

**PA10-183**

**HB5399**

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**CONNECTICUT  
GENERAL ASSEMBLY  
HOUSE**

**PROCEEDINGS  
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acted upon today for further action in the Senate.

Thank you, Mr. Speaker.

DEPUTY SPEAKER GODFREY:

Hearing no objection, so ordered.

Will the Clerk please call Calendar 203?

THE CLERK:

On page 9, Calendar 203, Substitute for House Bill Number 5399, AN ACT CONCERNING NOTICE BY THE DEPARTMENT OF SOCIAL SERVICES REGARDING REPAYMENT FOR SERVICES, favorable report of the Committee on Human Services.

DEPUTY SPEAKER GODFREY:

The gentlewoman from Enfield, Representative Jarmoc.

REP. JARMOC (59th):

Thank you, Mr. Speaker.

I move for acceptance of the joint committees -- committee's favorable report and passage of the bill.

DEPUTY SPEAKER GODFREY:

Question's on passage.

Would you explain the bill please, madam?

REP. JARMOC (59th):

Thank you, Mr. Speaker.

This bill requires that the Department of Social Services notify applicants of their liability to repay in certain circumstances. What this bill also does is require that the Department of Social Services also notify other persons who might be liable as well.

I move -- I move adoption.

I apologize, Mr. Speaker. I'd like to call an amendment.

DEPUTY SPEAKER GODFREY:

Okay.

REP. JARMOC (59th):

Would that be okay with you?

DEPUTY SPEAKER GODFREY:

That's fine.

REP. JARMOC (59th):

Thank you.

Mr. Speaker, the Clerk has an amendment, LCO Number 4900. I would ask that the Clerk please call and that I be granted leave of the chamber to summarize please.

REP. RYAN (139th):

The Clerk is in possession of LCO Number 4900 which will be designated House Amendment Schedule

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"A."

Will the Clerk please call the amendment?

THE CLERK:

LCO Number 4900, House "A" offered by  
Representative McCluskey and Olson.

DEPUTY SPEAKER GODFREY:

The gentlewoman has asked leave of the chamber  
to summarize. Is there objection?

Hearing none, please proceed, Representative  
Jarmoc.

REP. JARMOC (59th):

Thank you, Mr. Speaker.

This amendment is basically technical in  
nature. In line number 54, after the word "aid," it  
inserts "if known" which should take care of the  
fiscal impact so that there is no fiscal impact with  
this bill.

I move adoption.

DEPUTY SPEAKER GODFREY:

The question is on adoption of House Amendment  
Schedule "A."

Will you remark further on House Amendment  
Schedule "A"?

Representative Gibbons.

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REP. GIBBONS (150th):

Thank you, Mr. Speaker.

I support the amendment and urge the chamber to do the same.

DEPUTY SPEAKER GODFREY:

Thank you, madam.

Will you remark further on House Amendment Schedule "A"? If not, let me try your minds. All those in favor signify by saying aye.

REPRESENTATIVES:

Aye

DEPUTY SPEAKER GODFREY:

Opposed, nay.

The ayes have it. The amendment is adopted.

Will you remark further on the bill as amended?

Will you remark further on the bill as amended?

Representative Gibbons.

REP. GIBBONS (150th):

Thank you, Mr. Speaker.

This bill came about because of a noncustodial parent who found out several years after the fact that his child had used services of the state and he had not been notified and he didn't realize that he had to pay back the State. So it seemed that it was

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responsible for DSS and the State to notify all noncustodial parents or people who might be responsible for the financial liabilities of anyone who has been -- incurred the services of the state, and that is the reason for this bill. I'm glad that we were able to work it out because in all of our five hour -- or ten -- eight hour Human Service public hearings this bill did not take anywhere near that amount of time. So --

Thank you, Mr. Speaker.

I urge acceptance of the bill.

DEPUTY SPEAKER GODFREY:

Thank you, madam.

Will you remark further on the bill as amended?  
Will you remark further on the bill as amended? If not, staff and guests please come to the well of the House. Members take your seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by roll call. Members to the chamber. Members to the chamber. The House is voting by roll call.

DEPUTY SPEAKER GODFREY:

Have all the members voted? Have all the

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members voted? If so, the machine will be locked and the Clerk will take a tally.

Mr. Clerk, please announce the tally.

THE CLERK:

House Bill 5399 as amended by House "A."

Total Number Voting 144

Necessary for Passage 73

Those voting Yea 144

Those voting Nay 0

Those absent and not voting 7

DEPUTY SPEAKER GODFREY:

The bill, as amended, is passed.

Will the Clerk please call Calendar 353?

THE CLERK:

On page 14, Calendar 353, Substitute for House Bill Number 5434, AN ACT CONCERNING MINOR AND TECHNICAL CHANGES TO THE COMMON INTEREST OWNERSHIP ACT, favorable report of the Committee on Judiciary,

DEPUTY SPEAKER GODFREY:

The distinguished vice chairman of the Judiciary Committee, Representative Gerry Fox.

REP. FOX (146th):

Thank you. Thank you, Mr. Speaker.

I move for the acceptance of the joint.

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THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Calendar page 17, Calendar 540, House Bill 5494,  
move to place on the consent calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Calendar page 18, Calendar 543, House Bill 5399,  
move to place on the consent calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Calendar page 18, Calendar 544, House Bill 5434,  
move to place on the consent calendar.

THE CHAIR:

Without objection, so ordered.

SENATOR LOONEY:

Thank you, Mr. President.

Calendar page 18, Calendar 547, House Bill 5196,  
move to place on the consent calendar.

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Calendar page 10, Calendar 461, House Bill 5207;  
Calendar 483, House Bill 5244.

Calendar 484, on page 11, House Bill 5383; Calendar  
487, House Bill 5220; Calendar 488, House Bill 5297;  
Calendar 490, 5425 -- House; Calendar 496, House Bill  
5497; Calendar 509, House Bill 5126.

Calendar page 14, Calendar 511, House Bill 5527;  
Calendar 514, House Bill 5426; Calendar 516, House Bill  
5393.

Calendar page 15, Calendar 520, House Bill 5336;  
Calendar 521, House Bill 5424; Calendar 523, House Bill  
5223; Calendar 525, House Bill 5255.

Calendar page 16, Calendar 531, House Bill 5004.

Calendar page 17, Calendar 533, House Bill 5436;  
Calendar 540, House Bill 5494; Calendar 543, House Bill  
5399.

Calendar page 18, Calendar 544, House Bill 5434;  
Calendar 547, House Bill 5196; Calendar 548, House Bill  
5533; Calendar 549, House Bill 5387; Calendar 550, House  
Bill 5471; Calendar 551, House Bill 5413; Calendar 552,  
House Bill 5163; Calendar 553, House Bill 5159.

Calendar page 19, Calendar 554, House Bill 5164.

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Calendar page 20, Calendar 556, House Bill 5498;  
Calendar 557, House Bill 5270; 559, House Bill 5407; 562,  
House Bill 5253; and House Bill -- Calendar 563, House  
Bill 5340; Calendar 567, House Bill 5371; and Calendar  
573, House Bill 5371.

Mr. President, I believe that completes the items

THE CHAIR:

Mr. Clerk, could you please give me on Calendar 567,  
do you have 5516, sir?

THE CLERK:

What -- what calendar?

THE CHAIR:

567 on page 22.

THE CLERK:

It's 5516.

THE CHAIR:

Yes, sir. Okay.

Machine's open.

THE CLERK:

An immediate roll call vote has been ordered in the  
Senate on the consent calendar. Will all Senators please  
return to the chamber. Immediate roll call has been ordered in the Senate on the  
consent calendar. Will all Senators please return to the chamber.

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THE CHAIR:

Have all Senators voted? Please check your vote. The machine will be locked. The Clerk will call the tally.

THE CLERK:

Motion is on adoption of Consent Calendar Number 2.

Total number voting	35
Necessary for Adoption	18
Those voting Yea	35
Those voting Nay	0
Those absent and not voting	1

THE CHAIR:

Consent Calendar Number 2 passes.

Senator Looney.

SENATOR LOONEY:

Yes, Mr. President.

Mr. President -- Mr. President, before moving to adjourn, I would like to ensure the entire chamber will wish Laura Stefon, Senator McDonald's aide, my former intern, a happy birthday.

And with that -- and with that, Mr. President, I would move the Senate stand adjourn

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Any other questions from committee members?

Thank you very much, Representative.

REP. HWANG: Thank you.

SENATOR DOYLE: The next speaker is Commissioner Starkowski, and then Deb Polun, hopefully. It depends. It depends. I may ask you to go to public, who knows.

COMMISSIONER MICHAEL STARKOWSKI: Good afternoon, Senator Doyle, Representative Walker and members of the Human Services Committee.

My name is Michael Starkowski. I'm the Commissioner of the Department of Social Services.

I submitted some lengthy testimony on a number of bills. I'll try to be as brief as possible to go over what my testimony says.

Bill Number 370, AN ACT CONCERNING MEDICAID LONG-TERM CARE COVERAGE FOR MARRIED COUPLES. Section 1 would change the disregard to the maximum allowed by federal law, which is \$109,560. We already have a disregard where we disregard one-half of a married couple's assets for the benefit of the noninstitutional spouse of a long-term care Medicaid applicant.

That does go up to the maximum of \$109,560, but, of course, that's the maximum, so people could have a disregard that's less than that. If we automatically move up to the \$109,560, that change in a disregard would mean that people would be able to divert funds that are presently used to pay for long-term care services. If they do that, it would result in earlier findings of Medicaid eligibility and

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there is a potential existence of mental illness or mental retardation, that preadmission screening has a second-level screening with a face-to-face.

Because of those particular situations, we put a system in place recently in the past month that's a new PASRR screening. We call it PASRR, where an outside entity will work with the hospitals. They put up a web-based environment for the hospitals to gain entry to -- for the nursing facilities to get entry to -- to put the information in there.

We feel that that system will expedite the movement of clients from the -- the hospitals to the nursing homes. Right now, it's being piloted with a handful of nursing homes in the for-profit world and the not-for-profit world.

At the end of this month, all the hospitals will be online with the blood-based system. And at the end of April, all of the skilled nursing facilities will be on that, and we think that that will expedite the movement of individuals from the hospitals to nursing homes, and therefore we don't think that this bill is necessary.

AN ACT CONCERNING NOTICE BY THE DEPARTMENT OF SOCIAL SERVICES REGARDING REPAYMENT FOR SERVICES. On the back side of our application, I think it's page number 13, we do have all of the information necessary for an individual to see what the implications are if they apply for our programs and are granted benefits.

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We feel that -- and that's attached to the testimony -- we feel that that's in plain English now. When a client signs the back of that application, they're agreeing that they

are aware of those implications, and they agree to those implications, and they agree to what the process will be afterwards if we're going to try any recoupment for services rendered.

5411, AN ACT CONCERNING MEDICAID. This legislation seems to -- seeks to resume the provision of podiatry and include a smoking cessation in our state plan. Podiatry and tobacco cessation services are valuable health services, but unfortunately, the addition of these services will require additional financial resources which are unavailable in the current fiscal climate.

AN ACT TO MOVE THE HOSPITAL UNCOMPENSATED CARE FUNDS AND URBAN DSH FUNDS INTO THE FUND FOR HOSPITAL MEDICAID RATES. This bill would transfer the unexpended balance in our disproportionate share accounts and turn those dollars into rate adjustments to the rate adjustments to the hospitals across the state.

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We are opposed to this bill for a number of reasons. The intent of this bill is solely to increase the rates so we can capture the additional enhanced federal reimbursement during the period of the ARRA -- the stimulus dollars. That period ends December 31st, 2010.

It's approximately 10 percent more that we would receive. We get 61 percent under the ARRA arrangement as reimbursement from the federal government. We get 50 percent reimbursement on the DSH program. The enhanced reimbursement is not allowed on any -- on DSH payments.

