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## **Connecticut Elder Action Network (CEAN) 2007 Legislative Summary**

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### **Connecticut Elder Action Network (CEAN) - Brief Background**

In response to requests from legislators that older adults and their advocates do their best to speak with a common voice, stakeholders throughout Connecticut came together to form a working advocacy group whose main goal was to develop and pursue a well-supported short list of legislative priorities. This effort, which has become known as the Connecticut Elder Action Network (CEAN), has involved a dynamic group of leaders working together to advance responsible public policy for elders. Chaired by the Connecticut Commission on Aging, its Executive Committee members include: AARP-CT, the Center for Medicare Advocacy, the Connecticut Association of Area Agencies on Aging, the Connecticut Coalition on Aging, the Connecticut Association of Municipal Agents for the Elderly, the Connecticut Association of Senior Center Personnel, Connecticut Community Care, Inc., and Connecticut Legal Services.

### **CEAN 2007 Priority Statements**

During the 2007 session, CEAN developed and promoted priority statements in four principal areas:

- **Long-Term Care**
- **Medicare Part D and CHOICES**
- **Improvements for Housing for Older Adults and Individuals with Disabilities**
- **Elderly Nutrition Program**

Primary rationales for selection of these four areas were:

- 1) that re-balancing of the State's long-term care system will both achieve new cost savings and provide consumers with meaningful choices by expanding home and community-based service options;
- 2) that pharmaceutical drugs costs are prohibitively expensive for those elders without a source of financial assistance and that consumers are in need of current, unbiased information on Medicare and long-term care options;
- 3) that existing housing stock is in dire need of capital improvements and that there is substantial unmet need for skilled, on-site assistance by resident services coordinators; and
- 4) that home-delivered and congregate meals represent a core preventative long-term care benefit for older adults residing in the community.

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## **Detailed Results of the 2007 Session in CEAN Priority Areas:**

### **I. Long-Term Care**

#### **Issues:**

Though progress has been made, funding for long-term care in Connecticut, which represents over \$2 billion (14% of the entire State budget) remains heavily institutionally biased. Advocates of “re-balancing” seek use of a greater proportion of this funding for home and community-based care options and for enhanced support of family and informal care networks. This funding approach will achieve even more extensive cost savings for the state and will reflect consumers’ preference to remain at home.

Along with “re-balancing”, another important aspect of planning for and implementing forward-thinking long-term care policy is how best to universalize services to acknowledge common needs among individuals with disabilities of all ages.

#### **Position:**

- Support legislation designed to:
  - implement the Money Follows the Person Program
  - provide more expansive pre-admission screening for all potential nursing home residents
  - establish a single point of entry that ensures that consumers are easily able to access programs
  - expand planning and education initiatives
  - eliminate barriers posed by age and diagnosis-based program eligibility requirements

#### **Background:**

The 2007 release of the Connecticut Long-Term Care Plan (the “Plan”) provides the following context to the discussion concerning “re-balancing”:

- One in six non-institutionalized Connecticut residents has a disability (546,800 or 17%).
- The incidence of disability rises with age.
- In 2005, Connecticut spent over \$2.5 billion on long-term care. Of that, 69% was attributable to care in institutions and the remaining 31% was expended on community-based care.
- Of the community-based expenditures, 23% was spent on home health services, 54% on the two Department of Developmental Disabilities waivers, 11% on the Connecticut Home Care Program for Elders, and the remaining 12% on a composite of the Personal Care Assistant, Katie Beckett and Acquired Brain Injury waivers.

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The Plan cites as an ultimate goal shifting public long-term care resources until 75% of recipients of Medicaid long-term care services receive home and community-based care. Cited as rationales for this shift are cost savings, fulfillment of consumer preference and emphasis on the “least restrictive setting” in which care can be provided. The Plan also references the need for uniformity, flexibility and choice in waiver programs, and urges greater emphasis on client-centered care planning.

Connecticut has already made significant strides in serving those who wish to remain in the community. Since 1987, Connecticut has elected to offer care management and home and community-based services (HCBS) to eligible older adults through a Federal 1915(c) Medicaid waiver (the Waiver). As a complement to this program, Connecticut has also appropriated General Fund revenues in support of serving older adults at slightly higher income and asset levels than are permitted under the Waiver. These two components make up the Connecticut Home Care Program for Elders (CHCPE). In 2006, the CHCPE had an active client population of over 15,000 individuals, more than 10,000 of whom received services through the Waiver.

Over time, and in recognition of increased interest in self-directed care options, Connecticut has also created new vehicles through which participants of the CHCPE can receive their services.

One example of this is the state-funded Personal Care Assistant pilot (PCA Pilot) program that was established in 2000 to serve up to 50 individuals statewide. This program, which enables participants to hire and manage the schedules of their own helpers, was intended to serve younger individuals with disabilities who were aging into eligibility for the CHCPE, as well as older adults whose needs could not be effectively met through home care agency-based care plans. Over time, the PCA Pilot has been expanded. In the 2006 legislative session, the number of slots was increased to 250 statewide.

A second example is Connecticut’s affordable assisted living pilots:

- First authorized through Public Act 98-239, and then expanded to 300 units by Public Act 99-279, the **Moderate and Low-Income ALSA Demonstration Project** has underwritten construction of new, stand-alone Managed Residential Communities (MRC’s) through which residents who 1) are age 65 and older; 2) are at risk of nursing home placement; and 3) meet CHCPE financial eligibility criteria receive ALSA services. This project is a partnership involving the Department of Social Services (DSS), the Department of Economic and Community Development (DECD) and the Connecticut Housing Finance Authority (CHFA).
- In 2000, the Legislature extended the CHCPE to residents of state-funded congregate housing.
- Authorized by Public Act 00-2, then expanded in scope by Public Act 01-2, the **State Assisted Living Demonstration in Federally-Funded Elderly Housing** provides assisted living services to residents of certain designated buildings.
- The **Private Assisted Living Pilot** is intended to assist a limited number of individuals who have spent down resources while living in private managed

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residential care (MRC's) with payment for assisted living services (this excludes payment for room & board). Initially authorized by Public Act 02-7 for 50 individuals eligible for the Medicaid Waiver, and 25 individuals eligible for the state-funded levels of the CHCPE, Public Act 04-258 made it available to 75 individuals without respect for level of care. There is currently a substantial wait list.

