



*Connecticut Association of Area Agencies on  
Aging Representing:  
Agency on Aging of South Central CT  
North Central Area Agency on Aging  
Western CT Area Agency on Aging  
Senior Resources - Agency on Aging Eastern CT  
Southwestern CT Agency on Aging*

**To: Honorable Senator Beth Bye, Co-chairperson and Honorable  
Representative Toni Walker, Co-chairperson and Members  
Appropriations Committee**

**DT: Submitted February 27, 2015**

**RE: HB 6846 Governor's Budget proposals**

The CT Association of Area Agencies on Aging strongly rejects on principle the following items as proposed in the Governor's Budget:

**25% Reduction in the Statewide Respite Care Program.** This program helps family caregivers maintain the independence of their loved one and saves the State millions of dollars as compared to the Medicaid spending that would be necessary to provide nursing home level of care to Alzheimer's patients. The Statewide Respite Program is needed more now than ever because of lengthy waiting lists and enrollment caps on other long-term care programs. Connecticut has invested millions of dollars in an effort to "rebalance" the Medicaid system. Respite care is a cost-effective way to facilitate this rebalancing and is in alignment with the overwhelming personal preference of folks to stay in their homes.

**Increases in the Cost Sharing under the State-Funded Connecticut Home Care Program –increases to 15%** from its current 7%. Individuals eligible for this tier of the Connecticut Home Care program are in double- jeopardy. A review of records conducted by the Southwest CT Agency on Aging demonstrated that less than 20% of these State-funded clients had more than \$10,000 in assets. Financially they are neither "comfortable" enough to pay privately for services nor are they financially eligible for the Medicaid waiver portion of the program which would cover their costs 100%.

More than doubling the out-of-pocket costs of care for this population will necessitate some incredibly difficult choices; paying for their home care, or paying for food, shelter, and medications. In the wealthiest state in the nation we should be appalled that these “choices” are necessary.

The average 2014<sup>1</sup> cost of serving an individual per month through the Connecticut Home Care Program for Elders (CHCPE) was \$1,722 for Medicaid participants and \$1,018<sup>3</sup> for state-funded clients. By contrast, the current average 2014 monthly Medicaid cost of care for an individual in a nursing home is \$5,800. If cost share pushes clients into a nursing home prematurely by exhausting their private funds, this will only lead to greater reliance on State Medicaid funds to support the more costly institutionalization. When cost share was first implemented in 2009 to June of 2010, over 300 clients discontinued from the program because they were afraid to use their very limited assets on long term care. There is evidence that prolonging the start of services has a negative consequence by decreasing an individual's independence and adding complexity to the care he/she will need in the future.

**The closing of the intake to State-Funded Connecticut Home Care Program for those eligible Category 1 services.** Targeted to individuals who are functionally neither “frail enough” to *require* immediate hospitalization or nursing home placement but who are merely *at risk* for inpatient care, the closing of this tier of the Connecticut Home Care Program is an affront to all of Connecticut’s advances thus far in Medicaid rebalancing. By withholding necessary services from this population, we are simply creating an environment where the surest way to access care is through the most expensive care settings: Emergency Rooms; followed predictably by lengthy and costly nursing facility stays. By offering an entry point to Long Term Care Services, Category One enhances coordination of interventions and communication of need. These enhancement prolong the individual's independence allowing them to forego costly institutional care.

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<sup>1</sup> Latest available data.

## **The requirement that Dually Eligible Medicare/Medicaid Clients to Cover All**

**Medicare Part D Co-Payments**. Currently, Medicare Medicaid Enrollees (MMEs) are responsible for paying up to \$15 per month in Medicare co-pays for their Part D-covered drugs; after that, DSS pays all copays for the month similar in theory to an out of pocket maximum. In the Governor's proposal, MMEs will be responsible for covering the full costs of all of their prescriptions' co-pays without the kill-switch of an out of pocket maximum. This change will easily make drugs unaffordable for these low income individuals on multiple medications. Ironically, CT has already identified that this population suffers from poorer health outcomes and ~~higher~~ boasts higher Medicaid costs than almost any other demographic in the state. This proposal simply adds insult to injury.

For further information on programs and services offered through the Connecticut Association of Area Agencies on Aging:

1. <http://states.aarp.org/aarp-connecticut-2015-legislative-agenda-sc-ct-wp-advocacy/#sthash.SqX1vgCt.dpuf>

2. An average \$220/day x 30 days = \$6,600 x356 clients = \$2,349,600

2-3. [State of Connecticut, Department of Social Services, Monthly Report – Alternative Care Unit](#)

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~~Or any Area Agency on Aging via Web site:~~ [www.ctagenciesonaging.org](http://www.ctagenciesonaging.org)