We feel that it would be very difficult, and we would be the first state to ever try this,

information, and if it can be substantiated, we'll review our opposition to the bill.

REP. ABERCROMBIE: Thank you. I like to hear things like that. Okay. Then we'll work on that together.

My third question has to do with the House Bill 5399, AN ACT CONCERNING NOTICE BY THE DEPARTMENT OF SOCIAL SERVICES REGARDING REPAYMENT FOR SERVICES.

COMMISSIONER MICHAEL STARKOWSKI: Yes.

REP. ABERCROMBIE: If a mother -- when a -- when a mother applies for the services and there's a father on the birth certificate, but he's not involved in the child's life, does that person also have to sign this form at that time? The consent form? Like, who are you giving it to?

COMMISSIONER MICHAEL STARKOWSKI: For what -- what -- tell me what service -- I mean, if you're going to get a little bit more technical, but you're going to have to tell me what service are they applying --

REP. ABERCROMBIE: It's like the TANF services. It's where the -- for the reimbursement -- when they get those services and then you're able to get the money back at a later time. Who signs that when she signs up for that? The sheet that you gave us.

COMMISSIONER MICHAEL STARKOWSKI: If the -- if the noncustodial parent you're saying, right?

REP. ABERCROMBIE: Yes.

COMMISSIONER MICHAEL STARKOWSKI: So you have -- you have a -- a father that's not part of the family component now.

REP. ABERCROMBIE: Yes.

COMMISSIONER MICHAEL STARKOWSKI: The mother would sign for that, and the father does not have to sign for that.

REP. ABERCROMBIE: And then we're able to get the money back from him at a later time?

COMMISSIONER MICHAEL STARKOWSKI: I don't know.  
(Inaudible).

REP. ABERCROMBIE: Because that's -- that's the old -- that's the intent of this bill, and maybe you can help us with that. We have a -- a testimony here from a father who did child support. He paid everything that he was supposed to pay through the years --

COMMISSIONER MICHAEL STARKOWSKI: Yes.

REP. ABERCROMBIE: -- and when he went to refinance his house 20 years later, he found out that there was a lien against his house through DSS for services that his child had gotten through the mother years before. So if you can help us wrap our hands around how do we make sure that all the players that are going to have the consequences later --

COMMISSIONER MICHAEL STARKOWSKI: Are notified?

REP. ABERCROMBIE: Yes. Yes.

COMMISSIONER MICHAEL STARKOWSKI: Okay. Okay.  
Okay.

REP. ABERCROMBIE: And we can show you this. I don't even know -- maybe this gentleman is here, because we have his testimony, but I think, you know, I mean, I would want to be --

if I -- if someone's going to put a lien against my house for something and I was paying my child support and everything --

COMMISSIONER MICHAEL STARKOWSKI: Okay.

REP. ABERCROMBIE: -- that I was supposed to, I think that's where this -- this bill came from, so if you could help us with that, we'd greatly appreciate it.

COMMISSIONER MICHAEL STARKOWSKI: Yes. If that's the intent of the language, we'll work with you on some.

REP. ABERCROMBIE: Okay. Great.

Thank you, Mr. Chair.

Any other -- Representative Johnston.

REP. JOHNSTON: Thank you, Mr. Chairman.

Commissioner, I was trying to follow all the conversation on Senate Bill 391 and the Care 4 Kids.

COMMISSIONER MICHAEL STARKOWSKI: Yes.

REP. JOHNSTON: Are there two different components to submitting the information -- one set of data that needs to be submitted by the provider and then additional information submitted directly by the client?

COMMISSIONER MICHAEL STARKOWSKI: Yes. And it's -- and in most situations --

REP. JOHNSTON: And is there confidentiality reasons that the client can't provide all of that to the provider and then the provider can provide us one full and complete package?

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to the department to start this privatization and give them a timetable in which to complete it.

We have -- as I mentioned, by 2012, we'll be facing a minimum of about \$3.8 million budget problem. There's significant savings, both in the long-term care area and in the provision of community living arrangements that can be achieved. I think you need to start to achieve them now, the earlier the better.

Thank you very much for your opportunity to present the testimony. I'd be glad to answer any questions.

SENATOR DOYLE: Thank you.

Any questions from committee members?

Seeing none, thank you very much for your testimony.

PETER GIOIA: Thank you.

SENATOR DOYLE: The next speaker is Alfred Vagnini, then Amy Todisco and Paul Czepiga, then Kate Walton and Lesley Simone.

ALFRED VAGNINI: Good afternoon.

My name is Alfred Vagnini. I am a life-long resident of Connecticut. I wish to address Bill 5399 regarding repayment for services to the Department of Social Services. Specifically, I would like to address the notification of any potential liability to third parties. Below are some facts regarding my particular situation.

I have one son, Christopher Vagnini. His mother is Melony Hutchinson. Melony and I

were never married. Christopher was born June 14th, 1987. I began paying Melony child support in 1988, retroactively from Christopher's birth. I paid the court-ordered amount in full until Christopher came to live with me at age 15. At that -- at that time, the order was vacated, and I did not seek support from Melony going forward.

It was upon attempting to refinance my home I found a lien had been placed on my property without my knowledge. My attorney looked into the source of the lien and found it to be the state of Connecticut DSS in an amount in excess of \$11,000. I had no idea as to the basis for the lien, and when my attorney received the information from DSS, he told me it was to reclaim state assistance monies that had been paid to Melony.

I had absolutely no knowledge before or after the fact of Melony applying for or receiving state assistance or that any potential liability on my behalf existed. As far as I knew, my court-ordered support obligation for my son had been completely fulfilled.

That summary illustrates the simple fact that under current law, I am being held liable for a debt of which I had absolutely no knowledge. I cannot think of another example in American life where someone is liable, or even potentially liable, for a debt that they are not informed of when it is incurred. This is a disheartening and unsettling prospect.

I feel that this practice is unconstitutional, and it is my hope that the law could be changed to fairly inform any and all parties of potential liability for repayment to DSS at the time of said liability's inception.

Thank you for the opportunity to address this to the lawmakers of our great state, and I look forward to seeing Bill 5399 include third-party notification.

SENATOR DOYLE: Thank you.

Any questions?

Senator Kane.

SENATOR KANE: Thank you, Mr. Chairman.

Thank you for coming up here today and testifying. I know that you brought this to the attention of Senator Caligiuri, who has also put testimony in today in favor of the bill. I know you've brought it to my attention. It's -- it's pretty -- an incredible story, actually, when you think about it.

So you had no idea that Melony had even applied for any type of assistance, correct?

ALFRED VAGNINI: Correct.

SENATOR KANE: And, you know, all this time that she was getting the assistance, you had no information, DSS never contacted you, never provided you any information that she even was participating.

ALFRED VAGNINI: Correct.

SENATOR KANE: So now, one day, you are refinancing your home and there's a lien.

ALFRED VAGNINI: That's correct, yes.

SENATOR KANE: And never did they send you any notification that there even was a lien or the possibility of anything.

ALFRED VAGNINI: No, and I wouldn't -- I wouldn't expect that a liability could be assumed by someone, even partially assumed by someone, without any kind of prior knowledge. That's -- that, to me, is -- is the whole crux of it.

SENATOR KANE: Right. And -- and, you know, in my -- in my mind, it doesn't seem unreasonable that they would notify you, being the father of the child, that is getting some type of state assistance.

ALFRED VAGNINI: Right.

SENATOR KANE: So it makes sense that you would be notified.

ALFRED VAGNINI: Right, and I understand there may be privacy issues being that I am a third party, but if I'm going to be a first party at some point or potentially a first party with the financial obligation, then it -- it is incumbent on the DSS to inform me of that potential liability, and that's really --

SENATOR KANE: That's all we're looking for.

ALFRED VAGNINI: Yes.

SENATOR KANE: And it makes sense to me, honestly, and -- and I know Senator Caligiuri is in favor of it, and -- and I'm -- I'm sure the -- the committee will take great consideration in it. A lot of these bills come from individuals like yourself. So I appreciate you coming today and -- and bringing it to our attention, and -- and I thank you very much.

ALFRED VAGNINI: Thank you, Senator Kane. Thank you.

SENATOR DOYLE: Thank you very much.

Any other questions from committee members?

Seeing none, thank you for coming, sir.

ALFRED VAGNINI: Thank you.

SENATOR DOYLE: Oh, sorry. Senator Coleman.

SENATOR COLEMAN: I'm just curious --

ALFRED VAGNINI: Sure.

SENATOR COLEMAN: -- in the information that you got concerning the \$11,000 lien --

ALFRED VAGNINI: Uh-huh.

SENATOR COLEMAN: -- was anybody able to itemize what that was for? I'm assuming if you paid your child support payments, it couldn't have been that. Could it -- could it perhaps have been medical expenses or daycare expenses?

ALFRED VAGNINI: No, actually, thank you for asking that question. That's -- first, my attorney said it was \$25,000. Then no one at the state could really give an accurate balance easily. It took several weeks of -- of reconciliation on the part of the people at DSS to come up with a number that I didn't even feel after they came up with that number that they were -- it didn't seem like they were real confident of it, but they were going with that number.

And the -- the principle was that, you know, she had -- she had applied for the welfare benefit -- the welfare benefits and, again, it was -- I did not know about it, but there was no form given to me, like a statement like you just asked. There was no actual statement given. It was just basically a -- a verbal amount given to my attorney over the phone.

So it seems like that's -- there's some kind of disconnect there in that -- in that way. But there was not -- I wasn't able to get an easily-detailed statement -- itemized statement -- saying here's what you owe.

They do have accurate records going back to 1987 when Christopher was born, but -- and they show the offsets of monies that were paid, and the -- the principle of the matter is is that if I'm paying a court-ordered amount, and she is receiving benefits for her household and we were never married, how the state -- that's a -- that's another discussion that how the state is -- is seeking restitution from me.

But the way it was explained to me from DSS is that it's not 50-50, it's 100-100. So I am 100 percent responsible, and she is 100 percent responsible for her debt -- for her -- her assistance. So if they can't -- if she has no assets, then they will 100 percent come after me, not 50 percent, but 100 percent, but I don't think this bill addresses that, but that's also another -- you may be seeing me up here again if you bring forth legislation on that matter.

Because that's another situation that I think, you know, bears examination, that I'm 100 percent liable for assistance that she applied for and received. So, you know, in

addition to me meeting my -- my support order,  
I have to go that further. So --

SENATOR COLEMAN: Thank you.

ALFRED VAGNINI: Thank you, Senator Coleman.

SENATOR DOYLE: Let me just ask you a follow-up  
clarification. They said you were responsible  
for the care -- for the aid provided to your  
daughter or your wife?

ALFRED VAGNINI: Son.

SENATOR DOYLE: Sorry, your son or -- or the wife  
or just the son.

ALFRED VAGNINI: I was never married to her.

SENATOR DOYLE: Okay.

ALFRED VAGNINI: So -- we have a -- we have a child  
together. I was never married to her, and the  
state is seeking 100 percent restitution for  
state assistance that she applied for for  
herself.

SENATOR DOYLE: For herself?

ALFRED VAGNINI: Well, for herself and for her  
household, which is -- her household was  
herself and my son. So I'm sure a portion of  
that is her obligation to provide food and  
shelter for my son, but I -- I was also paying  
that through child support.

So her -- her side -- in other words, the  
state explained it to me that they will seek  
100 percent restitution from whoever they can  
get it from, regardless -- so if we have a --  
if we have a common dependent son, they're  
going to come after either party.

SENATOR DOYLE: Yes, but that's for reimbursement for the wife, which seems kind of bazaar.

ALFRED VAGNINI: Say that again, I'm sorry.

SENATOR DOYLE: It seems bazaar that you're responsible for aid to your wife. I can see for your son, but not for your wife.

ALFRED VAGNINI: I agree.

SENATOR DOYLE: Sorry, not even your wife. Sorry, that's right.

ALFRED VAGNINI: Yes. Yes.

