



## Testimony Before the Human Services Committee

S. B. No. 558 (RAISED) AN ACT CONCERNING THE AVAILABILITY OF HOSPICE SERVICES UNDER THE MEDICAID PROGRAM.

S. B. No. 559 (RAISED) AN ACT CONCERNING A PILOT PROGRAM FOR SMALL HOUSE NURSING HOMES.

S. B. No. 560 (RAISED) AN ACT CONCERNING FAIR AND ADEQUATE HOSPITAL REIMBURSEMENT.

S. B. No. 561 (RAISED) AN ACT CONCERNING THE MONEY FOLLOWS THE PERSON PROJECT AND ESTABLISHMENT OF A LONG-TERM CARE TRUST FUND.

S. B. No. 562 (RAISED) AN ACT CONCERNING INCREASED ACCESS TO THE MEDICAID PROGRAM FOR THE MEDICALLY NEEDY ELDERLY AND DISABLED.

S. B. No. 563 (RAISED) AN ACT CONCERNING EXPANSION OF ASSISTED LIVING SERVICES AND ADULT CARE OPTIONS.

S. B. No. 564 (RAISED) AN ACT CONCERNING SERVICES FOR PERSONS WITH MENTAL HEALTH NEEDS.

S. B. No. 567 (RAISED) AN ACT CONCERNING THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY.

H. B. No. 5791 (RAISED) AN ACT CONCERNING A SINGLE POINT OF ENTRY FOR LONG-TERM CARE.

H. B. No. 5792 (RAISED) AN ACT CONCERNING THE ASSET TEST USED TO DETERMINE ELIGIBILITY FOR THE STATE-ADMINISTERED GENERAL ASSISTANCE PROGRAM.

H. B. No. 5793 (RAISED) AN ACT CONCERNING GRANTS FOR RESPITE CARE SERVICES FOR CARETAKERS OF INDIVIDUALS WITH ALZHEIMER'S DISEASE.

H. B. No. 5796 (RAISED) AN ACT CONCERNING ELIGIBILITY FOR THE FEDERAL SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PROGRAM AND THE QUALIFYING INDIVIDUAL PROGRAM.

**Michael P. Starkowski**  
*Commissioner*  
*March 4, 2008*

Good morning, Senator Harris, Representative Villano and members of the Human Services Committee. My name is Michael P. Starkowski. I am Commissioner of the Connecticut Department of Social Services (DSS). I am here this morning to testify on several bills concerning the programs, services and operations of DSS.

**\*S. B. No. 558 (RAISED) AN ACT CONCERNING THE AVAILABILITY OF HOSPICE SERVICES UNDER THE MEDICAID PROGRAM.**

The Governor's Recommended Budget includes a proposal to amend the Medicaid state plan to include hospice benefits no later than February 1, 2009. Legislation to implement the Governor's budget recommendation is included in Senate Bill No. 34. Any additional costs of providing hospice services in home and community settings are expected to be offset by reductions in end-of-life inpatient and other institutional care. The Governor's recommended legislation directs DSS to work with OPM in evaluating the cost effectiveness of this approach and moving forward with a state plan amendment these provisions are found to be cost effective. We favor the provisions recommended in the Governor's bill and urge no action SB 558.

**\*S. B. No. 559 (RAISED) AN ACT CONCERNING A PILOT PROGRAM FOR SMALL HOUSE NURSING HOMES.**

This bill creates a pilot program for the development of up to ten small house nursing homes. As defined in the bill, a small house nursing home is a home-like facility for the care of no more than 10 residents. In this bill, the Commissioner of Social Services will provide up to 10 grants (unspecified amounts) to be financed with general obligation bonds. Grants would be awarded through a competitive process to be outlined by DSS by no later than October 1, 2008. It should be noted that our current bond fund authority does not reflect these additional capital commitments.

Developers of small house nursing homes must be providers of long-term care and grants would be awarded with a priority for conversion of existing nursing homes and use of energy efficient technologies. Development of the pilot homes would not be subject to DSS certificate of need processes or criteria.

Small home like facilities have the potential for providing more personalized care and enhanced quality of life for the elderly and development of such models under a pilot program will allow the state to assess care and cost effectiveness before expanding state-wide.

