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Testimony Before the Human Services Committee

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H. B. No. 5298 (RAISED) AN ACT INCREASING THE ASSET LIMITATIONS UNDER THE STATE-FUNDED CONNECTICUT HOME CARE PROGRAM FOR THE ELDERLY.

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Good morning, Senator Doyle, Representative Walker and members of the Human Services Committee. My name is Claudette J. Beaulieu. I am the Deputy Commissioner for Programs at the Department of Social Services. I am here this morning to testify in support of legislation introduced in the committee at the request of my department. I will also be providing remarks on various other bills that affect the department.

Legislation introduced at the request of the department

S. B. No. 852 (RAISED) AN ACT CONCERNING RENTAL PAYMENT LIMITS FOR RECIPIENTS OF RENTAL ASSISTANCE CERTIFICATES.

This bill would allow a Rental Assistance Program household to remain in a unit despite the rent being increased above the department's maximum payment standard. The household would be responsible for paying the landlord the amount above this standard. Currently such a tenant's only option is to move to a lower cost unit. This has created significant burdens for some families or individuals participating in the program.

Under this bill, should the tenant choose to remain in the unit and pay for the rental costs above the department's payment standard, he or she would be prohibited from paying more than 50 percent of the family's income toward the rental obligation. In addition, we would not permit this arrangement for new rental lease agreements, only to those households renewing existing lease agreements. This approach is currently permitted in the Section 8 Housing Choice Voucher Program, although Section 8 participants are only required to contribute 30 percent of their income toward the rent while families must contribute 40 percent in the RAP program.

There is currently little flexibility in the state program to allow a household to remain in a unit they are currently renting when a property owner requests a rent increase that exceeds the department's established payment standard. This bill would provide this needed flexibility. Allowing the family the option of paying the rental cost above the standard, as long as their total rental obligation does not exceed 50% of their income, instead of being forced to move to an apartment with a lower rent provides stability to the family. Capping the family's total rental obligation at 50% of income assures that the family does not overextend itself and create a potential for eviction for non-payment of rent.

I am asking for the committee's support of this bill.

H. B. No. 6442 (RAISED) AN ACT CONCERNING WORK ACTIVITIES PERMITTED IN THE JOBS FIRST EMPLOYMENT SERVICES PROGRAM.

The department thanks the committee for raising this bill which was submitted to clarify the authority of the state to include unpaid work experience activities as part of the employment plans of participants in the Jobs First Employment Services Program. The Department of Labor has informed the department that under current state minimum wage laws such an activity is not permissible. The changes to this bill in subsection (c)

provide the authority to permit such activities. The other changes to the bill were recommended by the Legislative Commissioners Office to eliminate redundancy in the existing language.

The department, working closely with the Labor Department and the regional workforce investment boards, has been struggling to meet federal TANF work participation requirements since they were modified by the Deficit Reduction Act of 2005 to impose more stringent requirements on states. The state is at risk of significant fiscal penalties for not meeting the new federal rules. Increased resources were provided to the Labor Department in 2006 in an attempt to address these new federal mandates by providing additional vocational education and subsidized employment opportunities for program participants. Although these funds have enabled the state to partially offset the adverse impact of the provisions of the 2005 federal law, they have not been adequate to allow the state to meet the federal participation requirements to date.

States that are meeting the work participation requirement commonly use unpaid work experience as a means to supplement the paid employment and other work activities of program participants to meet the 30 hour weekly TANF work participation requirement. Over 30 states include unpaid work experience as part of their TANF work programs. Under provisions of federal law, a TANF recipient, such as our Temporary Family Assistance/Jobs First Employment Services participant, works off his or her combined TFA and SNAP (Food Stamps) benefits by participating in work experience for the number of hours arrived at by dividing their monthly benefits by the state minimum wage. For example, a TFA recipient receiving \$470 in TFA benefits and \$200 in SNAP benefits would need to participate in work activities 84 hours per month or about 20 hours per week to meet the work requirement.

We would prefer not to use this work activity and will only do so if resources are not available to support other appropriate work activities and its use or unpaid work experience is necessary to avoid federal work participation penalties. We will also not use it just for make work jobs. It will typically be used in a structured, supervised setting for three to six months for program participants who have never worked and thus have no work experience and to supplement their participation in educational activities. The intent will be to either have participants enter unsubsidized employment at the end of their work experience period or enter another countable activity, such as subsidized employment or vocational education.

The department therefore recommends the committee's support of this bill.

Other legislation affecting the department

S. B. No. 927 (RAISED) AN ACT CONCERNING THE QUALITY OF SERVICES FOR RECIPIENTS OF SERVICES UNDER A MEDICAID WAIVER.

This legislation addresses three separate areas. The first would create a commission to oversee and improve service quality provided to Medicaid clients under waiver programs. This would create duplication of existing oversight councils and Federal requirements governing the Medicaid program. The Medicaid Managed Care Council and the Connecticut Behavioral Health Oversight Council already provide oversight of the Medicaid Managed Care Waiver in a collaborative way that recognizes that they both serve the same population. Both councils work together on coordination and service quality and have established joint subcommittees, such as the Coordination of Care subcommittee, towards these efforts. This proposal also runs counter to the Governor's recommendation to curb government during these difficult budgetary times as department resources would be needed to support the work of this additional oversight entity. Additionally CMS requires comprehensive quality management in its approvals of Medicaid waivers and closely monitor states to ensure that the Federal quality management requirements have been met.