Further, a specified number of younger individuals with disabilities have been able to access Medicaid home and community-based supports through:

- the **Acquired Brain Injury Waiver**, which provides care management and supportive services to individuals with that diagnosis;
- the **Department of Developmental Disabilities Comprehensive Supports and Individual and Family Supports Waivers**, which assist individuals who have been assessed as having mental retardation with care management and an extensive menu of services; and
- the **Personal Care Assistance Waiver**, which enables individuals who have chronic, severe, permanent disabilities to hire their own assistants for such tasks as bathing and dressing.

In the 2006 session, the legislature further expanded home and community-based options by:

- authorizing DSS to either amend the Medicaid State plan, or to seek approval from CMS, for a home and community-based waiver, to provide services that will allow individuals with severe psychiatric disabilities to avoid institutionalization or to return to the community from a nursing facility;
- authorizing DSS to apply to CMS to establish a "Money Follows the Person" demonstration project for no more than 100 persons; and
- authorizing DSS to implement new home and community-based pilot programs for those with HIV/AIDS and multiple sclerosis.

Excitingly, authorization for the "Money Follows the Person" project launched efforts at DSS to draft and submit an extensive application to the Centers for Medicare and Medicaid Services. What yielded was an award (representing enhanced federal match) that will permit Connecticut to serve significantly more individuals than was originally anticipated by the enabling legislation. Immediately following on the award notice, DSS convened and has since managed a progressive, multi-disciplinary work group that has coalesced representatives of the state departments, advocates and direct service providers in development of program protocol and strategies for implementation.

Finally, it should be noted that data gleaned by the just-completed statewide Long-Term Care Needs Assessment (funded in 2006 by the Legislature) will support a report comparing Connecticut's "re-balancing" efforts to those in other states. This report, which will be released in the near future, will contain recommendations for future long-term care policy initiatives.

### **2007 Session Results:**

The results of the 2007 Session can be grouped in three areas: 1) expansion of existing program capacity; 2) elimination of existing programmatic barriers; and 3) enhancement of the capacity of the home and community-based service network.

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### **Expansion of Existing Program Capacity:**

#### **Money Follows the Person**

Reflecting the level of available federal funding, **Section 5 of Public Act 07-2 (6/26/07 signed by Governor, effective 7/1/07)**, the DSS/DPH “implementer” increases from 100 to 700 the number of individuals to be served by the Money Follows the Person Program.

#### **Personal Care Assistance (PCA) Waiver**

**Public Act 07-1 (6/26/07 signed by the Governor)**, the budget, includes an additional appropriation for the PCA Waiver that will enable DSS to re-open the program to those on the waitlist.

### **Elimination of Programmatic Barriers:**

Led by advocates from the Multiple Sclerosis Society, advocates have for some years identified a serious unmet need for case management and supportive services for individuals who have not yet reached age 65 (the eligibility threshold for the CHCPE). The legislature responded with **Section 29 of Public Act 07-2 (6/26/07 signed by the Governor, effective 7/1/07)**, the DSS/DPH “implementer”, which creates a state-funded pilot program with services based upon the Connecticut Home Care Program model for up to 50 individuals age 18-64.

Also at issue has been a constraint on the capacity of the state-funded Alzheimer’s Respite Program to serve Medicaid-eligible individuals under the age of 65. Addressing this, **Public Act 07-86 (6/1/07 Signed by Governor, effective 7/1/07)**, which removes the restriction on serving Medicaid-eligible persons who are not yet eligible for the Home Care Program for Elders through the Statewide Respite Program.

### **Enhancement of the Capacity of the Home and Community-Based Service Network:**

Data from professional groups including the Connecticut Medical Society, the Connecticut Home Care Association and the Connecticut Association for Adult Day Care indicate that Medicaid reimbursement rates to providers of medical and home and community-based services have not kept pace with increased costs of doing business (e.g. staff recruitment and retention, insurance and quality assurance/ regulatory compliance efforts). Inadequacy of reimbursement has directly contributed to closure of many home care agencies and adult day care centers over the last five years, just when expansion of the available service array is most needed by both older adults and individuals with disabilities. The legislature recognized provider rates as a key issue through the following:

- The budget, **Public Act 07-1 (6/26/07 signed by Governor)**, provides the following fee-for-services rate increases:
  - 50% for physicians
  - 40% for clinics
  - 40% for dental providers
  - 40% for vision providers
  - 20% for personal care assistants

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- **Section 101** of the budget, **Public Act 07-1 (6/26/07 signed by Governor)**, provides a cost of living increase of 3% in FY'08 for private providers that contract with DMR, DMHAS, DCF, DSS, DPH, the Department of Correction, the Judicial Department and the Council to Administer the Children's Trust Fund.

**Section 101** is anticipated to be applied to all providers that contract with the CHCPE.

A final note concerning "re-balancing" is that **Section 2 of Committee Bill 5639 (6/21/07 Public Act 07-209, effective from passage, 6/6/07 House passed as amended by Senate Amendment Schedule A and House Amendment Schedule A, 6/6/07 Senate passed as amended by Senate Amendment Schedule A and House Amendment Schedule A)** extends the moratorium on new nursing facility beds through 2012.

