



# STATE OF CONNECTICUT

OFFICE OF POLICY AND MANAGEMENT

OFFICE OF THE SECRETARY

## *TESTIMONY PRESENTED TO THE HUMAN SERVICES COMMITTEE March 15, 2011*

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Testimony Supporting Senate Bill No. 1013

### AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET RECOMMENDATIONS CONCERNING HUMAN SERVICES

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Good morning, Senator Musto, Representative Tercyak and distinguished members of the Human Services Committee. Thank you for the opportunity to offer testimony on Senate Bill No. 1013, An Act Implementing the Governor's Budget Recommendations Concerning Human Services.

In total, excluding the user fee provisions, the initiatives in this bill will result in: savings of \$283.2 million in FY 12 and \$346.7 million in FY 13, as well as additional revenue of \$4.8 million in FY 12 and \$6.7 million in FY 13. The user fee provisions will result in net state savings of \$150.7 million in FY 12 and \$150.6 million in FY 13.

This bill makes the following changes:

**Section 1. Maintain Current Rates for Nursing Homes.** Under current statute, DSS is required to rebase nursing home rates no more than once every two years and no less than once every four years. Since nursing home rates were last rebased in FY 06, the current services budget includes a rate increase of 5.66% in FY 12 to reflect the rebasing of rates at a cost of \$66.9 million. To comply with DSS' regulations, the current services budget also includes a 1.9% inflationary adjustment in FY 13 based on the anticipated increase in the gross national product (GNP) deflator. In addition, under current statute, DSS incorporates an adjustment to accommodate improvements to real property (referred to as a "fair rent" adjustment) when setting annual nursing home rates. This bill eliminates these increases over the biennium. Even with this bill, Connecticut's rates will remain one of the highest in the country - the state's rates are currently in the top five in terms of highest Medicaid reimbursement. Savings of \$68.9 million in FY 12 and \$95.5 million in FY 13 are anticipated.

Note: A technical correction is required on line 165. After the period, insert: "Notwithstanding the provisions of this section, the Commissioner of Social Services may, within available appropriations, increase rates issued to licensed chronic and convalescent nursing homes and licensed rest homes with nursing

supervision.” This correction will allow for rate increases associated with the changes in the nursing home user fee.

**Section 2.** Implement the Recommendations of the Pharmaceutical Bulk Purchasing Committee for DSS. Pursuant to PA 09-206, An Act Concerning Health Care Cost Initiatives, the committee charged with developing an implementation plan for a prescription drug purchasing program concluded that significant savings could be achieved if DSS were to either join the state's prescription drug program administered by the Office of the State Comptroller for the state employee and retiree prescription drug plan or mirror the reimbursement levels. Under this bill, DSS' reimbursement levels will be reduced to align with those under the state employee and retiree programs. This recommendation is consistent with the guidance provided by the federal Centers for Medicare and Medicaid Services which advised the committee that mirroring the rates of the state employee and retiree program would be more efficient and administratively less burdensome. Savings of \$76.3 million in FY 12 and \$82.7 million in FY 13 are anticipated.

**Sections 3 and 4.** Suspend Cost of Living Adjustments for Clients on Public Assistance. Current statute provides recipients and applicants of Temporary Family Assistance, State Administered General Assistance (SAGA) and the Aid to the Aged, Blind and Disabled (AABD) programs a state-funded cost of living adjustment based on the percentage increase in the Consumer Price Index – Urban on July 1 of each year. This bill maintains the existing assistance levels and does not provide the cost of living adjustment estimated at 1.6% in FY 12 and 1.4% in FY 13. It should be noted that Connecticut is one of the few states that allows TFA recipients to keep their earnings up to the federal poverty level. Savings of \$6.3 million in FY 12 and \$12.5 million in FY 13 are anticipated.

**Section 4.** Apply Annual Social Security Increases to Offset Costs under the Aid to the Aged, Blind and Disabled Program. In past years, any cost of living adjustments (COLA) received as part of an AABD client's Social Security benefit were considered an increase in income and applied to the client's cost of care. Recent legislation, however, allows AABD clients to retain their Social Security COLA (by increasing the unearned income disregard) without a concurrent reduction in their state benefit. This bill reinstates the previous policy of applying any federal COLA to offset the cost per case. Savings of approximately \$459,000 in FY 12 and \$1.7 million in FY 13 are anticipated.

