Written Testimony before the Aging Committee
Submitted by the Department of Social Services
February 14, 2019

S.B. No. 561 (RAISED) - AN ACT RAISING THE PERSONAL NEEDS ALLOWANCE FOR LONG-TERM CARE FACILITY RESIDENTS

This bill proposes to increase the personal needs allowance (PNA) of residents of long-term care facilities from $60 to $72.

State Medicaid agencies are required to reduce their costs using available beneficiary income for coverage of institutional services provided. Residents of nursing facilities pay their Social Security and other unearned income towards their cost of care with the exception of a monthly PNA and other allowable deductions, such as medical premiums.

In 1998, Connecticut increased the PNA from the federal minimum of $30 to $50 per month and provided for July 1 annual updates equal to the inflation adjustment in Social Security. As a result of the indexing to Social Security increases, the state's PNA was $69 per month in FY 10. PA 11-44 reduced this amount to $60 and eliminated the indexing. The current level of $60 is above the average for the states in the Northeast and is $30 above the federal minimum.

State	Monthly PNA
Connecticut	$60
Maine	40
Massachusetts	73
New Hampshire	70
New Jersey	50
New York	50
Pennsylvania	45
Rhode Island	50
Vermont	48
Northeast Average	$53

The Department opposes increasing the PNA due to the negative fiscal impact it will have on the state's budget.

S.B. 564 (RAISED) - AN ACT PERMITTING A COMMUNITY SPOUSE OF AN INSTITUTIONALIZED SPOUSE TO RETAIN THE MAXIMUM AMOUNT OF 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 1, 2019, this amount is $126,420.

This proposal intends to increase the amount of assets the community spouse is allowed to keep. Under current statute, community spouses of long-term care Medicaid recipients are allowed to keep one-half of the couple's countable assets up to the federal maximum of $126,420. If the total of the assets are under $25,284, the minimum allowed by federal law, the community spouse may keep all of the assets. The couple's home and one car are excluded from the assessment of spousal assets. The federal amounts are adjusted annually based on increases in the Consumer Price Index.

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 sought to prevent the impoverishment of spouses of those applying for Medicaid coverage for long-term care. Furthermore, the department's current policy is in line with most other states.

We have opposed increases in the amount of assets protected for community spouses in past years because it will result in a significant fiscal impact to the state. With the challenging budget environment that exists today, we cannot support increasing the minimum community spouse protected amount as it will have a negative fiscal impact on the Medicaid account.

S.B. No. 565 (RAISED) - AN ACT CONCERNING A STUDY OF NURSING HOME SERVICES & H.B. No. 6175 (RAISED) - AN ACT CONCERNING A STUDY OF THE STATE'S LONG-TERM CARE NEEDS

The Department of Social Services commends the Aging Committee for its attention to the need for strategic planning for Medicaid long-term care services. This is a critical need given the 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. However, DSS respectfully states that this legislation is not needed.

In keeping with the legislation enacted by the General Assembly, DSS developed and implemented the Strategic Plan to Rebalance Long-Term Services and Supports in 2013. The Strategic Plan captures the data and planning strategies that are contemplated by this bill. The Strategic Plan guides the activities of the Department.

In addition, Connecticut General Statutes section 17b-337 requires the Connecticut Long-Term Care Planning Committee to prepare a long-term care plan every three years based on the

fundamental principle that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting. The most recent plan, titled Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut, was released in January 2019. The work of the Connecticut Long-Term Care Planning Committee informs DSS' Strategic Plan to Rebalance Long-Term Services and Supports.

S.B. No. 566 (RAISED) - AN ACT CONCERNING RETROACTIVE MEDICAID ELIGIBILITY FOR HOME CARE SERVICES

This bill proposes to provide up to three months of retroactive Medicaid eligibility to individuals applying for home and community-based services (HCBS) provided such applicant has not made a transfer of assets for less than fair market value.

Medicaid programs must provide coverage for up to three months prior to the month of application for any time during the three months prior that the applicant met the eligibility requirements, however CMS policy does not allow retroactive coverage when an applicant requests coverage of HCBS.

For Medicaid provided pursuant to a HCBS waiver, coverage is prospective-only from the date on which the state Medicaid program approves an HCBS service plan. There are provisions in the waiver that require, for example, the completion of a criminal background check for providers under the waiver. If retroactive payment were possible, there could be no assurance that this CMS requirement was met. In addition, there are specific rates and approved providers in a waiver. Private services that clients/families arrange prior to the determination of financial eligibility may be provided by a non-Medicaid provider at any range of rates. Neither of these would be permissible under a waiver program.

