



Connecticut Association of Area Agencies on Aging, Inc.

Testimony – Human Services Committee 2/23/10

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Positions

- **Senate Bill 32, An Act Concerning the Governor's Budget Recommendations Concerning Social Services**

C4A **opposes** various of the Governor's proposals to cut appropriations for, impose new cost-sharing on, and eliminate coverage of core, preventative home and community-based long-term care services that permit older adults and individuals with disabilities to live independently in the community and that achieve dramatic cost savings to the State in preventing institutionalization. These proposals will compromise:

- access to core, community-based long-term care services;
- utilization of essential programs of support; and
- capacity of the long-term care network.

Cuts that Will Compromise Access to Core, Community-Based Long-Term Care Services

- C4A **opposes** the Governor's proposal to reduce program funding for the Statewide Respite Program by \$1 m.

Effective May 11, 2009, the Department of Social Services closed this critical program, which supports families caring for loved ones with

dementia, to new participants. This has left over **300** family caregivers on a waitlist with nowhere to turn for help! The Governor's recent proposal to reduce total program funding by \$1 million will make it impossible to serve these and many other families.

Legislators should maintain funding for and re-open the program because **it saves money for the State of Connecticut!** This program was targeted to help middle-income families who have not traditionally qualified for state assistance with home care services. The assistance that is provided is a meaningful investment in making sure that these caregivers can continue to provide care at home, thereby deferring and in many cases entirely preventing the need for state expenditure on nursing facility care.

- C4A also **opposes** the Governor's proposal to reduce funding for the Connecticut Home Care Program for Elders (CHCPE) by \$10,774,600. Further, C4A urges the Legislature to rescind the co-payment of 15% of care plan that was imposed on participants of the state-funded portion of the program in the 2009 session.

This vital program, which prevents individuals from being placed in nursing facilities, should, at a minimum, remain funded at its current level. The 15% co-payment is burdensome for low-income participants of the program, has forced some off of services, and is very difficult to administer.

- C4A also **opposes** the Governor's proposal (Section 30 of Senate Bill 32) to eliminate Medicaid coverage for vision, including eyeglasses.

For older adults and people with disabilities, eyeglasses are an essential support for safe mobility and accurate use of prescription drugs.

Cuts that Will Compromise Utilization of Essential Programs of Support

- C4A **opposes** the Governor's proposal (Section 35 of Senate Bill 32) to further restrict state prescription drug "wrap-around" protection for enrollees of Medicare Part D by imposing additional cost sharing obligations on individuals who are already obligated to pay up to \$15 per month in co-payments.

In the 2009 session, the Legislature significantly retracted "wrap-around" coverage by:

- requiring participants to pay up to \$15 in co-payments per month;

- limiting state support to Medicare D plans whose cost is equal to or lesser than the cost of a "benchmark" plan; and
- drastically limiting state funded coverage of non-formulary drugs.

Older adults and individuals with disabilities who are surviving on fixed income budgets cannot bear additional cost sharing.

- C4A also **opposes** the Governor's proposal (Section 34 of Senate Bill 32) to impose \$3/service cost-sharing on low-income participants of the Medicaid program.

As a frame of reference, an individual applying for "community" Medicaid in most parts of Connecticut must show a monthly income of less than \$506.22 per month (\$672.10 for a couple). Given their low incomes, Medicaid recipients do not have sufficient income or savings through which they can bear cost-sharing for the services that they receive. Already burdened with significant out-of-pocket expenses, including over-the-counter medical supplies, utilities and food, recipients erode what little they have to live on each time a co-payment is made.

Cuts that Will Compromise the Capacity of the Provider Network

- C4A **opposes** the Governor's proposal not to give an increase Medicaid reimbursement rates to long-term care providers.

Medicaid reimbursement rates to providers of 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). This is particularly serious given the dramatic increase in need for direct home care staff that is anticipated based on demographics.

Background

Connecticut Home Care Program for Elders

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 2010, the CHCPE has an active client population of almost 15,000 individuals, more than 9,000 of whom received services through the Waiver. This vital program is the mainstay of Connecticut's efforts to keep people independent and self-determining in the community, at lower cost than would otherwise be expended in a nursing facility.

