Written Testimony before the Aging Committee
Department of Social Services
March 8, 2022

H.B. 5310 - AN ACT REQUIRING NURSING HOME FACILITIES TO SPEND AT LEAST NINETY PER CENT OF MEDICAID FUNDING PROVIDED BY THE STATE ON DIRECT CARE.

This bill requires nursing home facilities to spend at least 90% of Medicaid funding provided by the state on direct care. The Department of Social Services (DSS) supports the principle of aligning funding with direct care but, as written, believes the bill will have unintended, adverse consequences on total resident care.

Medicaid reimbursement for nursing homes is comprised of five allowable cost components: (1) direct; (2) indirect; (3) capital; (4) administrative and general; and (5) property or fair rent.

Each of these five cost components plays an important role in the delivery of total care to nursing home residents. Medicaid may only reimburse for these allowable costs, which are determined in accordance with the Medicaid State Plan, as well as state and federal regulations. The Department conducts reviews of annual cost report submissions to determine which costs are allowable and which are unallowable for Medicaid reimbursement purposes.

As written, the bill would require 90% of Medicaid funding to be spent solely on the direct care component which is defined in the bill under subdivision (6) as "hands-on care provided to a facility resident by nursing personnel, including, but not limited to, assistance with feeding, bathing, toileting, dressing, lifting or moving residents, medication administration and salary, fringe benefits and supplies related to direct care." This would leave only 10% remaining for the other vital nursing home services that support total resident need, such as: (i) dietary staff, food, housekeeping staff, laundry services, and resident supplies; (ii) capital costs such as moveable equipment needed for care; (iii) administrative and general costs such as facility maintenance and plant operation expenses; and (iv) property or fair rent to incentivize facility improvements and building upgrades.

Related, on July 1, 2022, the Department will transition nursing home reimbursement to an acuity-based methodology which will align Medicaid spend with the anticipated resource needs of the resident, and provide incentives for nursing homes to admit and provide for persons in need of comparatively greater level of care. Acuity-based reimbursement will also aid the Department in its goals of:

- supporting a meaningful continuum of long-term services and supports;
- modernizing Medicaid reimbursement;
- aligning payment with the acuity of residents; and

- preparing providers for value-based payment approaches.

The Department respectfully suggests consideration of language that would support total resident care and not just one component of the Medicaid funding. For example, New Jersey legislation requires 90% of profits to be reinvested into direct care of nursing home residents. New York and Massachusetts require 70% and 75%, respectively, of total revenue – not just Medicaid spend – directed towards total resident care. The Department also suggest language regarding transparency and reporting of real estate investment trusts ("REITs").

DSS would appreciate the opportunity to continue working with the committee and stakeholders to improve transparency in the costs and spending in Connecticut nursing homes.

Lastly, the Department respectfully suggests deletion of the proposed language starting on line 55 of the bill. DSS currently conducts quarterly reporting on the various cost categories reported by the nursing homes. These reports are available on the DSS webpage. Requiring additional reporting from the facility would unnecessarily create redundancy and an administrative burden on both the homes and the Department.

H.B. 5311 - AN ACT ENCOURAGING SOCIALIZATION FOR NURSING HOME RESIDENTS BY PROVIDING TRANSPORTATION FOR VISITS WITH FAMILY.

This bill requires nursing homes with available vehicles to provide non-emergency transportation to non-ambulatory residents to the homes of such residents' family members for the purpose of social visitation. The bill mandates that DSS, within available appropriations, establish a grant program to fund such non-emergency transportation.

DSS appreciates the intent of the bill and agrees that increasing the socialization opportunities for nursing home residents is a worthy goal. However, requiring nursing homes to dedicate staff to these transportation services, with current staffing issues, may have unintended consequences. Further, as this grant program would not be eligible for federal Medicaid reimbursement, these services would require additional state-only funding that is not in the Governor's budget. Lastly, were this bill to pass, the Department would need to hire additional staff to administer the grant program.

