



*Testimony before the Human Services Committee*

*Roderick L. Bremby, Commissioner*

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Good morning, Senator Slossberg, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of Social Services. I appear before you today to testify on several bills that impact the Department of Social Services (DSS).

**S.B. No. 1083 AN ACT CONCERNING THE DEPARTMENT OF SOCIAL SERVICES.**

As you are aware, the state's federally-funded Connecticut Energy Assistance Program provides heating assistance to some 110,000 of the state's most vulnerable households. The program is operated through the state's Community Action Agencies. In addition, a network of more than 130 volunteer intake sites has been maintained. This network includes municipalities, senior centers and other social services providers.

In addition to the extensive intake network, the department has maintained long-standing partnerships with numerous stakeholders, including the Community Action Agencies, utility companies, fuel vendors, 211 Infoline, Operation Fuel, Connecticut Legal Services, Connecticut Association for Community Action and the Low-Income Energy Advisory Board. These groups provide the department with recommendations concerning program development, benefit structure, implementation and improvement.

While the department and the network consistently strive to maximize program effectiveness, we do not believe that imposing further studies and reporting requirements, in addition to what has already been statutorily mandated under CGS 16a-41a, is necessary. Furthermore, the department is not the appropriate agency to undertake a study of adequacy of power sources to housing complexes as we do not possess the expertise to engage in this type of analysis. Housing matters also now fall under the purview of the new Department of Housing.

For these reasons, the department cannot support this proposed bill.

## **S.B. No. 1084 AN ACT CONCERNING DELAYS IN MEDICAID APPLICATION PROCESSING.**

Section 1 of the bill proposes timeframes for determining eligibility that are more restrictive than federal requirements, as this language does not recognize exceptions for unusual circumstances, such as emergencies and applicant delays. As you know, application delays are the subject of two pending federal lawsuits, one in Medicaid and one in SNAP. This section effectively creates a state law entitlement, more restrictive than that in federal law, which could result in a fiscal impact to the state.

As you are also aware, the department is fully engaged in a modernization initiative which includes technology that the department strongly believes will improve the speed of application processing. Finally, federal regulations governing timeliness standards are currently in the process of being rewritten by the Centers for Medicare and Medicaid Services.

Accordingly, the department cannot support section 1 as it is unnecessary and redundant of efforts already underway.

Section 2 of the bill requires the agency to establish a means by which to grant presumptive eligibility within the CT Home Care Program. While we generally support presumptive eligibility as a means of enabling access to services, we have several concerns about this bill.

The bill does not recognize that when an application is pending a Medicaid eligibility determination, there is no way for the system to permit payment to provider agencies. Thus, all claims would have to be held until the Medicaid determination is complete and the application is approved or denied.

If a screening tool were to be created, it should be uniform and developed by the department as the agency that administers the program. Otherwise, this sets up the potential for incongruent standards across the state.

In addition, applicants who are ultimately denied Medicaid eligibility, which we believe to be between 25-30% of the waiver applicants, would be responsible for the mandatory 7% cost share (which the department would not likely recover, representing a budget impact).

The proposed methods for implementation of presumptive eligibility in this bill are not practical from a logistical standpoint. Ultimately, the result would be increased costs under the state-funded portion of the program that the state is in no position to absorb.

We understand the importance of presumptive eligibility for this vulnerable population. In fact, after hearing concerns expressed on a similar concept last week, we immediately began assessing how we might craft a workable solution to satisfy the proponent's needs and address the department's operational concerns.

**S.B. No. 1087 AN ACT CONCERNING A RESPITE PILOT PROGRAM TO SAVE MEDICAID HOSPITALIZATION COSTS.**

This bill would establish a five-year medical respite pilot program for homeless persons in the city of New Haven, working with a planning group to include representatives from Yale-New Haven Hospital, Columbus House Inc., and other community service organizations. The program would serve at least 150 persons who require recuperative medical care but whose medical needs do not require hospitalization.