SENATOR DOYLE: It's less -- less of a relation than an ex-wife, actually.

ALFRED VAGNINI: Right. We had no -- no legal connection.

SENATOR DOYLE: Huh.

ALFRED VAGNINI: And -- and, you know, even if they said, well, you know, she's receiving \$500 per month, \$200 of that could be potential liability --

SENATOR DOYLE: Right, yes. We could allocate a portion of some.

ALFRED VAGNINI: -- allocate a portion of it, that would be completely understandable. But not only was that not done, but also I was never even informed that she was applied for welfare, which that's not my business, but now it -- it has become my business.

SENATOR DOYLE: If you're on the hook, yes.

ALFRED VAGNINI: Yes. So that's the whole crux of my -- my --

SENATOR DOYLE: But then when you were seeking -- when you -- when you got notice of the 25,000, it was negotiated down to 11, but you still never really got any evidence of the claim?

ALFRED VAGNINI: I really didn't negotiate it. What they did was they put -- again, this is -- speaks to Senator Coleman's point that they just -- there's no -- there wasn't a real accurate description. They just put a number out there. They liened my property for 25,000 as like a kind of a catch-all amount, and then it was upon the refinancing of the -- of the property --

SENATOR DOYLE: Right, you -- yes.

ALFRED VAGNINI: -- that they were able to reconcile it and say, okay, well, he did -- you know, they -- they put payments against that amount that was credited either when she went off of assistance or when I -- when they applied child support payments, so the final number was in excess of 11,000. It was like eleven eight or something like that.

SENATOR DOYLE: Thank you.

ALFRED VAGNINI: So now that's going to be on my house -- on my property until I either sell it or pay it, so --

SENATOR DOYLE: Thank you.

Any other questions from committee members?

Thank you, sir.

ALFRED VAGNINI: Thank you, Senator Doyle.

SENATOR DOYLE: Thank you for coming today.

ALFRED VAGNINI: Yes.

SENATOR DOYLE: The next speaker is Amy Todisco and Paul Czepiga, then Kate Walton, then Lesley Simone and Julia Wilcox. And I'll just point out, the fact that these two individuals are coming up together is a good thing, so if anybody else has, you know, a person as common testimony and you want to come up together to try to expedite, that would be welcome to the committee, so thank you.

AMY TODISCO: Senator Doyle, good afternoon, members of the Human Services Committee.

My name is Amy Todisco. I'm an elder law attorney in Fairfield. I'm here today as President of the Connecticut Chapter of the National Academy of Elder Law Attorneys. We are the proponents of S.B. 370, AN ACT CONCERNING MEDICAID LONG-TERM CARE COVERAGE FOR MARRIED COUPLES.

And I'm going to speak to Part 2 of the bill, having to do with the loan proceeds, and I won't -- we're very pleased, by the way, that DSS has agreed and -- so I'm not going to belabor that point.

I just want to clarify for the committee that this has been a longstanding policy of DSS, and when DSS promulgated certain regulations pursuant to the Deficit Reduction Act in 2007 in going through -- this is according to DSS, now -- in going through these various sections of the Uniform Policy Manual, they realized that they didn't have federal authority for the policy that they'd had all these years to exclude loan proceeds.



*Testimony before the Human Services Committee*

*Michael P. Starkowski*

*Commissioner*

*March 11, 2010*

Good afternoon, Senator Doyle, Representative Walker and Members of the Human Services Committee. I am Michael Starkowski, Commissioner of the Department of Social Services. I am pleased to be here to present testimony on a number of bills on today's agenda.

**S.B. No. 370 (RAISED) AN ACT CONCERNING MEDICAID LONG-TERM CARE COVERAGE FOR MARRIED COUPLES.**

Section 1 requires that the department disregard the maximum amount of assets permitted under federal law for the benefit of a non-institutionalized spouse of an applicant for long-term care Medicaid assistance. Under this proposal, the department would automatically disregard all of the assets of a married couple up to \$109,560 for the benefit of the non-institutionalized spouse. Since 1989, Connecticut, under federal law, has disregarded one-half of a married couple's assets (excluding the home and one car) for the benefit of a non-institutionalized spouse of a long-term care Medicaid applicant, up to a maximum of \$109,560.

The department opposes this proposed change as the disregard of additional assets would divert funds that are presently used to pay for long-term care services, resulting in earlier findings of Medicaid eligibility and thus increasing Medicaid costs to the state. Under current regulations, non-institutionalized spouses keep the home, one car and one-half of the couple's assets (with a minimum amount of \$21,912) without affecting the institutionalized spouse's eligibility for long-term care Medicaid assistance. We believe that these assets are sufficient to support the needs of the non-institutionalized spouse and do not need to be increased at the expense of the Medicaid program.

Section 2 would exclude funds derived from equity in home property through a reverse annuity mortgage loan or other home equity conversion loan in determining Medicaid eligibility. Currently, such funds are not counted in the month in which they are received; however, any funds retained after the initial month of receipt are counted as assets, which could result in the loss of Medicaid eligibility. Excluding these funds could allow individuals to use these funds to support themselves in the community for greater amounts of time and avoid costly nursing facility care. The language as drafted, however, is inaccurate as it excludes these funds as "income." Instead, these funds should be excluded as "assets."

HB5296 HB5398  
 HB5399 HB5411  
 HB5412 HB5431  
 SB282

The department feels that section 2 of the bill has merit however, cannot support the legislation if it includes section 1 due to its costs.

**S.B. No. 391 (RAISED) AN ACT CONCERNING CHILD CARE SUBSIDIES FOR THE UNEMPLOYED UNDER THE CARE 4 KIDS PROGRAM.**

The bill would require the department to complete a C4K application within 30 days after receipt of such application. Our existing goal is to process all "properly completed applications" applications within 30 days. However, our data shows that this timeframe is very difficult to meet and is dependent on the client and the child care provider submitting the proper information. Often it can take up to 3 submissions to collect the proper information to complete an application. During our efforts to obtain the correct required information, we hold the original date of application as the start date, in the event that the client is determined eligible.

Because there is no statutory timeframe, we are able to keep the application in pending status. Should this provision be enacted, if the required information is not received from the applicant or provider within the 30-day timeframe, the department would deny the application for failure to comply. Therefore, applicants would be required to reapply and start the process all over. In this scenario if the applicant is denied, the provider may be out payments if they provided services while the initial application was pending.

**H.B. No. 5296 (RAISED) AN ACT CONCERNING THE DEFINITION OF MEDICAL NECESSITY.**

The bill before you is based on earlier draft language proposed by the Medical Inefficiency Committee established under PA 09-5. Although the Department does not support the bill as drafted, we have been working with the Medical Inefficiency Committee on amendments to the bill that would enable the Department to reduce medical inefficiency consistent with legislative intent. We would like to work with members of the committee to amend the language to the most current recommendation from the Medical Inefficiency Committee. The Department supports ongoing monitoring of the impact of a new definition with respect to its impact on inefficiency and quality of care.

**H.B. No. 5398 (RAISED) AN ACT CONCERNING A PILOT PROGRAM TO TRANSFER HOSPITAL PATIENTS WHO RECEIVE MEDICAID BENEFITS TO NURSING HOMES IN A TIMELY MANNER.**

This bill would create a pilot program to decrease the period of time that Medicaid recipients who require long-term care remain hospitalized before transfer to a long-term care facility. All Medicaid applicants who are seeking admission to a long-term care facility must be screened for the potential existence of mental illness or mental retardation, known as Pre-Admission Screening/Resident Review (PASRR), prior to being placed in a nursing facility. If there is evidence of mental illness or mental

retardation (MI/MR), a second level of review must occur that includes a face-to-face evaluation by a mental health professional or a nurse consultant from the Department of Developmental Services. If this review is not done prior to hospital discharge to the nursing facility, the nursing facility is out of compliance with federal regulations and Medicaid cannot pay for the nursing home stay without jeopardizing federal reimbursement.

The department has begun to roll out a more streamlined PASRR and level of care screening system. For example, for discharges of persons with MI/MR, who require nursing home care for 30 days or less, nursing home admission will be expedited and such persons can be discharged to nursing homes under this provision on a 24-hour, seven-day-a-week basis.

The department feels that our current initiatives are improving the screening process and providing for more timely transfers and therefore this bill is unnecessary.

**H.B. No. 5399 (RAISED) AN ACT CONCERNING NOTICE BY THE DEPARTMENT OF SOCIAL SERVICES REGARDING REPAYMENT FOR SERVICES.**

This department is opposed to this bill because we already provide such notification, therefore feel it is unnecessary. When an individual or family applies for benefits the information regarding recovery and liens is disclosed on the application in plain language that is readable and understandable. By signing the application the applicant is acknowledging that he/she has read these provisions and understands that he/she are subject to them. A copy of the disclosure page of our application is attached to my testimony.

**H.B. No. 5411 (RAISED) AN ACT CONCERNING MEDICAID.**

This legislation seeks to resume the provision of podiatry and implement smoking cessation as state plan services.

Both podiatry services and tobacco cessation services are valuable health services and the addition of each to the state plan is a laudable goal. Unfortunately, addition of both services will require additional financial resources which are unavailable in the current fiscal climate.

Section 6 of this bill would require the Commissioner of Social Services to apply for an 1115 waiver to convert the state-funded portion of the CT Home Care for Elders Program to Medicaid. The Department believes an evaluation of the viability of such a proposal needs to be examined prior to a statutory requirement to implement. One of the basic requirements of an approvable 1115 waiver is cost savings to the federal government; this is a cost-effectiveness requirement. Based on the existing eligibility and other payment criteria, it is not clear that this cost-effectiveness requirement can be met.



**State of Connecticut**  
**SENATE**  
 STATE CAPITOL  
 HARTFORD, CONNECTICUT 06106-1591

**SENATOR SAM S.F. CALIGIURI**  
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 REGULATION REVIEW COMMITTEE

**Testimony of Senator Sam S.F. Caligiuri**

**Raised Bill 5399, AAC Notice By The Department Of Social Services Regarding Repayment For Services  
 Human Services Committee  
 March 11, 2010**

Senator Doyle, Representative Walker, Senator Kane, Representative Gibbons and Members of the Human Services Committee, my name is Sam Caligiuri, State Senator from the 16<sup>th</sup> District.

I am testifying today in support of Raised Bill 5399, An Act Concerning Notice By The Department Of Social Services Regarding Repayment For Services. This bill would require the Department of Social Services to disclose and explain to applicants for aid all provisions and circumstances under which the applicant would be required to repay the state for the cost of services received.

While I am pleased to see this legislation before the committee, I would like to recommend certain modifications. The underlying bill would require DSS to notify only the applicant for state aid. Currently, the state is empowered to recoup assistance received not only from the applicant, but also from certain relatives and liable third parties.

This issue was brought to my attention by a constituent. He had a child over 20 years ago. He and the mother were never married; however, as I understand it, he supported his child by paying all court ordered child support, providing medical insurance and providing other assistance for the child. His child lived with the mother until the age of 15 at which time the child came to live with him. In March of 2009, when the constituent began the process of refinancing his house, he learned that the state had placed a lien on his home for the repayment of Aid to Families with Dependent Children (AFDC) benefits paid to the child's mother.

His discovery of a lien on his home was the first time he had become aware of the fact that he could be held liable for repaying the assistance the state had provided to his child's mother. While I understand the state's desire to receive legal repayment for state aid from any potentially liable relative or third party, the state is not currently required to notify these individuals that a debt is accruing for which they may be held responsible.

I would respectfully request that House Bill 5399 be amended to require the state to notify any relative of a state aid beneficiary or any other potentially liable third party who might be required to make a repayment for aid received, of the fact that he or she can be held liable by the state for the repayment of such state aid.

I thank you for consideration of this proposed legislation and look forward to working with the committee in moving this bill forward.



