOR:

The bill passes.

Will the Clerk please call Calendar Number 453.

THE CLERK:

On page 21, Calendar 453, Substitute for Senate Bill Number 207, AN ACT AUTHORIZING THE HUNTING OF DEER BY PISTOL OR REVOLVER, favorable report of the Committee on Finance, Revenue and Bonding.

DEPUTY SPEAKER O'CONNOR:

S - 601

**CONNECTICUT
GENERAL ASSEMBLY
SENATE**

**PROCEEDINGS
2010**

**VOL. 53
PART 4
933 - 1266**

cd
SENATE

96
April 21, 2010

SENATOR STILLMAN:

Thank you, Mr. President.

The -- you raise a good -- a good point and I would certainly hope that reports such of that -- as that would be public.

THE CHAIR:

Thank you, Senator.

Senator Witkos.

SENATOR WITKOS:

Thank you, Mr. President.

I thank the gentlewoman for her answers.

THE CHAIR:

Any further comments or remark on this bill?

Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President.

Mr. President, if there is no objection, I would move to place this item on the consent calendar.

THE CHAIR:

Without objection, it will be so placed.

The Clerk will return to the call of the Calendar.

THE CLERK:

Calendar page 6, Calendar Number 66, File Number

cd
SENATE

97
April 21, 2010

50, Senate Bill Number 281, AN ACT CONCERNING THE
PUBLIC PARTICIPATION IN MEETINGS OF THE PHARMACEUTICAL
AND THERAPEUTICS COMMITTEE, favorable report of the
Committee on Human Services.

THE CHAIR:

Senator Doyle.

SENATOR DOYLE:

Thank you, Mr. President.

I move acceptance of the joint committee's
favorable report and passage of the bill.

THE CHAIR:

The bill has been moved.

Would you care to remark?

SENATOR DOYLE:

Yes, Mr. President.

What this bill does is in the existing
Pharmaceutical and Therapeutics Committee this
basically gives the public the opportunity to have --
or the opportunity for public comment at the meetings.
It's a rather simple bill. It simply gives the public
the opportunity to speak at these meetings. In the
past, some of our constituents have complained that
they had no opportunity at these meetings to present
their opinion. So this bill broadly gives the

cd
SENATE

98
April 21, 2010

committee the op -- the command without detailing specifically how to do it or how much time but just says, please give the public and opportunity for public comment.

I think it's a good bill, and I hope that the chamber will support it.

Thank you, Mr. President.

THE CHAIR:

Thank you, Senator Doyle.

Any further comment or remark on the bill?

If not, Senator Looney.

SENATOR LOONEY:

Yes. Thank you, Mr. President.

Mr. President, if there is no objection, would move to place this item on the consent calendar.

THE CHAIR:

Without objection, so moved.

SENATOR LOONEY:

Thank you, Mr. President.

THE CLERK:

Calendar Number 71, File Number 39, Senate Bill number 65, AN ACT CONCERNING UNEMPLOYMENT COMPENSATION EXTENDED BENEFITS, favorable report of the Committee on Labor and Public Employees.

cd
SENATE

216
April 21, 2010

Mr. President, those items placed on the first consent calendar begin on calendar page 1, Calendar 405, House Joint Resolution Number 94; Calendar 406, House Joint Resolution Number 95.

Calendar page 2, Calendar 407, House Joint Resolution 96; Calendar 408, House Joint Resolution Number 97; Calendar 409, House Joint Resolution Number 98; Calendar 410, House Joint Resolution Number 99; Calendar 411, House Joint Resolution Number 100.

Calendar page 3, Calendar 412, House Joint Resolution 101; Calendar 391, Senate Resolution 15.

Calendar page 4, Calendar 392, Senate Joint Resolution 43.

Calendar page 5, Calendar 47, Senate Bill 137; Calendar 55, Senate Bill 148; Calendar 56, substitute for Senate Bill 150.

Calendar page 6, Calendar 66, Senate Bill 281; Calendar 71, Senate Bill 65; Calendar 74, Senate Bill 132.

Calendar page 7, Calendar 87, Senate Bill 184; Calendar 90, Senate Bill 255.

Calendar page 8, Calendar 94, substitute for Senate Bill 133; Calendar 97, substitute for Senate Bill 310; Calendar 103, substitute for Senate Bill 43.

cd
SENATE

217
April 21, 2010

Calendar page 9, Calendar 117, Senate Bill 232.

Calendar page 10, Calendar 119, substitute for
Senate Bill 261; Calendar 124, substitute for Senate
Bill 251.

Calendar page 11, Calendar 149, Senate Bill 244.

Calendar page 12, Calendar 161, substitute for
Senate Bill 258.

Calendar page 13, Calendar 180, substitute for
Senate Bill 152.

Calendar page 14, Calendar 216, substitute for
Senate Bill 256; Calendar 217, substitute for Senate
Bill 201; Calendar 222, substitute for Senate Bill
275.

Calendar page 15, Calendar Number 233, Senate
Bill Number 97.

Calendar Number -- page 16, Calendar 239, Senate
Bill 105.

Calendar page 17, Calendar 270, substitute for
Senate Bill 234.

Calendar page 18, Calendar 296, substitute for
House Bill 5138; Calendar 297, substitute for House
Bill 5219; Calendar 298, House Bill 5250.

Calendar page 19, Calendar 301, House Bill 5263;
Calendar 302, House Bill 5292; Calendar 303, House

cd
SENATE

218
April 21, 2010

Bill 5265; Calendar 313, substitute for House Bill
5002.

Calendar page 20, Calendar 314, House Bill 5201.

Calendar page 24, Calendar 340, substitute for
Senate Bill 175.

Calendar page 25, Calendar 346, substitute for
Senate Bill 151; Calendar 350, Senate Bill 333;
Calendar 371, substitute for House Bill 5014.

Calendar page 26, Calendar 375, House Bill 5320.

Calendar page 27, Calendar 379, substitute for
House Bill 5278; Calendar 380, substitute for House
Bill 5452; Calendar 381, substitute for House Bill
5006; Calendar 382, House Bill 5157.

Calendar page 28, Calendar 384, substitute for
House Bill 5204.

Calendar page 29, Calendar 395, substitute for
Senate Bill 127; Calendar 396, Senate Bill 147.

Calendar page 30, Calendar 413, House Bill 5024;
Calendar 414, substitute for House Bill 5401.

Calendar page 31, Calendar 419, substitute for
House Bill 5303.

Calendar 32 -- page 32, Calendar Number 421,
substitute for House Bill 5388; and on calendar page
34, Calendar 46, substitute for Senate Bill 68;

cd
SENATE

219
April 21, 2010

Calendar 50, substitute for Senate Bill 17.

Calendar page 35, Calendar 64, substitute for
Senate Bill 187.

Calendar page 37, Calendar 109, substitute for
Senate Bill 189.

Calendar page 39, Calendar Number 148, substitute
for Senate Bill 226.

Calendar page 40, Calendar 182, substitute for
Senate Bill 218.

Calendar page 41, Calendar 188, substitute for
Senate Bill 200.

Mr. President, that completes those items placed
on the consent calendar.

THE CHAIR:

All right. If the Clerk has made an announcement
that a roll call vote is in progress in the Senate on
the first consent calendar, the machine will be open.
Senators may cast their vote.

THE CLERK:

The Senate is now voting by roll call on the
consent calendar. Will all Senators please return to
the chamber. The Senate is now voting by roll call on
the consent calendar. Will all Senators please return
to the chamber.

cd
SENATE

220
April 21, 2010

THE CHAIR:

Would all Senators please check the roll call board to make certain that your vote is properly recorded. If all Senators have voted and if all votes are properly recorded, the machine will be locked, and the Clerk may take a tally.

THE CLERK:

Motion is on adoption of Consent Calendar Number 1.