## **II. Medicare Part D Wrap-Around/CHOICES**

### **A. Medicare**

#### **Issue:**

Connecticut has demonstrated commitment to "hold harmless" people who are dually eligible for Medicare and Medicaid, and those who participate in ConnPACE, both of which populations now depend upon Medicare as the primary payer for prescription drug coverage. Connecticut law provides ongoing State coverage for many of the out-of-pocket costs not covered by Part D. Further, in the 2006 session, the Legislature appropriated \$5 million in the SFY'07 budget to create a Medicare Part D "Supplemental Needs" fund to cover medically-necessary drugs that are not on a dually eligible or ConnPACE enrollee's Part D plan formulary. Also in the 2006 session, the Legislature appropriated an additional \$1.5 million to DSS and directed it to use those funds to contract with an outside organization to assist consumers with the Medicare Part D exceptions (appeals) process.

#### **Position:**

- Support continued, full protections for participants in the ConnPACE and Medicaid programs who must rely on Medicare Part D to cover their prescription drugs (e.g. effective and adequate coverage of non-formulary drugs, protection of current dosage supplies available for each co-payment, and meaningful "exception" and appeal rights) as the Medicare Part D prescription drug benefit continues to be implemented.

#### **Background:**

**Sections 18-21 and 27-29 of Public Act 05-280**, enacted during the regular session in Spring, 2005, provided initial details of Connecticut's wrap-around.

#### **Dual-Eligibles:**

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P.A. 05-280 confirmed that as of the date of implementation of Medicare Part D (January 1, 2006), those who had historically received drug coverage as part of their Medicaid benefits would instead exclusively receive that coverage through Part D.

P.A. 05-280 also provided coverage for certain non-Part D drugs that were covered through December 31, 2005 by Medicaid.

**ConnPACE Participants:**

As conditions of eligibility for the ConnPACE program, P.A. 05-280 required participants 1) to select and enroll in a Medicare Part D plan; 2) to disclose information on income and assets; and 3) to appoint DSS as authorized representative for default selection of and enrollment in a plan and for purposes of appeal of denial of benefits.

P.A. 05-280 also provided that DSS would cover Medicare Part D monthly premiums, drugs needed during the “gap” period under the federal coverage, and prescription drug costs (co-payments and deductible requirements) over the standard \$16.25 co-payment unless there was a less expensive equivalent in the same category of drugs, whereupon the participant would be responsible for the difference.

Finally, P.A. 05-280 provided that participants would pay the actual cost of a given drug if it was less than \$16.25.

Separately, **Section 21 of Public Act 05-280**, also enacted in the regular session in Spring, 2005, required that ConnPACE participants make a \$16.25 co-payment when re-filling a prescription that has been lost, stolen or destroyed.

Following on calls to address several remaining gaps, legislators passed **Public Act 05-2**, An Act Concerning Implementation of the Medicare Part D Program, during a special session in November, 2005. P.A. 05-2 fully resolved two of the identified gaps, covering co-payments obligated of those dually eligible for Medicare and Medicaid and ensuring that ConnPACE participants pay no more than \$16.25 per prescription during the federal "gap" period. Less fully resolved, however, was the issue of coverage for non-formulary drugs. Although the act set up a \$5 million "Medicare Part D Supplemental Needs Fund" (the Fund) to provide some coverage of medically necessary non-formulary drugs, there were immediate concerns that it would not be adequate to meet existing need.

Aware that the primary concern was ensuring coverage of non-formulary drugs, legislators again addressed wrap-around issues in the 2006 Session. The final result fulfilled two of those recommendations: 1) a SFY'07 appropriation for the Fund; and 2) establishment of a mechanism through which consumers seeking coverage for non-formulary drugs could be represented in the Medicare Part D “exceptions” process.

The budget bill, **Public Act 06-186** provided \$5 million in funding for non-formulary drugs through the Fund and \$1.5 million in support of the contract for exceptions.

Details on how coverage of non-formulary drugs would work were provided by **Section 13 of Public Act 06-188**, which established, where a ConnPACE or

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Medicaid recipient is denied coverage for a non-formulary drug by a Medicare Part D plan, that:

- 1) after the individual makes any required co-payment, DSS would cover a 30-day-supply of such drug;
- 2) DSS was appointed as authorized representative for purposes of the exceptions process;
- 3) DSS was authorized to contract with an organization to seek exceptions;
- 4) this organization would be charged with pursuing exceptions at least through the Independent Review Entity level; and
- 5) DSS would continue to pay for the drug until the plan agreed to pay for the drug, the exception was successful or, further appeal was unwarranted, or, if none of those occurred, for the remainder of the calendar year.

Further, **Section 14 of Public Act 06-188**, among other provisions, 1) required participants of the Connecticut AIDS Drug Assistance Program (CADAP) to participate in a Medicare Part D plan; and 2) permitted DSS to cover their Part D premiums and co-payments.

Finally, **Public Act 06-170 (signed by the Governor on 6/6/06)** created a council to advise DSS on Part D implementation. (this has not been convened to date)

### **2007 Session Results:**

DSS must be commended for implementing Connecticut's Part D "wrap-around" in a flexible and consumer-oriented manner. The consistent experience throughout the past year was that DSS staff responded to issues that arose in the first stages of administering the benefit with pharmacies statewide in an expedient and consumer-oriented manner.

Despite this encouraging context, **Section 4 of Public Act 07-2 (6/26/07 signed by the Governor)**, the DSS/DPH "implementer", includes several potentially problematic changes to the existing "wrap-around" statute:

- first, it modifies the current prior authorization requirements for obtaining coverage for non-formulary drugs by removing the requirement that DSS "expeditiously review all requests" and notify the beneficiary within two hours as to whether the request has been granted;
- second, it removes the requirement that DSS contract with "an entity specializing in Medicare appeals" and substitutes language reflecting its practice of handling these exceptions internally; and
- third, it limits in statute the appropriation for the Medicare Part D Supplemental Needs Fund to the FY'06 amount (\$5 million).