## Human Services Committee

March 11, 2010

Testimony of the American Cancer Society

### Support for HB 5411 - An Act Concerning Medicaid

Good afternoon Senator Doyle, Representative Walker and honorable members of the Committee, My name is Dr. Andrew Salner. I am the Director of the Helen and Harry Gray Cancer Center at Hartford Hospital. I am the Past-Chair, American Cancer Society, New England Division. I am also Immediate Past Chair of the Connecticut Cancer Partnership, a public and private coalition of over 300 cancer experts and health care organizations funded by a grant from the CDC to create and implement a Comprehensive Cancer Control Plan here in Connecticut. Today, I am here today on behalf of the Society in strong support of HB 5411 - An Act Concerning Medicaid.

Smoking related diseases are the single most preventable cause of death in our society and it is estimated that 4,900 Connecticut residents will die from smoking-related illnesses in 2009 alone. Currently, 15.9% of adults in Connecticut and 21% of high school aged kids smoke, spending on average \$1825 per year on the habit. Connecticut incurs \$1.63 billion in annual health care costs and another \$1 billion in lost productivity directly caused by tobacco.

Connecticut receives over \$500 million annually between the MSA funds and tobacco tax revenue. Over the years, however, less than 2% of the cumulative total has been spent in support of smoking cessation services. In 2008 Connecticut spent \$0 dollars and was ranked last, 51 out of 50 states and Washington D.C. in allocating funds to tobacco cessation programs. While the state did not spend any money, the annual health care costs associated with tobacco use continued to increase.

70% of Connecticut's smokers indicate they want to quit while 40% attempt to quit each year, however only about 5% are successful. Many fail because, in part, of a lack of access to successful cessation programs. Funding prevention programs that alleviate this burden on our citizens and economy is not only consistent with our shared goal of insuring access to care to those in need, it is also the only fiscally responsible approach we can take.

From a cost perspective, the need is critical. According to the Centers for Disease Control and Prevention, tobacco use costs Connecticut's Medicaid program alone over \$507 million per year - costs primarily borne by Connecticut taxpayers. HB 5411 brings Connecticut a step closer to providing these much needed services by requiring the Department of Social Services to amend the state Medicaid plan to include smoking cessation treatments.

36% of Connecticut Medicaid beneficiaries smoke, more than a 50% higher rate than the population as a whole. Yet, Connecticut is one of only 4 states that does not provide Medicaid

coverage for at least one of the three primary smoking cessation services—nicotine replacement therapies, counseling or prescription drugs. Providing tobacco users with access to these services increases quit rates by up to 40%. Tobacco prevention and cessation programs are shown over and over to be effective ways of reducing the financial and human costs of tobacco.

Medicaid cessation is a proven success. For example, Massachusetts offers a Medicaid cessation benefit that includes low cost medication and counseling services. The program cost about \$12 million, and according to a recent pilot study of the benefit, 40% of smokers in Medicaid took advantage of the services (75,000 people). 33,000 smokers quit over the two-year study period, leading to a 26% decline in smoking prevalence. An analysis of the expected cost savings from promoting cessation before smoking-related disease develops or becomes more severe is forthcoming, but given the overwhelming use of the services as well as the substantial quit rate, the savings are considerable—more so than the cost of providing the service itself. We would urge support for amending HB 5411 using the suggested language the MATCH coalition has submitted. This language would more closely align the Connecticut Plan with this highly successful comprehensive Massachusetts model.

Funding Medicaid coverage of cessation services would allow for the state to take advantage of federal matching funds, reach a higher concentration of lower income smokers and ease the impact tobacco related illnesses have on the cost of the program.

The American Legacy Foundation estimated that within five years, Connecticut would see annual Medicaid savings of \$91 million (2005 dollars) with a 50 percent decrease in smoking rates, and \$18 million (2005 dollars) annually in Medicaid savings with a ten percent reduction in smoking. With a renewed and committed investment in aggressive tobacco control, we can reverse the damage already done, and impact the health and lives of the people of Connecticut.

Connecticut faces very real and very serious budget deficits. This fiscal emergency will need to be addressed through painful and necessary solutions and all options need to be on the table. As we continue to feel the impact of this economic downturn, it is important that we look for creative ways to utilize existing revenue that will allow us to protect access to the full range of health care, including tobacco prevention and cessation services.

The American Cancer Society stands ready and willing to work with the Legislature and the Administration to effectively establish coherent strategy which adequately addresses these and other health care related concerns. We cannot afford to do nothing to address this entirely preventable problem. Inaction will only escalate the current economic downturn and result in a greater number of lives being affected by cancer at a greater cost to the state.

We respectfully request your support for HB 5411. Thank You.

###

# 5411



# GENERATIONS

FAMILY HEALTH CENTER

**Giselle López, Project Manager, Smoking Cessation Program, Generations Family Health Center, Inc. Willimantic, Norwich, Danielson, and Putnam CT. Phone: (860) 450-7471 ext. 234**

As the program manager for two of DPH funded tobacco cessation programs at Generations and an American Lung Association group facilitator for the *Freedom from Smoking* and *Not-On-Tobacco* curriculum, I am here today to bring a positive yet familiar message to all of you. Tobacco cessation groups, individual counseling, the CT Quitline, and access to free nicotine replacement therapies; all work to help people addicted to tobacco products to reduce and stop their use of these products. The key is continuing to increase access to all of these supports for people in CT.

From February 2009 through February 2010 we have identified 936 individuals with the desire to try to quit smoking. Out of 936 referrals to date, 206 women were able to successfully enroll in the Smoking Cessation Program at Generations. To date there are 229 eligible women referred to the program awaiting contact. Of the remaining 501 individuals who were not eligible for our DPH funded smoking cessation program all were referred to the CT Quitline. Several of these individuals did attend out Smoking Cessation Groups as they are open to the public and received their NRT's from the CT Quitline.

The program uses the ALA *Freedom from Smoking* curriculum for the group sessions and an individual counseling curriculum developed by Project Manager and previously approved by DPH, based on ALA guidelines. We also provide nicotine replacement therapies at no cost to all participants, and access to other resources in the community.

#### Program Improvement Suggestions:

- Expand program guidelines to include males in target populations. Most pregnant women (and non-pregnant) are involved to some extent with a partner who is often using tobacco products as well. If both parties can receive their NRT's, counseling/group services from the same agency it helps to create a more seamless access to the service. While some male partners were able to utilize the CT Quitline, it took longer for the partner to receive their NRT's from the CT Quitline. Through our agency, NRT's could be accessed at the first intake session for one partner only creating some issues for the couple.
- Due to the rural nature of our health center service area, the current program model of one coordinator for smoking cessation services is inefficient. There are difficulties providing comprehensive services at 4 different sites spanning 90 miles. A revised program model would include smoking cessation facilitators at each site with oversight by a part time program manager. At Generations we have over the years of our grants trained approximately 6 ALA facilitators in an effort to be able to provide services at each site. The current funding model which the grant supports did not allow for the dispersion of funds to more than one staff.

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Testimony Regarding H.B. 5411, An Act Concerning Medicaid

March 11, 2010

Erin E. Jones

State Director of Public Affairs, March of Dimes CT Chapter

**BACKGROUND**

Currently, at least 18.7 percent of women smoke in Connecticut.<sup>1</sup> At least 10 percent are smoking during pregnancy. Because women who smoke during pregnancy are more likely than nonsmokers to have a preterm infant, the March of Dimes supports coverage of effective tobacco cessation methods for women of childbearing age, especially those who are pregnant. Smoking cessation services for pregnant women are among the handful of interventions that save enough in later medical expenses to offset the initial investment, and actually result in cost savings. Studies suggest that every \$1 spent on smoking cessation counseling for pregnant women could save about \$3 in reduced neonatal intensive care costs.<sup>2</sup>

Due to concern regarding the potential impact of tobacco cessation pharmaceuticals on a developing fetus, the American College of Obstetricians and Gynecologists (ACOG) recommends that providers refer pregnant smokers to tobacco cessation counseling in most cases, and that cessation pharmaceuticals primarily be used only for very heavy smokers and women for whom counseling has been ineffective. However, programs such as Medicaid and the State Children's Health Insurance Program (S-CHIP) should reimburse for counseling as well as pharmaceuticals to ensure that the physician and woman have access to both intervention

**STATE MEDICAID COVERAGE**

Pregnant women who rely on Medicaid for their health insurance are more likely than other pregnant women to smoke, according to state data collected by the Centers for Disease Control and Prevention. While Medicaid programs in 42 states reimburse for some form of tobacco cessation intervention for pregnant women, 22 states do not cover counseling—the treatment of choice for pregnant smokers.

**MARCH OF DIMES POLICY:**

The March of Dimes urges pregnant women to stop smoking to improve pregnancy outcomes, prevent infant mortality, and protect their own health. The March of Dimes supports legislation and regulatory action to reduce exposure to tobacco smoke by women of child bearing age (especially those who are pregnant) and infants, and to increase the availability and access to effective smoking prevention and cessation services. The March of Dimes supports and advocates for states to include smoking cessation programs as part of maternity care.

<sup>1</sup> March of Dimes 2009 Prematurity Birth Report Card, available at [www.marchofdimes.com](http://www.marchofdimes.com)

<sup>2</sup> See Ayadi M.F., et al., 2006 Costs of Smoking Cessation Counseling Intervention for Pregnant Women: Comparison of Three Settings. *Public Health Reports* 121:120-6.

**THE PROBLEM:**

In Connecticut, smoking cessation (pharmaceuticals and/or counseling) is not a covered treatment in the Medicaid state plan.

**RECOMMENDATION:**

The March of Dimes recommends an amendment to general statute (17b-278a) to require that smoking cessation treatment be included in Medicaid state plan.

For more information contact:

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## Support Medicaid Coverage of Tobacco Cessation for Pregnant Women

Smoking has been found to cause numerous health problems for women of childbearing age, and smoking during pregnancy has been linked to many poor birth outcomes, including preterm birth and low birthweight. Tobacco cessation counseling and pharmacological interventions have been found to save money, help women quit smoking, and improve birth outcomes. Unfortunately, some of the women who most need access to these services, lack health coverage for them. Ensuring that all pregnant women who rely on Medicaid have coverage for tobacco cessation counseling and pharmacotherapies can significantly increase the number of pregnant smokers who have access to effective cessation interventions.

### Smoking During Pregnancy

- Women who smoke during pregnancy are more likely than nonsmokers to have a low birthweight or preterm baby.<sup>1</sup>
- Conservative estimates indicate that at least one out of every ten pregnant women smoke, accounting for half a million births per year.<sup>2</sup>
- According to a 2004 Surgeon General's report, "Health Consequences of Smoking," infants of women who quit smoking by the end of the first trimester have weight and body measurements comparable to infants of nonsmokers.

### Cost of Preterm Birth and Low Birthweight

- According to a 2006 report by the Institute of Medicine, the annual societal economic cost (medical, educational, and lost productivity) associated with preterm birth in the US was at least \$26.2 billion.
- The average first year medical costs are about 10 times greater for preterm (\$32,325) than for term infants (\$3,325).

<sup>1</sup> Shah, NR and MB Bracken. 2000. "A Systematic Review and Meta-analysis of Prospective Studies on the Association Between Maternal Cigarette Smoking and Preterm Delivery." *American Journal of Obstetrics and Gynecology* 182(2):465-72.

<sup>2</sup> See, e.g., Markovic, R., et al., "Substance Use Measures Among Women in Early Pregnancy," *American Journal of Obstetrics & Gynecology* 183:627-32 (September 2000).



- Low birthweight accounts for 10% of all healthcare costs for children.

### Smoking and Medicaid

- Pregnant women on Medicaid are 2.5 times more likely than other pregnant women to smoke, according to Medicaid data collected by the Centers for Disease Control and Prevention (CDC).
- According to joint estimates by the CDC and the Centers for Medicare and Medicaid Services, smoking-attributable neonatal health care costs for Medicaid total almost \$228 million, or about \$738 per pregnant smoker.
- Thirty-nine state Medicaid programs cover tobacco cessation pharmacotherapies (gum, patch, etc.) and 26 cover tobacco cessation counseling.
- Counseling is typically the first treatment recommended to pregnant smokers, but for very heavy smokers, providers may choose to prescribe pharmacotherapy in addition to counseling.