Total Number Voting	35
Those voting Yea	35
Those voting Nay	0
Those absent and not voting	1

THE CHAIR:

Consent Calendar Number 1 is passed.

Are there any announcements or points of personal privilege? Are there any announcements or points of personal privilege?

Senator LeBeau.

SENATOR LEBEAU:

Thank you, Mr. President, for a -- for an announcement.

THE CHAIR:

Please proceed.

**JOINT
STANDING
COMMITTEE
HEARINGS**

**HUMAN
SERVICES
PART 2
353 – 704**

2010

worked with have worked with us through this process and, you know, as commissioner of DSS, we do receive quite of few concerns from provider groups on a number of issues and this has not been an issue --

REP. GIBBONS: -- It's not one of them.

COMM. M. STARKOWSKI: -- where we've received any major concerns. One or two provider's here and there with their particular. But when that happens, they can appeal to me. We work with our legal counsel. We look and see if all of the criteria was appropriate, whether the audit was done appropriately, whether the exceptions are done appropriately, and then we work with the provider. And a number of the providers, too, in the event that they do owe us significant dollars, we'll work through a repayment plan.

REP. GIBBONS: And what is the look-back period right now for an audit?

COMM. M. STARKOWSKI: You know, the audits will go back to anywhere from two to three to four years, depending on the service and the provider. We hope to increase the number of audits, which may not make providers happy, but the audits will be done more timely because we did get an authorization for 10 new staff in the audit division in DSS, and actually, two staff in the Attorney General's Office to work with us on some of those audits where we do find fraud or abuse.

REP. GIBBONS: Okay. Thank you.

One last question, on SB 281 on the public participation. We've certainly heard from DSS that there is ample time and room for public participation, but I believe the bill also adds two psychiatrists to the preferred drug bill or am I thinking of the wrong bill?

COMM. M. STARKOWSKI: I think that was another bill I testified on last week --

REP. GIBBONS: Okay

COMM. M. STARKOWSKI: -- where there's a -- two individuals or a child's psychiatrists and an individual from DCF.

REP. GIBBONS: Okay. All right. And thank you very, Commissioner.

And thank you, Mr. Chairman.

SENATOR DOYLE: Thank you.

Representative Holder-Winfield.

REP. HOLDER-WINFIELD: Thank you, Mr. Chair.

Just a couple of clarifying questions because I was going in and out.

I was listening part of the time to your conversation with Representative Cook, and it sounded to me as though her issue was that some of the people who want to get in can't get in because of where the program is right now. And then you talked rolling the program out and you talked about two cities at a time. And I was just wondering, I didn't hear what the logic was behind why you thought that was. I don't know if it was just simply what you think you can handle or not, or if there was some other logic to it? So if you could explain that a little bit?

[AB5056]

COMM. M. STARKOWSKI: Well, it was authorized as a pilot program, and when we submitted the federal -- the waiver to the federal government, we told them in the waiver it would be a pilot program and it would be brought on incrementally, again, once we guarantee access and once the evaluation is appropriate.

So we worked with the Legislature. We worked with other's around, the advocates, and we determined that Waterbury and Windham were

KATHLEEN WYATT: Right.

SENATOR DOYLE: -- which is not a defined term --

KATHLEEN WYATT: Right.

SENATOR DOYLE: And then it just says, these homes should, once they're established, they should just report their existence to the DMHAS. There's no big police here. There's references to police -- policing.

KATHLEEN WYATT: Right.

SENATOR DOYLE: The bill, as presented, doesn't have it.

KATHLEEN WYATT: But next year when it comes out --

SENATOR DOYLE: Oh, well, look, next year -- okay. I'm just -- just for the audience here.

KATHLEEN WYATT: Oh, okay.

SENATOR DOYLE: To make it clear, there's no big police presence in this bill. It simply -- it's -- it's -- at this point, it's saying let's have a manager and let's report your existence to DMHAS. There's nothing else.

Thank you.

KATHLEEN WYATT: Thank you.

SENATOR DOYLE: Next speaker is Vicki Veltri. Is Vicki here? Yes, she is, and then after Vicki will be Diane Potvin.

VICKI VELTRI: Good afternoon, Senator Doyle, Representative Walker, members of the Human Services Committee.

SB220 SB281

HB5056 HB5297

For the record, my name is Vicki Veltri, and I'm the general counsel with the State of Connecticut's Office of Healthcare Advocate. And before I go any further, I just want to assure that, Representative Gibbons, if you

ever call our office it'll be the best experience you've ever had with the state government.

So rather than read through the testimony since you have a lot of people here, I just wanted to make a couple points.

I think that -- that -- the bills that we were testifying in favor of, which are 5056, 5297, and 281 are about accountability. And I think, it doesn't matter who's in charge at DSS, who's running that agency. That's a \$5 billion budget and it's one-quarter of the State's budget, so it needs to be accountable, and it needs to be accountable down to every penny. The rest of the State agencies, as you know, are going through the same kind of thing, whether their budget is 1 million or 5 billion, we need everyone to be accountable.

Just a couple of points, I think it's a great idea. I think 50 -- 5056, talks about doing annual audits. I think that's overdue and a great idea for both the performance side and the financial side. And I think it should be done regardless of whether the delivery system is MCO, the current capitated system, or the ASO system.

It's -- what's a little concerning to me about the ASO -- and I know the Commissioner talked about going to the ASO and saving \$28 million. And I just wanted to ask the Committee maybe one of things to look at is -- the Commissioner's also testified that the MCOs have a five-year contract. That's a long contract to have -- to have entered last year and to now be switching systems entirely. So it raises some -- some questions.

I do want to say that there's absolutely no reason that PCCM cannot be rolled out to the state. Any barrier that there is right now is just artificial. And it seems to me we have a lot of clients, and I can't remember off the top of head which committee hearing it was,

but we have a lot of people living in towns that are contiguous to towns where providers are who want to provide those services to people.

So it's -- there's absolutely no downside to expanding the PCCM. I think we should try it, and I think that the providers who are participating in public programs, whether it's HUSKY A, HUSKY B or Charter Oak may hop aboard. And the best way to find out is to get the program going statewide.

And, lastly, I will say out loud, the SB 220, which I think the Commissioner also addressed about -- about reports to the Legislature. There's a change in there that -- that we are vehemently opposed to and that is allowing 30 days for the agency to notify the Legislature of a sanction or an imposition of a penalty by the federal government on any state program run by DSS. The current statute says five days. That's reasonable but 30 days, to me, is unacceptable. That's way too long.

One last thing, Commissioner Starkowski addressed 281, which is public participation in meetings of the P&T Committee. It is true that there is a mechanism for public participation, but it is at the discretion of the committee itself as opposed to a mandatory period of public participation. So we favor the latter because the P&T Committee is making decisions about pharmaceuticals that effect hundreds of thousands people, 500,000 people in the Medicaid program. So we think public participation is -- is warranted.

And I think I'll wrap there.

REP. WALKER: Thank you.

Questions?

Representative Abercrombie.

REP. ABERCROMBIE: It's actually not a question but HB 5056

Representative Gibbons.

REP. GIBBONS: Thank you, Madam Chairman.

I can't wait to call your agency.

VICKI VELTRI: Okay. Great, great.

REP. GIBBONS: I had about the public comment part of the pharmaceutical -- I don't know what committee it is or what's with the preferred drug list, I believe.

9B281

VICKI VELTRI: Yes, it's pharmacy.

REP. GIBBONS: Certainly, from what we understood from the Commissioner today, there is ample time for public comment, and it is allowed at every single meeting. From what we're hearing from you, that is not so?

VICKI VELTRI: Well, what I understand the process to be is that there is some room for the committee to decide to allow public comment but what they -- but the committee decides who they will hear from.

REP. GIBBONS: So it's not a public hearing the way we have it here?

VICKI VELTRI: Yes.

REP. GIBBONS: That anybody can sign up.

VICKI VELTRI: Correct, correct.

