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Testimony of

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Connecticut Commission on Aging

Human Services Committee  
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Thank you for this opportunity to comment on three important proposals before you today.

As you know, the Connecticut Commission on Aging (CoA) is the nonpartisan state agency devoted to preparing Connecticut for a significantly changed demographic and enhancing the lives of the present and future generations of older adults. For seventeen years, CoA has served as an effective leader in statewide efforts to promote choice, independence and dignity for Connecticut's older adults and persons with disabilities. As part of our statutory mandate set forth in CGS §17b-420, CoA reviews and comments on proposed state legislation and budgetary issues.

**Senate Bill 297: An Act Concerning an Amendment to the Medicaid State Plan Under Section 1915(i) of the Social Security Act to Provide Home Care Services**  
~CoA Supports

Medicaid has a long history of being institutionally-biased. Medicaid rules require states to pay for nursing home care while home and community-based services are “optional.” Over time (and based on good intentions) in an attempt to use Medicaid dollars in the community, Connecticut has developed various Medicaid HCBS Waivers. (See the attached silo graphic, created by CoA.)

Unfortunately, these HCBS waivers are difficult to navigate and access. Consumers as well as professionals are challenged by the “silo” effect of Medicaid waivers, each of which are associated with distinct age, diagnostic or disability-specific eligibility criteria. Further, due to a limited number of “slots” for most of these waivers, many eligible individuals are presently on waiting lists. **There are no such waiting lists for institutional care.**

With the Affordable Care Act (ACA), a variety of options and improvements became available to Connecticut and all states to help reform their long-term care systems. In Connecticut, a group of stakeholders have been meeting for the last year reviewing these opportunities in an attempt to address the highly fractured Medicaid HCBS Waiver system – which represents the most significant barrier to helping people stay in their homes and communities. After lengthy analysis and discussion, the 1915(i) State Plan Amendment was determined to be the very best vehicle for major systems change.



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**Section 1.** Directs the Commissioner of DSS to pursue a 1915(i) State Plan Amendment to improve access to HCBS. Through this action it would:

- **Eliminate the “silos”** by establishing eligibility criteria based on functional limitations as opposed to current criteria using age, diagnosis, or disability;
- **Provide services** for eligible individuals who are currently on waiting lists for HCBS Medicaid Waivers;
- **Enhance federal match** for individuals whose services are currently fully funded with state funds. (It is important to note that Governor Malloy’s budget proposal regarding a highly limited 1915(i) would only accomplish in small part this third objective.) Primarily these folks include: participants of the state-funded (Levels 1 & 2) Connecticut Home Care Programs for Elders (CHCPE) who are financially eligible for Medicaid, but do not currently meet the functional requirements for participation in a “waiver” and individuals served by the Department of Mental Health & Addiction Services (DMHAS) through state grants.

#### **Why Prioritize Home and Community Based Services:**

- **Honors Individuals Preference:** 80% of Connecticut residents indicate that they would prefer and expect to remain at home as they age, with or without home modifications (according to Connecticut’s LTC Needs Assessment as conducted by UConn Health Center, Center on Aging).
- **Honors Individuals Rights:** Consistent with the ADA, the US Supreme Court Olmstead Decision and Connecticut law (PA 05-14) – people have the right to choose and receive care in the least restrictive, most appropriate environment.
- **Consistent with national trends/policy directions/best practices:** Connecticut is ranked about 30<sup>th</sup> compared to other states in their commitment to invest the percentage of the Medicaid long-term care dollars in home and community-based services.
- **Costs Less:** Study after study demonstrate that utilization of Medicaid LTC expenditures for home and community-based services costs anywhere between a 1/3 to 1/2 the cost of nursing home care/institutional care.

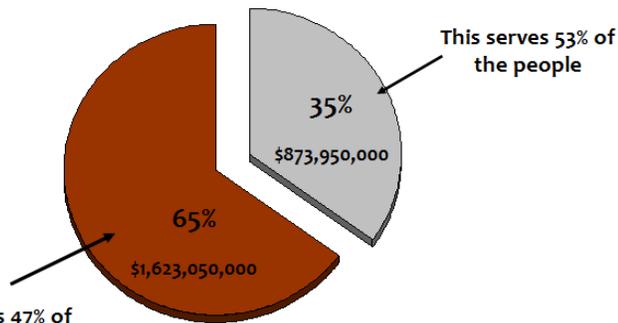
A Snap shot of one of the Medicaid HCBS Waivers: Connecticut Home Care Program for Elders (CHCPE).

**DSS reports that the CHCPE saves the state \$101,931,462, in SFY 2008.**

*Latest published Annual Report of CHCPE by DSS.*

### Percent of Medicaid LTC Dollars - FY 2009

- Medicaid HCBS Expenditures
- Medicaid Institutional Care Expenditures



**Sect  
Prog** This serves 47% of  
the people

### State Balancing Incentive Payment

...ity for states to receive a temporary increase in federal matching assistance payments (FMAP) by 2% or 5% for Medicaid HCBS. All of these enhanced funds will be solely used to help expand Medicaid home and community based services. According to CMS, within six months of application, the following administrative changes (as featured in this bill) must be instituted: establishment of a no-wrong door single entry point system” 2) the provision of conflict free case management; 3) utilization of a core standardized assessment instrument to determine eligibility and appropriate services.

