Testimony of AARP Connecticut State President
Laura Green before the Human Services Committee in Support of
S.B. 230, Sec.14 of S.B. 30, and S.B. 229
March 1, 2012

Good afternoon members of the Human Services Committee. My name is Laura Green and I am the Volunteer State President for AARP Connecticut. On behalf of nearly 600,000 members in Connecticut, AARP appreciates this opportunity to speak in support of S.B. 230, Section 14 of S.B. 30, and S.B. 229, which collectively are cost effective ways that support consumers and family caregivers by providing information, assistance and additional options for home and community based care.

AARP Supports the Establishment of a Statewide Community Choices Program to Help Consumers and Family Members Navigate Connecticut's Long-Term Care System (S.B. 230)

First, AARP supports S.B. 230. This bill would establish the Community Choices program, a statewide Aging and Disability Resource Center (ADRC) system designed to provide a single point of entry for information and assistance on a full range of long-term services and supports for older adults and people with disabilities. ADRCs are already in place for three regions of the state. These ADRCs help consumers and family caregivers navigate long-term care options and explore ways to pay for those services.

Connecticut residents strongly support the creation and expansion of ADRCs. A 2008 survey of Connecticut AARP members found a large majority "strongly support" their creation and a majority called the need for a centralized resource center "extremely important."

AARP believes S.B. 230 is a necessary prerequisite to any future long-term care reform. In the short-term, the legislation is necessary for the current ADRCs to receive federal funding and grants so they can continue operation. Additionally, the establishment of a statewide Community Choices program fulfills a major requirement for many federal rebalancing incentive programs available under the Affordable Care Act.

For example, creation of a statewide single point of entry like the one outlined in S.B. 230 is a major requirement for the State Balance Incentive Payment Program (BIPP). BIPP provides an enhanced FMAP for states that increase access to home and community based services and supports. Connecticut would be well-positioned to take advantage of a 2 percent FMAP increase—potentially saving Connecticut over $37 million over 5 years—if we establish a statewide Community Choices program.[1]

[1] The increased FMAP is provided to states in return for their implementation of 3 main structural changes to their Long Term Service and Supports (LTSS) systems: single point of entry/no wrong door, conflict free case management services, and a core standardized assessment instrument.

AARP Supports Governor Malloy's Proposed Medication Administration Reform (S.B. 30, Sec. 14)

AARP also supports the concept of permitting nurses to delegate administration of medication to home health aides and allowing agency-based personal care assistants (PCAs) to administer medication. These advancements included as part of the Governor's Budget proposal (S.B. 30, Section 14) are critical to support family caregivers. Currently CT allows family members to be trained to administer drugs, but has significant limitations on what a paid direct care worker can do, even if under the supervision of a nurse. As a result, a family caregiver may have to rush home from work during a break or lunchtime to administer medication. Alternatively, the caregiver can hire a nurse for this routine procedure. But, since medication administration is typically performed several times each day, it's not feasible, affordable, or practical to hire a nurse to administer each dose. AARP believes medication administration reforms are needed to ease the burden on individuals living on their own in the community with paid supports and/or with the support of family caregivers.

A Robert Wood Johnson Foundation funded pilot in NJ from 2008 to 2011 included medication administration, with oversight by RN's to be completed by certified home health aides. The nurses trained the aides to give medications for each of 215 individuals enrolled in the program. Different routes of administration included: oral (including via feeding tube), topical, injection, suppositories and inhalants. As part of that pilot, Rutgers Center for State Health Policy conducted a process review which found no negative outcomes regarding medication administration. The study noted:

- No evidence of adverse health outcomes;
- A significant positive effect for consumers enrolled, in terms of health and quality of life improvement; and,
- All groups reviewed (including nurses, aides, consumers, and policymakers) expressed satisfaction with delegation as proposed and implemented.

AARP Urges Return to Maximum Spousal Impoverishment Protections (S.B. 229)

Finally, AARP urges this Committee to support S.B. 229, which would reinstate the spousal impoverishment protections in place between July 2010 and June 2011. Under S.B. 229, a couple applying for Medicaid long-term care coverage in Connecticut would be allowed to keep the maximum community spouse protected amount (CSPA) to support the healthy spouse living in the community, without substantiation. Fourteen states currently allow this protection.[2]

S.B. 229 provides a more humane approach that respects the needs of the community spouse. It is also fiscally prudent. At best, the current rule ***delays*** state costs; it does not ***avoid*** them. While a married couple may be forced to spend down "excess" assets, the law does not require a married couple use those "excess" assets to pay for the institutionalized spouses medical or health care expenses. The excess assets may be spent in any way the couple wishes (provided fair value is received). Thus, any delay in Medicaid eligibility for the institutional spouse is speculative. On the

[2] Maximum CSPA states include: Alaska, California, Colorado, Florida, Georgia, Hawaii, Illinois, Louisiana, Maine, Massachusetts, Mississippi, South Carolina, Vermont, and Wyoming.

other hand, forcing spend-down leaves the community spouse with fewer resources to use on her/his own care down the road. Additionally, since the community spouse cannot rely on their institutionalized spouse for free caregiving support, they are typically more reliant on paid services and supports. That means that the community spouse will have fewer resources to privately pay for their long-term services and supports, forcing them onto Medicaid prematurely when they need assistance.

Hence, any cost potentially avoided if a couple chooses to spend "excess" assets on the institutional spouse's care, will likely be incurred by the state later when the community spouse is forced onto Medicaid prematurely because they cannot afford their own long-term care needs. Moreover, S.B. 229 has the added benefit of reducing administrative appeals for CSPA, which could actually save administrative costs and alleviate some of the backlog in processing Medicaid applications.

AARP strongly supports the change proposed in S.B. 229. Connecticut should ensure that caregivers do not have to become poor themselves when they care for their loved ones. We should set the highest "community spouse resource allowance" and "spousal maintenance needs allowance" possible under federal law (as we had done previously) to provide community spouses with the greatest financial protections.

Conclusion

Long-term care rebalancing is about personal dignity and choice; it is also fiscally expedient. We need a public long-term care system that respects true consumer choice and responds to consumer preferences, while also ensuring cost effectiveness. We know that most consumers prefer options that enable them to remain in their home and community for as long as possible. In addition, one of the most important things Connecticut can do to bend the cost curve in Medicaid long-term care spending is to adequately support unpaid family caregivers. In Connecticut, an estimated 711,000 family caregivers provided 465 million hours of care valued at approximately $5.8 billion in 2009. AARP supports: establishing the Community Choices program, a statewide Aging and Disability Resource Center (ADRC) system designed to provide a single point of entry for information and assistance on a full range of long-term services and supports for older adults and people with disabilities; adopting the medication administration reforms recommended by the Governor; and setting the highest "community spouse resource allowance" possible under federal law (as we had done previously) to provide community spouses with the greatest financial protections. AARP looks forward to working with you to advance these important policy objectives. Thank you.