REP. GIBBONS: If we change that -- I think one of the issues was how long to make the public hearing?

VICKI VELTRI: Right, right.

REP. GIBBONS: And as people know who've sat in things, they can go on for hours. I don't mind the committee being able to restrict the public comment because I think you end up with

redundant comments. And -- and I don't know how this committee works, but I do think there should be a period of time for public comment at any time.

I was chairman of our local board of education and we always had two public comments -- two public comment sessions. One at the -- for a half an hour at the beginning and one for a half an hour at the end, they were defined. They were contained and if that is not what's happening now than maybe that's a suggestion we could make to the committee.

VICKI VELTRI: I think that's a much fairer way to go.

REP. GIBBONS: Okay. Thank you.

Thank you, Madam Chair.

REP. WALKER: Thank you.

Any other questions from the Committee?

Thank you, thank you very much.

Next we have Diane Potvin -- Potvin? Okay. And behind Diane is Susan Aranoff, and after Susan is Gary Waterhouse. Thank you.

Good afternoon.

Would you push -- push the microphone button so we can hear you?

DIANE POTVIN: Okay.

Good afternoon, Senate -- Representative Walker and distinguished members of the Human Services Committee.

I am here to express my opposition to House Bill 52 --

REP. WALKER: Your name please, you have to

Good afternoon.

GARY WATERHOUSE: Good afternoon, Representative Walker, members of the Committee.

My name is Gary Waterhouse, I'm the executive director of the Connecticut Association of Centers for Independent Living.

Centers for Independent Living work for the full integration and dependence and civil rights of people with disabilities through Centers for Independent Living.

Here today to testify in support of Senate Bill 217, AN ACT LIMITING FINANCIAL INSTITUTION FEES FOR RECORDS NEEDED FOR MEDICAID APPLICATIONS.

Bottom line is, generally people applying for Title 19 do not have resources to pay for five years of financial documents from financial institutions, therefore, the burden often falls on the family.

We'd like to support Senate Bill 281, AN ACT CONCERNING PUBLIC PARTICIPATION IN MEETINGS OF PHARMACEUTICAL AND THERAPEUTIC COMMITTEES. I believe there needs to be public participation in any decision-making progree -- program.

We liked to support House Bill 5297, AN ACT CONCERNING STATEWIDE EXPANSION OF THE PRIMARY CARE CASE MANAGEMENT PILOT PROGRAM. PCCM is an important fourth option for HUSKY A.

We liked to support House Bill 5354, AN ACT TO PROVIDE INCENTIVES FOR HOSPITALS WHO DEVELOP ELECTRONIC HEALTH RECORDS.

The US Department of Veterans Administration has been developing a national electronic records database for years. When Hurricane Katrina destroyed the VA Hospital in New Orleans, the medical records were backed up off site and were immediately available to the

SB 315
HB 5232

121
cd

HUMAN SERVICES COMMITTEE

March 2, 2010
10:00 A.M.

oversee because that might be the model that we want to move towards? So after this, if you'd like, we could step outside and give contact information to talk more about it, if you feel comfortable with that. Okay?

WILLIAM CERAVONE: My belief -- my belief to CCAR -- it's open to anybody.

REP. ABERCROMBIE: I agree. But not everybody --

WILLIAM CERAVONE: So -- so I mean --

REP. ABERCROMBIE: -- is getting involved with them. That's -- that's the other part of that.

WILLIAM CERAVONE: Well, that's -- that's on the people that don't want to be involved in that.

REP. ABERCROMBIE: Absolutely. You're hitting right on the point that we're trying to make.

WILLIAM CERAVONE: Uh-huh.

REP. ABERCROMBIE: So I would be more than happy to exchange contact information with you.

WILLIAM CERAVONE: Okay.

REP. ABERCROMBIE: Thank you, sir.

SENATOR DOYLE: Thank you.

Sheldon Toubman and Jody Bishop-Pullan.

SHELDON TOUBMAN: Good afternoon.

Senator Doyle, Representative Walker, members of the Committee.

I'm Sheldon Toubman. I'm a staff attorney with New Haven Legal Assistance Association, and I'll try to talk more slowly this time.

HB 5297 HB 5056

First, I'm here to testify in support of SB 281. The Commissioner, this morning, said

that the P&T Committee which decides critical issues of access to drugs has no problem with public input. I can prove that that's incorrect.

Just two week ago, I was explicitly denied permission to testify or speak before the committee. I have an email that says, The Committee has decided that Sheldon Toubman's written testimony is sufficient and has declined his request to speak at the meeting.

Now, I can understand people not wanting to have me speak before them, but there is this thing called the First Amendment, and, in addition, there's something lost when you just take written statements. You don't get to ask questions. So I -- I strongly urge you to pass SB 281.

I'm also here to testify in support of HB 5297 and 5056. Both of these bills would require statewide PCCM. I know that the Governor has announced that we're going to move to ASO model for the HUSKY population which we support.

Optimistically, we think we're going to save the money and more that the Governor has stated. However, we can save more money by statewide PCCM. We can care coordinate better because it'll be the primary care doctor rather than some impersonal call center doing it. And it's going to be more stable because primary care doctors aren't going anywhere, whereas, we all know that companies look at the bottom line whether a contract's worth it for next year or not.

I heard the Commissioner's testimony this morning. He said that in other states where they've gone to it -- Oh, well, you know, it took a long time; it took years.

I have attached to my testimony the actual PowerPoint presentation excerpt from the Oklahoma Medicaid Director. Because last time

**JOINT
STANDING
COMMITTEE
HEARINGS**

**HUMAN
SERVICES**

**PART 3
705 – 1071**

2010

may not be here. Okay, Ellen's not here.

Is Brandon Levan here? Brandon? No.

Is Dominique Thornton here? Yes, she is.

After Dominique is Mary Farnsworth.

DOMINIQUE THORNTON: Good evening, Senator Doyle and Representative Walker, members of the Committee. Thank you for your patience all day today. I've been watching you. I've been able to leave this room, but I know some of you -- many of you have not.

I'm here to speak in favor of two bills, Senate Bill 281, AN ACT CONCERNING PUBLIC PARTICIPATION AND MEETINGS OF THE PHARMACEUTICAL AND THERAPEUTICS COMMITTEE; and also, House Bill 5297, AN ACT CONCERNING THE STATEWIDE EXPANSION OF PRIMARY CARE MANAGEMENT PILOT PROGRAM.

The president of Mental Health Association and a man with 25 years of experience in the community of mental health and Dr. Steve Madonick who's a member of our board, also submitted testimony to the P and T Committee and were declined to have permission to speak at this committee. And I -- I submit to you that it is urgently important that the public be able to participate because, as I mentioned in -- the last time I spoke before this Committee, restrictions of Medicaid -- medications increase other costs. And I emailed to the entire committee a list of sources that I was aware of. And I've also submitted additional sources -- these are different sources, additional sources, in this testimony as well that shows that there's a significant and drastic increase in the number of outpatient hospital visits and physicians visits when they -- when PDL is implemented. So what we're looking for is a robust panoply, an arrangement, a variety of mental health medications to be made available and not to be constrictive.

The committee was looking at prior authorization as a way to restrict the access and reduce cost. Prior authorization really doesn't take into consideration the impact that it will have, and, indeed, in fact, it has many unintended impacts on Medicaid prior authorization. And there's a PHD Medical Care Journal listed that shows that it does achieve a less -- less optimal outcomes among low-income patients with chronic mental illness.

And on the second page, I've outlined a very eloquent and lengthy -- I'm not going to read it for you because it's in there -- quotation from a researcher who found, you know, that it's not the cheapest alternative.

And just in summation, why would the Mental Health Association be in support of Primary Care Case Management because people with severe mental illness die 25 years earlier than the average population. And the reason for this is not necessarily suicide but the nontreatment, nonregulation, noncare coordination of chronic co-morbid conditions, physical conditions. So with -- we believe that with case management, they will get a better -- better care, better quality of outcome and be able to live longer healthier lives.