The last item is of particularly serious concern in that the appropriation may not, in the future, be sufficient to cover all requests for coverage of needed non-formulary drugs, once all other administrative means (the "exceptions" process) have been pursued.

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A final note on Medicare Part D “wrap-around” is that **Section 21 of Public Act 07-2 (6/26/07 signed by the Governor, effective from passage)**, the DSS/DPH “implementer”:

- prohibits pharmacies from submitting prescription drug claims to DSS unless the involved individuals’ drug coverage has been exhausted;
- authorizes DSS to recoup payments made on claims where other coverage is available; and
- permits DSS to investigate pharmacies that consistently submit ineligible claims.

## **B. CHOICES**

### **Issue:**

Connecticut’s Program for Health Insurance Assistance, Outreach, Information & Assistance, Counseling & Eligibility Screening (CHOICES) has been identified as the focal point for information and referral regarding health care coverage by numerous state and national sources. The CHOICES program, a collaborative effort among the CT Area Agencies on Aging, the State Unit on Aging (DSS-Aging Services Division), the Center for Medicare Advocacy (the Center), and numerous community partners, including senior centers, provides older consumers, caregivers and individuals with disabilities with unbiased and comprehensive information on Medicare, Medigap, Medicaid, and a range of community resource topics. Since 2005, it has seen exponential growth in requests for assistance because of its outreach and educational activities in support of implementation of Medicare Part D. In 2006, with temporary federal grant funding, CHOICES helped 60,000 individuals and caregivers navigate the Medicare Part D benefit and held almost 900 outreach presentations and forums. This funding was dramatically reduced in July 2006 and expired in April 2007.

### **Position:**

- Appropriate \$2 million in support of CHOICES’ efforts to help older adults navigate the complex Medicare Part D program and to make effective long-term care decisions.

### **Background:**

Education of consumers regarding financial planning, the limited scope of public benefits, and available home and community-based options will be a key component of Connecticut’s efforts to rationalize and rebalance its long-term care spending. This is evidenced by diverse sources.

Preliminary results of the consumer survey component of the Connecticut Long-Term Care Needs Assessment [University of Connecticut, 2007] indicate:

*People have limited resources set aside for long-term care and have done little in the way of long-term care planning. Some people continue to erroneously believe long-term care costs will be paid by Medicare or private health insurance.*

*Finances and lack of knowledge about services are the primary barriers to receiving services.*

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Further, the reissued Connecticut Long-Term Care Plan [January, 2007] states:

*Individuals often do not seek information about long-term care until they are in a crisis situation and need immediate help. At that point it is difficult to navigate the complex systems to get needed information so that supports can be secured quickly. Minority families are even less likely to have information about available supports due to cultural assumptions that such supports should be provided by families. Often this lack of information leads individuals to assume that institutional placements are their only option.*

#### **Action Steps**

*Initiate public/private partnerships to enhance public education regarding all aspects of the long-term care system in Connecticut. This should be done, in part, by building upon existing resources such as CHOICES and Infoline.*

Through the CHOICES program, AAA and CMA staff and volunteers have over the past three years provided Medicare Part D outreach, education and enrollment assistance to tens of thousands of older adults, individuals with disabilities and family caregivers.

Over and above this critical Medicare Part D work, CHOICES has for the last twelve years also:

- connected older consumers and their caregivers through a one-source 1-800 number with clear, unbiased and comprehensive oral and written resource information on Medicare, Medicare supplement insurance (Medigap), Medicaid, Connecticut Partnership for Long Term Care policies, entitlements and community-based services;
- empowered older adults to make informed and autonomous choices;
- provided older adults and others with a meaningful volunteer opportunity; and
- ensured that elderly services professionals have a reliable and current source of training and materials to help them optimally serve their clients.

#### **2007 Session Results:**

**Public Act 07-155 (6/25/07 Signed by the Governor, effective July 1, 2007)** expands the existing statutory description of the role of the CHOICES program to include 1) Medicare Part D and long-term care options; and 2) collaboration with state agencies and other entities on the long-term care web site.

**Sections 59 (g) and (h)** of the budget , **Public Act 07-1 (6/26/07 signed by the Governor, effective 7/1/07)**, transfer \$1 million in each of Fiscal Years '08 and '09, from the Tobacco and Health Trust Fund to DSS for the CHOICES Program.

### **III. Improvements in Senior Housing**

#### **Issue:**

The stock of affordable housing for older adults and individuals with disabilities, much of which was built in the 1970's, is in poor repair and in need of capital improvements. Notable among these needs is the fact that many buildings still rely on electricity as the primary source for heat. Significant increases in electric rates have made it increasingly untenable for these fixed-income tenants to pay their utility bills.

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Further, tenants of these buildings are in need of support from skilled, on-site staff capable of addressing service needs and connecting them with the provider network to enhance their capacity for safe and fulfilled independence in the community.

**Position:**

- Fund capital improvements for existing senior housing and expand the availability of Resident Services Coordinators.

**Background:**

In 2004, staff of the Legislative Program Review and Investigations Committee released a major study on issues of concern (safety, potential for conflicts, need for supportive services) raised by advocates for both older adults and individuals with disabilities residing together in subsidized housing. After evaluating five potential planning strategies, the Committee made the following recommendations:

- 1) that DECD revise and update its operating manual and practices (e.g. eviction) to ensure compliance with federal/state law;
- 2) that by July 1, 2005, DSS, DMHAS, DMR jointly review and expand the existing resident service coordinator job description to include work with individuals with disabilities, and then provide training to equip these individuals to do so;
- 3) that the agency establish stronger contacts with local housing authorities;
- 4) that a comprehensive assessment of current and future needs for rental assistance be performed; and
- 5) that the Legislature annually appropriate \$10 m. to create additional affordable housing for low-income elderly and disabled persons.