**Section 5.** Restructure Charter Oak Health Plan. This section of the bill implements three provisions included in the Governor's budget:

1. Limit State-Funded Premium Assistance. Last year, as part of deficit mitigation efforts, premium assistance under the Charter Oak Health Plan was limited to clients who were enrolled in the program as of June 1, 2010. Premium assistance is scheduled to resume for all clients beginning July 1, 2011. Under this provision, state-funded premium assistance will continue to be limited to clients who were enrolled in the program as of June 1, 2010. Lower income individuals who choose to enroll in the Charter Oak Health Plan will be responsible for the full premium costs. Savings of \$7.2 million in FY 12 and \$12.4 million in FY 13 are anticipated.

2. Reduce State-Funded Premium Assistance under the Charter Oak Health Plan. Currently, individuals with income at or below 300% of the federal poverty level, enrolled in the Charter Oak Health Plan as of June 1, 2010, receive state-funded premium assistance, which ranges from \$50 to \$175, depending on income. Under this provision, clients whose premiums are being subsidized by the state will be responsible for a greater share of the premiums. Savings of \$4.8 million in FY 12 and \$4.9 million in FY 13 are anticipated.
3. Revise Charter Oak Eligibility to Maximize Federal Dollars under the State's High Risk Pool. Under this provision, individuals will not be able to enroll in the Charter Oak Health Plan if they are eligible for coverage under the state's high risk pool, Connecticut Pre-existing Condition Insurance Plan (CT PCIP). This change will allow the state to leverage the \$50 million available to Connecticut to support clients' premium costs and will increase the likelihood that Connecticut's administrative costs will fall within the 10% cap and thus can be charged in their entirety to the federal allotment. This proposal will not impact current enrollees in the Charter Oak Health Plan who have a pre-existing condition. Due to the changes already being proposed under this program, no additional savings are anticipated.

**Section 6.** Reduce Non-Emergency Dental Services for Adults under Medicaid. This bill allows DSS to reduce overall program expenditures while maintaining non-emergency dental services that will prevent further disease, unnecessary emergency department use and maintain appropriate oral health. Changes include limiting adult periodic exams, cleanings and bitewing x-rays to once per year for healthy adults. Less than half of the states provide full dental benefits for adults under their Medicaid programs; most states have annual expenditure caps or provide only emergency coverage. In the last few years, many states have reduced or eliminated adult dental benefits offered through Medicaid. Savings of \$9.8 million in FY 12 and \$10.3 million in FY 13 are anticipated.

**Section 7.** Impose Cost-Sharing Requirements on Certain Individuals Receiving Medicaid Services. According to a report by the Kaiser Family Foundation, a total of 44 states impose co-payments under their Medicaid programs. Under this bill, DSS will require co-pays of up to \$3.00 per service on allowable medical services (excluding hospital inpatient, emergency room, home health, laboratory and transportation services), not to exceed 5% of family income. Co-pays for pharmacy services will be capped at \$20 per month. Consistent with federal rules, the following populations will be exempt from the cost sharing requirement: certain children under age 18; individuals at or below 100% of the federal poverty level; Supplemental Security Income (SSI) recipients; pregnant women; women being treated for breast or cervical cancer; and persons in institutional settings. Savings of \$8.3 million in FY 12 and \$9.5 million in FY 13 are anticipated.

**Sections 8 and 9.** Maintain Current Rates for Boarding Homes. Under current statute, DSS is required to annually determine rates for various boarding homes. Per DSS regulations, boarding home rate increases are based on actual cost

reports submitted by facilities, barring any legislation to remove rate increases for a particular fiscal year. Under the normal rate calculation structure, boarding homes would have received increases of over 7%. This bill maintains existing reimbursement levels over the biennium by eliminating these rate increases that have been included in the current services budget. Savings of \$4.9 million in FY 12 and \$8.6 million in FY 13 are anticipated.