My department is interested in exploring this new model of care further with the proponents, although we have concerns over the efficiencies of limiting the maximum number of residents as this does.

**\*S. B. No. 560 (RAISED) AN ACT CONCERNING FAIR AND ADEQUATE HOSPITAL REIMBURSEMENT.**

This bill would be very unfair to Connecticut taxpayers as it provides for a full cost reimbursement system with no consideration to patient mix/care resource requirements or efficiency factors. The bill precludes reasonableness in rate setting considerations. In addition, a guaranteed full cost reimbursement system discourages necessary hospital cost containment.

This bill requires that Medicaid inpatient, outpatient clinic and emergency room rates for general hospitals and chronic disease hospitals (CDHs) equal 100% of costs effective July 1, 2008. It also provides for the establishment of separate rates for Medicare certified psychiatric units in general hospitals. Preliminary cost estimates indicate that SFY 2009 budget requirements would increase by at least \$100.0 million.

As you know, the adopted budget from last session reflected a substantial commitment to increasing Medicaid hospital rates. In accordance with the budget, we increased Medicaid inpatient and outpatient rates to apply the \$46.2 million and \$72.6 million appropriated for SFY 2008 and SFY 2009, respectively. In addition, the Department allocated \$10.0 million of \$24.0 million included in SFY 2008 and SFY 2009 managed care funding toward the total amount available for hospital rate increases.

Inpatient rates were increased by a weighted average of 20.4% with associated annual costs of \$69.3 million (\$46.2 in SFY 2008). October 1, 2007 Medicaid rate increases for individual hospitals ranged from 4% to 34.8%.

In addition to inpatient rate increases, the Department used available funding to increase outpatient rates for clinic, emergency room and other services effective retroactive to July 1, 2008 with an associated cost of \$9.5 million in SFY 2008.

In recognition that additional Medicaid rate increases may be warranted, the Governor's recommended budget adjustments for SFY 2009 include \$250,000 for a study of Medicaid hospital reimbursement systems by the Office of Health Care Access (OHCA) that we would be extensively involved in.

The Medicaid rate-setting method for hospital inpatient services is presently cost-based and does not directly take into consideration the resource and/or treatment requirements of patients. Cost-based payment methods can result in a misdirection of state resources from hospitals that need higher reimbursement to meet care needs to those with lower resource requirements.

We would assist OHCA in the engagement of a consultant to study and propose resource utilization-based payment methods for hospital services. The consultant would examine rate-setting methods used by Medicare and other state Medicaid programs that take into account the direct (nursing, aides) and indirect (therapies, medical supplies, dietary) care

resource requirements of patients. The consultant would examine the benefits/negatives of various proposals as well as analyze and estimate administrative and Medicaid program costs.

**\*S. B. No. 561 (RAISED) AN ACT CONCERNING THE MONEY FOLLOWS THE PERSON PROJECT AND ESTABLISHMENT OF A LONG-TERM CARE TRUST FUND.**

This bill is a long-term care rebalancing proposal. It focuses on three elements of rebalancing: 1) transition from nursing homes; 2) increased funding to support changes in the long-term care infrastructure including increased funding to HCBS; and, 3) activities to prevent unnecessary institutionalization by providing information about community options and streamlining access to HCBS for those at risk in the community (single point of entry).

Specifically, the bill increases number of persons served under the MFP demonstration from 700 to 5000 over 4 years. There is no provision in the current federal financial participation (FFP) scheme allowing Connecticut to increase the number of slots so significantly and still retain the advantage of the enhanced match. The budget in the award would simply not support it. We would have to assume that the additional slots would receive the normal 50% Medicaid match, as opposed to the enhanced match rate of 75% under MFP, which applies only in the first year. Moreover, this program is gross appropriated in the state Appropriations Act is accordingly treated as revenue for the state General Fund.

The proposed targeted increase to 5,000 participants represents approximately 25% of Connecticut's existing Medicaid funded institutionalized population. The increased annual costs to the MFP demonstration is estimated at \$50,000,000 assuming the same target populations identified in the MFP operating protocol.