For these reasons, the Department cannot support this bill.

H.B. 5312 - AN ACT CONCERNING MEDICAID COVERAGE FOR ADULT DAY SERVICES AND TRANSPORTATION TO AND FROM SUCH SERVICES.

The Department appreciates the intent of this bill which requires DSS to amend the Medicaid state plan to provide coverage for adult day services. The bill also requires the Department to increase Medicaid rates paid to providers who transport Medicaid beneficiaries to or from such services to cover the cost of such transportation.

Adult day services are presently available to adults aged 65 and older under the Medicaid state plan and some 1915(c) home and community-based services waivers. The Department recognizes the value provided to its members. However, expanding this service under the state plan to older adults would require additional funding not accounted for in the Governor's budget. Further, increasing the Medicaid rates of providers that provide transportation for such services

would result in an additional cost that is not included in the Governor's budget. Therefore, the Department cannot support this bill.

H.B. 5314 - AN ACT DETERRING FRAUD AND ABUSE PERPETRATED AGAINST SENIOR CITIZENS.

Section 1 requires mandated reporters to complete training by December 31, 2022. DSS notes that mandatory reporters typically have frequent contact with elders and are in a unique position to identify maltreatment concerns. Ensuring that mandated reporters are aware of the signs of abuse, neglect and exploitation and informed about the means to report is extremely important to the safety and welfare of some of Connecticut's most vulnerable residents. To support compliance, the Department has an online training, readily available on the DSS website, detailing the Protective Services for the Elderly (PSE) program for mandated reporters. In addition, the Department offers in-person or virtual mandated reporter training upon request.

Section 3 of the bill requires DSS to employ sufficient staff for the PSE program to ensure that no staff member is investigating more than 25 suspected cases of abuse, neglect, exploitation or abandonment at any one time. DSS agrees that sufficient staffing resources are critical to the delivery of effective and timely protective services. The Administration for Community Living (ACL) and the National Adult Protective Services Association (NAPSA) recommend that there should be program-specific caseload standards to ensure delivery of quality and responsive interventions. These organizations also note that to identify an ideal caseload size or range requires detailed study. DSS will be receiving an American Rescue Plan Act (ARPA) funding allocation from ACL to support activities in the PSE program. With such ARPA funds, the Department intends to identify a recommended cap for the number of cases per PSE social worker and a suggested ratio of supervisors to social workers

Section 4 of the bill requires that any person providing an elderly person with assistance completing an application for Medicaid, who is not related to such person, disclose any affiliations with any business or entity that may bill Medicaid for services, while section 5 requires any person assisting with the completion of a Medicaid application to provide the applicant with additional written disclosures. DSS appreciates that the process for applying for Medicaid, in particular long-term services and supports, can be a complex, circumstance-specific procedure. There may be concerns that private, for-profit corporations that offer, for a fee, assistance in preparing Medicaid applications may do so without full appreciation of the complexities of federal and state rules impacting financial planning and Medicaid eligibility. However, DSS notes that federal law expressly provides that all applicants must be permitted to designate any individual or organization to assist with that individual's Medicaid application. *See* 42 CFR 435.923. While not the intent of the bill, DSS is concerned that the language, as drafted, may provide applicants with a misconception that they are *required* to seek the services of an elder law attorney prior to applying for Medicaid, and thus may decide not to apply. DSS respectfully suggests that the use of the word "person" in lines 42 and 49 of the proposed legislation be replaced with "for-profit organization or business" and that "who is not related to such elderly person by blood or marriage" likewise be deleted from lines 43-44 and 51 of the proposal. This proposed amendment would limit the notice requirement to for-profit entities. Such revisions would avoid any such misconception by Medicaid applicants that they are required to hire an attorney while specifically addressing any underlying concerns related to the quality of advice currently provided by for-profit assistance services.

DSS appreciates the opportunity to comment on this proposed legislation.