**Sections 10 - 12.** Restructure Non-Emergency Medical Transportation under Medicaid. Current regulations require DSS to pay for ambulance service for individuals who are stretcher bound but do not require medical attention during transport. Under this bill, transportation options under Medicaid will be expanded to include stretcher van service for those individuals who are medically stable but must lie flat during transport. The new stretcher van rate will be significantly less - roughly one-fifth of the non-emergency ambulance rate, which has a base rate of \$218 plus \$2.88 per mile (approximately \$275 for a 20 mile one-way trip). This change is consistent with at least a dozen other states that have recognized the economic value of stretcher vans and will allow clients to be transported in a more cost-efficient manner while still assuring client safety. Savings of \$6.3 million in FY 12 and \$7.0 million in FY 13 are anticipated.

Note: Two technical corrections to this section are required -

1. Strike lines 567 - 571, inclusive, in their entirety and insert in lieu thereof "of the general statutes, to establish oversight of the operation of stretcher vans as a livery service for which a permit shall be required. The regulations shall prescribe safety standards for stretcher vans, including, but not limited to, a requirement that an attendant in addition to the driver shall accompany a person transported in a stretcher van."
2. Strike lines 634 - 641 and renumber the sections accordingly.

**Section 13.** Delay Coverage of Medical Interpreters thru an Administrative Process. Under Title VI of the Civil Rights Act of 1964, all health care providers who receive federal funding are required to ensure "meaningful" services for individuals with limited English proficiency. Thus providers must ensure meaningful access to programs and services by ensuring effective communication, including the provision of interpreter services. Although it is the provider's responsibility to arrange and pay for interpreter services, the legislature required that DSS amend the Medicaid state plan to include foreign language interpreter services provided to any beneficiary with limited English proficiency as a covered service under the Medicaid program. This bill will require providers to continue to cover the cost of interpreters until FY 14. When implemented, services will be provided from one centralized vendor. This is a more cost-efficient, streamlined model than requiring a Medicaid state plan amendment, where providers will be allowed to submit claims for reimbursement of medical interpreter costs, and is federally reimbursable. Savings of \$6.0 million in FY 12 and FY 13 are anticipated.

**Section 14.** Restructure State-Funded Connecticut Home Care Program. This section of the bill implements two provisions included in the Governor's budget:

1. Freeze Intake on Category 1. The state-funded Connecticut Home Care Program provides home and community-based services to elderly who are at risk of nursing home placement and meet the program's financial eligibility criteria. This bill freezes intake to Category 1, which serves individuals who are at risk of hospitalization or short-term nursing facility placement but not frail enough to require nursing facility care. It should be noted that the Governor has directed the department to pursue a new opportunity under a 1915(i) state plan option that will allow the department to transfer dually eligible clients under the state-funded program who do not meet the functional requirements for the home care waiver program to Medicaid and claim reimbursement. Thus, intake to the state-funded program for Category 1 will be closed, but intake under the newly established Medicaid program will continue for those who qualify. Savings of \$1.8 million in FY 12 and \$2.1 million in FY 13 are anticipated.
2. Increase Cost Sharing. PA 09-5, September special session, introduced a client cost sharing requirement of 15% of the costs of his or her care under the state-funded Connecticut Home Care program. This requirement was reduced to 6% under PA 10-179. Under this bill, the cost sharing requirement will be returned to 15%. Savings of \$5.5 million in FY 12 and \$5.8 million in FY 13 are anticipated.

**Section 15. Require Certification for Medication Administration.** Current statute permits unlicensed personnel to obtain certification for the administration of medication from the Department of Public Health. This bill requires that home health care agencies have specially trained and qualified home health aides to administer oral and topical medications and eye drops. Nurses will still be required to administer all injections as well as those medications that a physician specifies must be administered by a nurse. While the Medicaid program will realize savings due to reduced reliance on nurse administration of medications, funds are provided for training and other implementation costs associated. It should be noted that this initiative is similar to the process used by the Department of Developmental Services, as well as the initiative authorized by the legislature two years ago to support medication administration by trained staff in residential care homes. Savings of \$1.8 million in FY 12 and \$4.2 million in FY 13 are anticipated.