### Tobacco Cessation Effectiveness and Cost Savings

- *Studies suggest that every \$1 spent on smoking cessation counseling for pregnant women could save about \$3 in neonatal intensive care costs.*<sup>3</sup>
- In a managed care setting, a comprehensive smoking cessation benefit (counseling and pharmacotherapy) costs less than \$5.92 per member per year (about \$0.40 per month).<sup>4</sup>
- Prenatal smoking cessation programs have been shown to have a protective effect on intrauterine growth retardation.<sup>5</sup>
- A study in the July 2001 *American Journal of Preventive Medicine* ranked the effectiveness of various clinical preventive services recommended by the U.S. Preventive Services Task Force, using a one to ten scale, with ten being the highest possible score. Of the thirty preventive services evaluated, tobacco cessation ranked second in its degree of effectiveness, scoring a nine out of 10 (the highest ranking was for childhood vaccines which scored a 10). Among other preventive services covered by Medicaid, colorectal cancer screening received a score of eight and mammography screening scored a six.
- In 2006, a National Institutes of Health (NIH) state-of-the-science panel found that tobacco cessation interventions could double or triple quit rates if more smokers had access to them. The panel found that smoking cessation interventions/treatments such as nicotine replacement therapy and counseling were individually effective, and even more effective in combination.

<sup>3</sup> Ayadi, MF and others. 2006. "Costs of Smoking Cessation Counseling Intervention for Pregnant Women: Comparison of Three Settings." *Public Health Reports* 121: 120-26.

<sup>4</sup> Curry SJ, Grothaus LC, McAfee T, Pabniniak C. Use and cost effectiveness of smoking cessation services under four insurance plans in a health maintenance organization.

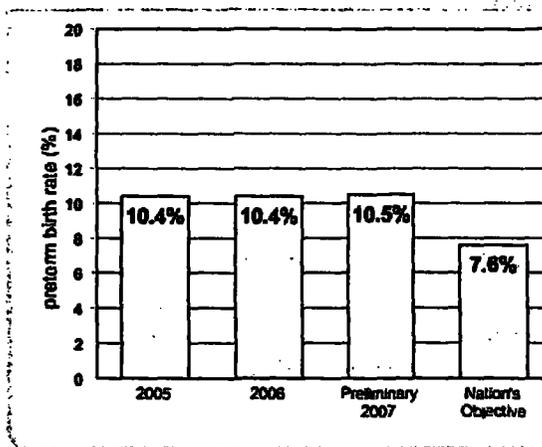
<sup>5</sup> Ershoff DH, Quinn VP, Mullen PD, et al. Pregnancy and medical cost outcomes of a selfhelp prenatal smoking cessation program in a HMO. *Public Health Reports* 1990; 105(4):340-7.

# March of Dimes 2009 Premature Birth Report Card

Grade for Connecticut  
Preterm Birth Rate: 10.5%

C

The March of Dimes graded states by comparing each state's rate of premature birth to the nation's objective of 7.6 percent or less by 2010. This year we are also awarding a star when the rate for one of the selected contributing factors (below) is moving in the right direction. We don't yet understand all the factors that contribute to premature birth. The nation must continue to make progress on research to identify causes and prevention strategies, improve the outcomes of preterm infants, and better define and track the problem.



## Status of Selected Contributing Factors

Factor	Previous Rate	Latest Rate	Status	Recommendation
Uninsured Women	13.5%	12.2%	★	Health care before and during pregnancy can help identify and manage conditions that contribute to premature birth. We urge federal and state policymakers to expand access to health coverage for women of childbearing age, and we urge employers to create workplaces that support maternal and infant health.
Women Smoking	16.7%	18.7%	×	Smoking cessation programs can reduce the risk of premature birth. We urge federal and state support of smoking cessation as part of maternity care.
Late Preterm Birth	7.1%	7.2%	×	The rise in late preterm births (34-36 weeks) has been linked to rising rates of early induction of labor and c-sections. We call on hospitals and health care professionals to voluntarily assess c-sections and inductions that occur prior to 39 weeks gestation to ensure consistency with professional guidelines.

★ = moving in the right direction    n/c = no change    × = moving in the wrong direction

### State Actions:

For information on how we are working to reduce premature birth, contact the March of Dimes Connecticut Chapter at (860) 812-0080.

march  of dimes®

# March of Dimes 2009 Premature Birth Report Card

## Technical Notes

### Data Sources and Notes

All calculations were conducted by the March of Dimes Perinatal Data Center.

Indicator	Definition	Data Sources	
		50 states and D.C.	Puerto Rico
<b>Preterm birth (percent)</b>	Percentage of all live births less than 37 completed weeks gestation	National Center for Health Statistics (NCHS), 2007 preliminary, 2006 and 2005 final birth data	Puerto Rico Health Department, 2007 preliminary, 2006 and 2005 final birth data
<b>Late preterm birth (percent)</b>	Percentage of all live births between 34 and 36 weeks gestation	NCHS, 2007 preliminary and 2005 final birth data	Puerto Rico Health Department, 2007 preliminary and 2005 final birth data
<b>Uninsured women (percent)</b>	Percentage of women ages 15 to 44 with no source of health insurance coverage	U.S. Census Bureau, Current Population Survey, 2007 to 2009 and 2006 to 2008	Percentage of women ages 18-44 with no health care coverage, Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS), 2008 and 2007 data
<b>Women smoking (percent)</b>	Percentage of women ages 18 to 44 who currently smoke either every day or some days and who have smoked at least 100 cigarettes in their lifetime	CDC, BRFSS, 2008 and 2007 data	CDC, BRFSS, 2008 and 2007 data

Where possible, national data sources were used so that data is consistent for each state and jurisdiction-specific premature birth report card. Therefore, data provided on the report card may differ from data obtained directly from state or local health departments and vital statistics agencies. This could be due to multiple causes. For example, as part of the Vital Statistics Cooperative Program, states are required to send NCHS natality and mortality data for a given year by a specific date. Sometimes states receive data after this date, which may result in slight differences in the rates calculated using NCHS-processed data and state-processed data. Another reason preterm birth rates, in particular, may vary is due to differences in the way NCHS and the states calculate variables and impute missing data. Collaboration among March of Dimes chapters, state and local health departments and other local partners, will provide a deeper understanding of specific contributors to preterm birth. 2007 preliminary data are reported for the percentage of preterm birth and late preterm birth by state. Preliminary data are based on more than 99 percent of the births in 47 states, D.C. and Puerto Rico but are less complete for three states, Louisiana (91.4 percent), Georgia (86.4 percent) and Michigan (80.2 percent). 2007 final preterm and late preterm birth rates are expected to be very similar to the 2007 preliminary rates but may differ for these three states.

## March of Dimes 2009 Premature Birth Report Card Technical Notes, continued

### Grading Methodology

Premature birth report card grades are based solely on the distance of a state's rate of preterm birth from the nation's *Healthy People 2010* (HP) objective of 7.6 percent. The grading criteria established for 2008 report cards is used as a baseline and provides for annual preterm birth report card grade comparison. Each jurisdiction was assigned a grade based on the following criteria.

Grade	Preterm birth rate range/Scoring criteria
A	Preterm birth rate less than or equal to 7.6 percent (HP score less than or equal to 0)
B	Preterm birth rate greater than 7.6 percent, but less than 9.4 percent (HP 2010 score greater than 0, but less than 1)
C	Preterm birth rate greater than or equal to 9.4 percent, but less than 11.3 percent (HP 2010 score greater than or equal to 1, but less than 2)
D	Preterm birth rate greater than or equal to 11.3 percent, but less than 13.2 percent (HP 2010 score greater than or equal to 2, but less than 3)
F	Preterm birth rate greater than or equal to 13.2 percent (HP 2010 score greater than or equal to 3)

To determine the above ranges, an "HP 2010 score" was calculated in 2008 using the following formula: (2005 preterm birth rate – HP 2010 objective) / standard deviation of 2005 state and D.C. preterm birth rates. Scores were rounded to one decimal place.

### Selected Contributing Factors

The March of Dimes has identified and provided geographically-specific data for three selected contributing factors: uninsured women, women smoking and late preterm births. While these important and potentially modifiable factors represent prevention opportunities for consumers, health professionals, policymakers and employers, they do not represent an exhaustive list of contributors to preterm birth. With the momentum provided by the premature birth report card, states and jurisdictions may likely identify and take action to address other potentially modifiable contributors that play an important role in the prevention of preterm birth.

### Status of Contributing Factors

Rates for all contributing factors are rounded to one decimal. Under the status column, changes in rates of contributing factors between the baseline and current year are designated with a star, an X or n/c. A star signifying movement in the right direction indicates a decline in the rates of contributing factors. An X signifying movement in the wrong direction indicates an increase in the rates of contributing factors. No change between the baseline and current year is designated with n/c.



## Connecticut Association of Area Agencies on Aging, Inc.

Testimony – Human Services Committee 3/11/10

Kate McEvoy, Esq., Deputy Director  
Agency on Aging of South Central CT  
(203) 785-8533

### Positions

- C4A cautiously supports Section 6 of Raised House Bill 5411, which seeks to require DSS to apply for an 1115 Medicaid waiver in support of all or part of the state-funded components of the Connecticut Home Care Program for Elders, and to invest proceeds of any such waiver in the Long-Term Care Reinvestment Account toward enhancing provider reimbursement rates. Obtaining federal matching funds in support of Levels 1 & 2 of the CHCPE, which are currently exclusively state-funded, would be of obvious benefit in defraying state expenditures on the program. Also of benefit would be using these matching funds to increase reimbursement to providers of home care services. What remains of concern, however, is that the 1115 waiver process permits the states considerable flexibility in gaining authorization to modify eligibility standards, service array, service delivery methods and payment methodologies (please see p. 2 for additional detail). Any such initiative could therefore pose risks of loss or erosion of coverage to those who are currently eligible for the state-funded component of the CHCPE (please p. 4 for a description of current eligibility criteria and covered services). On this basis, C4A urges the Legislature to consider amending the bill to insert limiting language with respect to preserving eligibility standards and coverage that is at very least comparable to those that are currently in place.
- Further, C4A supports Raised House Bill 5296 with the amendments proposed by the Medical Inefficiency Committee. Related, C4A opposes the Governor's proposal to use a more restrictive definition of "medical necessity" for Medicaid coverage determinations, which would be limited to "reasonable and necessary" or "appropriate" services.