S.B. 264 - AN ACT CONCERNING A QUALIFIED DEDUCTION FROM MEDICAID APPLIED INCOME FOR CONSERVATOR COSTS.

This bill proposes to exempt conservator and fiduciary fees from Medicaid income eligibility and asset transfer determinations.

A state Medicaid agency is required to reduce costs to the state by using the member's income (applied income) for payment of institutional services. A Medicaid member's gross income is reduced by all allowable deductions in a specific order defined by the post eligibility treatment of income rules. This process results in a resident liability amount paid directly by the member to the long-term care provider, thereby reducing the amount that the state pays to the provider each month.

Currently, allowable monthly deductions consist of a personal needs allowance established by state law, a community spouse allowance, a community family allowance, Medicare and other health insurance premiums, costs for medical treatment approved by a physician when incurred subsequent to the effective date of eligibility which are not covered by Medicaid, expenses for services provided by a licensed medical provider in the six-month period immediately preceding the first month of eligibility, $90 for a war veteran or spouse of a deceased war veteran with a reduced Veterans Administration Improved Pension, and a deduction of the costs of maintaining a home in the community when expected to return home.

Section 1(a) of this bill proposes to add conservator expenses, including conservator compensation, probate court filing fees and expenses, and premiums for any probate court bonds as additional allowable deductions. If passed, this provision would increase the costs of the Medicaid program in several ways.

First, each expense that is deducted from the resident's liability will increase the percentage of costs the state will be liable to pay for institutional services provided to a Medicaid member.

In addition to an increase to the Medicaid budget, implementing a change to the Department's resident liability calculation will require numerous system enhancements, as the current eligibility system is not programmed to include conservator and fiduciary fees as an allowable deduction. Such system enhancements, depending on their complexity, can cost several hundred thousand to up to several million dollars.

In addition to the need for system enhancements, the requirement to track and calculate expenses related to conservatorship would impact the long-term services and supports eligibility determination process, requiring additional staff at DSS to ensure compliance with timeliness standards.

Section 1(c) requires the Department, on an annual basis, to calculate and inform the Probate Court Administrator of the total amount deducted from applied income under section 1(a), and requires the Probate Court Administrator to transfer one-half of this amount to the Department. While the Department would welcome partial reimbursement of the amounts deducted from individuals' applied income, the task and cost of tracking such data, making necessary system

changes, and maintaining the processing workload would fall exclusively on the Department, also requiring additional staff for implementation.

Section 2 of the bill establishes a minimum baseline conservator compensation of $125 per month. The bill does not require the conservator to provide documentation to demonstrate that actual services were provided. Section 16 of the Probate Court Regulations, however, requires the submission of invoices for time expended in increments of one-tenth of an hour; documentation relating to who is performing services; and a summary of the activity for each entry. In addition, for individuals who are already on Medicaid, this language also conflicts with section 45a-594(a) of the Connecticut General Statutes, which governs payment to conservators of individuals who receive benefits through the state. Therefore, this proposed bill is in conflict with both state law and regulation.

Section 3 of the bill states that the Department may not consider a Probate Court-approved conservator fee paid for services rendered as an improper transfer for purposes of establishing Medicaid eligibility. It is important to note that the Department is the single state agency that determines Medicaid eligibility and must retain discretion to consider whether there has been a transfer of assets for fair market value. Currently, if the Department determines that payment of a conservator fee was made in exchange for the fair market value of the services performed, the payment will not be considered an improper transfer. If, however, the Department concludes that an individual has paid a conservator fee that is excessive and not consistent with the services provided by the conservator, the Department must have the ability to impose a transfer of asset penalty, consistent with state and federal law.

Because portions of this bill are inconsistent with state and federal law and would have a negative fiscal impact on the state budget, the Department must oppose this bill.

The Department also acknowledges the need for work on this very important issue of adequately compensating conservators who are appointed to individuals with limited resources. The Department welcomes the opportunity to work with the Probate Courts to analyze the fiscal impacts and develop a long-term solution to the issue.