**Sections 16 - 18. Phase-out the ConnPACE Program.** For the majority of ConnPACE enrollees, ConnPACE is the secondary payor to Medicare Part D. ConnPACE recipients are required to exhaust their Part D benefits under Medicare. The department pays any copays above \$16.25 and any premiums and deductibles, as well as any coverage gap costs, for those enrolled in Medicare Part D. With the recent increase in income eligibility under the Medicare Savings Programs (MSP), ConnPACE clients who are Medicare eligible are encouraged to enroll in MSP, which makes them eligible for the federal low income subsidy under Medicare Part D. As a result, prescription co-pays are reduced from a maximum of \$16.25 to no more than \$6.30 (co-pays could be as low as \$1.10). Under this bill, ConnPACE coverage for Medicare eligible clients will be eliminated. Those clients who are Medicare eligible, but who do not

otherwise qualify for the federal low income subsidy, will need to enroll in MSP to ensure their pharmacy costs remain affordable. By doing so, they will also be able to take advantage of the assistance provided under MSP. The remaining 110 clients or so who are not eligible for Medicare Part D benefits will be grandfathered under the ConnPACE program and will continue to receive assistance. Savings of \$4.4 million in FY 12 and \$4.1 million in FY 13 are anticipated.

Note: To ensure that all ConnPACE clients who are Medicare eligible meet the eligibility requirements for the Medicare Savings Programs, the following section should be inserted with the remaining sections renumbered accordingly -

Sec. 19. Section 17b-256f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Beginning October 1, 2009, and annually thereafter, the Commissioner of Social Services shall increase income disregards used to determine eligibility by the Department of Social Services for the federal Specified Low-Income Medicare Beneficiary, the Qualified Medicare Beneficiary and the Qualifying Individual Programs, administered in accordance with the provisions of 42 USC 1396d(p), by an amount that equalizes the income levels and deductions used to determine eligibility for said programs with income levels and deductions used to determine eligibility for the ConnPACE program under subsection (a) of section 17b-492. The commissioner shall not apply an asset test for eligibility under the Medicare Savings Program. The Commissioner of Social Services, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided the commissioner prints notice of the intent to adopt the regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policies and procedures shall be valid until the time final regulations are adopted.

**Section 19.** Maintain Current Rates for Intermediate Care Facilities. To comply with DSS' regulations, the current services budget includes a 3.0% increase in FY 12 and FY 13 for Intermediate Care Facilities for those with developmental disabilities based on the anticipated increase in the gross national product (GNP) deflator. This bill eliminates these increases over the biennium. Savings of \$1.9 million in FY 12 and \$3.9 million in FY 13 are anticipated.

Note: A technical correction is required on line 1164. After the period, insert: "Notwithstanding the provisions of this section, the Commissioner of Social Services may, within available appropriations, increase rates issued to intermediate care facilities for the mentally retarded." This correction will allow for rate increases associated with the implementation of a user fee.

**Section 20.** Restructure Medicaid Reimbursement for Certain Hospital Outpatient Services. Currently, DSS sets the rates for outpatient hospital services that are paid using revenue center codes. Some codes are fixed fees - a specific dollar amount for a code and every hospital approved for that code gets the same amount. Other outpatient services are paid a percentage of cost to charges - the ratio is hospital specific and code specific based on the hospital department

where the costs and charges are reported. This bill will allow DSS to set state-wide fixed Medicaid fees for certain outpatient hospital services that are now paid based on hospital specific ratio of cost to charges. Savings of \$1.1 million in FY 12 and \$2.4 million in FY 13 are anticipated.

**Section 21.** Revise Medicare Part D Co-Pay Requirements for Dually Eligible Clients. Connecticut is one of only a few states assisting dually eligible clients with the costs of the Medicare Part D co-payments, which range from \$1.10 to \$6.30 in 2011. Currently, dually eligible clients are responsible for paying up to \$15 per month in Medicare co-pays for Part D-covered drugs. Under this bill, dually eligible clients will be responsible for paying up to \$25 per month in Medicare co-pays for Part D-covered drugs. Capping monthly cost-sharing at \$25 will continue to protect dually eligible individuals who have a high number of prescriptions. Savings of \$2.2 million in FY 12 and \$2.3 million in FY 13 are anticipated.

**Section 22.** Reduce the Number Served under the HIV/AIDS Waiver. The HIV/AIDS waiver is a home and community-based services waiver that is being developed by DSS to provide additional services beyond those traditionally offered under Medicaid (e.g., case management, homemaker, personal care assistance, adult day health and respite) for up to 100 persons. Given that the projected cost of the waiver is expected to exceed \$4.3 million when fully annualized, this bill reduces the number to be served under the waiver to no more than 50 persons. It is important to note that despite the reduction in the number served under the waiver, eligible individuals will continue to receive traditional Medicaid services. Savings of \$700,000 in FY 12 and \$2.2 million in FY 13 are anticipated.

