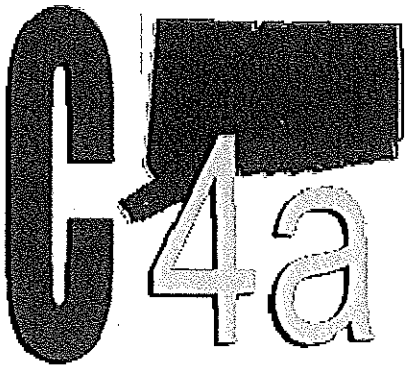

Connecticut Association of Area Agencies on Aging, Inc.

Testimony – Human Services Committee 3/11/10

Kate McEvoy, Esq., Deputy Director
Agency on Aging of South Central CT
(203) 785-8533

Positions

- C4A **cautiously supports Section 6 of Raised House Bill 5411,** which seeks to require DSS to apply for an 1115 Medicaid waiver in support of all or part of the state-funded components of the Connecticut Home Care Program for Elders, and to invest proceeds of any such waiver in the Long-Term Care Reinvestment Account toward enhancing provider reimbursement rates. Obtaining federal matching funds in support of Levels 1 & 2 of the CHCPE, which are currently exclusively state-funded, would be of obvious benefit in defraying state expenditures on the program. Also of benefit would be using these matching funds to increase reimbursement to providers of home care services. What remains of concern, however, is that the 1115 waiver process permits the states considerable flexibility in gaining authorization to modify eligibility standards, service array, service delivery methods and payment methodologies (please see p. 2 for additional detail). Any such initiative could therefore pose risks of loss or erosion of coverage to those who are currently eligible for the state-funded component of the CHCPE (please p. 4 for a description of current eligibility criteria and covered services). On this basis, C4A urges the Legislature to consider amending the bill to insert limiting language with respect to preserving eligibility standards and coverage that is at very least comparable to those that are currently in place.

- Further, C4A **supports Raised House Bill 5296** with the amendments proposed by the Medical Inefficiency Committee. Related, C4A **opposes** the Governor's proposal to use a more restrictive definition of "medical necessity" for Medicaid coverage determinations, which would be limited to "reasonable and necessary" or "appropriate" services.

Capsule Comparison of 1915(c) Medicaid Home and Community-Based Services (HCBS) Waivers with 1115 Medicaid Research and Demonstration Waivers

	1915(c) HCBS Waivers	1115 Waivers
Procedure	Waiver applications/renewals originate in Connecticut with the Department of Social Services. Once application/renewal is prepared, it is forwarded to the legislature for review of the committees of cognizance (procedure outlined in C.G.S.A. Section 17b-8). Application/ renewal is submitted to Centers for Medicare and Medicaid Services (CMS) for approval).	Waiver applications/renewals originate in Connecticut with the Department of Social Services. Once application/renewal is prepared, it is forwarded to the legislature for review of the committees of cognizance (procedure outlined in C.G.S.A. Section 17b-8). Application/ renewal is submitted to Centers for Medicare and Medicaid Services (CMS) for approval).
Permissible Population Groups	Aged, individuals with physical disabilities, individuals with MR/DD, medically fragile/tech. dep. children, individuals with HIV/AIDS, individuals with TBI/SCI	Any experimental, pilot or demonstration project which, in the judgment of the Secretary of HHS is likely to assist in promoting the objectives of Medicaid
Permissible Waivers of Federal Law	• Statewideness • Comparability of services (e.g. can include the Medicaid "social services" without expanding to entire Medicaid population) • Income/resource rules	• State plan requirements including eligibility requirements, services, service delivery, and payment methodology • Provides "costs-not-otherwise-matchable" authority (e.g. federal match for populations and/or services that are not typically covered)
Cost-Neutrality	Required (waiver services must be no more costly than institutional care).	Required (based on projections of what federal costs would have been had there been no waiver; must agree to aggregate or per capita cap on expenditures)
Eligibility Criteria	Income cannot exceed 300% of the Supplemental Security Income (SSI) limit (in 2010, $2,022 per month). Individuals must require institutional level of care (hospital, nursing facility or ICF/MR). To some degree, states have latitude in defining functional eligibility based on the above criteria.	Negotiated (eligibility criteria could be more restrictive than standards used under a 1915(c) waiver).
Covered Services	Medicaid "medical services" (e.g. nursing, home health aide) plus an elective array of optional "social services", which includes case management, homemaker, personal care services, psychosocial rehabilitation, adult day care, habilitation, respite care and day treatment. DD waivers also typically include vocational supports, as well as home and vehicle modification.	Negotiated (covered services could be more limited than those provided under a 1915(c) waiver).
Cost-Sharing	States may impose "post-eligibility" cost sharing. In CT, this is known as "applied income", and typically means that after monthly income has been reduced by allowable medical expenses (e.g. Medicare B premium, insurance premiums), the remaining amount in excess of 200% of the FPL (in 2010, $1,806 per month) must be contributed as cost-sharing.	Negotiated.

