Connecticut Department of Social Services

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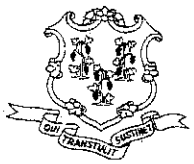

Written Testimony before the Aging Committee

Roderick L. Bremby, Commissioner

February 26, 2013

Good morning, Senator Ayala, Representative Serra and distinguished members of the Aging Committee. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services. I am pleased to be before you today to testify in strong support of SB 837, AAC the State Department on Aging. In addition, I offer written testimony on a number of bills that impact the department.

S.B. No. 837 AN ACT CONCERNING THE DEPARTMENT ON AGING.

Pursuant to section 19 of PA 12-1, June special session, the State Department on Aging (SDA) became effective on January 1, 2013. The Governor Bill No. 837 implements the Governor's budget recommendations by transferring the appropriate functions, programs, and duties from the Department of Social Services to the State Department on Aging. I strongly support this bill, as it demonstrates our commitment to improving the quality of life of our senior citizens, and helping them live with dignity, security, and independence. As our population ages, it is crucial to streamline the services that provide a safety net for our most vulnerable residents.

Public Act 12-1 from June Special Session provides that "*The Department of Social Services shall administer programs under the jurisdiction of the Department on Aging until the Commissioner on Aging is appointed and administrative staff are hired.*" As of this time, a commissioner on Aging has not yet been appointed and accordingly, the Department of Social Services (DSS) continues to administer these programs. DSS has been coordinating with staff from the various transitioning units and the Office of Policy and Management to ensure that programs are currently running smoothly and will be able to be transferred with the least disruption to the beneficiaries of vital services. We are fully committed and prepared to work with the new leadership at SDA and intend to maintain a collaborative relationship as we work towards our shared goal of ensuring the elderly access to crucial benefits such as health, food, and energy assistance.

We applaud the work and efforts of the Governor's Office, and look forward to assisting with the development of the new State Department on Aging.

Thank you for the opportunity to testify today. I respectfully request that the Committee support this bill and I welcome any questions you may have.

Written Comments of the Department of Social Services

S.B. No. 882 (RAISED) AN ACT CONCERNING ADDING THE PACE PROGRAM TO THE MEDICAID STATE PLAN.

This bill seeks to amend a statute enacted in 1998 that required DSS to implement a Program for All-Inclusive Care for the Elderly (PACE) pilot. This bill requires DSS to submit a Medicaid state plan amendment to include PACE as a covered service. PACE is a capitated model of integrating Medicare and Medicaid services for dually-eligible individuals. PACE serves individuals age 55 and older who are at nursing home level of care but can live in the community.

The Department opposes this proposal because the PACE model, which is a managed care approach, is incompatible with the Department's current policy direction, which is to focus on a managed fee-for-service approach. Although the PACE model has merits in seeking to integrate Medicare and Medicaid services and supports for eligible individuals, it requires participants to join a closed network of providers and subjects payments for such Medicare and Medicaid services to a blended capitated rate.

By contrast, the Department's current policy preference and strategy is to use a managed fee-for-service approach, through which beneficiaries may use any provider that they wish to see, and to build upon this approach with various initiatives that support beneficiaries and providers in more integrated practice. These initiatives include: (1) Person-Centered Medical Home (PCMH) funding support and technical assistance; (2) the Electronic Health Record (EHR) Incentive Program; (3) the Rewards to Quit tobacco cessation program; and, most notably, (4) the Department's application for the Demonstration to Integrate Care for Dual Eligible Individuals.