The second section would require the department to amend the state plan to cover tobacco cessation treatment. Although the department does not include tobacco cessation counseling on its fee schedule, these services are routinely provided within the context of a provider visit. The department does not at this time provide tobacco cessation medications as a covered benefit. Providing such a benefit will increase costs to the Medicaid program. The department estimates that coverage of smoking cessation medications would cost close to \$9 million in SFY 2010 and about \$8 million in SFY 2011.

The third section would require the department to submit a waiver for coverage of family planning services to adults in households with income that does not exceed one hundred and eighty-five percent of the federal poverty level. The department has researched the feasibility of a family planning waiver and demonstration of cost neutrality required by CMS. The expansion of Medicaid coverage to parents and relative caregivers up to 185% FPL and the availability of Charter Oak Health Plan, both of which cover family planning services, make the Family Planning waiver a duplicative effort as the majority of the targeted population already has coverage or options for coverage. The only population remaining would be the small number of individuals with commercial insurance plans that do not cover family planning services. Other than catastrophic plans, most commercial plans cover family planning services. The smaller target population and the additional administrative cost for the waiver make it difficult to demonstrate cost neutrality as required by CMS.

S. B. No. 957 (RAISED) AN ACT CONCERNING MEDICAID ELIGIBILITY FOR PERSONS LIVING IN RESIDENTIAL CARE HOMES.

This bill would allow certain disabled individuals to use specific types of trusts to qualify for payment of residential care homes or New Horizons Village through the State Supplement program.

Federal Medicaid law allows disabled individuals to transfer income and assets into certain types of trusts described in section 1917(d)(4) of the Social Security Act without affecting their eligibility for assistance. Any amounts transferred into these trusts, often referred to as "p(d)(4)" trusts, are not considered when determining Medicaid eligibility. As a result, individuals can effectively decrease their monthly income by transferring part of it into a p(d)(4) trust.

Disabled individuals with incomes in excess of Medicaid limits may transfer income into p(d)(4) trusts to qualify for assistance. The most common occurrence are individuals who need assistance from one of our Medicaid waiver programs, which currently have a monthly income limit of \$2,022. Individuals with incomes over \$2,022 can qualify for a Medicaid waiver program by transferring the amount of their monthly income in excess of \$2,022 into a p(d)(4) trust.

Currently, the use of p(d)(4) trusts does not extend to Connecticut's State Supplement program, which has an income limit of \$2,022 per month. Disabled individuals who transfer funds into these trusts are prohibited from receiving State Supplement assistance, even though these transfers are permitted under Medicaid law.

The combination of the State Supplement income limit and the prohibition on the use of p(d)(4) trusts results in the inability of disabled individuals with monthly incomes over \$2,022 to qualify for the State Supplement program. This becomes a problem for residents of residential care homes and New Horizons Village, which typically cost more than \$2,022 per month. Without assistance from the State Supplement program, disabled individuals often move to more costly nursing facilities, which are funded by Medicaid.

This bill would provide a way for disabled individuals to remain in less costly residential care homes and New Horizons Village. In addition to supporting disabled individuals in less costly community settings, the bill protects the state's financial interest by requiring repayment of assistance upon the death the individual.

This bill's language is virtually identical to the provision in Section 61 of Governor's Bill 843, An Act Implementing the Governor's Budget Recommendations Concerning Social Services. The Governor's budget includes this provision allowing such trusts as it results in a net cost savings to the state, in addition to permitting program recipients to live a less restrictive setting.

The department therefore supports the provisions of this bill, but we would recommend passage of SB 843. However, if SB 957 continues to move forward as a separate bill, the following technical revision should be made to the title of the bill which is confusing. The title of the bill should be amended to read "AAC State Supplement Eligibility" instead of "Medicaid Eligibility" since the bill actually targets the State Supplement population.

H. B. No. 6443 (RAISED) AN ACT CONCERNING DIRECT BILLING FOR HOME CARE NURSING SERVICES PROVIDED TO MEDICAID RECIPIENTS.

Under current Medicaid regulations, advanced practice registered nurses are allowed to bill the state as independent providers and are issued Medicaid provider numbers. The department's physician fee schedule, off of which APRN's are reimbursed for their services, reimburses for evaluation and management provided in a client's home (CPT codes 99341 – 50). Therefore, it is the position of the department that this legislation is unnecessary as it is written.