In 2005, the Legislature furthered these recommendations in enacting the following:

- **Public Act 05-206** supplemented the existing duties of resident service coordinators (RSC's) with responsibilities for conflict resolution, liaison work with community providers, orientation of new residents, and organizing opportunities for socialization; and permitted the Department of Economic & Community Development (DECD) to provide monthly RSC training.
- **Public Act 05-239** implements the recommendations of the Legislative Program Review and Investigations Committee. It 1) obligates state agencies to support housing authorities in identifying and accessing services for residents; 2) requires DECD to conduct an assessment of current and future need for subsidized housing for the elderly and those with disabilities; 3) requires DECD to create an inventory of accessible housing; and 4) requires DECD, in consultation with other agencies, to evaluate role and oversight of RSC's.

Disappointingly, however, in 2006 Session, **Senate Bill 357**, which sought to 1) require DSS to partner with DECD, DMHAS and CHFA to establish a program of rental assistance and supportive services for nonelderly individuals with disabilities living in public or private housing, and provide \$2.5 m. in support of such program; 2) provide \$1 m. in grants-in-aid for resident services coordinators; and 3) provide \$2 m. for rental assistance for the elderly died in committee.

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### **2007 Session Results:**

**Public Act 07-1 (6/26/07 signed by the Governor)**, the budget, includes \$1 m. in funding in the DECD budget for resident services coordinators.

## **IV. Support for Elderly Nutrition Program**

### **Issue:**

State match and state supplemental funds for home-delivered and congregate meal programs are provided through the “Elderly Services” line item of the Dept. of Social Services budget. These critical funds are inadequate to meet the growing demand in Connecticut, especially given significant recent reductions in federal funding. Home-delivered meals are a core long-term care support for frail, homebound elders representing a vital source of balanced nutrition, a social connection with the delivery person, and an essential element of preventative health. Congregate meals have similar nutritional and psycho-social benefits.

### **Background:**

Dietary quality/good nutrition plays a key role in preventing or delaying the onset of chronic diseases (Federal Interagency Forum on Aging-Related Statistics, 2000). In a national study conducted by the Interagency Forum and based on the U.S. Department of Agriculture’s food guide pyramid and dietary guidelines for Americans, 67% of individuals age 60 and older reported diets that need improvement. The study further revealed that older persons living in poverty (21%) were more likely to report poor diets than were older persons living above the poverty line (11%). Scores for older persons were lower on components of the instrument measuring daily servings of fruit and dairy products.

Social support is believed to exert a beneficial effect on food intake and dietary habits among older Americans, especially when they are asked to follow dietary modifications or when they have difficulty performing routine activities of daily living. Research conducted by the University of Connecticut and published in the *Journal of the American Dietetic Association*, concludes that single low-income older women living in subsidized housing (living in one of 1,916 housing units in one of 16 Connecticut towns) are at nutritional risk and would benefit from social support. In this study social support is defined as an interaction, distinct from social contact or companionship, extended in response to an identified stressor. (Pierce, 2000). Community café meals are specifically intended to combine the nutritional benefits of a balanced meal with the socialization opportunities available in a group setting, thereby meeting the need for social support.

The nutritional needs of the elderly as perceived by the elderly community were assessed by the Senior Nutrition Awareness Program (SNAP) at the Universities of Connecticut and Rhode Island. Conducted in early 2000, the survey revealed the following nutritional needs:

- 22% reported the need for help with shopping and cooking;
- 19% reported they ran out of food frequently;
- 15% reported they didn’t have enough money to purchase all the food they need;

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- 10% reported they eat fewer than 2 meals a day;
- 15% reported they participate in free food programs when available; and
- 25% reported they currently receive food stamps.

Last year, 27,000 older adults received 2,479,375 meals through the Connecticut Elderly Nutrition Program. Of these, 1,497,385 were home-delivered meals and 981,990 were congregate meals.

In 2006, Connecticut received \$4,103,847 in Title IIIC-1 (congregate meals) and \$2,250,669 in Title IIIC-2 (home-delivered meals) funding from the Administration on Aging, Older Americans Act. In addition, Connecticut received \$1,081,969 in Nutritional Services Incentive Program (NSIP) dollars to assist in the operation of the Elderly Nutrition Program. The State of Connecticut contributed \$3,051,792 in matching funds to the Nutrition Program. Finally, \$447,936 in Social Services Block Grant funds were used. Total dollars spent on elderly nutrition equaled \$10,936,213.

Since 2004, Connecticut's allotment of Older Americans Act nutrition funds has increased by less than 1% and NSIP funding has decreased by over 4%. While the Department of Social Services was in SFY'06 able to absorb reduction of federal funds by utilizing underruns in other accounts, in SFY'07, it took an additional State appropriation of \$800,000 over previous State funding levels to do so. Without renewal of this additional financial support from the State, programs faced with hard realities of increased staffing, gas and other operating costs will otherwise be forced to reduce the number of people served.

#### **Positions:**

- Maintain and enhance funding for the Elderly Nutrition Program.

#### **2007 Session Results:**

Pending release of details on the "Elderly Services" line of the DSS budget.

## **IV. Other Bills of Interest**

### **Favorable Action**

#### **Alzheimer's Respite**

- **Funding: Public Act 07-1 (6/26/07 Signed by the Governor)**, the budget, appropriates an additional \$1 million to the Statewide Respite Program (total FY'07 budget figure = \$2,294,388).