In addition, the proposed Trust Fund will restrict funds for only long-term care infrastructure change. This would prevent reallocating funds to 'non-rebalancing' line items as surplus is identified. While many initiatives in Connecticut may be laudable for this purpose, the transfer of lapsing funds, revenues and other funds to an off-budget trust fund compromises the intent of our state's expenditure cap and restricts the ability of the Executive and Legislative branches to order spending priorities on an annual basis.

**\*S. B. No. 562 (RAISED) AN ACT CONCERNING INCREASED ACCESS TO THE MEDICAID PROGRAM FOR THE MEDICALLY NEEDY ELDERLY AND DISABLED.**

This bill would increase the Medicaid income limits for aged, blind and disabled recipients to the same level as that used for adults under the HUSKY A program. This is 185% of the federal poverty level. Such an increase in the income limit would more than

double the limit for this program and result in major additional costs to the program. Because funding for such a significant increase is not included in the Governor's budget the department cannot support this bill.

**\*S. B. No. 563 (RAISED) AN ACT CONCERNING EXPANSION OF ASSISTED LIVING SERVICES AND ADULT CARE OPTIONS.**

DSS opposes this legislation as written for a number of reasons. Currently, under the 75 person pilot, 72% of the participants are state funded where the state receives no federal match. Expanding this program would add significant costs to the state. Under federal rules, the home care program can only pay for the assisted living service packages for program participants and cannot pay for room and board. Medicaid waivers are clear that programs cannot include room and board payments. In order for a person to live in a private assisted living facility either they must have the income and/or assets to pay the room and board privately or have family members who contribute to the cost of services. This ensures that people who would qualify for Medicaid, at least for the most part, lack the financial resources to pay for assisted living on a private pay basis.

Currently, the private assisted living pilot program has a waiting list of 375 persons but it appears that only 61 of them meet the financial eligibility requirements of the CT Home Care Program. Most are spending their assets toward costs of the Assisted Living Facility.

Private Assisted Living Facilities can choose to participate in this program or not participate. Some persons on the waiting list reside in facilities that do not participate and the state can only encourage participation.

Managing this program has been a continuous challenge for DSS staff. There seems to be a high turnover rate in clinical staff in assisted living facilities making it a challenge for DSS to obtain the necessary program paperwork to determine participants' eligibility for the Home Care Program on an ongoing basis particularly at annual reassessment. The Department has collected extensive data on the program since its inception. Perhaps a prudent course of action would be to authorize a study of the data to determine if the program has in fact been successful in offering more alternatives to our frail elders in a cost effective manner.

**\*S. B. No. 564 (RAISED) AN ACT CONCERNING SERVICES FOR PERSONS WITH MENTAL HEALTH NEEDS.**

The Department of Social services opposed bill 564, An Act Concerning Services for Persons with Mental Illness. Section one of this bill would provide DSS with grant funds to increase acute care capacity in Connecticut. It disregards OHCA's role in determining whether acute care capacity is needed and sidesteps the bonding process for supporting the capital costs associated with service expansions. Furthermore, available data suggests that no additional child acute care capacity is needed at this time, although the

department recognizes that a redistribution of available capacity to Region V is necessary.

Section 2 of this bill duplicates Bill 5038, which DSS supports. In addition, it places DMHAS in the lead role for determining the need for intermediate care, prevention, early intervention, treatment and rehabilitation services for children, in contravention to DCF's role as the lead child mental health agency in Connecticut and the departments' joint role in administering public sector behavioral health services for children under the Connecticut Behavioral Health Partnership. The departments have processes in place for identifying service gaps and developing new services of the type proposed under this bill.

Section 3 of this bill would require that the departments pay rates that are no less than the actual cost of services provided under the Connecticut Behavioral Health Partnership. Similarly, section 4 of this bill would require the same for hospital outpatient mental health services provided under the Medicaid FFS program. These proposed rate strategies do not take into account whether such rates would be economic or efficient and thus the proposed rate strategy is not permitted under Federal Medicaid law. Rates set under this provision would be inflationary and would necessarily result in payments for costs that are excessive or that result from provider inefficiency.

All of the above provisions would substantially increase the cost of providing behavioral health services under the CT BHP and Medicaid FFS programs. These policies and their associated costs are not consistent with the Governor's budget.

**\*S. B. No. 567 (RAISED) AN ACT CONCERNING THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY.**

There are three components to this bill that represent expansive changes to the Home Care program.

