



*Written Testimony before the Aging Committee
Submitted by the Department of Social Services
March 1, 2018*

S.B. No. 151 (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 a 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.

S.B. No. 152 (RAISED) – AN ACT INCREASING FINANCIAL ASSISTANCE FOR GRANDPARENTS AND OTHER NONPARENT RELATIVES WHO ARE RAISING 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 16 data, we estimate the cost of such a change to be approximately \$14.4 million. Therefore, we must oppose the bill due to the significant costs associated with providing such a benefit increase.

S.B. No. 154 (RAISED) – AN ACT INCREASING FUNDING FOR ELDERLY NUTRITION

This bill would increase the rate to providers of home-delivered meals who participate in the Connecticut Home Care Program for Elders.

While the Department certainly values the work community providers deliver to beneficiaries of our programs, there are multiple services and hundreds of providers participating in not only the Connecticut Home Care Program for Elders but other waiver and community-based services programs. The Department believes singling out one provider type at the exclusion of the others is inequitable and cannot be supported. If the Department increased the rates for all DSS waiver services by even 1%, the potential additional cost would be approximately \$7 million.

Additionally, there are not funds included in budget to support this addition; therefore, the department must oppose this proposal.

S.B. No. 155 (RAISED) - AN ACT INCREASING THE PERSONAL NEEDS ALLOWANCE FOR LONG-TERM CARE FACILITY RESIDENTS

This bill proposes to increase the personal needs allowance of residents of long-term care facilities from \$60 to \$72.75.

A state Medicaid agency is required to reduce its cost 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 personal needs allowance (PNA).

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	35
New York	50
Pennsylvania	45
Rhode Island	50
Vermont	48
Northeast Average	\$51

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

S.B. No. 157 (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 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 the CHCPE program and result in an increase of 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 on the state and therefore the Department is unable to support this legislation.

H.B. No. 5142 (RAISED) - AN ACT CONCERNING NURSING HOME SERVICES & H.B. No. 5145 (RAISED) - AN ACT CONCERNING 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, Governor Malloy, the Office of Policy and Management, and DSS released the Strategic Plan to Rebalance Long-Term Services and Supports. The strategic plan captures the data and planning strategies that are contemplated by this bill. Also, 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, entitled Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut, was released in 2016.

H.B. No. 5144 (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. The Department maintained an ACA compliance tracking tool and has fulfilled 100% of ACA provisions mandated to date.

The Department also provides detailed monthly reports (see this link for our posted materials <https://www.cga.ct.gov/med/mh-meetings.asp?sYear=2017>) 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 5144.

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.

2014 legislation (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 and would divert resources the Department needs to focus on the provision of services.