#### **Assisted Living**

- **Standards for Managed Residential Communities - Sections 30 through 43 of Public Act 07-2 (6/26/07 signed by the Governor, with exception of Sections 32 & 33, which are effective April 1, 2008, all sections effective October 1, 2007)**, the DSS/DPH implementer, 1) create statutory definitions of relevant terms (e.g. "managed residential community" and "assisted living

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services agency”); 2) require assisted living residences to provide written residency agreements, facilitate access to assisted living services, maintain individualized service plans, arrange for ancillary medical services for residents, and distribute and post a residents’ bill of rights document (including contact information for the Department of Public Health and the Office of the State Long-Term Care Ombudsman); 3) require that DPH review each site biennially; 4) establish notice and appeal procedures for situations in which DPH identifies violations; and 5) prohibit residences from entering into contracts with individuals who require 24-hour care unless the resident has arranged for and maintains such care.

### **Fall Prevention**

- **Fall Prevention: Public Act 07-1 (6/26/07 Signed by the Governor)**, the budget, appropriates \$500,000 in support of fall prevention.

### **Grandparents Raising Grandchildren**

- **Financial Support: Section 2 of Public Act 07-2 (6/26/07 Signed by the Governor, effective 7/1/07)**, the DSS/DPH “implementer”, requires the DSS commissioner to annually increase the payment standards (benefits) in the Temporary Family Assistance (TFA) by the percentage increase, if any, in the most recent calendar year average in the consumer price index for urban consumers over the average for the previous year, up to 5%. This rate increase will benefit children being cared for by relative caregivers as most are eligible to receive support through a TFA “child –only grant”.
- **Guardianship Subsidies/Notice in Legal Proceedings: Public Act 07-174 (7/5/07 Signed by Governor, effective 10/1/07)** seeks 1) to provide guardianship subsidies to half and step-siblings of children who are living with relative caregivers; and 2) to allow relative caregivers to receive notice of and appear at legal proceedings concerning a child in foster care.
- **Extended Family Guardianship and Assisted Care Pilot Program: Section 6 of Public Act 07-4 (6/29/07 Signed by the Governor, effective 10/1/07)**, the OPM “implementer”, establishes an Extended Family Guardianship and Assisted Care Pilot Program in the regional children’s court for the district of New Haven.

### **Home Care**

- **Personal Care Assistant Pilot: Section 9 of Public Act 07-130 (6/19/07 Signed by the Governor, effective 10/1/07)** removes the cap (currently 150) on participation in the state-funded personal care assistance pilot.

### **Insurance**

- **Refund of Prepaid Premiums on Cancellation of Medigap Policy: Public Act 07-48 (5/22/07 Signed by Governor, effective 10/1/07)** requires providers of Medigap plans to refund any prepaid premium paid by a policyholder who chooses to cancel his/her policy prior to its expiration date.
- **Non-Forfeiture Benefits in Long-Term Care Insurance Policies: Public Act 07-28 (5/18/07 Signed by the Governor, effective 7/1/07)** seeks to require

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issuers of long-term care insurance policies to offer purchasers optional “non-forfeiture” benefits.

- **Expanded Elimination Period for Long-Term Care Insurance Policies:** **House Bill 7283 (6/25/07 Public Act 07-226, 6/6/07 Senate passed as amended by House Amendment Schedule A, 5/31/07 House passed as amended by House Amendment Schedule A)** seeks 1) to establish a long-term care policy with an elimination period of up to a) up to 100 days of “confinement”; or b) between 100 days and two years where there is in place an irrevocable trust that is estimated to be sufficient to pay for that period; and 2) to require any such trust to make payments directly to health care providers.

#### **Long-Term Care Needs Assessment Issue Briefs:**

- **Public Act 07-1 (6/26/07 Signed by the Governor,)**, the budget, includes, in the budget for the Commission on Aging, \$100,000 in support of use of the data derived from the state-wide long-term care needs assessment to develop “issue briefs” on specific topics of interest.

#### **Medicaid**

- **Eligibility Guidelines - Limitation on Use of “Spousal Refusal”:** **Section 6 of Public Act 07-2 (6/26/07 Signed by the Governor, effective 7/1/07)**, the DSS/DPH “implementer” 1) limits the right of Medicaid applicants who are in need of or receiving institutional care from assigning right of support to DSS to situations in which a) the applicant’s assets are less than or equal to the Medicaid asset limit; and b) the applicant cannot locate the community spouse, or the community spouse is unable to provide information about his or her assets; and 2) authorizes DSS to seek recovery of monies paid on behalf of the institutionalized spouse up to the amount in excess of the community spouse protected amount held by the community spouse.
- **Process for Medicaid “Waiver” Applications:** **Raised House Bill 7065 (6/1/07 Transmitted to Secretary of State, 5/31/07 Public Act 07-83, effective 7/1/07, 5/22/07 Veto overruled by House and Senate, 5/16/07 Vetoed by Governor)** seeks 1) to require that any waiver application submitted per C.G.S. Section 176-8 reflect any comments made by the committees of cognizance; and 2) to establish that DSS may not submit a waiver application that has been denied by those committees.

#### **Medicare**

- **Consumer Protections for Medigap Plans:** **Public Act 07-48 (5/22/07 Signed by Governor, effective 10/1/07)** requires providers of Medigap plans to refund any prepaid premium paid by a policyholder who chooses to cancel his/her policy prior to its expiration date.

#### **Nursing Home Issues**

- **New Hearing Requirements and Extension of Moratorium:** **Committee Bill 5639 (6/25/07 Transmitted to the Secretary of the State, 6/21/07 Public Act 07-209, 6/6/07 House passed as amended by Senate Amendment Schedule A**

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**and House Amendment Schedule A, 6/6/07 Senate passed as amended by Senate Amendment Schedule A and House Amendment Schedule A)** seeks 1) to require DSS to hold a public hearing within 30 days of the date on which an owner submits a letter of intent or applies for a CON to establish a new facility, modify an existing facility, make certain capital expenditures or close a facility; 2) to authorize DSS to impose up to a \$5,000 penalty where a facility fails to comply; and 3) to extend the moratorium through 2012.