Under the Duals Demonstration, DSS, in partnership with the Departments of Mental Health and Addiction Services (DMHAS) and Developmental Services (DDS) will serve dual eligible individuals age 18-64, and age 65 and older. The Demonstration will integrate Medicare and Medicaid long-term care, medical and behavioral services and supports, promote provider practice transformation, and create pathways for information sharing through key strategies including:

- data integration and state of the art information technology and analytics;
- Intensive Care Management (ICM) and care coordination in support of effective management of co-morbid chronic disease;
- expanding access for Medicare/Medicaid eligible individual (MMEs) to Person-Centered Medical Home (PCMH) primary care;
- electronic care plans and integration with Connecticut's Health Information Exchange to facilitate person-centered team based care;

- use of performance measures concerning quality of care and care experience to assess impact and to determine eligibility for performance payments; and
- a payment structure that will align financial incentives, including:
    - advance payments for care coordination and supplemental services
    - performance payments to promote value.

S.B. No. 883 (RAISED) AN ACT CONCERNING A COMMUNITY SPOUSE'S ALLOWABLE ASSETS.

This bill proposes to allow the spouse of an institutionalized person who is applying for Medicaid (referred to hereafter as the "community spouse") to retain marital assets up to the maximum allowed under federal law. Effective January 1st, 2013, this amount is $115,920. Under current statute, community spouses of long-term care Medicaid recipients are allowed to keep one-half of the couple's liquid assets up to the federal maximum. If the total of the assets are under the minimum allowed by federal law ($23,184), the community spouse may keep all of the assets. The couple's home and one car are excluded from the assessment of spousal assets.

Allowing community spouses to keep up to the maximum allowed would have a significant, negative fiscal impact. In 2010, the legislature passed Public Act 10-73, which did exactly what this bill proposes, to allow the community spouse to retain up to the federal maximum. It was reversed in the 2011 legislative session due to the projected additional costs of over $31 million to the 2012-2013 state budget.

To demonstrate the potential fiscal impact of this change, we offer the following two examples.

1. Mr. S entered a nursing home on January 1, 2013. The spousal assets as of that date were $80,000. They applied for Medicaid on January 1, 2013.

Under the current rules, Mrs. S is allowed to keep one-half of the spousal assets ($40,000), plus the home and one car. The couple reduces their assets of $80,000 to $40,000 for Mrs. S and $1,600 (the Medicaid asset limit) for Mr. S in February 2013 and DSS grants Medicaid eligibility for Mr. S. They spend $11,000 of their money on Mr. S's nursing home care – approximately one month's worth of care. The rest of the money is spent on funeral contracts and home repairs.

Under the proposed legislation, Mrs. S would automatically be allowed to retain assets up to $115,920 – the maximum amount allowed under federal law. Since their assets were below this amount when Mr. S was admitted to the nursing facility, Mr. S would have been immediately eligible for Medicaid, shifting cost of nursing home care for one month to the state's Medicaid program.

2. Mr. H entered a nursing home on January 1, 2013. The spousal assets as of that date were $150,000. They applied for Medicaid on January 7, 2013.

Under the current rules, Mrs. H is allowed to keep one-half of the spousal assets ($75,000) plus the home and one car. The couple reduces their assets of $150,000 to $75,000 for Mrs. H and

$1,600 (the Medicaid asset limit) for Mr. H by May 2013 and DSS grants Medicaid eligibility for Mr. H. They spend $35,000 on home repairs for Mrs. H and $40,000 on Mr. H's nursing home care – approximately 3½ months of care.

Under the proposed legislation, Mrs. H would automatically be allowed to retain assets up to $115,920 – the maximum protection amount allowed under federal law. They would only need to spend $32,480 to be eligible ($150,000 - $115,920 for Mrs. H - $1,600 for Mr. H), which they can accomplish through the home repairs. They would not need to spend any money on Mr. H's care and would therefore shift the cost of care for 3 ½ months of care to the state's Medicaid program.

The Department continues to maintain that the current policy, which has been in place since 1989 (with the exception of FY 2011), is fair and reasonable and supports the original intent of the 1988 Medicare Catastrophic Coverage Act, which seeks to prevent the impoverishment of spouses of those applying for Medicaid coverage for long-term care. We do not support this bill as it would result in a fiscal impact to the Medicaid account.

