2005 Connecticut Elder Action Network (CEAN) Legislative Priorities:

Medicare Part D, ConnPACE and Medicaid Programs

Issue:

Beginning in January, 2006 Medicare will include a prescription drug benefit under a new Part D which is part of the Medicare Modernization Act of 2003, passed in December 2003. With the advent of Medicare Part D, individuals eligible for both Medicaid and Medicare, known as "dually eligible", will be required to obtain their prescription drug coverage under Medicare, not Medicaid. In addition, people who participate in the ConnPACE program will also be eligible for assistance under the Part D program.

These new benefits provide both an opportunity and a challenge for Connecticut's low-income elders and people with disabilities, as well as for the State. With help from Connecticut's legislature, these vulnerable individuals can participate in the new federal prescription drug program without losing the valuable assistance that they have been receiving from Medicaid and ConnPACE.

It is our goal to ensure that those who are currently receiving drug coverage through Medicaid or ConnPACE do not have higher costs for prescription drugs or fewer available covered drugs once they begin participating in the Medicare Part D program. We want to help the State obtain savings from shifting some of this important medical coverage to the new federal program, but not at the expense of this older, disabled, and poor population.

Positions:

In particular, CEAN supports the following core principles:

- that dually eligible individuals and people on ConnPACE retain access to at least as many prescription drugs as they would have if they were not required to move to Medicare Part D;
- that dually eligible individuals and people on ConnPACE have no greater co-insurance than they would have if they were not required to move to Medicare Part D;
- that dually eligible individuals have no fewer appeal rights, and access to the medications ordered by their physicians pending an appeal decision, than they would have if they were not required to move to Medicare Part D; and
- that all reasonable efforts are made to automatically enroll eligible individuals in Part D.

Many details and other issues about Medicare Part D and Connecticut's elderly and disabled population will need to be discussed. Medicare Part D is a complicated program and the transitions ahead will require much work. We hope that the principles stated above and good faith efforts from all stakeholders will make this a successful endeavor for all concerned.

Restoration of the Commission on Aging

The Commission on Aging, which is charged by statute with advocating on behalf of the elderly, is the only state agency solely devoted to focusing on the needs of present and future generations of elders. In recent years, the Commission staff has been reduced from four employees to one – an Executive Director – and the total budget reduced by 58%. The Commission on Aging (off the administrative branch of government) is clearly not at parity with other state Commissions with similar breadth and scope of charge (affiliated with the legislative branch).

At the same time that its resources have been reduced, need for the Commission's work is increasing with Connecticut's elderly population on the verge of profound growth. While the Commission (staff of one, Board, volunteers and interns) has proven its dedication and resourcefulness during this difficult period, it is burdensome, inappropriate and unfair for the Commission to further its work without adequate funding and staff. To meet the complex needs of a burgeoning aging population, restoration and parity are essential.

Positions:

- support efforts to restore program budget for staff and other priorities to $300,000
- support efforts to co-locate the Commission with others at the Legislature

Transportation

Issue:

Transportation is a vital link between older adults, community services and social connections that promotes high quality of life. Currently, elders struggle to utilize a fragmented system of public, quasi-public and private transportation services that has posed significant challenges of coordination. Those seeking rides are faced with diverse eligibility standards, confusion over service times and geographic boundaries, increasing out-of-pocket costs, and limitations on the type of rides that are covered (e.g. non-medical and weekend rides are not commonly covered). Even more important is that cuts in program funding have meant that many have gone without needed rides.

Both the Connecticut Long Term Care Plan and the Legislative Program Review and Investigations (LPRI) Committee have recognized transportation as an essential facet of a workable and affirmative system of long-term care supports. Remedies that have been proposed include improved coordination among transit districts, additional state funding for demand transportation, and need-based distribution of funds throughout the state. Public Act 99-265 required the Legislature's transportation committee to establish statewide objectives for providing transportation to certain constituencies; notably, older adults, those with disabilities and those eligible for Americans with Disabilities Act-funded rides. Further, it provided for a state-funded grant program through on which apportionment of funds to the towns was to be premised. As no new funds were appropriated for these purposes, however, neither initiative has yet been implemented.

Another important element of ensuring an effective system of long-term care is to provide adequate coverage of transportation costs involved in providing home care and adult day care services. Currently, Medicaid reimbursement rates to homemaker and companion agencies do not adequately compensate them for mileage, insurance or parking costs associated with rides provided by their staff. Similarly, the per diem reimbursement rate to adult day care centers does not compensate for the costs of transporting clients to and from sites.