- **Dementia-Specific Direct Staff Training Requirements: Public Act 07-34 (5/18/07 Signed by Governor, effective 10/1/07)** requires dementia-specific minimum training requirements for all staff who provide direct care, not just, as was enacted in 2006, those who are “licensed and registered”.
- **Reimbursement: Sections 11-13 of Public Act 07-2 (6/26/07 Signed by the Governor)**, the DSS/DPH implementer, provide a 2.9% rate increase for nursing facilities and ICF-MR’s effective July 1, 2007.
- **Provider Tax: Section 1 of Public Act 07-2 (6/26/07 Signed by the Governor)**, the DSS/DPH “implementer” lowers the maximum nursing home provider tax from 6% to 5.5%, effective January 1, 2008.

#### **Probate Matters**

- **Conservatorship:**
  - **Public Act 07-116 (6/11/07 Signed by the Governor, effective 10/1/07)** makes revisions to the conservatorship statutes including 1) stronger notice requirements; 2) guidance on appointment of counsel for the respondent; 3) a prohibition on serving as both counsel for the respondent and guardian ad litem or conservator; 4) a requirement that jurisdiction be established by clear and convincing evidence; 5) adoption of new procedural protections (e.g. use of rules of evidence, taping of hearings; 5) enhanced guidance on standards for appointment of and role of conservators; 6) adoption of a rebuttable presumption of limited conservatorship; and 7) standards for appeals.
  - **Public Act 07-117 (6/11/07 Signed by the Governor, effective 10/1/07)** clarifies appointment and powers of conservators and special limited conservators with respect to psychiatric treatment.
- **Health Care Decision-Making: Sections 1-2 and 18-21 of Raised Senate Bill 7163 (6/29/07 Transmitted to Secretary of State, 6/28/07 Public Act 07-252, 6/6/07 Senate passed as amended by House Amendment Schedules A & B, 6/6/07 House passed as amended by House Amendment Schedules A & B )** seek to make technical corrections to the advance directives statutes that were amended in the 2006 session.
- **Court Administration: Public Act 07-184 (7/5/07 Signed by the Governor)** seeks to 1) expand the existing description of court facilities to include court recording systems and equipment; 2) authorize the Probate Court Administrator to issue and enforce regulations concerning audits, reassignment and transfer of cases, and training and continuing education for judges and court personnel; 3) provide a process for intervention in situations in which a court has not complied with the law, has not expeditiously heard a matter or has not provided suitable

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court facilities; 4) establish authority for “special assignment judges”; 5) require that courts observe minimum hours of operation (at least 20 hours per week, Monday through Friday); and 6) provide new notice requirements for actions concerning guardianship and termination of parental rights.

- **Public Act 07-32 (5/18/07 Signed by the Governor, effective 10/1/07)** seeks to increase from \$20,000 to \$40,000 the property value cap on filing an affidavit in lieu of admission of a will to probate.

## **State Structure**

- **Department on Aging**
  - **Extension of Implementation Date: Section 25 of Public Act 07-2 (6/26/07 Signed by the Governor, effective upon passage)**, the DSS/DPH “implementer”, 1) defers implementation of the Department on Aging until 7/1/08; and 2) provides a general description of the duties of the Department.
  - **Use of FY’08 Funding: Section 117 of Public Act 07-1 (6/26/07 Signed by the Governor)**, the budget, transfers in FY’08 to DSS: 1) \$100,000 of the funds appropriated for the State Department on Aging for the purposes of analyzing and recommending the best structure, services, staffing and allocation of funds for the establishment of the new department; and 2) \$350,000 of the funds appropriated for the State Department on Aging to enhance elderly services.
- **Department of Developmental Disabilities**
  - **Public Act 07-73 (5/30/07 Signed by Governor, effective 10/1/07)** re-names the Department of Mental Retardation the Department of Developmental Services.

## **Taxation**

- **Individual Savings Accounts for Long-Term Care: Public Act 07-130 (6/19/07 Signed by the Governor, effective 10/1/07)** creates individual savings accounts to which tax-deductible contributions can be made for later coverage of certain long-term care expenses through “eligible home care providers”.

## **Transportation**

- **State Matching Grant Program: Public Act 07-1 (6/26/07 Signed by the Governor)**, the budget, appropriates full funding of \$10 million in both fiscal years.
- **Independent Transportation Networks: Public Act 07-1 (6/26/07 Signed by the Governor)**, the budget, includes \$250,000 in support of the ITN Program. Of this, \$125,000 will be used to provide five \$25,000 grants to each of the existing ITN projects, and \$125,000 will fund five \$25,000 grants to new projects.

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- **Assistive Devices on Vehicles:** **Public Act 07-134 (6/19/07 Signed by the Governor, effective October 1, 2007)** seeks to require that various types of vehicles (e.g. livery, invalid coaches, school buses, ambulances) be equipped with assistive devices to ensure the safety of those who use wheelchairs.

#### **Veterans' Benefits**

- **Burial Expenses:** **Section 45 of Public Act 07-2 (6/26/07 Signed by the Governor, effective 7/1/07)**, the DSS/DPH "implementer", increases from \$150 to \$1,800 the maximum state-funded burial benefit for indigent veterans.

#### **No Action/Veto**

##### **Assisted Living**

- **Various:** Bills that sought 1) to increase funding for the assisted living pilots; 2) to cover long-term placement under Medicaid; and 3) to establish a set-aside percentage of units in each MRC to accommodate Medicaid-funded residents and to ensure Medicaid payment for such residents died in the Human Services Committee. Bills that sought 1) to permit individuals younger than age 55 to utilize assisted living services; 2) to appropriate \$500,000 to help clients of DMR to move into MRC's; and 3) to restrict use of the term "assisted living facility" to those entities licensed by DPH died in the Public Health Committee. A bill that sought to increase the number of slots in the assisted living pilots from 75 to 300 died in the Appropriations Committee.