Thank you. Any questions?

SENATOR DOYLE: Thank you, Dominique.

Any comments or questions?

Thank you. Thank you for your patience.

DOMINIQUE THORNTON: Thank you.

SENATOR DOYLE: Next speaker is Mary Farnsworth, and then we have Wanda Nelson, Laurel Risom. Maybe some can come up together possibly.

CONNECTICUT LEGAL RIGHTS PROJECT, INC.

P. O. Box 351, Silver Street, Middletown, CT 06457
Telephone (860) 262-5030 • Fax (860) 262-5035

TESTIMONY OF JAN VANTASSEL, ESQ.
HUMAN SERVICES COMMITTEE
March 2, 2010

My name is Jan VanTassel. I am the Executive Director of the Connecticut Legal Rights Project, Inc. (CLRP), a statewide non-profit agency that provides free legal services to low income adults with severe and persistent mental illness on matters related to their treatment and civil rights. A CLRP staff attorney is testifying today in support of H.B. 5232, a bill proposed by the Office of Protection and Advocacy for Persons with Disabilities to assure that persons with disabilities who reside in residential care facilities have access to advocacy services. Therefore, I will not comment on that bill, except to say that CLRP's paralegal advocates, who work under the direct supervision of attorneys, have represented many such individuals, and we want to be certain that our right to continue doing so is protected.

I want to express CLRP's support for two other bills being considered by the Human Services Committee today.

9B315

SUPPORT FOR RAISED BILL 281.AAC PUBLIC PARTICIPATION IN MEETINGS
OF THE PHARMACEUTICAL AND THERAPEUTICS COMMITTEE

The purpose of this bill is a simple one; to provide Connecticut residents the same opportunity for public comment on access to medications and therapies that is provided in nearly every other state. As you know, Connecticut, like most other states, has placed almost every medication covered by the Medicaid program on a preferred drug list. In order to have a prescription drug placed on the list the pharmaceutical company must agree to pay rebates to the state, thereby generating cost savings to the state. While I appreciate the financial benefit to the state derived from this practice, if a medication is excluded from the preferred drug list, an state administrative prior authorization process must be followed which often delays access to medications.

Last year Connecticut expanded the preferred drug list to include medications for the treatment of mental illness, which had previously been exempted. Like the complex and specialized medications to treat AIDS, which are still exempted, medications that treat mental illness have very individualized effects, both positive and negative. It can sometimes take years to determine the combination and dosage of medications that will support and sustain an individual's recovery and stability. An interruption of those medications is likely to trigger a relapse that will require inpatient treatment to be resolved.

While the Pharmaceutical and Therapeutics (P&T) Committee currently has the authority to invite members of the public and organizational representatives to speak, and does so on occasion, there is no mandate to do so. By enacting Raised Bill 281, you can assure that there is an opportunity at every meeting for persons directly affected by the committee's recommendations to speak to them directly. When the committee is acting on matters that have such a significant impact on individual lives, protecting the right of those individuals to be heard seems to be fundamental to our system of open government.

Most other states have determined that public comment must be an essential element of the P&T Committee process, and I hope that you will agree and take favorable action on Raised Bill 281.

SUPPORT FOR S.B. 315 AAC SEXUAL ASSAULT OF A DEVELOPMENTALLY DISABLED OR SEVERELY PHYSICALLY DISABLED PERSON

I am testifying in favor of SB 315 in my capacity as a member of the advisory committee of the Office of Victim Services. The purpose of this legislation is to clarify what we already believe to be the legislative intent of the current statute, protecting persons whose ability to resist or consent to sexual intercourse is substantially impaired because of a mental or physical condition when the perpetrator has reason to be aware of that impairment. It seems to me that the logic behind this clarification is so apparent that it should require very little explanation. We simply want to be absolutely certain that persons with disabilities are adequately protected against exploitation, and they are not required to demonstrate that they were helpless to a point that there was absolutely no conceivable means of expressing their lack of consent in order to convict their assailant. Substantial impairment combined with the reasonable knowledge of the perpetrator provides a fair balance of interests, and I urge you to support this bill.

I also urge you to take this opportunity to delete the archaic use of the term "mentally defective" from the bill as recommended by the Office of Protection and Advocacy for Persons with Disabilities.



KEEP THE PROMISE COALITION
Community Solutions, Not Institutions!
241 Main Street, 5th Floor, Hartford, CT 06106
Phone: 860-882-0236; 1-800-215-3021, Fax: 860-882-0240
E-Mail: keepthepromise@namict.org, Website: www.ctkeepthepromise.org

**Testimony before the Human Services Committee
In Favor of SB 281
March 02, 2010**

Good morning/afternoon distinguished co-chairs and members of the Human Services Committee. My name is Cheri Bragg, Coordinator of the statewide Keep the Promise Coalition. The Coalition was formed in 1999 in response to the community mental health crisis following the failure to properly invest in a community mental health system after the closure of two of CT's large state psychiatric hospitals. The Coalition is dedicated to investment in a comprehensive, community mental health system in CT.

Keep the Promise Coalition is here today to testify in favor of SB 281, an Act Concerning Public Participation in meetings of the Pharmaceutical and Therapeutics Committee. This bill would help ensure that members of the public who are affected by decisions made by the P&T committee would have an adequate opportunity to testify and provide personal, expert testimony.

As you know, decisions that are made by the Pharmaceutical and Therapeutics Committee have very real consequences on the citizens of CT, including members of the Keep the Promise Coalition, many of whom live with mental illnesses. When issues concerning pharmaceuticals come up, it is important to hear from medical professionals, prescribers, and pharmaceutical experts. It is equally important to hear first-hand the personal effects that potential decisions might have on people who will take these medications, individual responses to medications, and the impact of limiting access to those medications.

It is this Coalition's belief, after witnessing 10 years of member testimony, that there is no substitute for testimony based on personal experience. This is true

for both professionals as well as for consumers of medications. Connecticut's own Department of Mental Health and Addiction Services was recently awarded a multi-year Federal grant to transform the system based upon input from consumers, youth and families directly impacted by that system. The Federal government recognizes the basic, but critical nature of input from people who are directly affected by services and their families as it correlates to best outcomes.

Furthermore, in other States, the Pharmaceutical & Therapeutics Committees have already demonstrated this understanding by presenting an opportunity for public input in their states' processes. This Coalition feels that moving CT's P&T Committee to be in-line with these other states would be the right direction to head in and a sound decision for CT's citizens. We respectfully ask this Committee to pass SB 281.

Thank you for your time.



National Alliance on Mental Illness

NAMI Connecticut

Testimony before the Human Services Committee

March 2, 2010

SB 281

Good afternoon, Chairs and members of the Human Services Committee. My name is Alicia Woodsby, and I am the Public Policy Director for the National Alliance on Mental Illness, CT (NAMI-CT). I am here to testify on SB 281 – AAC Public Participation in Meetings of the Pharmaceutical and Therapeutics Committee.

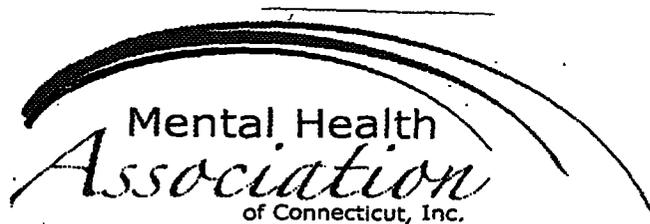
NAMI-CT strongly supports SB 281, which would allow members of the public to participate in meetings of the Pharmaceutical and Therapeutics Committee. The P&T Committee makes decisions that greatly impact the lives of thousands of Connecticut residents, and it is important that members of the committee hear directly from people affected by these decisions.