CT Home Care Program for Elders Elder Waiver

Waiver Information:

Waiver Type: 1915(c)
Current Enrollment: 9,386
Year First Approved: 1987 (authorized by C.G.S. Section 17b-342)
Waitlist Status: no wait list for waiver or state-funded personal care assistance pilot; wait list exists for state-funded pilot that funds ALSA services in private MRC's

Eligibility Criteria:

Age Range: 65 and older
Functional status: must be in need of nursing facility care and evidence at least three "critical needs" (critical needs include bathing, dressing, toileting, transferring, eating/feeding, meal preparation, and medication administration)

Income limits effective January 1, 2010:
Individual: $2,022 per month (300% SSI)
Couple: based on applicant's income
Comments: may use a pooled trust; VA "homebound" benefit to surviving spouses is excluded

Asset limits effective January 1, 2010:
Individual: $1,600
Couple: starts at $23,512 (minimum CSPA of $21,912 + applicant's $1,600); MCCA rules apply
Exemptions: MCCA rules apply

Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based	X	Majority of clients receive services via agencies
Agency + Choice		
Self-Direct	X	Where client does not require care management
PCA	X	A state-funded pilot option for waiver and state-funded clients (2007 legislation removed the 250-person cap).
Other	X	Services can also be provided to 1) residents of state-funded congregate housing; 2) residents of assisted living pilot projects; and 3) up to a statewide total of 75 residents of private managed residential communities who spend down to program limits and require assisted living services

Covered Services: adult day care, care management, chore, companion, home health aide, homemaker, home-delivered meals, laundry, mental health counseling, minor home modifications, respite, personal emergency response systems, skilled nursing visits, transportation

Cost Caps/Cost Effectiveness Standards: Waiver can pay no more than $5,598.00 per month per individual (100% of the average monthly Medicaid cost). Within that cap, program can pay for no more than $3,978.00 per month per individual for social services (all services other than skilled nursing visits and home health aide – the "medical services" covered by Medicaid).

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective April 1, 2009, 200% FPL = $1,806 per month; amount is updated each April 1), adjusted for medical expenses (e.g. Medicare Part B premium of $96.40, medical insurance premiums); legally liable relative may have obligation to contribute.

To Apply: Contact DSS Alternate Care Unit at 860-424-4904 and choose option #4 for initial screening and referral to regional Access Agency.

CT Home Care Program for Elders State-Funded Levels 1 & 2

Waiver Information:

Waiver Type: N/A
Current Enrollment: 5,342
Year First Approved: authorized by C.G.S. Section 17b-342
Waitlist Status: no wait list for Levels 1 or 2 or state-funded personal care assistance pilot; wait list exists for state-funded pilot that funds ALSA services in private MRC's

Eligibility Criteria:

Age Range: 65 and older
Functional status: **Level 1:** must be at risk of hospitalization or short-term nursing facility placement and evidence one or two "critical needs"; **Level 2:** must be in need of short or long-term nursing facility care and evidence three or more "critical needs" (critical needs include bathing, dressing, toileting, transferring, eating/feeding, meal prep, and med. admin.).

Income limits effective January 1, 2010:
Individual: none
Couple: none
Comments:

Asset limits for Levels 1 & 2 effective January 1, 2010:
Individual: $32,868
Couple: $43,824
Exemptions: UPM 8040.35 follows MCCA rules but does not require spousal assessment.
Comments: Note that as of April 1, 2007, the asset limit for an individual increased to 150% of the minimum CSPA and for a couple to 200% of the minimum CSPA.

Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based	X	Majority of clients receive services via agencies
Agency + Choice		
Self-Direct	X	Available where a client does not require care management
PCA	X	A state-funded pilot option for waiver and state-funded clients (2007 legislation removed the 250-person cap).
Other	X	Services can also be provided to 1) residents of state-funded congregate housing; 2) residents of assisted living pilot projects; and 3) up to a statewide total of 75 residents of private managed residential communities who spend down to program limits and who require assisted living services

Covered Services: adult day care, care management, chore, companion, home health aide, homemaker, home-delivered meals, laundry, mental health counseling, minor home modifications, respite, personal emergency response systems, skilled nursing visits, transportation

Cost Caps/Cost Effectiveness Standards: Level 1 can pay no more than $1,399.00 per month per individual (25% of average monthly Medicaid cost). Level 2 can pay no more than $2,799.00 per month per individual (50% of average).

Cost Sharing Requirements: Except for individuals who reside in an affordable assisted living demonstration project, each participant whose income is at or below 200% of the FPL (effective April 1, 2009, $1,806 per month; amount is updated each April 1) must make a 15% co-payment and each participant whose income exceeds 200% of the FPL must make a 15% co-payment over and above his/her applied income obligations, if any; legally liable relative may have obligation to contribute.

To Apply: Contact DSS Alternate Care Unit at 860-424-4904 and choose option #4 for initial screening and referral to Access Agency.