##### **ConnPACE**

- **Eligibility Guidelines:** Bills that sought: 1) to provide graduated ConnPACE benefits; 2) to increase ConnPACE income eligibility limits by 20% and to permit buy-in on a sliding scale basis by higher income individuals; and 3) to provide coverage for annual physical examinations for participants of the ConnPACE program died in the Human Services Committee.
- **Prior Authorization Process:** A bill that sought to require DSS to implement consumer protections (e.g. expedited approval process, adequate supply pending resolution of any appeal, limitation on use of prior authorization for individuals who require the same prescription drugs) in the use of preferred drug lists and prior authorization procedures and to evaluate the effectiveness of those procedures died in the Appropriations Committee.

##### **Consumer Protections**

- **Bank Records:** A bill that sought to prohibit individuals and entities from charging fees for accessing or disclosing records (e.g. bank statements) that are needed in support of an application for medical assistance or other state program, was not acted upon prior to the end of the session.
- **Money Management Assistance:** A bill that sought to appropriate \$600,000 to DSS in support of a new state-wide money management program for low-income older adults and individuals with disabilities died on the House calendar.

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### **Grandparents Raising Grandchildren**

- **Various:** Bills that sought 1) to permit grandchildren of residents age 55 and older to live with them in elderly housing (Housing Committee); and 2) to increase State funding of the free and reduced lunch program to provide free lunches to children who are in the custody of grandparents or foster grandparents (Education Committee) died in committee.

### **Home Care**

- **Eligibility:** A bill that sought to increase the asset limit for the State-funded component of the CHCPE to \$50,000 for an individual and \$75,000 for a married couple died in the Human Services Committee.

### **Housing**

- **Various:** Bills that sought 1) to limit residency in state-funded housing projects to those age 62 and older; 2) to prohibit smoking in elderly housing; and 3) to preserve affordability of accessory apartments died in the Housing Committee.
- **Enhanced Support for Older Adults and Individuals with Disabilities:** A bill that sought to 1) provide \$2 m. for rental assistance for the elderly; and 2) require DSS to partner with DECD, DMHAS and CHFA to establish a program of rental assistance and supportive services for nonelderly individuals with disabilities living in public or private housing, and provide \$2.5 m. in support of such program died in the Appropriations Committee.

### **Insurance**

- **Various:** Bills that sought: 1) to require that issuers of long-term care policies annually issue to insureds detailed disclosures on the benefits and limitations of policies; 2) to require all health insurers in the State to offer long-term care insurance to any person requesting such coverage; and 3) to lower from 62 to 55 the age of eligibility for auto insurance discounts that are based on completing an accident prevention course died in the Insurance Committee. A bill that sought to appropriate \$1 million and to require that DSS use these funds to establish a hearing aid assistance program to pay for up to 25% of the cost of an aid for individuals age 65 and older who meet annual income eligibility requirements (individual < \$23,100; couple < \$31,100) and who do not have other insurance coverage for aids died in the Appropriations Committee.

### **Medicaid**

- **Medicaid Cost-Sharing Programs:** A bill that sought to require that DSS increase the income disregards used to determine eligibility for the Medicaid cost-sharing programs (QMB, SLIMB) such that more individuals would have been eligible for low-income subsidies under Medicare Part D, died on the House calendar.
- **Eligibility Standards:** Bills that sought to increase the medically needy income limit were not acted upon by the end of the session.

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- **Coverage:** Bills that sought 1) to require that the Medicaid State Plan be amended to cover as optional services chiropractic, natureopathy, podiatry, psychology, optometry, audiology, speech pathology, optician service, hospice and personal care assistant services; and 2) to create a state-funded pilot to permit 75 individuals with incomes in excess of 300% of SSI to remain in residential care homes died in committee.
- **Provider Reimbursement:** A bill that sought to require DSS to fully reimburse medical providers that serve those dually eligible for Medicare and Medicaid died in committee.

### **Nursing Home Issues**

- **Various:** Bills that sought: 1) to increase requirements for direct care staffing levels in nursing homes; 2) to authorize DPH to disclose investigative reports concerning care to a member of the complainant's family; 3) to allow nursing homes to establish feeding assistance training programs; 4) to require nursing homes and adult day care facilities to provide air conditioning; and 5) to bar individuals with psychiatric disabilities from being admitted unless the patient is assessed by a psychiatrist and the facility determines that it is capable of meeting the individual's needs, died in the Public Health Committee. A bill that sought to provide protections for residents during periods of receivership and to provide a process for rate adjustments during such periods died in Appropriations.

### **Probate**

- **Electronic Registry of Advance Health Care Directives: Raised Senate Bill 1144,** which sought 1) to create an advance directives index housed by the Office of the Secretary of State; and 2) to specify that health care providers would not be required to use the index, died on the House calendar.

### **Taxes**

- **Income Tax:** Bills that sought: 1) to exempt all or part of pension and Social Security income from the state income tax either on an immediate or a phased-in basis; 2) to exempt veterans' pensions from the state income tax; 3) to create new income tax credits (e.g. for expenses related to caregiving or to those who purchase long-term care insurance policies; and 4) to create new income tax deductions for long-term care expenses and for premiums paid out on long-term care insurance policies all died in committee.
- **Property Tax Abatements Based on Volunteer Service:** A bill that sought to permit property tax abatements based on volunteer service died on the House calendar.
- **Estate Tax:** A bill that sought to 1) clarify that property in which a QTIP election was made prior to 1/1/05 is not part of the taxable estate; 2) clarify that Connecticut does not have jurisdiction over out-of-state property; 3) eliminate the "cliff"; and 4) increase the tax rate, died on the Senate calendar.