Many NAMI-CT members and others with mental illnesses from across our state are Medicaid and SAGA beneficiaries and use prescription drugs to treat their conditions. The P&T Committee decides which medications are on the Preferred Drug List, determining which drugs will be reimbursed by Medicaid and SAGA. Through this process, the committee directly affects the ability of these people to take the appropriate medications. Medicaid and SAGA beneficiaries must be able to communicate their concerns regarding the PDL to members of the committee, and SB 281 would enable them to do so. It is important to note that this is the standard in many states that dedicate a portion of their P& T Committee agenda to the public.

The P&T Committee has jurisdiction over numerous medications, and it is very difficult for members of the committee to fully appreciate the impact of their decisions on patients. Although the committee is charged with taking cost into account when deciding whether to include a drug on the PDL, these decisions can sometimes result in the unintended consequence of someone with a serious illness failing to receive the proper medication. Preferred drug lists and prior authorization can have particularly devastating consequences for people with serious mental illnesses. People that are unable to get their mental health related medications filled often experience medical and psychiatric emergencies resulting in greater costs to the system. Every study shows that barriers to medication access for low-income people with behavioral health needs most often lead to an interruption in their treatment and can have serious life-threatening consequences.

NAMI-CT strongly urges you to pass SB 281, so that the public can communicate openly with members of the P&T Committee and provide them with information to make informed decisions regarding drugs on the PDL.

Thank you.



T55
32-8

Service, Education, Advocacy

Contact: Domenique Thornton at (860) 529-1970 extension 11

Good Morning Mr. Chairman and members of the Human Services Committee. My name is Domenique Thornton. I am the Director of Public Policy for the Mental Health Association of CT, Inc., (MHAC). MHAC is a 100-year old private non-profit dedicated to service, education and advocacy for people with mental health disabilities. I would like to thank you for the opportunity to speak to you in favor of both Senate Bill 281 An Act Concerning Public Participation in Meetings of the Pharmaceutical and Therapeutics (P & T) Committee and House Bill 5297 An Act Concerning the State-Wide Expansion of the Primary Care Case Management Pilot Program. Concerning public input on the P & T Committee, mental health medications have long been exempted in this state from the Preferred Drug List (PDL) in this state for good reason. Adding mental health medications to the PDL will not save the state money. One study showed that "There was a statistically significant increase in the number of outpatient hospital visits and physician visits for the test group compared with the control group in the first 6 months after PDL implementation,"¹ Requiring Prior Authorization (PA) is no guaranteed remedy for this situation. The legislature has difficult decisions to make balance the costs of care with the lives of some of the sickest and poorest residents in the state of Connecticut. But, you should consider that PA ignores the setbacks, bad experiences, symptom remission or other life problems caused by step therapy required to "fail first" for persons who have severe and chronic mental illness. One study² reports that the "PA implementation can be a barrier to initiation of non preferred agents without offsetting increases in initiation of preferred agents, which is a major concern. There is a critical need to evaluate the possible unintended effects of PA policies to achieve optimal health outcomes among low-income patients with chronic mental illness." Members of the public, health care providers and others should be

¹ Murawski MM, Abdelgawad T, Exploration of the impact of preferred drug lists on hospital and physician visits and the costs to Medicaid. The American Journal of Managed Care [Am J Manag Care], ISSN: 1088-0224, 2005 Jan; Vol. 11

² Lu, Christine Y. PhD; Soumerai, Stephen B. ScD; Ross-Degnan, Dennis ScD; Zhang, Fang PhD; Adams, Alyce S. Unintended Impacts of a Medicaid Prior Authorization Policy on Access to Medications for Bipolar Illness. PhDMedical Care: January 2010 - Volume 48 - Issue 1 pp 4-9

allowed to inform the decisions of the P & T Committee before they include or exclude any mental health medications. As another researcher voiced this eloquent conclusion:

In the current climate of tight budgets, most payers of health care have restricted coverage and reimbursement for prescription drugs in an effort to control spiraling medical costs. These efforts have relied on methods such as using a "preferred drug list" that includes only the cheapest drugs of a class, or requiring treatment failures before approving newer, more expensive drugs for a patient. These strategies, especially in the case of the mentally ill, are seriously flawed because they result in poorer therapeutic outcomes and may eventually cost substantially more. Serious mental illness is marked by frequent relapses that lead to brain degeneration and chronicity of symptoms. As such, relapse prevention is essential. Treatment non adherence is attributed to a variety of causes, chief among which are intolerable side effects of prescribed drugs. Therein lies the benefit of newer atypical antipsychotic drugs, which are as effective, if not more so, than older conventional drugs but have a far more tolerable side-effect profile. Though the older antipsychotics are cheaper on a pill-for-pill basis, the increased incidence of relapse due to side-effect-induced non adherence is shown to offset any short-term saving by increasing other costs of care such as re-hospitalization and increased outpatients costs. In the long run, attempt at cost control by restricting formularies and by using older, cheaper drugs is fundamentally flawed and needs to be reconsidered.³

A better way to control costs would be through utilization management to identify high users of pharmacy benefit by certain individuals. It may be possible to link the DSS database on claims now to the database compiled by DMHAS that hold information on hospitalizations, employment, substance use, current level of care and system-wide admissions and discharges. By looking at two different sets of information, high pharmacy costs and outcome data, it may be revealing to see whether the pharmacy charges are justified in achieving the goals everyone hopes for. Cost outliers could be examined and monitored in a much more person centered approach that aims to provide a balance between cost and quality. Such utilization review may also identify individuals where poly-pharmacy – numerous prescription medications given to one individual from different providers, often without coordination or knowledge among those providers – could cause medical risks to the individual. Barriers to access to mental health medications such as placing mental health medications on a preferred drug list requiring prior authorization regardless of its past success require more public input as in other states that do use a preferred drug list for mental health medications have other protections in place consisting of sub-committees, advisory boards, etc. comprised of medical professionals and academicians to inform and advise the drug selection process to ensure a robust array of choices of medications to treat effectively treat a variety of conditions. Thank you for the opportunity to speak to you. Our Association is ready to help DSS, DMHAS or other state agencies in helping Connecticut improve its system of care.

3. Verma, Kiran; Verma, Sumer; is the Cheapest Drug the best Alternative? Primary Psychiatry, Vol. 11(1), Jan,

Similarly, House Bill 5297 An Act Concerning State-Wide Expansion of the Primary Care Case Management Pilot Program is a very good idea. Medical homes can reduce health care spending, improve health status, support disease management and prevention, improve the quality of care, reduce medical errors, and reduce racial and ethnic health disparities. Medical homes have become an important theme of health reform discussions at the federal and state levels.⁴ Medical homes are not buildings but are a coordinated and patient centered approach to attending to medical care delivery. Eight states have recognized the potential of adopting a medical home model and seven are in the process of developing a criteria to recognize medical homes.⁵ Medical home pilots and programs are operating in at least 37 states including Connecticut.⁶ The patient-centered medical home has the potential prevention as well as for better management of chronic diseases. I currently serve on the Sustinet Advisory Subcommittee for Patient Centered Medical Homes. Thank you.

⁴ PCCM: A New Option for HUSKY, CT health Policy Project, www.cthealthpolicy.org/pccm

⁵ Christopher Atchison, presentation at Building a Medical Home: issues and Decisions for State Policy Makers, NASHP, Oct. 5, 2008, Tampa, FL

⁶ Patient Centered Medical Home: Building Evidence and Momentum, PCPCC, 2008, national Academy for State Health Policy, November 2008, National Partnership for Women and Families, Sept. 2008

SUPPORT SB-283

Senator Doyle, Representative Walker, and members of the Human Services Committee,

This testimony is in support of Raised Bill No. 283, an act concerning audits by the Department of Social Services.

This bill's amendments address some of the concerns remaining with the fairness of DSS compliance audits of provider agencies in the Connecticut Home Care Program for Elders. Despite recent improvements made to the process, there are still areas of the audits that should be corrected and/or clarified. First and foremost, provider agencies should be given the guidelines by which the Department of Social Services conducts its audits and sampling methodologies, as stated in section 1.