## Capsule Comparison of 1915(c) Medicaid Home and Community-Based Services (HCBS) Waivers with 1115 Medicaid Research and Demonstration Waivers

	<b>1915(c) HCBS Walvers</b>	<b>1115 Walvers</b>
<b>Procedure</b>	Waiver applications/renewals originate in Connecticut with the Department of Social Services. Once application/renewal is prepared, it is forwarded to the legislature for review of the committees of cognizance (procedure outlined in C.G.S.A. Section 17b-8). Application/ renewal is submitted to Centers for Medicare and Medicaid Services (CMS) for approval).	Waiver applications/renewals originate in Connecticut with the Department of Social Services. Once application/renewal is prepared, it is forwarded to the legislature for review of the committees of cognizance (procedure outlined in C.G.S.A. Section 17b-8). Application/ renewal is submitted to Centers for Medicare and Medicaid Services (CMS) for approval).
<b>Permissible Population Groups</b>	Aged, individuals with physical disabilities, individuals with MR/DD, medically fragile/tech. dep. children, individuals with HIV/AIDS, individuals with TBI/SCI	Any experimental, pilot or demonstration project which, in the judgment of the Secretary of HHS is likely to assist in promoting the objectives of Medicaid
<b>Permissible Walvers of Federal Law</b>	<ul style="list-style-type: none"> <li>• Statewideness</li> <li>• Comparability of services (e.g. can include the Medicaid "social services" without expanding to entire Medicaid population)</li> <li>• Income/resource rules</li> </ul>	<ul style="list-style-type: none"> <li>• State plan requirements including eligibility requirements, services, service delivery, and payment methodology</li> <li>• Provides "costs-not-otherwise-matchable" authority (e.g. federal match for populations and/or services that are not typically covered)</li> </ul>
<b>Cost-Neutrality</b>	Required (waiver services must be no more costly than institutional care).	Required (based on projections of what federal costs would have been had there been no waiver; must agree to aggregate or per capita cap on expenditures)
<b>Eligibility Criteria</b>	Income cannot exceed 300% of the Supplemental Security Income (SSI) limit (in 2010, \$2,022 per month).  Individuals must require institutional level of care (hospital, nursing facility or ICF/MR). To some degree, states have latitude in defining functional eligibility based on the above criteria.	Negotiated (eligibility criteria could be more restrictive than standards used under a 1915(c) waiver).
<b>Covered Services</b>	Medicaid "medical services" (e.g. nursing, home health aide) plus an elective array of optional "social services", which includes case management, homemaker, personal care services, psychosocial rehabilitation, adult day care, habilitation, respite care and day treatment. DD waivers also typically include vocational supports, as well as home and vehicle modification.	Negotiated (covered services could be more limited than those provided under a 1915(c) waiver).
<b>Cost-Sharing</b>	States may impose "post-eligibility" cost sharing. In CT, this is known as "applied income", and typically means that after monthly income has been reduced by allowable medical expenses (e.g. Medicare B premium, insurance premiums), the remaining amount in excess of 200% of the FPL (in 2010, \$1,806 per month) must be contributed as cost-sharing.	Negotiated.

## CT Home Care Program for Elders Elder Waiver

### Waiver Information:

**Waiver Type:** 1915(c)  
**Current Enrollment:** 9,386  
**Year First Approved:** 1987 (authorized by C.G.S. Section 17b-342)  
**Waitlist Status:** no wait list for waiver or state-funded personal care assistance pilot; wait list exists for state-funded pilot that funds ALSA services in private MRC's

### Eligibility Criteria:

**Age Range:** 65 and older  
**Functional status:** must be in need of nursing facility care and evidence at least three "critical needs" (critical needs include bathing, dressing, toileting, transferring, eating/feeding, meal preparation, and medication administration)

<b>Income limits effective January 1, 2010:</b>		<b>Asset limits effective January 1, 2010:</b>	
<b>Individual:</b>	\$2,022 per month (300% SSI)	<b>Individual:</b>	\$1,600
<b>Couple:</b>	based on applicant's income	<b>Couple:</b>	starts at \$23,512 (minimum CSPA of \$21,912 + applicant's \$1,600); MCCA rules apply
<b>Comments:</b>	may use a pooled trust; VA "homebound" benefit to surviving spouses is excluded	<b>Exemptions:</b>	MCCA rules apply

### Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based	X	Majority of clients receive services via agencies
Agency + Choice		
Self-Direct	X	Where client does not require care management
PCA	X	A state-funded pilot option for waiver and state-funded clients (2007 legislation removed the 250-person cap).
Other	X	Services can also be provided to 1) residents of state-funded congregate housing; 2) residents of assisted living pilot projects; and 3) up to a statewide total of 75 residents of private managed residential communities who spend down to program limits and require assisted living services

**Covered Services:** adult day care, care management, chore, companion, home health aide, homemaker, home-delivered meals, laundry, mental health counseling, minor home modifications, respite, personal emergency response systems, skilled nursing visits, transportation

**Cost Caps/Cost Effectiveness Standards:** Waiver can pay no more than \$5,598.00 per month per individual (100% of the average monthly Medicaid cost). Within that cap, program can pay for no more than \$3,978.00 per month per individual for social services (all services other than skilled nursing visits and home health aide – the "medical services" covered by Medicaid).

**Cost Sharing Requirements:** Participants must pay applied income over 200% FPL (effective April 1, 2009, 200% FPL = \$1,806 per month; amount is updated each April 1), adjusted for medical expenses (e.g. Medicare Part B premium of \$96.40, medical insurance premiums); legally liable relative may have obligation to contribute.

**To Apply:** Contact DSS Alternate Care Unit at 860-424-4904 and choose option #4 for initial screening and referral to regional Access Agency.

## CT Home Care Program for Elders State-Funded Levels 1 & 2

### Waiver Information:

**Waiver Type:** N/A  
**Current Enrollment:** 5,342  
**Year First Approved:** authorized by C.G.S. Section 17b-342  
**Waitlist Status:** no wait list for Levels 1 or 2 or state-funded personal care assistance pilot; wait list exists for state-funded pilot that funds ALSA services in private MRC's

### Eligibility Criteria:

**Age Range:** 65 and older  
**Functional status:** Level 1: must be at risk of hospitalization or short-term nursing facility placement and evidence one or two "critical needs"; Level 2: must be in need of short or long-term nursing facility care and evidence three or more "critical needs" (critical needs include bathing, dressing, toileting, transferring, eating/feeding, meal prep, and med. admin.).

### Income limits effective January 1, 2010:

**Individual:** none  
**Couple:** none  
**Comments:**

### Asset limits for Levels 1 & 2 effective January 1, 2010:

**Individual:** \$32,868  
**Couple:** \$43,824  
**Exemptions:** UPM 8040.35 follows MCCA rules but does not require spousal assessment.  
**Comments:** Note that as of April 1, 2007, the asset limit for an individual increased to 150% of the minimum CSPA and for a couple to 200% of the minimum CSPA.

### Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based	X	Majority of clients receive services via agencies
Agency + Choice		
Self-Direct	X	Available where a client does not require care management
PCA	X	A state-funded pilot option for waiver and state-funded clients (2007 legislation removed the 250-person cap).
Other	X	Services can also be provided to 1) residents of state-funded congregate housing; 2) residents of assisted living pilot projects; and 3) up to a statewide total of 75 residents of private managed residential communities who spend down to program limits and who require assisted living services

**Covered Services:** adult day care, care management, chore, companion, home health aide, homemaker, home-delivered meals, laundry, mental health counseling, minor home modifications, respite, personal emergency response systems, skilled nursing visits, transportation

**Cost Caps/Cost Effectiveness Standards:** Level 1 can pay no more than \$1,399.00 per month per individual (25% of average monthly Medicaid cost). Level 2 can pay no more than \$2,799.00 per month per individual (50% of average).

**Cost Sharing Requirements:** Except for individuals who reside in an affordable assisted living demonstration project, each participant whose income is at or below 200% of the FPL (effective April 1, 2009, \$1,806 per month; amount is updated each April 1) must make a 15% co-payment and each participant whose income exceeds 200% of the FPL must make a 15% co-payment over and above his/her applied income obligations, if any; legally liable relative may have obligation to contribute.

**To Apply:** Contact DSS Alternate Care Unit at 860-424-4904 and choose option #4 for initial screening and referral to Access Agency.



William F. Sullivan Jr.  
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Chief Executive Officer  
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TESTIMONY REGARDING

HB 5411 – AN ACT CONCERNING MEDICAID

Before the Human Services Committee

March 11, 2010

Senator Doyle, Representative Walker, and members of the Human Services Committee, my name my name is William F. Sullivan, Jr. and I am President & CEO of Visiting Nurse Services of Connecticut, Inc.. I am also Chair of the Board of Directors of the Connecticut Association for Home Care & Hospice (CAHCH).

I am pleased to provide this testimony in support of Section 6 of H.B. 5411, which requires the Department of Social Services to file a Medicaid waiver to convert some, or all, of the state-funded portion of the CT Home Care Program for Elders to Medicaid. This bill would provide a sustainable framework to expand consumer-preferred home care while saving the taxpayer money.

Visiting-Nurse Services of Connecticut just celebrated its 100<sup>th</sup> anniversary providing home care to a wide range of Connecticut citizens in 54 communities. Our non profit agency serves more than 9,700 patients each year from Fairfield, New Haven, and Litchfield counties, including more than 1,700 Medicaid patients. Unfortunately though, inadequate Medicaid rates are threatening our ability to continue with our chartered mission. In the most recently completed fiscal year, VNS of Connecticut lost in excess of \$2.6 million dollars providing care to Medicaid and State funded patients.

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The Board of Directors of my agency is asking difficult questions about how much longer we can continue down this path, as they design our business direction for the future. Our concerns are heightened by the prospect of a 5% Medicaid cut in the Governor's Deficit Mitigation Plan, as well as Medicare cuts in Washington.

The plan for a Medicaid waiver and placement of funds into the Long Term Care Reinvestment Account would create a sustainable mechanism to ensure that funds are available to maximize home care's ability to save the State taxpayer significant money. Last year, the CT Home Care Program for Elders saved State taxpayers over \$100 million by preventing or delaying placement in institutions -- \$2 saved for every \$1 invested. This is a great return on investment for the State.

Finally, I would like to point out that the approach of filing a Medicaid waiver is a vastly preferable way to generate funds than the 15% copayment currently being applied to State funded clients, which has led to concerns among my State funded clients, and could ultimately lead to premature placement in nursing homes.

For all of these reasons, we are pleased to express our strong support for this bill and we urge a Joint Favorable recommendation from this Committee. If appropriately funded, home care does offer valued and measurable solutions to our State's foremost issues --- relief to the budget crisis, and creation of jobs. Thank you.

## Heart Disease and Stroke. You're the Cure.



The Honorable Paul Doyle, Chair  
 The Honorable Toni Walker, Chair  
 Human Services Committee  
 Room 2000, Legislative Office Building  
 Hartford, CT 06106

Good afternoon Senator Doyle, Representative Walker and members of the Human Services Committee. On behalf of the thousands of volunteers of the American Heart Association, it is indeed our privilege to offer a few thoughts on the proposed legislation, House Bill ~~5541~~<sup>5411</sup>, An Act Concerning Medicaid.

The American Heart Association / American Stroke Association is the largest voluntary organization in the world working to reduce disability and death from cardiovascular disease and stroke—the number-one and number-three killers in Connecticut. Tobacco continues to remain the leading cause of death and disease in Connecticut. The American Heart Association is joined today by a handful of anti-tobacco advocates to ask the committee to broaden and clarify the current Medicaid state plan. The AHA would like to see all smoking cessation treatments such as over the counter products (NRT), behavioral counseling and pharmaceutical products be made available to Medicaid recipients.

Connecticut remains only one of four states in the U.S. that do not cover any smoking cessation treatments for Medicaid clients, despite the fact that legislation was passed in 2002 authorizing the Department of Social Services to do so. Approximately 70% of all smokers want to quit, yet many (especially low-income smokers) lack the resources to afford help in doing it. Coverage of comprehensive smoking cessation treatment provides a quick and inexpensive solution to not only reduce smoking among Medicaid recipients and their families' exposure to secondhand smoke, but also will save Connecticut millions of dollars annually.

Smoking Cessation Programs have been proven to be very effective. On average, 27.6 % of smokers who receive both counseling and medications are able to quit. According to the U.S. Centers for Disease Control and Prevention (CDC), tobacco cessation is more cost-effective than other common, covered disease prevention interventions, such as the treatment of hypertension and high blood cholesterol. Connecticut is also now able to extrapolate data coming out of Massachusetts's MassHealth Plan. The DPH/MTCP MassHealth Cessation Study is a first-of-its kind study that shows a dramatic drop in acute health factors within one year of a smoker's access of a barrier-free smoking cessation benefit through Medicaid. Massachusetts now offers a Medicaid cessation benefit that includes all FDA-approved medications to quit smoking and behavioral counseling. A recent pilot study of the benefit reported that 40% of smokers in Medicaid took advantage of the services (75,000 people). Over the two-year study period, 33,000 smokers quit.