- Reducing the age for participation from 65 to 60
- Increasing rates to providers under the program
- Adding Personal Care Assistance services

As to the addition of Personal Care Assistance services to the Home Care Program, PCA services have been provided to home care program participants both state funded and Medicaid Waiver clients. A recent agency analysis based on actual costs and projected the expenditures for 250 program participants. For the waiver clients, if PCA were to be an approved waiver service, the state could receive 50% federal match. When 250 slots are filled, the estimated cost is \$5.2 million. Currently, 68% of the clients are waiver recipients so the cost of their services would be \$3,536,000 making the match of \$1,768,000 available to the state.

The addition of PCA as a service under the Home Care program would require an amendment to the Medicaid waiver but since most states do offer the service as part of their waivers, this would not be likely to pose any problems.

DSS is unable to support these changes because of the significant unfunded new costs reflected in these proposals.

**\*H. B. No. 5791 (RAISED) AN ACT CONCERNING A SINGLE POINT OF ENTRY FOR LONG-TERM CARE.**

HB 5791 provides for the establishment of a state-wide single-point of entry (SEP) system by DSS for individuals seeking long-term care. No funding is included in the bill for either Section 1 (the establishment of the system) or Section 2 (development and maintenance of the web-site and a state-wide toll free number for information). However, in Section 2, an amendment to Section 17b-367 of the 2008 supplement, the phrase "within existing budgetary resources" has been deleted.

Although the Department certainly supports the concept of SEP, the Department is opposed to this legislation as written not only because of the lack of funding but also because it conflicts with or fails to recognize several processes and systems already in development and does not acknowledge the important impact of the federal Administration on Aging's (AoA) vision upon the states.

AoA has widely been a proponent of the development of Aging & Disability Resource Centers (ADRCs) as SEPs and having all Area Agencies on Aging serve as SEPs. Following the recommendation of the CT Long-Term Care Needs Assessment, DSS, through the Aging Services Division, has begun expansion of CHOICES – the "umbrella" program for all aging information and assistance programs. Pursuant to legislation passed in the last session requiring CHOICES to provide long-term care options, the Area Agencies on Aging, in partnership with Centers for Independent Living (CILs), are already in process to put on line the first ADRC to provide "single points of entry" for all long-term services. Several federal funding initiatives have facilitated such a development, including Money Follows the Person and a Nursing Home Diversion grant. In fact, under the leadership of the Aging Services Division, the South Central CT region will have a fully functional ADRC utilizing the Area Agency on Aging of South Central CT and the Center for Independent Living by March, 2009.

The legislation does not specifically designate the SEP to be handled by Aging Services or CHOICES despite the legislation passed in the last session. The requirement for an RFP to select SEPs has the potential to fragment the development of comprehensive information and assistance Aging and Disability Resource Centers (ADRCs) to serve both older adults and those with disabilities should an Agency on Aging or a CIL not be awarded such a grant. This would necessarily run contra to AoA's vision. The goal of ADRCs is to serve as highly visible and trusted places where people of all income and ages can get information on the full range of long-term support options as well as a single

point of entry for access to public long-term support programs and benefits. The comprehensive services of the ADRC, including screening, assessment and plan for services help prevent unnecessary institutional placement and “diversion” complementing other rebalancing efforts in the state.

The language “the department shall not award a contract to an agency that is a direct provider of Medicaid services” may impact the ability of two of the Area Agency on Aging that already serve as Access Agencies for the CT Home Care Program to also be an SEP thereby eliminating an essential partner in the process. Further, an important element that needs to be added for an SEP is the capacity to provide assistance in filling out applications to those requiring this type of assistance rather than the language in Section 1 (3) generally requiring assistance to obtain timely determinations of eligibility.

Finally, Section 2 provides extended responsibilities for website development and having a toll-free number to provide information for OPM. OPM completed development of this site. CHOICES has the added responsibility, in statute, of coordinating with the website. Since it is becoming an SEP site and DSS is taking the lead on SEP, the capability to have DSS lead the expansion of the website with its current management information resources should be explored.