In section 2, the audit would be limited to services performed during the two-year period up to notification of the audit or 200 claims, whichever is less. Currently, all companies, no matter their size, are audited with 100 claims as the random sample. A sampling of 100 claims is not statistically relevant across all agencies and therefore unfair to the larger companies when error rates are applied. To go a step further and still keep the math easy to apply, a suggestion would be to have a graduated sampling system, such as 100 samples for companies' under \$1 million in total population for a two-year period; 200 samples for \$2 million, and so on.

In section 3, this legislation seeks to limit extrapolation projections to only those claims that result in a financial finding, not a clerical error. A missing checkmark or a wrong day of the week on a time/activity sheet should not be considered a willful violation of program rules and providers should not be subjected to a financial consequence. Extrapolation should only be used if the findings resulted in an overpayment, i.e. paid for work not delivered, or underpayment to a provider.

Also, a provider aggrieved by the decision should have the right to appeal to a third party. In Section 9, the designee of the DSS will not just preside over the review, but can render a decision. This is important for the outcome to be determined by an impartial person.

While audits are necessary for the integrity of the program, these provisions ensure the state's vendors have the right to due process and you should approve these amendments.

Sincerely yours,

Eileen H. Adams

FAV Home Care LLC

16 Vincent Road

Bristol, CT 06010

Also a member of the Connecticut Homemaker & Companion Association

CONNECTICUT
VOICES
 FOR CHILDREN

Testimony Regarding

S.B. No 220: An Act Concerning the Elimination of Certain Department of Social Services Reporting Requirements

S.B. No. 281: An Act Concerning Public Participation in Meetings of the Pharmaceutical and Therapeutics Committee

H.B. 5056: An Act Implementing the Milliman Report's Recommendations to Achieve Cost Savings in the HUSKY program

H.B. No. 5297: An Act Concerning the State-Wide Expansion of the Primary Care Case Management Pilot Program

Sharon D. Langer

Human Services Committee

March 2, 2010

Senator Doyle, Representative Walker and Members of the Human Services Committee:

I am a senior policy fellow with Connecticut Voices for Children, a research-based public policy think tank that works statewide to promote the well-being of Connecticut's children, youth, and families. I am submitting this written testimony on behalf of CT Voices.

Senate Bill No. 220 would eliminate the Department of Social Services' statutory obligation to report on various programs under its jurisdiction. While it may make sense in some cases to eliminate or reduce reporting requirements where a program is defunct or a mandate has been fulfilled, we suggest that this Committee first determine whether the underlying obligation contained in a statute has been met before considering whether elimination of the reporting requirement is warranted. We therefore have the following comments about three specific sections of S.B. 220:

Maintain the reporting requirement regarding presumptive eligibility for pregnant women until it has been successfully implemented. (Sec. 8)

In 2008, the Department was mandated to implement presumptive eligibility (PE) for pregnant women in accordance with the federal definition of PE under Medicaid. PE allows certain health care providers to make an initial eligibility determination and therefore allows pregnant women to obtain coverage quickly. This is no time to eliminate the reporting requirement set forth in paragraph (e) since the Department has yet to fulfill this statutory mandate. Department personnel recently stated that presumptive eligibility will be implemented this month (March 2010). Presumably, the biannual reporting requirement in paragraph (e) is being eliminated because the Governor has proposed to eliminate the Medicaid Managed Care Council in another bill, and the report required by this section is to be sent to the Council. As we and others testified last week before this Committee, we oppose the elimination of the Council whether or not Medicaid managed care is converted to an administrative services organization. The Council provides an important public forum for discussion of the financing, coverage and access issues related to the HUSKY program which serves about 380,000 children, pregnant women and parents, and an advisory council is required by federal law. See 42 CFR Sec. 431.12 (requiring a medical care advisory committee). In any event, this committee and the Council should be monitoring the implementation of PE for pregnant women. It is good public policy and it is mandated by this statute.

We support S.B. 281 which would allow members of the public to express their views at a meeting of the Pharmaceutical and Therapeutics Committee. An opportunity for public comment seems reasonable and is consistent with an open government. The P&T Committee advises the Department of Social Services regarding drugs that are included on the "preferred drug list" for the state's pharmacy program which serves over 500,000 residents receiving health coverage through HUSKY, Medicaid, SAGA or the Charter Oak Health Plan. Changes continue to be proposed concerning prior authorization of mental health drugs, for example, and concerns that such a mechanism will prevent patients with serious mental illness will not receive timely and appropriate medications. Allowing public comment at the P&T Committee meetings would facilitate better communication between the decision makers and the public.

H.B. 5056 would require the state to "recover fifty million dollars in over payments from [HUSKY] managed care organizations . . . and implement primary care case management state wide. . ." We take this opportunity to reiterate our support for the Governor's proposal to convert HUSKY risk-based managed care to a non-risk administrative services organization model. The Governor's budget assumes a budgetary savings of \$50 million – based on the state Comptroller's audit (i.e., the "Milliman Report" referenced in this bill). In addition, we urge utilization of an ASO in combination with primary care case management (PCCM) and support permitting children in HUSKY B the opportunity to participate in PCCM as an alternative to risk-based managed care plans – assuming the health plans remain in place. Finally, we would also support the transparency and accountability provisions in the bill, e.g., conducting an annual audit of the program.

H.B. 5297 would require the Department of Social Services to expand the primary care case management pilot state-wide by October 1, 2010. We would add to this requirement that PCCM be supported by an administrative services organization for certain functions that primary care providers may find challenging to implement. Under federal and state Medicaid guarantees of "early and periodic screening, diagnostic and treatment" (EPSDT) services, primary care providers – particularly those in smaller practices – may find it difficult to arrange all of the EPSDT mandated services, such as transportation. An ASO can help facilitate such arrangements, as well as provide other back office functions for PCPs.

Thank you for this opportunity to submit testimony concerning the above mentioned bills. If you have any questions or need additional information, please contact me.

¹ Testimony Supporting H.B. 5020: An Act Implementing the Governor's Recommendations regarding the Tobacco and Health Trust Fund, T. Ali & S. Langer, M.Ed., J.D. (Mar. 12, 2008), available at www.ctkidslink.org/testimony_archive.html

² If Connecticut had instituted smoking cessation, it would be receiving almost 62 cents on the dollar from the federal government for Medicaid covered services under the stimulus package, from October 1, 2008 through December 31, 2010 – and most likely beyond 2010 – since the expectation is that Congress will authorize continuation of the increase in federal Medicaid matching funds.

T 27

22-25

NEW HAVEN LEGAL ASSISTANCE ASSOCIATION, INC.

426 STATE STREET
NEW HAVEN, CONNECTICUT 06510-2018
TELEPHONE (203) 946-4811
FAX (203) 498-9271

March 2, 2010

Testimony of Sheldon Toubman in Support of HB 5297 and HB 5056, Expanding PCCM in the HUSKY Program, and SB 281, Requiring the Pharmaceutical and Therapeutics Committee to Allow Public Comment at Its Meetings

Good afternoon, Members of the Human Services Committee:

My name is Sheldon Toubman, and I am an attorney with New Haven Legal Assistance Association. I am here to speak in support of three bills before you today: SB 281, which would require the Pharmaceutical and Therapeutics (P & T) Committee to receive public comment at its meetings, and HB 5297 and HB 5056, both of which would require an expansion of primary care case management (PCCM) to become a statewide option. All of these bills take us in the right direction by improving public input and accountability in the delivery of health care.

First, SB 281 will correct a serious deficiency in the way in which the P & T Committee goes about deciding whether to remove a drug from the state's preferred drug list and thus subject that drug to restrictive prior authorization under the Medicaid and SAGA programs, specifically its refusal to allow members of the public, including consumers and consumer advocates, to speak at its meetings in order to ensure input into those decisions, unless they are specifically invited to do so. This was recently confirmed directly for me last week, when the Committee, after receiving my written statement, decided not to let me speak at its next meeting on March 4th, while specifically allowing others to make oral presentations at this meeting.

