



Testimony to the Human Services Committee

Submitted by Mag Morelli, President of LeadingAge Connecticut

March 5, 2015

In Support of

- **SB 899, An Act Concerning Voluntary Bed Reductions at Nursing Home Facilities**
- **SB 915, An Act Concerning the Treatment of Assets in Medicaid Eligibility Determinations**
- **SB 978, An Act Concerning Residential Care Homes**

And Regarding

- **SB 1022, An Act Concerning Requirements for Facilities that Complete Medicare or Medicaid Applications for Patients**

My name is Mag Morelli and I am the President of LeadingAge Connecticut, a statewide membership organization representing over 130 mission-driven and not-for-profit provider organizations serving older adults across the continuum of long term care, services and supports and including senior housing. On behalf of LeadingAge Connecticut, I would like to submit testimony on four of the bills that are before you today and offer the Committee our assistance as you consider these various issues.

SB 899, An Act Concerning Temporary Nursing Home Bed Reductions

LeadingAge Connecticut would like to lend our support to this proposal and encourage the Committee to expand the scope of subsection (b) of the bill.

Connecticut is currently transitioning our Medicaid program through several initiatives, including a rebalancing of the long term services and supports system so that more people may receive these services in community based settings. LeadingAge Connecticut members support this systems change and we continue to work with the state to find creative ways to achieve this balance.

Part of the state's rebalancing effort is the nursing home "right-sizing" initiative which is aimed at adjusting and redistributing the number of nursing home beds in the state to meet the changing consumer demand for nursing home care. Toward this goal, LeadingAge Connecticut has been advocating for a collaborative and flexible regulatory and reimbursement environment for all nursing home providers so as to encourage nursing homes to adjust, modernize and diversify their models of care. We believe that a regulatory environment that is adaptive and receptive to individual providers forward thinking ideas will encourage creative nursing home rightsizing initiatives.

While this specific bill was not our proposal, it does fit into this model of a collaborative and flexible regulatory environment. It could be one element in a variety of initiatives to assist existing nursing home providers in adapting to the current consumer demand while preserving the opportunity to adjust to future demand. This proposal could indeed be an opportunity to help appropriately adjust the nursing home bed supply and move us forward with our rebalancing plan.

We strongly encourage the Committee to consider expanding the proposal in subsection (b) of the proposal. This is the subsection which would require that the Commissioner of Social Services to increase the Medicaid rate to the facility in an amount derived from the recalculation of the facility's fixed costs allocated to the new reduced licensed bed capacity whenever a nursing home facility voluntarily reduces licensed beds under subsection (a) of this section. We would propose that the Department be required to do this not only for nursing homes doing so under the auspices of the process outlined in subsection (a) of the proposal, **but also whenever a nursing home voluntarily reduces licensed beds that would otherwise be occupied.**

We make this request because there are LeadingAge Connecticut member nursing homes that have already voluntarily and permanently reduced their beds in order to repurpose areas in their nursing homes in accordance with the state's long term services and supports strategic plan. We have others who are in the planning stages to do so. The Department of Social Services has not and will not renegotiate a rate in those circumstances. We strongly encourage this Committee to insist that the policy of the state be changed to encourage voluntary reduction by making the appropriate rate adjustments under all such circumstances.

SB 915, An Act Concerning the Treatment of Assets in Medicaid Eligibility Determinations

We strongly agree with this proposal and have long called for these types of modifications to the Medicaid eligibility determination process. In fact a similar proposal was passed into law in 2013 (PA 13-234, Section 127) related to life insurance policies valued at \$10,000 or less. This Committee was instrumental in the passage of the 2013 law and the Department of Social Services has pursued the change, but unfortunately the Centers for Medicare and Medicaid Services (CMS) has not yet approved the implementation of the change.

