



December 5, 2011

Roderick Bremby, Commissioner  
Department of Social Services  
25 Sigourney Street  
Hartford, CT 06106

RE: DSS proposed changes to the Medicaid LIA program

Dear Commissioner:

I write to express my serious reservations with the concept paper submitted by the Department of Social Services (DSS) to the Center for Medicare and Medicaid Services (CMS) on October 27th that requests approval for submission of a Section 1115 waiver that would substantially restructure the Medicaid Low Income Adult (LIA) program. The restructuring of the program would be accomplished through various means, including elimination or reduction of covered benefits, the imposition of additional utilization review measures on the pharmacy benefit, the imposition of an asset test and a potential cap on enrollment. The concept paper is extreme in design and, if such a waiver were allowed, would shred the safety net for the over seventy thousand people currently enrolled in the program.

Governor Malloy rightly claimed the establishment of the Medicaid LIA group as a success. The program elevated an entirely state-funded program for the lowest-income residents in the state, many of whom suffer from chronic diseases, to a program that is now equally funded between the federal and state governments. The program is also a success in that we have insured tens of thousands of additional residents, ensuring a substantial reduction in the cost-shifting of healthcare costs to commercially insured residents and vesting low-income individuals with an adequate benefit package.

Unfortunately, the DSS LIA proposal is in complete contrast to the efforts of the Health Insurance Exchange to ensure that all Connecticut residents are insured and that those who qualify for Medicaid are enrolled in the program. On the one hand, the Exchange is spending considerable time and resources on finding ways to insure uninsured individuals. On the other, DSS' LIA proposal will increase the number of uninsured.

Whether it is through harmful benefit reductions, caps on enrollment, new utilization management requirements or asset tests that force people from the program, the concept paper takes us in the opposite direction from where the state should be heading. Further, there is a reason that Medicaid is not designed as a commercial product with limited benefits. Generally speaking, lower income populations are not as healthy as moderate income populations, and people who have medical conditions that have gone untreated for long periods of time may need a wider range of healthcare to return them to a healthy condition. We need to remain sensitive to the needs of our residents in program design.

As one simple example, the DSS concept paper proposes a cut to home health benefits to 60 days per episode. Such a benefit is inconsistent with providing home based community services to individuals with chronic and complex illnesses that require regular home health services. There are undoubtedly many people in the LIA population who need regular home health services. DSS' proposal would likely lead to exacerbations of medical conditions that could be easily maintained with the current home health benefit.

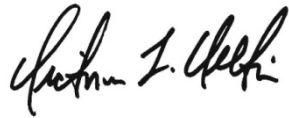
While I understand the costs of the LIA program are higher than DSS predicted, it is unclear from the concept paper whether the reason for that, in major part, is not simply from pent-up demand for healthcare services for tens of thousands of individuals who had no insurance before they enrolled in LIA--as opposed to a function of plan design, which the concept paper intimates. I do not believe that DSS has publicly provided a detailed analysis of the level and types of services utilized by the LIA population, or a breakdown of the costs to the Medical Assistance Program Oversight Council, to determine whether the increased costs in LIA are typical in the first years of a Medicaid expansion. Further, DSS states that many of the new enrollees in LIA are 19 and 20 year olds whose parents are moving them from employer sponsored insurance to LIA coverage. DSS has not shared any data with the council to either substantiate this statement or explain how a group of traditionally lower cost individuals would contribute a significant increase the costs of the program. To make a sound judgment about costs in the program over time, it would help to have an analysis of the overall expenditures of LIA enrollees who were initially enrolled in the former SAGA program to determine whether their costs have dropped off over a longer period of coverage, after they received treatment for long unattended to medical needs. (Note, that half of the LIA expenditures are matched by the federal government.)

It is important to note that in 2014, the LIA group will be funded at 100% by the federal government, which calls into question the utility for such a drastic proposal as the one submitted by DSS. There is no evidence in the paper that DSS considered any other options to reduce costs than to treat one of our lowest income Medicaid populations less favorably than our traditional Medicaid population. I also was surprised that the projections for increased costs did not seem to include any savings from the new ASO administration of the program, the development of person-centered medical homes and the utilization of the Behavioral Health Partnership for mental health needs.

I strongly urge DSS to reconsider its proposal as it is inconsistent with Connecticut's efforts to insure our residents with adequate coverage, keep them insured and to avoid shredding the safety net.

I am available to meet with you to discuss ways in which my office can assist in finding alternatives to those proposed in the concept paper. Thank you for your consideration of my comments.

Very truly yours,

A handwritten signature in black ink, appearing to read "Victoria Veltri". The signature is fluid and cursive, with the first name being more prominent.

Victoria Veltri  
State Healthcare Advocate

C: Richard McGreal, Associate Regional Administrator, CMS  
Christie Hager, Regional Director, U.S. Department of Health and Human Services  
Nancy Wyman, Lieutenant Governor, Health Insurance Exchange Chair  
Benjamin Barnes, Secretary, Office of Policy and Management  
Mark Schaefer, Director of Medical Administration, DSS  
Senator Toni N. Harp  
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Representative Cathy Abercrombie