Connecticut received about \$500 million annually between the Master Settlement Agreement funds and tobacco tax revenue, even before the additional \$1.00 cigarette tax passed in 2009. A small amount of these funds could pay for this benefit, and in addition, the federal waiver will return 50% of the investment to the state. Anti-tobacco advocacy groups support smoking cessation funding for Medicaid recipients. The lack of comprehensive cessation coverage leaves smokers in our state without clinically proven treatment options when they try to quit.

Helping more Connecticut residents quit remains a top public health priority of American Heart Association. I ask that the committee consider supporting House Bill No. 5411, An Act Concerning Medicaid and the substitute language as submitted by Pat Checko representing the MATCH Coalition.

Joni Czajkowski  
 Sr. Director Government Relations  
 American Heart Association, CT & RI



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**Testimony in Support of Raised House Bill 5411: An Act Concerning Medicaid  
March 11, 2010**

My name is Dr. Pat Checko. I am Chairman of the statewide MATCH Coalition (Mobilizing Against Tobacco for Connecticut's Health). MATCH and its partners support this bill, particularly Section 2 that would finally require the funding for smoking cessation treatment that was first authorized by the legislature in 2002. Thank you for your continuing efforts to provide critical services for those who need them the most and have the least access and voice to obtain them.

The prevalence of tobacco use among adults in Connecticut has decreased by half since the 1960s, but not for low-income populations, such as Medicaid enrollees, who continue to smoke at over twice the rate of the general population (36% vs. 16%) and suffer the health consequences at a higher rate. There are 169,000 adult Medicaid clients aged 19-64 and 61,000 of them are smokers. Like most smokers, they would like to quit.

Years of evaluation have proven that Smoking Cessation Programs are effective. On average, 27.6 % of smokers who receive both counseling and medications are able to quit. Despite this, Connecticut remains only one of four states in the U.S. that do not cover any smoking cessation treatments for Medicaid clients. While state employees and legislators have insurance with smoking cessation benefits, Medicaid recipients do not.

Connecticut's total annual health care costs associated with smoking are nearly \$2 billion in 2008 dollars. The associated health care costs for Medicaid recipients who smoke is more than \$507 million in 2008 dollars, costs primarily borne by Connecticut taxpayers.

Medicaid cessation is a proven success. For example, Massachusetts offers a Medicaid cessation benefit that includes all FDA-approved medications to quit smoking and behavioral counseling. According to a recent pilot study of the benefit, 40% of smokers in Medicaid took advantage of the services (75,000 people). Over the two-year study period, 33,000 smokers quit leading to a 26% decline in smoking prevalence.

In this time of fiscal crisis, it is legitimate to question where funding can be found for these benefits. Connecticut received about \$500 million annually between the MSA funds and tobacco tax revenue, even before the additional \$1.00 cigarette tax passed in 2009. A small amount of these funds could pay for this benefit, and in addition, the federal waiver will return 50% of the investment to the state.

We would like to take this opportunity to recommend some additional language for the proposed legislation. This language is included in the packet and we feel that it would clarify and broaden the tobacco cessation products and services that would be covered under Medicaid, and reduce the barriers to accessing them.

**MOBILIZE AGAINST TOBACCO FOR CONNECTICUT'S HEALTH**

Checko

page 2

One goal of *Healthy People 2010* is to ensure that evidence-based treatments for smokers are available through state Medicaid programs. In addition, the USDHHS Clinical Practice Guidelines, *Treating Tobacco Use and Dependence: 2008* recommends that evidenced based medication and behavioral smoking cessation treatments should be offered as covered services in public as well as private health insurance plans. That means that smoking cessation coverage should be comprehensive including behavioral counseling and both legend and over the counter (OTC) drugs. The proposed language is consistent with the U.S. Public Service Guidelines. Smoking cessation is not a one size fits all treatment. While some smokers can quit with just the benefit of nicotine replacement therapy (NRT), others may need all three components and may need them more than once. So the benefit needs the flexibility to cover one and any combination of modalities.

The language would also increase access for Medicaid clients while maintaining DSS control over utilization, since all therapies would be accessed through a health care provider. For example, DSS currently covers certain OTC drugs including Claritin, a drug that previously required a physician prescription. So there is already a mechanism in place to provide OTC drugs like nicotine patches that were also prescription drugs at one time.

We would be happy to work with the committee on refining language and attempting to estimate the cost of implementing it. All Medicaid recipients should have access to comprehensive smoking cessation therapies because they save lives and money. The Massachusetts MassHealth report noted that 33,000 smokers quit over a two-year period. An individual who quits smoking by age 30 eliminates almost all excess risk associated with smoking, and those who quit by age 50 cut in half their risk of dying in the next 15 years.

Tobacco cessation is among the most cost-effective health interventions. Such treatments are considered the gold-standard of preventive interventions. In addition, tobacco use treatment is more cost-effective than such commonly provided clinical preventive services as mammography, PAP tests, colon cancer screening, treatment of mild to moderate hypertension, and treatment of high cholesterol.

Investing in tobacco prevention and cessation today saves lives and health care costs tomorrow. If this smoking cessation program is as successful as those in other states, and as CT's other smoking cessation efforts, we estimate that there would be 4,107 fewer smokers among Medicaid clients in the first year alone. For every dollar invested, the state can save \$2 - \$3.

The American Legacy Foundation estimated that within five years, Connecticut would see annual Medicaid savings of \$91 million (2005 dollars) with a 50 percent decrease in smoking rates, and \$18 million (2005 dollars) annually in Medicaid savings with a ten percent reduction in smoking.

A comprehensive smoking cessation benefit for Medicaid recipients has widespread support in the community, as evidenced by the number of organizations that have already joined MATCH in urging passage and implementation of this benefit. (See attached letter.)

2010 GENERAL ASSEMBLY SESSION  
HUMAN SERVICES COMMITTEE  
(March 10, 2010)

**SUMMARY:** This proposal would clarify and broaden the tobacco cessation products and services that would be covered under Medicaid

**TEXT:**

Section 17b-278a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

The Commissioner of Social Services shall amend the Medicaid state plan to provide coverage for treatment for smoking cessation ordered by a licensed health care [professional] provider. Only a health care provider who possesses valid and current state licensure to prescribe [such] drugs may order treatment that includes legend drugs. [in accordance with a plan developed by the commissioner to provide smoking cessation services. The commissioner shall present such plan to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations by January 1, 2003, and, if such plan is approved by said committees and funding is provided in the budget for the fiscal year ending June 30, 2004, such plan shall be implemented on July 1, 2003. If the initial treatment provided to the patient for smoking cessation, as allowed by the plan, is not successful as determined by a licensed health care professional, all prescriptive options for smoking cessation shall be available to the patient.] Such treatment shall be consistent with the United States Public Health Service guidelines for tobacco use cessation and shall include legend and over the counter drugs and counseling by a physician, qualified clinician, or a certified tobacco use cessation counselor. The plan shall limit coverage to no more than two treatment plans per beneficiary annually.



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### **Why Comprehensive Smoking Cessation for Medicaid Clients Should Be Funded**

All Medicaid recipients should have access to comprehensive smoking cessation therapies. Such programs would not only save lives, but also provide significant savings to Connecticut's Medicaid program. Based on the experience in other states, we would estimate that there would be 4,107 fewer smokers annually. The MATCH Coalition believes the time for action is now – and so do our members and partner organizations who have signed on to support passage of HB 5411: An Act Concerning Medicaid.

- Connecticut remains only one of four states in the U.S. that do not cover any smoking cessation treatments for Medicaid clients, despite the fact that legislation was passed in 2002 authorizing the Department of Social Services to do so.
- Connecticut's total annual health care costs associated with smoking are nearly \$2 billion in 2008 dollars. The associated health care costs for Medicaid recipients who smoke is more than \$507 million in 2008 dollars, costs primarily borne by Connecticut taxpayers.
- Medicaid recipients continue to smoke at over twice the rate of the general population (36% vs. 16%). There are 169,500 adult Medicaid clients aged 19-64 and 61,000 of them are smokers.
- Smoking Cessation Programs are effective. On average, 27.6 % of smokers who receive both counseling and medications are able to quit. State employees and legislators have insurance with smoking cessation benefits, Medicaid recipients do not.
- Medicaid cessation is a proven success. Massachusetts offers a Medicaid cessation benefit that includes all FDA-approved medications to quit smoking and behavioral counseling. A recent pilot study of the benefit reported that 40% of smokers in Medicaid took advantage of the services (75,000 people). Over the two-year study period, 33,000 smokers quit.
- Connecticut received about \$500 million annually between the MSA funds and tobacco tax revenue, even before the additional \$1.00 cigarette tax passed in 2009. A small amount of these funds could pay for this benefit, and in addition, the federal waiver will return 50% of the investment to the state.
- The American Legacy Foundation estimated that within five years, Connecticut would see annual Medicaid savings of \$91 million (2005 dollars) with a 50 percent decrease in smoking rates, and \$18 million (2005 dollars) annually in Medicaid savings with a ten percent reduction in smoking.

Patricia J. Checko, Dr. P.H., M.P.H.  
Chairman

**MOBILIZE AGAINST TOBACCO FOR CONNECTICUT'S HEALTH**



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**Organizations Supporting Passage of HB 5411: An Act Concerning Medicaid**

CT Chapter of the American Academy of Pediatrics

American Lung Association of New England

American Cancer Society

Campaign for Tobacco-Free Kids

East of the River Action for Substance Abuse Elimination (ERASE)

The Connecticut Cancer Partnership

Connecticut Children's Medical Center

Connecticut Oral Health Initiative

Asthma & Allergy Foundation

ASPIRA

Multicultural Leadership Institute

Urban League of Greater Hartford

National Association of Social Workers, Connecticut Chapter

Connecticut Society for Respiratory Care

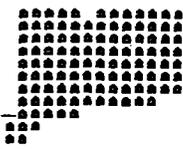
Connecticut Association of Public Health Nurses

Jewish Family Services of Greater Hartford

Catholic Charities, Inc. – Archdiocese of Hartford

CT Voices for Children

**MOBILIZE AGAINST TOBACCO FOR CONNECTICUT'S HEALTH**



TESTIMONY REGARDING

HB 5411 – AN ACT CONCERNING MEDICAID

Before the Human Services Committee

March 11, 2010

Senator Doyle, Representative Walker, and members of the Human Services Committee, my name my name is Brian Ellsworth and I am President & CEO of the Connecticut Association for Home Care & Hospice (CAHCH), whose members serve over 100,000 elderly, disabled, and terminally ill Connecticut citizens.

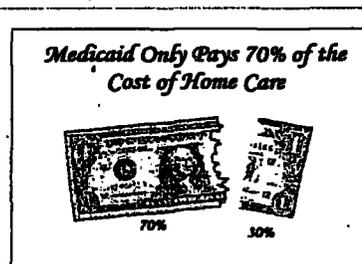
I am pleased to provide this testimony in support of Section 6 of H.B. 5411, which requires the Department of Social Services to file a Medicaid waiver to convert some or all of the state-funded portion of the CT Home Care Program for Elders to Medicaid. The new federal reimbursements obtained from this waiver would be deposited into the Long Term Care Reinvestment Account, to be used to finance future rate increases for home care providers. This initiative is part of the Association's 2010 Legislative Agenda and we are pleased to lend our enthusiastic support for this proposal.

The Governor's Mid-Term Budget adjustments project that the State will spend \$76 million on the state funded portion of the CT Home Care Program for Elders. If clinical and financial eligibility standards are adjusted through a Medicaid waiver and at least half of the otherwise state funded clients could be converted to Medicaid, then approximately \$19 million in increased federal reimbursements annually could be deposited into the Long Term Care Reinvestment Account. In turn, those funds would provide the basis for \$38 million in necessary increases to provider rates at no cost to the General Fund.