The program would consist of a 12-bed unit equipped to provide care to persons with a projected average length of stay of four weeks; it would provide 24 hour supervision of persons in the program, referrals to health care providers, and case management services to include housing and support opportunities to help such persons avert homelessness; and operate until July 1, 2018. The planning group would pursue public and private funding sources for the medical respite program.

The Department of Social Services supports the intent of this proposal and understands the problem it seeks to address. However, we are concerned about the potential difficulties entailed in identifying adequate funding for the pilot, especially if it is to provide 24 hour-a-day service for up to 12 recipients with complex needs. Medicaid funds cannot be used to fund non-medical services, which, according to the bill, would be included in the range of services provided. Furthermore, Medicaid funds cannot be used to fund pilot programs, thus any such pilot would be entirely state funded. During a time of continued fiscal constraints, such funding is not proposed or available.

Were such a pilot to move forward, at a time when resources permit, we respectfully suggest that that the Department of Mental Health and Addiction Services be included as a partner in the initiative.

**H.B. No. 6609 AN ACT CONCERNING NURSING HOME TRANSPARENCY.**

The department proposed a bill this session, SB 852, that attempts to provide what we feel are the appropriate means by which to evaluate the industry in a systematic manner. Based on feedback received during the public hearings and subsequent meetings, we are in the process of modifying our proposal. We are attempting to address concerns of various stakeholders while balancing the needs of the department and our view of the public interest.

With the long-term care industry in the midst of a significant rebalancing effort consistent with the recently released Strategic Plan to Rebalance Long-Term Services and Supports, the department is working with other interested parties to improve the reporting requirements for nursing homes. This effort is intended to assist the state in its current

rebalancing efforts and to enhance the state's ability to measure quality, acuity and economy of the long-term care system.

Additional financial information is not necessarily a meaningful tool to evaluate the sustainability of the industry or health of any one facility. The department is interested in developing measures that focus on the entire long-term care system and skilled nursing facilities' role in that continuum.

**H.B. No. 6607 AN ACT CONCERNING NURSING HOMES;  
H.B. No. 6610 AN ACT CONCERNING FEDERAL MEDICAID WAIVERS;  
S.B. No. 1086 AN ACT CONCERNING LONG-TERM CARE.**

The Department of Social Services commends the Committee for its attention to the need for strategic planning for Medicaid long-term care services. This is a critical need given strong preferences of older adults and individuals with disabilities to live in home and community-based settings, the State's interest in controlling escalating costs, and support for town-level tailoring of strategies to meet local needs. DSS respectfully suggests to the Committee, however, that the studies that are being proposed by HB 6607, SB 1086 and HB 6610 are not needed. In keeping with the legislation enacted by the General Assembly, Governor Malloy, Office of Policy and Management and DSS recently released the Strategic Plan to Rebalance Long-Term Services and Supports, which already captures the data and planning strategies that are contemplated by these bills.

The State of Connecticut is committed to creating a more efficient and effective long-term services and supports (LTSS) system aligned with the principles of choice, autonomy and dignity. The envisioned system will allow Medicaid recipients who need LTSS to choose whether they want to receive these services in a nursing facility (NF) or in a community setting. In order to attain the vision of enhanced quality of life and increased choice for individuals across all disabilities to live, work and age within their own communities, the concept of a town-based LTSS compendium was developed. A town-based approach to LTSS will provide choices ranging from various types of supportive housing options to care provided in a nursing facility; these options will reflect the preferences of the persons they are designed to serve and support a seamless transition from hospital to short-term rehabilitation and back into the community.

Through a multi-month process of deliberate stakeholder briefings, engagement, data and system analysis, culminating in the November 2011 Right-sizing Strategic Planning Retreat, Connecticut sought the input and expertise of those interested in building a sustainable LTSS system within the state. Stakeholders participating in the strategic planning process included family members, advocates, ombudsmen, State staff, providers (community and institutional), Money Follows the Person Steering Committee members, academics and others. Recommendations from the Right-sizing retreat provided a foundation on which the Strategic Rebalancing Plan was developed. With an unprecedented level of partnership and collective work toward the common goals, stakeholders will continue to play a key role in the implementation and evaluation of

## LTSS strategic initiatives.

The plan, guided by the vision of choice, autonomy and dignity for the people whom we serve, aims to achieve a rebalanced system by: 1) removing barriers that prevent choice in where people receive LTSS at a state policy and systems level; and 2) partnering with nursing homes, communities, and existing community providers to implement change at a local level.