Positions:

- support efforts to fund the Municipal Elderly and Disabled Transportation Matching Grant Program established under the Connecticut General Statutes 13b-38bb
- support efforts to formally assess service definitions and adequacy of reimbursement rates to home care and adult day care providers and make adjustments to accommodate uncovered costs
- support efforts to establish statewide objectives for providing transportation to specific constituencies; notably, older adults, those with disabilities and those eligible for rides funded through the Americans with Disabilities Act
- support efforts to fund innovative transportation programs on a pilot basis

Recommendations of the Long Term Care Advisory Council

Issues:

Statement of Principle

The Long-Term Care Advisory Council proposed to amend Section 501, Subsection (a) of C.G.S. 17b-337, which established the Long-Term Care Planning Committee, with a guideline principle to be considered when coordinating policy development and implementing the recently released Long Term Care Plan. The statement is as follows:

"Such policy and plan shall provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting."

The guideline principle is consistent both with the Supreme Court's 1999 decision in Olmstead, which addressed claims of institutionalized individuals under the federal Americans with Disabilities Act, and with the expansion in 2001 of the statutory scope of authority of the Long Term Care Planning Committee to include all people in need of long-term care, not simply older adults.

Regrettably, there was no action on the bill that contained this policy statement prior to committee deadline, and it was not successfully appended to another bill prior to the end of the session.

Needs Assessment

In support of data needs identified by the Long-Term Care Plan, the Long-Term Care Advisory Council advocated for state funding of $100,000 in support of a comprehensive assessment of need for long-term care in Connecticut.

Personal Care Assistant (PCA)

A small state-funded Personal Care Assistant pilot (PCA Pilot) program was established in 2000 to serve up to 50 individuals statewide who are age 65 or older and meet all of the technical, functional and financial eligibility requirements of the CHCPE. This program is available to (1) individuals who have previously received services under the PCA Waiver; and (2) individuals who are unable to access adequate home care services to remain in the community. The PCA Pilot allows eligible individuals to hire a PCA to perform up to 25.75 hours of assistance per week.

After three years of operation, it became apparent that the 50 slots available under the PCA Pilot would not accommodate the needs of all individuals aging out of eligibility for the PCA Waiver. Efforts by the Legislature in 2004 to correct this problem unfortunately did not offer an effective remedy due to cost cap constraints, but DSS took the position of expanding the number of available slots to 100 under existing statutory authority. Based on ever-increasing projections of need, however, the Long-Term Care Advisory Council is now advocating that the legislature increase available program slots to 150 and that certain technical issues, including a sunset provision, be corrected.

Positions:

- support adoption of the long-term care principle statement
- support state funding for a comprehensive assessment of long-term care needs
- support expansion of the PCA pilot to 150 slots

Opposition to Block Granting of Medicaid Program:

Background:

In 2004, the federal budget included provisions that proposed to offer states "flexibility" (e.g. authorization to limit optional coverage groups and increase cost-sharing) in administration of their Medicaid programs in exchange for the compromise of capping the amount of Medicaid funding that they would receive from the federal government. In response, the Department of Social Services submitted a concept paper to the Centers for Medicare and Medicaid Services (CMS) outlining its intent to seek a waiver and suggesting that they would consider a global cap on CT's federal Medicaid funding. Concerned about implications for various beneficiary populations, the Legislature responded to this by prohibiting the Commissioner from negotiating any waiver that would change the current federal match formula. Section 106 of P.A. 04-2 (the Office of Policy and Management implementer) provided:

From the effective date of this section to June 30, 2005, inclusive, the Commissioner of Social Services shall not agree to any Medicaid waiver in which the federal

government, as a condition of granting the waiver, requires the state to agree to limit the normal fifty per cent federal cost sharing in the program.(effective from passage – May 12th, 2004)

Other states also grappled with this same issue. For example, in New Hampshire, the Legislature enacted a provision that required:

The department of health and human services shall not amend nor seek to amend, nor gain nor seek to gain approval of waivers to, the state Medicaid plan in any way that results at any time in the consolidation of federal grants or allotments, caps on the federal portion of Medicaid spending, reductions in the federal share of Medicaid spending, or increases in the state share of Medicaid spending, without the prior approval of the fiscal committee of the general court.

It is expected that the FY '05 – '06 Governor's budget will again include proposals that will reduce coverage for Medicaid recipients. On the federal level it is clear that the administration favors capping funding of the Medicaid program through Congressional action. This is of serious concern because funding caps (or block granting) will mean that program funding is no longer related to actual enrollment and that it is inelastic to increased medical and prescription drug costs. It could also involve limiting optional services to various beneficiaries, reduction of services in certain geographic areas, increased out-of-pocket obligations, and/or loss of program safeguards (e.g. managed care protections).

Position:

- oppose efforts to use the waiver process or Congressional action to cap funding for the Connecticut Medicaid programs