*There is a need to address the asset rules in the eligibility process. A nursing home resident is deemed eligible for Medicaid once his or her assets are spent down to less than \$1,600. If a Medicaid applicant's assets exceed the \$1,600 limit, the asset causing the resident to go over the limit it is considered a "disqualifying asset" and the applicant is not eligible for Medicaid during the month in which the resident possessed the disqualifying asset. The difficulty occurs when a single disqualifying asset is not discovered right away or cannot be easily liquidated and serves to deem the applicant ineligible for several months. A simple example would be if you applied for Medicaid in January and it was discovered months later in June that you possessed a \$2,000 disqualifying asset, then that \$2,000 asset disqualified you in January, in February, in March, in April, in May, and then in June. Six months of ineligibility because of a single \$2,000 asset and the *nursing home will not be paid for any of those months of care provided.**

The delays in processing Medicaid applications have exacerbated this problem. Medicaid applicants are being deemed ineligible for several months due to the *delayed discovery* of a single disqualifying asset that triggers ineligibility for all the months the application sat pending in the state office. Similarly, single disqualifying assets that are difficult to liquidate, such as small life insurance policies, have historically caused distressing eligibility situations and months of uncompensated care.

This proposed legislation inserts common sense rules into the eligibility process so that a person would not be deemed over assets based solely on a single, unliquidated asset that is inaccessible to the individual. It also would create common sense procedures for liquidating newly discovered assets found after the date of application. While these changes seem small, this would be a great help to many law abiding residents and families that are earnestly trying to meet the rules of eligibility and are frustrated by these situations that are outside of their control.

While CMS appears to be resistant, we should not be deterred and states should continue to pass legislation and seek appropriate, common sense changes to the Medicaid eligibility process. It is pressure from the states that will influence this federal agency into recognizing the need for these changes.

SB 978, An Act Concerning Residential Care Homes

LeadingAge Connecticut supports this effort to provide additional funding to the residential care home rate system that recognizes the need to retain staff and to maintain physical plant. The residential care home model of housing is both supportive and affordable and is a setting of choice for many older adults. Residential care homes vary in their character and culture, but the model offers much promise within our state's rebalancing long term services and supports system – a system designed to encourage choice, autonomy and dignity.

SB 1022, An Act Concerning Requirements for Facilities that Complete Medicare or Medicaid Applications for Patients

LeadingAge Connecticut has no objection to this bill as proposed.

Thank you for this opportunity to provide testimony on these bills.

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LeadingAge Connecticut is a membership organization representing over 130 mission-driven and not-for-profit provider organizations serving older adults across the continuum of care including nursing homes, residential care homes, housing for the elderly, continuing care retirement communities, adult day centers, home care and assisted living agencies. By continuing a tradition of mission-driven, consumer-centered management and competent, hands-on care, not-for-profits set the standard in the continuum of housing, care and services for the most vulnerable aging adults.



The Medicaid Eligibility Determination Crisis:
Need for Immediate Remedies for Consumers and Providers
Throughout the Continuum of Care and Services

As statewide associations representing providers of Medicaid services throughout the continuum, we urge the state legislature to immediately address the crisis caused by delays in the Medicaid eligibility determination process.

Delays in Medicaid eligibility determination are adversely affecting both the individuals desperately in need of services and the providers of medical care and long-term services and supports across the continuum.

We understand that DSS is attempting to find solutions to the issues and will continue to work with them toward long-term solutions, but the crisis is immediate and we are asking for system-wide attention and relief now.

The problems are system-wide:

- Older adults and individuals with disabilities who should be eligible for home and community-based services through the Connecticut Home Care Waiver Program are not receiving services due to the delays in processing their Medicaid applications. These are individuals who are at risk of nursing home placement or emergency hospital care if they are not able to receive services and supports through the home care program.
- Skilled nursing facilities are caring for residents with pending status for months and months without receiving any reimbursement. Meanwhile the state is continuing to collect a daily bed tax on those same residents.
- Home care agencies sit on phone lines for hours and hours, waiting to speak to eligibility workers to assist their home care clients who are seeking Medicaid coverage for desperately needed medical home care services.
- Hospital discharges are delayed for days, weeks, and months while patients wait for their Medicaid eligibility determination so that placement can be found in the next level of the continuum.
- Hospitals, physicians, home care agencies, and nursing homes are providing care without funding or reimbursement while patients wait for their Medicaid eligibility determination. Moreover, during that time patients have to rely on the Emergency Department for their primary source of care, since without coverage their access to care is limited.

The Medicaid eligibility determination problems are system-wide. We therefore need a system-wide approach to developing and enacting solutions. We urge you to take immediate action and we offer you our assistance in this endeavor.

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