It is unwise policy for a quasi-governmental entity to selectively allow consumers and consumer advocates an opportunity to speak before it prior to making its decisions. Each speaker brings their own perspectives to the issues before the Committee, and its members will benefit from hearing that breadth of concern. In addition, by not allowing oral presentations by some members of the public, including consumers and advocates, the Committee deprives its members of the ability to ask any pertinent follow-up questions of those who have submitted written statements. Finally, I note that, because the P and T Committee is a quasi-governmental agency, it would raise First Amendment concerns if it were to persist in selectively allowing some individuals to speak before it, based on their written statements, while denying this same opportunity to others based on their written statements.

SB 281 will correct this by requiring the Committee to hear public comment at its meetings.

Second, I am here to support HB 5297 and HB 5056, because it is time to require an expansion of primary care case management (PCCM) so it can be an option for the entire state. Although the Governor's proposed move from capitated HMOs to ASOs is welcome, moving to PCCM will save more money, put care in the hands of those most able to coordinate it—the treating primary care providers—and provide a stable alternative to the ever-changing set of risk and non-risk corporate contractors which have moved in and out of the HUSKY program over the last three years. Unlike companies which will not hesitate to terminate a contract if it is not in their bottom line interest, individual doctors coordinating care under PCCM are committed to their patients and are not likely to go anywhere. At the very least, we need a statewide alternative to compete with the ASO-administered model.

There also is a very relevant precedent from Oklahoma, where that state in 2003-2004, under pressure from capitated HMOs demanding more state money, went from 3 Medicaid HMOs to statewide PCCM—and saved millions of dollars for the taxpayers right away. In Oklahoma,



Connecticut Association of Centers for Independent Living
 151 New Park Ave. Suite 106, Hartford, CT 06106
 voice 860-656-0430 fax 860-656-0496
 www.cacil.net

715

14-4

...Working for the full integration, independence, and civil rights of people with disabilities
 through Centers for Independent Living

Testimony of Gary Waterhouse, Executive Director

CT Association of Centers for Independent Living

March 2, 2010

Human Service Committee Public Hearing

Center for Disability Rights
 764A Campbell Ave.
 West Haven, CT 06516
 V 203-934-7077
 TDD 203-934-7079

Disabilities Network of
 Eastern CT
 238 West Town Street
 Norwich, CT 06360
 V/TDD 860-823-1898

Disability Resource Center
 of Fairfield County
 80 Ferry Boulevard
 Suite 210
 Stratford, CT 06497
 V 203-378-6977
 TDD 203-378-3248

Independence Northwest
 1183 New Haven Rd.
 Naugatuck, CT 06770
 V 203-729-3299
 TDD 203-729-1281

Independence Unlimited
 Suite D
 151 New Park Avenue
 Hartford, CT 06106
 V/TDD 860-523-5021

S.B. No. 217 (RAISED) AN ACT LIMITING FINANCIAL INSTITUTION FEES FOR RECORDS NEEDED FOR MEDICAID APPLICATIONS.

SUPPORT- CACIL supports limiting to \$20.00 the fees charged by financial institutions to people during the Title XIX eligibility process. All funding available to an individual should be reserved for Medical Care and Treatment. Generally people applying for Title XIX do not have the resources to pay for five (5) years of documents from financial institutions, so the burden falls to the family.

S.B. No. 281 (RAISED) AN ACT CONCERNING PUBLIC PARTICIPATION IN MEETINGS OF THE PHARMACEUTICAL AND THERAPEUTICS COMMITTEE.

SUPPORT- CACIL supports the inclusion of a requirement that the Pharmaceutical and Therapeutics committee shall ensure that each meeting includes an opportunity for public comment. Giving the public the opportunity to provide anecdotal testimony and records of personal experience will undoubtedly give the committee important and valuable evidence leading to better decision making.

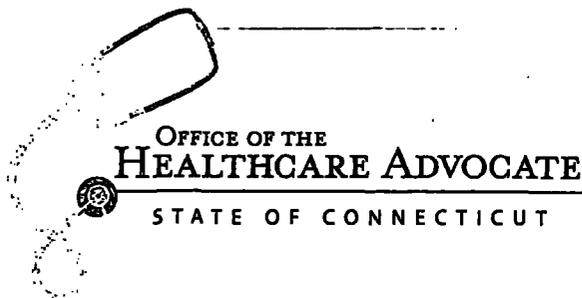
H.B. No. 5297 (RAISED) AN ACT CONCERNING STATE-WIDE EXPANSION OF THE PRIMARY CARE CASE MANAGEMENT PILOT PROGRAM.

SUPPORT- CACIL supports the expansion of the delivery of health care services through the primary care case management system and the application by the Connecticut Department of Social Services of a waiver from the Centers for Medicare and Medicaid Services for the purpose of expanding the primary care case management system.

HB 5354

SB 315

HB 5232

T12
12-11

OFFICE OF THE
HEALTHCARE ADVOCATE
STATE OF CONNECTICUT

**Testimony of Victoria Veltri
General Counsel**

**Before the Human Services Committee
In support of HB 5056, HB 5297 and SB 281
And
In Opposition to SB 220
March 2, 2010**

Good morning, Senator Doyle, Representative Walker, Senator, Representative Gibbons and members of the Human Services Committee. For the record, I am Vicki Veltri, General Counsel with the Office Healthcare Advocate ("OHA"). OHA is an independent state agency with a three-fold mission: assuring managed care consumers have access to medically necessary healthcare; educating consumers about their rights and responsibilities under health insurance plans; and, informing you of problems consumers are facing in accessing care and proposing solutions to those problems.

I am here today to testify on behalf of OHA, in favor of several bills. The first is HB 5056, An Act Implementing the Milliman Report's Recommendations to Achieve Cost Savings in the Husky Program. This bill does many things, all of which we support.

First, the projected savings from the Milliman study were incorporated last year by the Governor into her proposed biennial budget. The final budget reflected a savings of \$50 million in the Medicaid line from the expected recovery of this money from the participating managed care organizations ("MCOs") by the Department of Social Services ("DSS"). The administration has yet to recover these sums, though the Governor actually suggested the recovery. Since the administration has yet to recover the money, or to fairly explain to the legislature and the public why the recovery has not taken place, it is appropriate to place a specific statutory duty on DSS to recover the \$50 million. It does not bode well that neither DSS nor OPM has closed the deal on this budget item. Maybe clear and unambiguous direction will force compliance.

Second, replacing sealed bids with negotiated bids makes sense as a sealed bid may either qualify or disqualify a potential contractor too early in a bid process.

Third, OHA supports an annual audit of the program. It is unclear from the language of the bill whether the proposed audit would be financial or performance-based or

both. We recommend both. HUSKY is one of the biggest items in the state's budget. Although we've gained some transparency through the Freedom of Information cases and some of the reporting that the MCOs and DSS provide, we do not have an ongoing understanding of the finances of the HUSKY program. Since it is clear that there are some financial questions hanging over HUSKY, it is an appropriate time to initiate annual audits of the program, regardless of its structure. Mercer currently conducts the external quality review ("EQR") monitoring of HUSKY. Mercer has a conflict of interest in conducting the EQR since it is also the DSS actuarial services contractor. An annual performance audit can go farther than the EQR review and focus on particular areas or the entire program. (Should HUSKY be converted to an ASO model, there will still be a need for regular financial and performance audits.) Requiring yearly auditing of an \$800 million program will keep the program focused on the efficient delivery healthcare to its 400,000.