The urgency for design and implementation of a strategic plan was imperative given that over the next several years the number of people estimated to need LTSS will increase dramatically due to the aging population. According to the U.S. Administration on Aging's Profile of Older Americans, the number of people age 65 and older is expected to grow to 19.3% of the population by 2030, marking a significant growth in the portion of this population nationally. This trend is evident in Connecticut, where projections indicate a 40% growth in individuals age 65 and older between 2010 and 2025. Notably, in the November 2011 report entitled 90+ in the United States: 2006-2008, Connecticut ranked second among states with the highest percentage of the population in both the 'Aged 90 and Over' and 'Aged 65 and Over' categories. The report also notes that age is positively associated with the presence of physical difficulty, and the oldest have the highest levels of physical and cognitive disability. By 2025, demand for Medicaid LTSS alone is expected for more than 64,000 individuals in Connecticut – an increase of more than 24,000 individuals over current levels. Estimating future demand, building sufficient supply with quality assurances, and eliminating policy and procedural barriers that prevent choice are all key to the State's Strategic Rebalancing Plan.

The projected increase in the aging population is especially relevant to the design of benefit and eligibility in the State's Medicaid program. Since 42% of the costs associated with LTSS in Connecticut are paid by the Medicaid program, it is essential that the Medicaid LTSS cost structures be modified with the aim of not only assuring choice, but also controlling costs. In SFY 2009, Connecticut spent 65% of its Medicaid LTSS dollars on institutional care for individuals who are aging and individuals with disabilities. A 2011 analysis of adults age 31 and over using Medicaid LTSS shows that Connecticut has the highest or the second highest nursing home rate per 1,000 population in each of the following categories in both 2000 and 2008: total state nursing home rate of use, rate of use for ages 31-64 and rate of use for age 65 and older. The state's high utilization of nursing homes for persons receiving LTSS is a statistic that stands in contrast to surveys completed by LTSS users where 75% indicate their preference for services in the community. In addition, the average cost of serving a Medicaid participant in the community is approximately one third of the average cost of serving someone in an institution. Serving people in the community when it is preferred, safe and on average more cost-effective will result in more people served for each LTSS dollar spent.

The Plan already captures town-level data concerning projections of need for nursing facility level care, and associated needs for home and community-based services. Related, the Plan commits to evaluating supply and demand trends and

projections every six months. The current model detailed in the Plan projects a surplus of 5,000 institutional beds assuming barriers that prevent choice are removed. As demand for institutional care decreases, the plan details a proactive approach to reducing unneeded beds and building community capacity. Key strategies focus on partnerships with institutional providers who are interested in diversifying their business models to provide identified community LTSS as identified in town level supply and demand data maps. In support of this, the plan includes competitive procurements targeted to institutional providers for the purpose of building community LTSS which reflect the needs and preferences of the town. Additionally, the Plan explicitly contemplates a range of initiatives with respect to Medicaid waivers and State Plan amendments that will support evolving need for long-term care. Finally, the Plan flags and proposes strategies in support of addressing various procedural, capacity and/or policy barriers, including lack of sufficient service, supply, and information about home and community-based services; insufficient practices supporting self-direction and person-centered planning, and lack of housing and transportation. The Plan also addresses the need for a streamlined process for discharges to the community, accessing Medicaid as a payer, and promoting a sufficient workforce.

DSS recommends the Plan to the Committee as an existing source of the data that it seeks and therefore we do not support HB 6607, SB 1086 and HB 6610 as they are unnecessary and duplicative. The Plan can be accessed at [www.ct.gov/dss/rebal](http://www.ct.gov/dss/rebal).

Thank you for the opportunity to testify before you today. I welcome any questions you may have.