In the 2009 session, the Legislature imposed new cost sharing requirements on the state-funded clients of the CHCPE. Effective January 1, 2010, 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 toward the cost of his or her monthly care plan; and
- each participant whose income exceeds 200% of the FPL must make a 15% co-payment over and above his/her previous cost-sharing obligations.

These new cost sharing requirements have influenced several hundred participants to opt out of receiving services under the CHCPE. Older adults who are surviving on fixed income budgets cannot bear additional cost sharing. Already burdened with significant out-of-pocket expenses, including over-the-counter medical supplies, utilities and food, recipients erode what little they have to live on each time a co-payment is made. The Legislature should reaffirm its commitment to protecting this population from cost sharing that inhibits access to services that are desperately needed to remain safe and stable in the community.

Prescription Drug Coverage

Connecticut should affirm its long-time commitment to older adults, individuals with disabilities and other low-income people by resisting proposals to make further cuts in Connecticut's "wrap-around" coverage to the Medicare Part D prescription drug benefit; notably, imposition of additional cost-sharing requirements on those least able to bear these costs.

For participants of ConnPACE, the State has in the past several years covered Medicare Part D monthly premiums, formulary drugs needed during the "gap" period under the federal coverage, and most prescription drug costs (co-payments and deductible requirements) over the standard \$16.25 co-payment. Additionally, the Legislature provided those who are dually-eligible for Medicare and Medicaid with coverage of the \$1-\$5 co-payments that they would otherwise have been obligated to pay. Finally, for both ConnPACE and Medicaid recipients, the

Legislature in 2006 appropriated \$5 million to provide initial coverage for non-formulary drugs.

In the 2009 session, the Legislature significantly retracted "wrap-around" coverage by:

- requiring participants to pay up to \$15 in co-payments per month;
- limiting state support to Medicare D plans whose cost is equal to or lesser than the cost of a "benchmark" plan; and
- drastically limiting state funded coverage of non-formulary drugs.

Older adults and individuals with disabilities who are surviving on fixed income budgets cannot bear additional cost sharing. As a frame of reference, an individual applying for "community" Medicaid in most parts of Connecticut must show a monthly income of less than \$506.22 per month (\$672.10 for a couple). Given their low incomes, Medicaid recipients do not have sufficient income or savings through which they can bear cost-sharing for the services that they receive. Already burdened with significant out-of-pocket expenses, including over-the-counter medical supplies, utilities and food, recipients erode what little they have to live on each time a co-payment is made. The Legislature should reaffirm its commitment to protecting this population from increased co-payments, which leave those affected exposed to unacceptable barriers to accessing drugs that are desperately needed to enable them to remain safe and stable in the community.

Over and above issues of cost, full coverage of needed drugs is also a critical issue. Due to frailty and compromised health status, this population is heavily dependent on pharmacy coverage. Older Medicaid recipients are predominantly female, widowed and likely to live at home alone. Recipients evidence high incidence of chronic health conditions including congestive heart failure, hypertension, and diabetes that necessitate an evolving array of complementary medications. A significant incidence of clients must also contend with the debilitating effects of Alzheimer's or other dementia. Younger individuals with disabilities face parallel financial and physical constraints as they also subsist on fixed income budgets and require multiple medications to remain physically and psychiatrically stable. For all of these reasons, the proposal to impose prior authorization requirements on all mental health drugs is of great concern.

Provider Workforce and Reimbursement Issues

The Connecticut Long-Term Care Needs Assessment illustrates that Connecticut is facing serious challenges in personing long-term care staffing needs. Providing this care in the community is physically

demanding, poorly compensated and presents few opportunities for advancement. Turnover rates among agencies are extremely high, compromising ability to maintain consistency in provision of care. Furthermore, few direct care workers receive fringe benefits such as health care coverage or paid sick and vacation leave. Finally, inadequate reimbursement rates have made it extremely difficult for agencies to maintain effective training and oversight programs in support of direct care staff. A global approach that takes into account the educational, training, wage, benefits and support needs of nurses, home health aides, homemakers and personal care assistants is needed. This will support care needs of older adults, and will help to create career path jobs for Connecticut's unemployed citizens.

Data from professional groups including the Connecticut Home Care Association and the Connecticut Association for Adult Day Care indicate that Medicaid reimbursement rates to providers of 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. Further, reimbursement rates for self-directed options including personal care assistants do not adequately compensate for physically taxing, critically-needed work.