Fourth, OHA supports a statewide roll out of primary care case management ("PCCM") to allow all HUSKY and Charter Oak recipients the choice of enrolling in PCCM. Statewide enrollment should erase some of the problems that have come to light, including PCCM recipients in one town not being able to access care in a contiguous town where providers are signed up with PCCM. Opening the program statewide will undoubtedly bring more providers into the PCCM model. To the extent that there providers who treat patients in the state's public programs, it makes sense to encourage the providers to participate in both HUSKY and Charter Oak. For families who have a child in HUSKY B or A, and a parent in Charter Oak, this is common sense. Providers and consumers often have trouble telling whether they or their children are on HUSKY A, B or Charter Oak.

OHA also supports HB 5297, *An Act Concerning Statewide Expansion of the Primary Care Case Management Pilot Program*. We recommend that this bill be revised to include expansion of PCCM to the HUSKY B and Charter Oak populations.

OHA supports SB 281, *An Act Concerning Public Participation in Meetings of the Pharmaceutical and Therapeutics Committee*. This body makes decisions about which medications should and should not be included on the state's Preferred Drug List. We believe that because the committee's decisions impact approximately half of a million Connecticut residents and are of critical importance, that public comment should be allowed.

OHA opposes SB 220, *An Act Concerning the Elimination of Certain Department of Social Services Reporting Requirements*. OHA believes that while DSS has multiple reporting requirements, its multi-billion dollar budget requires this reporting and, in fact, OHA encourages the committee to require more transparency from DSS, particularly on its budget. Section 2 of the bill changes DSS' reporting time on federal sanctions or fines, from five to thirty days. When a state agency is sanctioned or fined by a federal agency, notification to the legislature should be instantaneous. Five days, however, is a reasonable window, thirty days is not. In an era in which strict accountability standards are applied to all state agencies, elimination of these reporting requirements also eliminates some of the legislature's oversight.

Thank you for your attention to my testimony. Please contact me directly with any questions at victoria.veltri@ct.gov or (860) 297-3982.



T6
5-11



Testimony before the Human Services Committee

Michael P. Starkowski

Commissioner

March 2, 2010

Good morning, Senator Doyle, Representative Walker and Members of the Human Services Committee. I am Michael Starkowski, Commissioner of the Department of Social Services. I am pleased to be here this morning to present testimony on legislation introduced at the request of the department and would like to thank the committee for raising these bills. I am also providing testimony on several other bills with significant impact on the department.

Legislation Introduced at the Request of the Department

S. B. No. 220 (RAISED) AN ACT CONCERNING THE ELIMINATION OF CERTAIN DEPARTMENT OF SOCIAL SERVICES REPORTING REQUIREMENTS.

This bill was raised at the request of the department and again I would like to thank the committee for doing so. This bill would eliminate or amend a number of the statutory reporting requirements that have been placed upon the department. We bring this bill before you not in an effort to circumvent transparency but rather to lighten the large reporting burden on the department so we may focus our efforts on administering our programs.

To give you a few examples, in 17b-14 the department is not asking that the report be eliminated but rather is asking for an extension of time to submit the required report.

Also in 17b-114o the department is required to report to the legislature on the TANF block grant. We are not suggesting that our reporting be eliminated altogether, rather we are asking that we simply be allowed to continue to share the report that we are federally mandated to produce as opposed to having to create an entirely new state report.

Some examples of requirements we wish to eliminate are one time reports as in 17b-342a which was a report on the PCA pilot program and in 17b-366 which was a report on the assisted living pilot.

SB281

SB283

HB5056

HB5297

HB5328

HB5354

HB5355

HB5329

Other Legislation Impacting the Department

S. B. No. 217 (RAISED) AN ACT LIMITING FINANCIAL INSTITUTION FEES FOR RECORDS NEEDED FOR MEDICAID APPLICATIONS.

This legislation was proposed by the Attorney General's office and would limit the fees that financial institutions may require for records of account needed by the Commissioner of Social Services to determine eligibility for Medicaid.

The department has experienced situations in the past where financial institutions charged fees to Medicaid applicants for documents provided necessary to determine eligibility. These fees are financially burdensome to Medicaid recipients, most of whom are already financially compromised. If an applicant cannot afford to pay the fees and the financial institution refuses to provide the copies, the applicant will be unable to complete the application. Failure to provide the Department with required documents will result in the denial of the application.

We strongly support this legislation.

S. B. No. 281 (RAISED) AN ACT CONCERNING PUBLIC PARTICIPATION IN MEETINGS OF THE PHARMACEUTICAL AND THERAPEUTICS COMMITTEE.

A consumer representative is already a very active member of the P&T Committee. Committee members are appointed by the Governor and represent clinicians, pharmacists, drug manufacturers and consumers. Committee members have established guidelines for public comment. When needed, public comment takes place during the first half hour of the meeting. There appears to be no need for this legislation given the below guidelines already in place as follows:

A member of the public may submit clinical and other relevant information to the P&T Committee for their review and request an opportunity to speak at the committee meeting.

Speakers must submit a written document to the committee at least 2 weeks prior to the meeting at which they wish to speak. The document should outline the subject matter to be covered. The written document may not be more than 10 pages in length (including references and package inserts), and the font not smaller than 12. *Written materials which do not conform to these specifications, will not be distributed or considered by committee members.*

The Committee chairperson (or designee) will distribute submitted materials to committee members.

At least 1 week prior to the scheduled meeting, the committee chairman will notify those individuals who will be asked to speak at the meeting based on discussion with committee members, interest or questions. These individuals will be given an approximate time for appearance at the meeting. The committee chairman will also notify those individuals whose submitted materials were sufficient and presentation at the meeting will not be required.

The first 30 minutes of each committee meeting will be designated as the public portion of the meeting. Speakers' are limited to a maximum of 5 minutes at the discretion of the Committee Chairman. Questioning by committee members after speakers' presentations may be permitted at the discretion of the chairperson.

Speakers will state their names and identify the company, group, or organization they represent, and only one speaker per company, group or organization is permitted.

S. B. No. 283 (RAISED) AN ACT CONCERNING AUDITS BY THE DEPARTMENT OF SOCIAL SERVICES.

The Department is opposed to Senate Bill No.1085 for the following reasons:

First, this bill is extremely costly: It puts the department in a position of violating federal law, thereby jeopardizing all of the Federal Financial Participation (FFP) funding of the Medicaid program. The state could lose \$1.8 billion in FFP. In addition, since this bill affects the audits of all providers, it will cost the Department \$15 million in audit recoveries and cost avoidance, annually. Lastly, as this bill will embolden fraudsters and greatly impede the Department's ability to identify vendor fraud, it will cost the Department millions each year in undetected fraudulent claims.

Implementation of this bill will provide a negative incentive to those individuals and corporations that hunger to take inappropriate advantage of the billions of dollars paid out by the Connecticut Medical Assistance Programs. This proposed bill effectively cuts the heart out of the program integrity function of this Department and will actually promote vendor fraud.

Moreover, this bill will place the Department in violation of federal law. In a recent Connecticut Supreme Court decision; Goldstar Medical Services, Inc., et al. v. Department of Social Services, the Supreme Court Justices unanimously found that the Department's auditing method and use of sampling and extrapolation were not only appropriate, they were required by federal law.

In response to a very similar proposed bill in 2005, PA 05-195 was crafted with the assistance of the bill's sponsors and put into law. The Public Act addressed both the providers concerns with the audit process and the Department's federally mandated requirement to audit the billions of dollars paid to providers. Among other things, the Public Act provided for limits on the use of extrapolation and formalized a review process for providers who felt aggrieved by the audit process. The reforms enacted by the Public Act have been successful and the majority of the bill's sponsors have been satisfied with the changes.

*The bill will resound
negative to 2.2 million yr*

*0.5% funds
4 billion in health care*

Proposed H. B. No. 5056 AN ACT IMPLEMENTING THE MILLIMAN REPORT'S RECOMMENDATIONS TO ACHIEVE COST SAVINGS IN THE HUSKY PROGRAM.