**Section 3: Expands the Long-Term Care Reinvestment Account:** Connecticut Public Act 08-180 and 09-5 established the Long-Term Care Reinvestment Account, directing that any funds resulting from the enhanced federal medical assistance percentage (FMAP) received by the state under the Money Follows the Person demonstration project must be deposited in the account. Further, SB 297 adds that any funds received by the state under the Affordable Care Act and related to home and community based services shall be deposited into the account. These federal revenues and savings contained in the account would be reinvested into a broad range of services and supports across the continuum of care including the 1915(i) State Plan Amendment. **Unfortunately, this account has not yet been implemented due to deferrals.** Additionally, Governor Malloy has recommended eliminating the account. The Account should be implemented immediately as it will give us better guidance in our state’s goal to rebalance our long-term care system, provide greater transparency within state government and will ensure accountability in the use of federal money that must be dedicated to an identified purpose.

**Relationship to Money Follows the Person (MFP)** a multi-million dollar federal demonstration grant (up to \$300 million): The CoA fully supports MFP and is grateful to the legislature for its ongoing support as well as Governor Malloy’s proposal to dramatically expand it (as approved by CMS). The CoA has close involvement with this initiative through our daily work (utilizing Results-Based Accountability), in my leadership role as co-chair of an active MFP Steering Committee and as chair of the workforce development subcommittee. The most recognizable component or “benchmark” of MFP is that it now proposed by Governor Malloy to move 5,200 people from nursing homes into the community by 2016 (DSS had originally committed to transition 890 people). After the first year of transition, “waiver” slots are guaranteed for folks who qualify for these Medicaid HCBS waiver services. Frustration is mounting as Medicaid waiver slots are not also being expanded on the “community-side.” So, in place now is a perverse and dangerous

incentive to first go into a nursing home – to be able to transition out after three months – to be able to access one of the waivers. Additionally, some people are falling through the cracks of services not being able to fit into these narrowly defined waivers but no less deserving of the services. As a state it is smart policy to transition people out of nursing homes if that is their choice – **it is at least equally important and our responsibility to ensure that those same community supports are afforded to those who are in the community first.**

***House Bill 5436: An Act Concerning the Use of Prescription Drugs Returned by Long-Term Care Facilities.***

~ CoA supports

Connecticut General Statutes §17b-363a establishes the drug recycling program for long-term care facilities. Under this program, unused individually-packaged medication is returned from long-term care facilities to vendor pharmacies, who then redistribute the drug through the Medicaid program. Separately, Connecticut General Statutes §18-81q establishes a similar program for our state's correctional facilities. Just like in our own homes, medications go unused for a variety of reasons – a change in health status, a change in dosing, discharge from the facility, et cetera. Before the establishment of these two programs, nursing homes and prisons threw away leftover drugs.

In FY '09, the long-term care drug recycling program saved the state about \$695,000, while the corrections program saved about \$1.2 million. Notably, the long-term care program is budgeted to save the state \$1.5 million annually – but not all facilities have complied, and the Department of Social Services has not exercised its authority to fine nonparticipating facilities. The Commission on Enhancing Agency Outcomes recommends expansion of the long-term care program for a potential annual savings of \$2.4 million.

This proposal goes one step further and could reduce duplication and enhance efficiency, by allowing the drugs returned from long-term care facilities to be used either for other Medicaid recipients or for inmates in correctional facilities. It also streamlines the process by establishing a central repository where unused drugs would be sent, instead of sending them to individual pharmacies for redistribution.

Given the safeguards currently in place and proposed to move forward, CoA recommends support of this proposal as a creative way to achieve savings without reducing services.

***House Bill 6486: An Act Concerning Home Health Care Services and the Establishment of a Personal Care Attendant Workforce Council***

~ CoA informs

Personal care assistance services are among the most cost-effective types of home- and community-based services. PCA services vary for each consumer, but can include tasks like bathing, dressing, transferring from a bed to a chair, light housekeeping, shopping and more. The key to PCA services is that they are individualized – they are designed by the consumer or his or her representative to meet the needs of that person. Many individuals who have PCAs hire them themselves; they are able to work and be active participants in community life.

According to the Long-Term Care Needs Assessment, Connecticut is projected to need 9000 new direct care workers, including 28% more personal and home care aide positions, between 2004 and 2014. This projection, combined with demographic changes, has profound implications for workforce development and public policy. Connecticut must commit itself to recruiting and retaining personal care attendants (and other long-term care workers) with a coordinated plan. In crafting this plan, policymakers must consider current concerns in this occupation – including low wages, poor or no benefits, difficult working conditions and retention issues.

CoA acknowledges the controversial nature of the bill before you today, which is an attempt to address some of those concerns and plan for future needs.

Specifically, many consumers and advocates remain concerned that this proposal would remove independence, dignity and choice from consumers, many of whom are able to self-direct their care. The working relationship between a PCA and his or her client is paramount. For example, individuals whose PCAs bathe them rightly want choice in who is performing that most personal of tasks. Similarly, PCAs who are entrusted with personal financial information, or are given authority to write checks on their clients' behalf, should be vetted by consumers who are able to do so. It is the Commission's understanding based on the bill language that individuals would under this proposal retain authority to hire, direct and, if necessary, fire PCA's. If enacted, this should be carefully implemented and monitored to ensure that their rights to do so are maintained.

An additional concern for this Committee to consider is the current methodology of payment. Currently, consumers are allocated a certain amount of money for their care; therefore, the amount of service they receive is directly tied to the wages their PCAs receive. If they choose to give their PCA a raise, they must reduce the amount of services commensurately. This system disincentivizes higher wages and does not benefit either the consumer or the PCA. CoA recommends that the Committee address this methodology.

Thank you.