If, however, the purpose of this legislation is as its title suggests, to enable APRNs to directly bill for *home care nursing services*, such services are currently provided by home care agencies, which in turn employ nurses. Allowing APRNs to independently bill these for services would allow the prescriber of the service to also be the provider of the service. It is the department's position that this change potentially will increase health care costs without significantly improving access to or quality of care and therefore we oppose this legislation.

S. B. No. 210 (COMM) AN ACT CONCERNING THE ESTABLISHMENT OF A STREAMLINED APPLICATION FOR STATE HEALTH AND HUMAN SERVICES.

This bill requires the Commissioner of Social Services, in collaboration with the Commissioners of Children and Families, Mental Health and Addiction Services, Public Health and Developmental Services to develop a streamlined application process for the programs administered by these agencies by implementing a single, simplified application.

The department agrees that there would be value in developing a common process for Connecticut residents to access the human services programs administered by the state's human services agencies. However this would be a major and complex undertaking given the number of programs involved and the complexity of the requirements for many of these programs. It would be impossible to develop a single, simplified application for all of these programs. Rather, what is needed is a single process to screen interested residents for programs for which they may be potentially eligible and then to offer them the opportunity to apply for these programs through a common web-based application process.

The department is developing a web-based on-line application system for its public assistance programs that does just this. It will include a prescreening component, through

which interested residents via internet access can provide basic information about their circumstances and that of their family. They will then be informed about which programs they may potentially qualify for and be allowed to select those they wish to apply for and complete a common application online that is customized for the particular programs for which they are applying.

Although the department is initially intending to implement this process for its own programs, including Medicaid, HUSKY, Supplemental Nutrition Assistance Program (SNAP – formerly Food Stamps), TFA and SAGA, it is our intent to eventually expand the system to include additional programs administered by DSS, such as Care 4 Kids and Energy Assistance. It could also be expanded to include the programs administered by other state human services agencies, such as WIC and free and reduced school meals, as well as other programs administered by the agencies mentioned in this bill.

The department expects to implement this online application system in late 2010 or early 2011. It could be the building block for meeting the needs that this bill proposes to address. Because of this, rather than devote resources to a paper application process that would be less effective, we recommend that an automated approach be pursued and therefore oppose this bill in its current form.

S. B. No. 954 (RAISED) AN ACT CONCERNING PERSONAL SERVICE AGREEMENTS.

This bill was introduced at the request for the Office of Policy and Management (OPM). This bill implements Purchase of Service (POS) contract guidelines published by the OPM following the release of Attorney General Blumenthal's opinion a few years ago. The AG's opinion clarifies that a POS contract is subject to the same requirements as a Personal Service Agreement (PSA). The proposed revisions also remove certain reporting requirements of the department that are no longer necessary since OPM can obtain the information through the CORE CT system.

The department is already in compliance with these requirements and therefore lends its support to this legislation.

S. B. No. 956 (RAISED) AN ACT CONCERNING MANAGED CARE CONTRACTS.

The addition of section (b) makes it clear that the managed care organizations are subject to FOI as they perform a governmental function. Our current contracts with Aetna, AmeriChoice and CHN were written to affirmatively state that they are performing a governmental function and therefore subject to FOIA. The language in (b) also subjects the department's contract with CHN for the administration of SAGA to the FOIA language which is currently not the case. However, CHN has openly agreed to the FOIA language in the MCO contracts in the past so we believe that this can be accommodated through a contract amendment.

The proposed additional language is specific in its application to only managed care contracts and contracts related to the SAGA program. Since this is our current policy, the department is in support of this legislation.

H. B. No. 5298 (RAISED) AN ACT INCREASING THE ASSET LIMITATIONS UNDER THE STATE-FUNDED CONNECTICUT HOME CARE PROGRAM FOR THE ELDERLY.

DSS opposes this increase for several reasons. First, the asset limit for the state funded program was increased significantly in April 2007 from \$20,328 for individuals and \$30,492 for a couple to \$30,492 for individuals and \$40,656 for a couple. The state-funded CHCPE asset limit is set as a percentage of the minimum Community Spouse Protected Amount (CSPA). This increase represents a rise from 100% of the minimum CSPA to 150% for individuals and from 150% of the minimum CSPA to 200% of the minimum CSPA for couples.

Moreover, this asset test by state statute increases annually on January 1 by in the Consumer Price Index for Urban Consumers (CPI-U) in the prior October through September period. The current minimum CSPA is \$21,912 compared to \$19,908 three years ago in 2006. As a result, this month the asset limit was increased again to \$32,868 for individuals and \$43,824 for a couple.

As the state funded asset test increases against the Medicaid component of the program's asset test, which has remained level, the effect is a disproportionate increase in the percentage of state funded clients versus Medicaid clients on the Home Care Program. As you know, there is no federal financial match in the state component cases compared to the 50% federal match we receive in the Medicaid component. Currently 37% of the CHCPE clients are state funded. Increasing the state funded asset limit would increase that that even more all at state expense.

Given that the Governor's budget does not include funding to support the increase in eligible people that raising the asset limit would create, the department cannot support this proposal.