**Section 23.** Reduce the Personal Needs Allowance for Residents of Long-Term Care Facilities. Social Security and other income received by residents of long-term care facilities are applied towards the cost of care except for a monthly personal needs allowance (PNA). Residents use funds for such items as gifts, clothing, cosmetics, grooming, personal phone, cable TV, reading materials and entertainment outside of the facility. In 1998, Connecticut increased the PNA from the federal minimum of \$30 to \$50 per month and provided for July 1 annual updates equal to Social Security inflation increases. The Connecticut PNA is currently \$69 per month. Under this bill, the PNA will be reduced from \$69 to \$60 per month, which is \$30 above the federal minimum. This level is the same as the amount allowed in Massachusetts and \$10 higher than New York. Savings of \$1.9 million in FY 12 and \$2.1 million in FY 13 are anticipated.

**Section 24.** Restrict Vision Services for Adults under Medicaid. The provision of eyeglasses, contact lenses and services provided by optometrists for adults are considered optional under federal Medicaid rules. Under this bill, the coverage of eyeglasses will be reduced to no more than one pair every other year. To comply with federal rules, the current benefit will continue to be provided to all children under the age of 21 under the HUSKY A program. Savings of \$825,000 in FY 12 and \$950,000 in FY 13 are anticipated.

**Section 25.** Cap the Total Number of Beds under Small House Nursing Home Projects. PA 08-91 requires DSS to establish, within available appropriations, a

pilot program to support the development of up to ten "small house nursing home" projects with the goal of improving the quality of life for nursing home residents by providing care in a more home-like setting. While each unit can house no more than ten individuals, each project can have multiple units. One project that is in the early stages of development will convert approximately 280 certified beds to this model. To control future costs, this bill restricts any further development of "small house nursing home" projects by capping the number of beds at 280. Savings of \$750,000 in FY 13 are anticipated.

**Section 26.** Reduce Benefits under the State-Funded Supplemental Nutrition Assistance Program. The State-Funded Supplemental Nutrition Assistance Program provides benefits for non-citizens who are ineligible for the federal Supplemental Nutrition Assistance Program (SNAP). Connecticut is one of only seven states to offer such a program for non-citizens. Clients under the state-funded program receive a benefit that is equal to 75% of what they would have received under the federal program. This bill reduces the monthly state-funded benefit from 75% to 50% of the federal SNAP benefit. Savings of approximately \$478,000 in FY 12 and \$675,000 in FY 13 are anticipated.

**Section 27.** Implement Changes to the Security Deposit Guarantee Program. This bill makes several changes to the Security Deposit Guarantee Program to strengthen program criteria and enhance identification of fraudulent claims: (1) the time required before a client can reapply for a Security Deposit will be extended from 18 months to 5 years; (2) the proof of homelessness criteria will be improved to require legal documentation that is filed in court; (3) landlords will be required to provide DSS with receipts (rather than estimates) for the damage caused by the tenant; and (4) a small client co-pay will be added to ensure clients have a buy-in in the program. The co-pay will not exceed 10% of one month's rent and may be waived at the Commissioner's discretion. Savings of approximately \$458,000 in FY 12 and \$499,000 in FY 13 are anticipated.

**Section 28.** Transfer the Child Day Care Program to the State Department of Education. This bill transfers the responsibility for child day care center slots under DSS to the State Department of Education (SDE). The State Department of Education already provides funding for child day care center slots under the School Readiness program. Approximately \$16.4 million in FY 12 and FY 13 is reallocated to SDE.

**Section 29.** Transfer School Readiness Grant in the Child Care Quality Enhancements Account to State Department of Education. Currently, DSS transfers funds to the State Department of Education for enhancement grants for SDE's School Readiness Program. Under this bill, responsibility for this portion of the program will shift to SDE. Approximately \$1.2 million in FY 12 and FY 13 is reallocated to SDE.