S.B. No. 884 (RAISED) AN ACT INCREASING ELIGIBILITY FOR HOME AND COMMUNITY-BASED CARE FOR ELDERLY PERSONS AND THOSE WITH ALZHEIMER'S DISEASE.

This proposed bill would increase the asset limit for an individual applying for the Home Care Program by 47 percent and would increase the asset limit for couples by 71 percent. This change would also set a fixed asset limit in statute, where currently the statute ties the asset limit to the community spouse protected amount, determined by the federal government, so that each year the amount changes accordingly.

Raising the asset limit would open the program to a much larger pool of applicants, which could reduce the amount of funds available to applicants with more limited resources. If the demand were to exceed the state appropriation, which is likely, then this bill would result in (1) a waiting list; (2) a reduction of services to those currently being served; or (3) additional costs to the program.

Any expansion of the eligibility pool is not recommended as it will require additional appropriations to ensure that services to those most in need are not compromised; the state's limited resources should be targeted to those most in need.

S.B. No. 938 (RAISED) AN ACT CONCERNING THE PURCHASE OF MEDICARE SUPPLEMENT POLICIES BY QUALIFIED MEDICARE BENEFICIARIES.

SB 938 would allow Qualified Medicare Beneficiaries (QMB), to the extent permissible by federal law, to purchase a Medicare supplement policy. DSS supports this proposal, but cautions that there are limited exceptions currently allowed by the federal government for QMB recipients to purchase a Medicare supplement insurance policy. The QMB program is a publicly-funded program that pays for Medicare premiums, copayments and deductibles on Medicare Part A and

B services. The ability of individuals to purchase Medigap policies would provide coverage for services not covered by Medicare A or B, and may also defray cost under the QMB program as the QMB program is the payor of last resort.

H.B. No. 6395 (RAISED) AN ACT CONCERNING THE EXPANSION OF A SMALL HOUSE NURSING HOME PILOT PROGRAM.

This bill would allow the Commissioner of Social Services to expand, within available appropriations, a second small house nursing home in the state. This additional facility would include Masonicare Health Facilities in Wallingford. The total number of beds in the second pilot would be 380 beds.

Based on a previously approved small house project, DSS estimates the proposed small house at Masonicare may cost approximately $9.0 million in fair rent annually for 30 years based on an initial cost of $147.0 million and 4.5% rate of return. There are 6,529 licensed beds in towns within a 15 mile radius of Wallingford (91.4% occupancy). DSS estimates there are currently over 325 excess beds in the area and the amount of excess beds may increase due to the impact of MFP.

Thus, we cannot support this proposal.

H.B. No. 6396 (RAISED) AN ACT CONCERNING LIVABLE COMMUNITIES.

The bill would establish a "Livable Communities" initiative to be led by the Commission on Aging. The Department supports the philosophy and principles of 'livable communities' which are consistent with both consumer choice and rebalancing efforts.

H.B. No. 6398 (RAISED) AN ACT CONCERNING A SAFE HAVEN FROM EVICTION FOR ELDERLY AND DISABLED TENANTS.

The purpose of this bill is to provide a safe haven from eviction for senior citizens and those with disabilities. While we understand the intent of the bill, we do not necessarily agree that the Department of Social Services is the appropriate agency to oversee this initiative. Given the creation of the State Department on Aging and the Department of Housing, we feel it would be better suited for either or both of these agencies, which will have oversight of such matters.

H.B. No. 6461 (RAISED) AN ACT CONCERNING PRESUMPTIVE MEDICAID ELIGIBILITY FOR THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY.

While we believe this proposal may have merit we need to assess the fiscal and programmatic implications. We have, however, identified some initial concerns.

While we generally support presumptive eligibility as a means of enabling access to services, our primary concern centers around financial exposure in situations when Medicaid eligibility is determined not to exist.

We are also concerned that the 72 hour timeframe after the functional assessment may be too aggressive. Conducting a presumptive Medicaid eligibility determination in some cases (e.g. spousal cases, estate planning etc.) would likely take longer.