**\*H. B. No. 5792 (RAISED) AN ACT CONCERNING THE ASSET TEST USED TO DETERMINE ELIGIBILITY FOR THE STATE-ADMINISTERED GENERAL ASSISTANCE PROGRAM.**

This bill would increase the asset limit for the SAGA cash assistance program to \$1,000, the same level as that used for the SAGA medical assistance program. Because this would allow individuals with higher assets to qualify for SAGA cash assistance, or allow them to qualify sooner if they are spending down their assets, it will result in additional costs that are not contemplated in the Governor’s mid-term budget adjustments. For this reason the department must oppose this bill.

**\*H. B. No. 5793 (RAISED) AN ACT CONCERNING GRANTS FOR RESPITE CARE SERVICES FOR CARETAKERS OF INDIVIDUALS WITH ALZHEIMER'S DISEASE.**

This legislation increases the maximum grant to families under the respite care services program for Alzheimer's patients from \$3,500 to \$7,500 per year beginning in July, 2009.

Since the initial legislation creating the program in 1998, clients who participate in the Connecticut Statewide Respite Care Program, coordinated by the Aging Services Division and operated through the five regional Area Agencies on Aging and the CT Alzheimer’s Association, have been eligible to receive up to \$3,500 in respite services per year to help them to continue to reside at home. In SFY 07, 656 clients (an increase in 100 from SFY 06) received services such as adult day care, companion/homemaker and home health aide . Given that there are over 100,000 individuals in Connecticut with diagnoses of dementia, many more can be expected to seek the program’s assistance in

the coming years. While this has represented a very meaningful respite benefit for caregivers, the cap has not kept pace with the increasing cost of home and community-based services and may be quickly exhausted by families in need.

The program utilizes a multifaceted screening tool to ascertain the client's level of need for services, and makes referrals to other programs for which the client is eligible. In order to efficiently maximize program funding, money has been allocated in varying increments in order to serve the greatest number of clients. This process to ensure maximum program participation would not change. Past experience indicates that not all clients request the maximum of \$3,500 in services and will not request the maximum of \$7,500 if approved. For those who do, however, the increase to maximum services will allow a more comprehensive combination of services or additional levels of services to meet the increasing needs of a client.

With the increase of funding provided by the legislature last year, this change in the cap could be accomplished within budget limits beginning in the next SFY beginning July 2008 rather than waiting until July 2009 as provided in the bill, while continuing to increase the total numbers of clients served. The increased level of flexibility afforded to care plan development and the resulting assistance provided to each client is certainly a meaningful investment in making sure that these clients can remain at home longer despite increasing needs, thereby deferring and in some cases entirely obviating the need for state expenditure on nursing facility care.

It should be noted that fewer persons would be served under the bill as DSS must operate the program with available funding and additional appropriations would be needed to fund this expansion.

**\*H. B. No. 5796 (RAISED) AN ACT CONCERNING ELIGIBILITY FOR THE FEDERAL SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PROGRAM AND THE QUALIFYING INDIVIDUAL PROGRAM.**

This bill would require the department to increase income disregards and therefore effectively increase the income limits for the Specified Low-Income Medicare Beneficiary (SLMB) and Qualified Individual (QI) programs in order to enable all participants in the ConnPACE program to qualify for these programs. It would also permit the department to act as an authorized representative for purposes of enrolling existing ConnPACE recipients in these programs.

The Centers for Medicare and Medicaid Services has made it clear that the any income disregards for the Medicare Savings Programs but be applied equally to all three programs in that category. Therefore the department cannot increase the SLMB or QI income disregards without also increasing the income disregard for the Qualified Medicare Beneficiary (QMB) program, the third of the Medicare Savings Programs. The effect of doing this would be to classify the majority of the ConnPACE recipients under the QMB program, the most expensive of the three MSP programs, as, in addition to paying for the participants Medicare Part B premiums, QMB also covers all Medicare co-

insurance and deductible charges. In light of this the department will need to calculate whether the savings achieved by reducing ConnPACE costs through this change would be more than offset by additional costs related to the QMB coverage. Moreover, this will very likely require significantly rebudgeting expenses between the ConnPACE and Medicaid accounts.

The bill also permits the department to be the authorized representative for purposes of applying for these MSP programs. We are exploring with CMS whether they would permit the department to act in this role of applying to itself on behalf of these ConnPACE recipients.

For these reasons, we recommend this matter should be studied further at this time.

I would be happy to answer any questions you may have.