**Sections 30 - 34.** Reinstate Hospital User Fee. The hospital user fee was first instituted in April 1994 and was eliminated in April 2000. Under this bill, a user fee on hospitals will be reinstated. This is consistent with the direction that many other states have taken - according to the Kaiser Family Foundation, 29 states (including all of the other New England states) had in place a hospital user fee in 2010 and another 5 plan to adopt a user fee in 2011. Under this proposal, funds

will be redistributed to the hospitals under the disproportionate share hospital (DSH) program and the state will receive 50% federal reimbursement. The user fee, in the aggregate, will hold the hospitals harmless. Recognizing that the DSH program may be phased down beginning in 2014 due to changes under the Affordable Care Act, hospital rates may be increased in combination with the DSH payments to hospitals to maintain the overall payments to hospitals in the aggregate. Net state savings of \$133.3 million in FY 12 and \$134.5 million in FY 13 is anticipated.

**Section 35. Restructure Nursing Home User Fee.** Federal rules allow for user fees not to exceed 5.5% of provider revenue through September 30, 2011, increasing to 6.0% thereafter. Under this bill, the existing nursing home user fee will be increased to maximize the amount of revenue to the state. In addition, the nursing home industry will receive a substantial infusion of new funding through their Medicaid rates. The revenue gained from the user fee assessment will be returned to the nursing homes in the form of increased Medicaid rates as well as any federal dollars gained from that initial federal claiming. When fully annualized in FY 13, nursing homes will be assessed an additional user fee of \$34.3 million while realizing a Medicaid rate increase of \$51.5 million. Net state savings of \$9.7 million in FY 12 and \$8.5 million in FY 13 is anticipated.

**Sections 36 – 38. Implement ICF/MR User Fee.** Under this bill, the user fee will be extended to both private and public intermediate care facilities for the mentally retarded (ICF/MRs). Extending a user fee to ICF/MRs is consistent with the direction that many states have taken – according to the Kaiser Family Foundation, 33 states had in place an ICF/MR user fee in 2010 with an additional state planning to adopt an ICF/MR user fee in 2011. For private ICF/MRs, the revenue gained from the user fee assessment will be returned in the form of increased Medicaid rates as well as any federal dollars gained from that initial federal claiming. When fully annualized in FY 13, private ICF/MRs will be assessed a user fee of \$3.9 million while realizing a Medicaid rate increase of \$5.8 million. For public ICF/MRs, the Department of Developmental Services' appropriation has been increased to cover the cost of the user fee that will be assessed by and paid to the Department of Revenue Services; DSS will then be able to claim revenue on the DDS payments for net savings of \$6.7 million in FY 13, when fully annualized. In total, this bill will result in a net gain to the state of \$7.7 million in FY 12 and \$7.6 million in FY 13.

**Section 39. Expedite DSS' Ability to Implement Initiatives.** This section allows DSS to implement various initiatives under this bill while in the process of developing policies and procedures in regulation. This is necessary to ensure savings are achievable over the biennium and are not delayed until final approval of regulations implementing programmatic changes.

**Section 40. Modify Transfer of Assets Provisions.** The Deficit Reduction Act (DRA) of 2005 introduced new rules to discourage the improper transfer of assets to gain Medicaid eligibility and receive long-term care services. Since the passage of the DRA, however, estate planners and elder law attorneys have attempted to find ways to get around the new law with the goal of allowing individuals to continue to transfer approximately half of their assets and become

eligible for Medicaid without penalty. To address this loophole, DSS proposed a regulation that discourages this activity and preserves the intent of the federal law. The legality of the proposed regulation, however, has come under challenge (there are a number of cases now pending in court) and concerns have been raised by the Centers for Medicare & Medicaid Services (CMS). This bill supersedes the department's proposed regulation and represents an alternative way to ensure that people who have the means to pay for the costs of their own nursing home care do so. The bill provides that (1) a partial return of a transferred asset does not result in a reduced penalty period and (2) a full return of a transferred asset, while negating the penalty period, will be regarded as an available asset if the transfer and subsequent return were done to shift costs to the Medicaid program. These provisions are consistent with recent CMS guidance and will ensure that the state is not paying for care that could have been paid for by the individual if the assets had not been transferred. Failure to pass this bill will result in future unbudgeted costs.