Federal law requires the imposition of a penalty when individuals transfer assets for less than fair market value for the purpose of obtaining Medicaid payment of long-term care services. Long-term care services include home and community-based services under a Medicaid waiver, as well as services provided in an institutional setting. The penalty period begins on the date when Medicaid would otherwise pay for long-term care services had the improper transfer not occurred. Medicaid does not pay for long-term care services during the penalty period as the individual could have paid for his or her care had the improper transfer not occurred.

In addition, federal financial participation cannot be claimed for waiver services that are furnished prior to the development of the service plan or for waiver services that are not included in an individual's service plan. A service plan cannot be backdated.

A waiver, such as the Connecticut Home Care Program for Elders waiver, specifies to CMS that clients are provided a choice of providers and that they receive care management services that include ongoing monthly monitoring of the clients' status and the effectiveness of the person-centered plan. This standard cannot be met retroactively. As transfer of asset penalties cannot begin until Medicaid would otherwise pay for waiver services and since waiver services cannot

begin until the application is processed, transfer of asset penalties cannot begin until the application is processed.

CMS guidance and federal law does not support the changes sought by this proposal, therefore the Department cannot support this bill.

H.B. No. 6169 (RAISED) – AN ACT INCREASING FINANCIAL ASSISTANCE FOR GRANDPARENTS AND OTHER NONPARENT RELATIVES RAISING NEEDY CHILDREN

This bill would increase the payment standard for child-only assistance units in the Temporary Family Assistance (TFA) program to seventy-five percent of the foster care rate paid by the Department of Children and Families.

While the Department appreciates the goal of achieving equity in these benefits, based on SFY 19 data, we estimate the cost of such a change to be approximately $17.6 million. Therefore, we must oppose the bill due to the significant costs associated with providing such a benefit increase.

H.B. No. 6171 (RAISED) - AN ACT CONCERNING A STUDY OF MEDICAID FUNDED PROGRAMS

This bill requires the Commissioner of DSS to conduct a study of Medicaid programs to assess factors pertinent to quality of care, gaps in care, and necessary actions to comply with the Affordable Care Act (ACA).

The DSS Division of Health Services is already charged with these functions on a standing basis, regularly reporting to the Commissioner on quality of care (through such means as annual reports on HEDIS measures, measures of the effectiveness of Intensive Care Management, and consumer and provider satisfaction), access (through such means as geo-access analysis and mystery shopper surveys) and necessary actions to comply with the ACA (documented by a compliance tracking tool; 100% of mandated provisions have been fulfilled).

For detailed recent, publicly available information on HUSKY Health (Connecticut Medicaid and Children's Health Insurance Program) quality and access, please see the following:

- Extensive overview of HUSKY Health medical services: https://www.cga.ct.gov/med/council/2018/0608/20180608ATTACH_CHNCT%20Presentation.pdf
- Extensive overview of HUSKY Health behavioral health services: https://www.cga.ct.gov/med/council/2018/0713/20180713ATTACH_Beacon%20Presentation.pdf

- Extensive overview of HUSKY Health dental services: https://www.cga.ct.gov/med/council/2018/0309/20180309ATTACH_CTDHP%20Presentation.pdf

The Department also provides detailed monthly reports - see this link for our posted materials https://www.cga.ct.gov/med/mh-meetings.asp?sYear=2018 - to the Medical Assistance Program Oversight Council (MAPOC), which is charged under statute with a broad range of oversight activities that encompass the goals of HB 6171.

Consistent with 2013 legislation, MAPOC convened an ad hoc Medicaid Network Access Committee that ultimately produced a detailed report, incorporating DSS material, on access to care as well as other factors relevant to provider participation (ACA Ordering, Prescribing and Referring requirement) - see this link for the posted report: http://www.cga.ct.gov/med/council/2014/0314/20140312ATTACH_Network%20Adequacy%20Report.pdf.

In 2014, Public Act 14-206 also expanded MAPOC membership and created a new standing committee to focus on "evidence-based best practices concerning Medicaid cost savings."

While the Department does not oppose the general concept of this bill, we respectfully suggest that the legislation is duplicative and unnecessary. It would divert resources the Department needs to focus on the provision of services.

H.B. No. 6172 (RAISED) - AN ACT REDUCING PARTICIPANT COSTS AND EXPANDING ELIGIBILITY FOR THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY

This bill proposes to increase the assets limits for the state-funded portion of the Connecticut Home Care Program for Elders (CHCPE) from $35,766 for individuals and $47,688 for couples to $40,000 for individuals and $65,000 for couples. It would also decrease the applied income contribution for recipients from nine percent to seven percent.

These proposed changes would expand eligibility for CHCPE and result in an increase in recipients that would be determined eligible for the program. To this end, the Department would need an increase in the CHCPE appropriation to serve this expanded caseload and also require an additional appropriation for the reduced contribution of such recipients. As this program is completely state funded and receives no federal match on such expenditures, this proposal would result in a significant fiscal impact to the state and therefore the Department is unable to support this legislation.