Note: Two technical corrections to this section are required -

3. Strike line 1793 and insert in its place "An institutionalized individual, as defined in subsection (B) of section 3029.05 of the Department of Social Services' Uniform Policy Manual, shall not be penalized for the"
4. On lines 1797 - 1798, delete "by the institutionalized individual"

**Section 41.** Revise School Based Child Health Legislation to Comply with Federal Requirements. On February 10, 2010, the federal Centers for Medicare and Medicaid Services notified DSS that its Medicaid rate setting and claiming methodology for School Based Child Health (SBCH) services do not meet federal requirements and will need to be modified. Specifically, CMS is requiring that the current SBCH bundled service monthly rate method be revised to a fee-for-service system. This section authorizes DSS to modify the reimbursement methodology to comply with federal requirements.

**Section 42.** Repeal Certain Statutory Language. This section of the bill implements the following provisions included in the Governor's budget:

1. Eliminate Funding for DSH - Urban Hospitals in Distressed Municipalities Grant (section 17b-239a). The DSH - Urban Hospitals in Distressed Municipalities account provides disproportionate share payments to certain acute-care general hospitals that serve a large number of low-income patients, such as people on Medicaid and the uninsured. Funding is provided for hospitals located in (a) distressed municipalities with populations greater than 70,000 and (b) targeted investment communities with enterprise zones that have populations in excess of 100,000. Hospitals designated as DSH - Urban are: Bridgeport, Central Connecticut, Hartford, St. Francis, St. Mary, St. Raphael, St. Vincent, Stamford, Waterbury and Yale-New Haven. These payments are in addition to the regular payments hospitals receive for providing inpatient care to Medicaid beneficiaries. As a result of the recent Medicaid expansion to low-income adults (LIA), hospitals are receiving more than triple the funding that they received under SAGA. (In FY 11,

hospitals would have received \$66.3 million under the SAGA hospital pool, which was capped regardless of caseload growth, but under LIA, which has already experienced a caseload growth of over 27% in the first six months of this fiscal year, hospitals are projected to receive over \$226.8 million - an increase of \$160.5 million. These figures do not include the increased reimbursement hospitals are receiving from DMHAS as a result of LIA.) Due to this significant influx in funding for hospitals, this bill eliminates the DSH account. In addition, it should be noted that under federal health care reform, DSH payments to states will be significantly phased down beginning in 2014 to account for anticipated reductions in the number of uninsured individuals. Savings of \$31.6 million in FY 12 and FY 13 are anticipated.

2. Reverse Recent Change to Marital Asset Exemption for Community Spouses (section 17b-261k). Legislation from last session requires that the spouse of someone in an institution who remains in the community be allowed to receive the maximum amount of assets allowed by federal law. With this change, Connecticut became one of only 14 states that allows the community spouse to keep up to the federal maximum of \$109,560. Prior to the passage of PA 10-73, non-institutionalized spouses were allowed to keep the home, one car and one-half of the couple's assets (with a minimum amount of \$21,912) without affecting the institutionalized spouse's eligibility for long-term care Medicaid assistance. These asset levels are much higher than the vast majority of states, which use the federal minimum of \$21,912, with a few states using a slightly higher minimum. Under this bill, the state's prior asset exemption of 50% of liquid marital assets, capped at \$109,560, will be reinstated. Savings of \$29.3 million in FY 12 and \$32.0 million in FY 13 are anticipated.
3. Eliminate the Establishment of a Long-Term Care Reinvestment Account (section 17b-371). Current statute requires the establishment of a Long-Term Care Reinvestment account, a non-lapsing account within the General Fund, beginning in FY 12. The account is to be funded with the 25% enhanced federal match received under Money Follows the Person in the first year of each transition to support changes in the long-term care infrastructure. Under this bill, the 25% enhanced match will continue to be treated as General Fund revenue. Additional revenue of \$4.8 million in FY 12 and \$6.7 million in FY 13 is anticipated.
4. Eliminate Funding for Adult Foster Care Program (section 17b-424). The pilot adult foster care program matches seniors in need of room, board and personal care with approved host families, who receive a monthly allowance from DSS. Intake to this program is closed, as DSS is currently phasing out the program due to low interest. Savings of approximately \$14,000 in FY 12 and FY 13 are anticipated.
5. Repealers Related to Other Provisions (sections 17b-265e and 17b-492a). See write-up for Sections 16 - 18 (Phase-out the ConnPACE Program).