The Association strongly believes that this strategy of maximizing federal reimbursements for existing programs will help CT's economy in the short term, as well as "prime the pump" for

rebalancing of the long term care system in favor of cost-effective and consumer-preferred home care. The recently released report on long term care by the CT Regional Institute for 21<sup>st</sup> Century cited a projection that state taxpayers would be saving over \$900 million annually by 2025 if the system was rebalanced. Among that report's recommendations are to: aggressively pursue federal funding and ensure the viability of providers. This legislation is a specific action step that will meet both of those goals.

The important goal of rebalancing the long term care system will not be met without addressing the currently inadequate Medicaid rates for home care providers. Today, the typical home health agency is only paid about 70 percent of its actual costs of care by Medicaid. Unfortunately, home care's ability to make up this shortfall is being reduced as the federal Medicare program is cutting back on the home health reimbursements. The Governor's proposed 5% cut to Medicaid would make this already difficult situation much worse.



The bill's requirement for a waiver provides other benefits as well: it is vastly preferable to the 15% copayment currently being applied to state funded clients, which leads to disruption and premature placement in nursing homes. A waiver could also be an integral part of rationalizing and streamlining the myriad of state programs for persons needing long term care.

For all of these reasons, we are pleased to express our strong support for this bill and we urge a Joint Favorable recommendation from this committee.



VISITING NURSE ASSOCIATION  
OF SOUTH CENTRAL CONNECTICUT, INC.

March 11, 2010

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Testimony in Favor of  
Raised H.B. 5411

From John R. Quinn  
President/CEO

VNA Health Systems/Visiting Nurse Association of South Central Connecticut  
One Long Wharf Drive  
New Haven, CT 06511

Good afternoon Chairman Doyle, Chairman Walker and members of the Human Service Committee. My name is John Quinn, and I am President and CEO of VNA Health Systems which operates the Visiting Nurse Association of South Central Connecticut located in New Haven and CareSource, a private duty service based in Orange. We primarily serve patients and provide Home Care support in Greater New Haven County, the lower Naugatuck Valley and the Milford area. I appear before you today to support section 6 and section 2 of Raised Bill # 5411 "An Act Concerning Medicaid".

**Section 6** will basically maximize federal funding for homecare by submitting a Medicaid Research and Demonstration Waiver under section 1115 of the Social Security Act designed specifically to convert some or all of the State-funded portion of the Connecticut Home Care Program for the Elderly to Medicaid. This waiver could add up to savings from \$15 million to \$30 million annually to the state. These savings would be deposited in the existing Long Term Care Reinvestment Account and serve as the source of rate increase for providers under the Connecticut Home Care Program for the Elderly. It was in 2007 that a Medicaid increase of 3% was given for homecare, with no increase for the past three years.

Let us take advantage of enhanced federal match under the stimulus bill to assure that non profit agencies receive rates that can cover expenses so that organizations like the VNA are able to carry on our services instead of having to close the doors to the poor and underinsured.



*Serving Greater New Haven, Milford, the Shoreline and the Valley*



VISITING NURSE ASSOCIATION  
OF SOUTH CENTRAL CONNECTICUT, INC.

March 11, 2010

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Testimony in Favor of  
Raised H.B. 5411  
Page Two

From John R. Quinn  
President/CEO  
VNA Health Systems/Visiting Nurse Association of South Central Connecticut  
One Long Wharf Drive  
New Haven, CT 06511

**Section 2** allows for Medicaid to provide coverage for treatment for smoking cessation if ordered by a licensed healthcare professional with prescription licensure. I understand that 36% of Connecticut's Medicaid beneficiaries smoke. Many of the patients that we see under the Medicaid program could benefit from a smoking cessation treatment. Part of the Visiting Nurses role is to promote education to patients on the importance of taking their prescription drugs and how to maintain a lifestyle that would help keep them from being re-admitted to the hospital. Many patients including those with chronic heart failure and breathing difficulties would benefit from this coverage under Medicaid. It is time that Connecticut fund this program under the Medicaid State Plan to follow up on the 2006 legislative authorization for the Commissioner of the Department of Social Services to cover smoking cessation services and that Connecticut remove itself from the list of being one of only four states that does not have any cessation coverage in its Medicaid Plan.

Thank you for the opportunity to testify.

Respectfully Submitted,

John R. Quinn  
PRESIDENT/CEO

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*Serving Greater New Haven, Milford, the Shoreline and the Valley*

March 11, 2010

Senator Paul Doyle  
Representative Toni Walker  
Re: HB 5411: An Act Concerning Medicaid

**Why Comprehensive Smoking Cessation for Medicaid Clients Should Be Funded**

Smoking harms nearly every organ of the body. Cigarette smoking causes 87 percent of lung cancer deaths. It is also responsible for many other cancers and health problems. These include lung disease, heart and blood vessel disease, stroke and cataracts. Women who smoke have a greater chance of certain pregnancy problems or having a baby die from sudden infant death syndrome (SIDS).

Non-smokers who breathe in secondhand smoke take in the same toxic chemicals as smokers, and through no choice of their own. The 2006 U.S. Surgeon General's report reached several important conclusions: secondhand smoke causes premature death and disease in children and adults who do not smoke; children exposed to secondhand smoke are at an increased risk of SIDS, acute respiratory infections, ear problems and more severe asthma; immediately effects the heart and blood circulation; over a long period of time also causes heart disease and lung cancer.

As a Registered Nurse in Public Health, a former smoker and a smoking cessation counselor, I have witnessed the negative outcomes of smoking on individuals and families, and the difficulties smokers experience in the quitting and staying quit experience. Smoking cessation programs are effective. On average, 27.6% of smokers who receive both counseling and medications are able to quit. The 2008 Clinical Practice Guidelines recommend that all insurers provide coverage for counseling and medications.

Currently, Connecticut does not cover any smoking cessation treatments in its Medicaid plan. In 2006, the state legislature authorized the Commissioner of the Department of Social Services to cover smoking cessation services for Medicaid recipients but the benefit has never been funded. The CT Medicaid smoking rate is higher than the national average – 36% of Medicaid beneficiaries smoke.

Medicaid recipients should have access to comprehensive smoking therapies. These programs are effective in helping people quit. Not only will lives be saved and chronic diseases decreased, but there would be significant savings to Connecticut's Medicaid program. I strongly encourage you to support passage of HB 5411: An Act Concerning Medicaid

Thank you for your attention,

Monica Wheeler, MSN, RN  
Resident, Fairfield, CT  
President, CT Public Health Nurses Association  
Community Health Director, Westport Weston Health District  
Phone: 203-227-9571, ext. 242  
Email: mwheeler@wwhd.org

Statement of Jeffrey Steinberg, M.D.  
before the  
Human Services Committee  
in support of  
HB 5411

Sen. Doyle, Rep Walker and members of the committee:

My name is Dr. Jeffrey Steinberg and I am the Chairman of Surgery at Saint Francis Hospital and Medical Center. As the Chairman of Surgery, I am responsible for the credentialing standards, medical quality program and educational initiatives of the 35 Podiatrists who practice and the 6 Podiatry Residents who are in training at Saint Francis.

As you are aware, Saint Francis Hospital is a critically important safety net provider for many of the vulnerable underinsured and uninsured citizens of the Greater Hartford area. Saint Francis, as a Catholic Health Ministry, has a long history of providing uncompensated health services for the greater community benefit. In fiscal year 2008, the hospital provided nearly \$40 million of community benefit services, \$36 million of which represented Charity Care and unpaid costs of Medicaid. During this same time period, hundreds of podiatry patients were seen by our podiatry staff and podiatry residents in the Burgdorf Health Center and Center for Advanced Wound Healing on the Mount Sinai Campus; both venues serve a disproportionate share of Medicaid patients. Despite receiving state-of-the-art podiatric and wound care, the current system provides for no reimbursement for our dedicated podiatry providers. These vital clinics are chock full, and because of the lack of care alternatives in the community, many patients unfortunately have to turn to our already over-crowded emergency rooms. As a result, these patients often times are seen in the later stages of their disease, needing more complex and expensive limb salvage treatments because of difficulty accessing podiatrists in the community for more appropriate preventive care.

Given the multiple strains on our already teetering health care system, I strongly urge you to approve HB 5411. Let's use our well trained podiatrists in the State of Connecticut to provide this care in their offices, a much more appropriate and economical venue rather than in our crowded and ultimately more expensive hospital emergency rooms.

Thank you for your kind consideration.

RICHARD BLUMENTHAL  
ATTORNEY GENERAL



55 Elm Street  
P.O. Box 120  
Hartford, CT 06141-0120

Office of The Attorney General  
**State of Connecticut**

**TESTIMONY OF  
ATTORNEY GENERAL RICHARD BLUMENTHAL  
BEFORE THE HUMAN SERVICES COMMITTEE  
MARCH 11, 2010**

I appreciate the opportunity to support the attached amendment to House Bill 5411, An Act Concerning Medicaid.

The attached amendment clarifies the scope of tobacco cessation products and programs that would be covered under Medicaid, requiring the Department of Social Services to implement the program to provide life-saving assistance to the poor.

The amendment -- encouraging thousands of Medicaid beneficiaries to quit smoking -- is a win/win for the beneficiaries and the taxpayers. It provides citizens with better health and saves scarce taxpayer dollars in medical costs.

Smoking kills 4,000 Connecticut residents each year. While adult smoking rates have plummeted from 22.8% in 1999 to 15.9% in 2008, smoking rates among the Medicaid population remains over 30%. Smoking costs Connecticut hundreds of millions of dollars in health care expenses.

It simply makes fiscal and health sense to extend Medicaid coverage to smoking cessation products and programs. Yet, Connecticut is one of only 5 states that do not provide any smoking cessation coverage to their Medicaid population.

Funding should not be a problem. More than \$400 million annually is generated from cigarette taxes and tobacco settlement funds. A small portion of those funds ought to be set aside to assist Medicaid smokers to quit.

Massachusetts has a hugely successful Medicaid program -- more than 35,000 Medicaid smokers have quit. Smoking rates for Medicaid beneficiaries have fallen to 28% from 38% prior to the initiation of the program.

We can -- and should -- implement a similar program here. I urge the committee's favorable consideration of the attached amendment to House Bill 5411.

2010 GENERAL ASSEMBLY SESSION  
HUMAN SERVICES COMMITTEE  
(March 10, 2010)

**SUMMARY:** This proposal would clarify and broaden the tobacco cessation products and services that would be covered under Medicaid

**TEXT:**

Section 17b-278a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2010*):

The Commissioner of Social Services shall amend the Medicaid state plan to provide coverage for treatment for smoking cessation ordered by a licensed health care [professional] provider. Only a health care provider who possesses valid and current state licensure to prescribe [such] drugs may order treatment that includes legend drugs. [in accordance with a plan developed by the commissioner to provide smoking cessation services. The commissioner shall present such plan to the joint standing committees of the General Assembly having cognizance of matters relating to human services and appropriations by January 1, 2003, and, if such plan is approved by said committees and funding is provided in the budget for the fiscal year ending June 30, 2004, such plan shall be implemented on July 1, 2003. If the initial treatment provided to the patient for smoking cessation, as allowed by the plan, is not successful as determined by a licensed health care professional, all prescriptive options for smoking cessation shall be available to the patient.] Such treatment shall be consistent with the United States Public Health Service guidelines for tobacco use cessation and shall include legend and over the counter drugs and counseling by a physician, qualified clinician, or a certified tobacco use cessation counselor. The plan shall limit coverage to no more than two treatment plans per beneficiary annually.



**Testimony of the American Lung Association in Connecticut  
in Support of Raised House Bill No. 5411,  
An Act Concerning Medicaid**

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John J. Votto, DO (New Britain)

March 11, 2010

Human Services Committee  
Room 2000, Legislative Office Building  
Hartford, CT 06106

Dear Senator Doyle, Representative Walker and Honorable members  
of the Human Services Committee:

Thank you for the opportunity to address you today. My name is Dawn Mays-Hardy and I serve as the Connecticut Director of Health Promotion and Public Policy from the American Lung Association. On behalf of the American Lung Association in Connecticut, I am here to ask for your support for Raised House Bill No. 5411, An Act Concerning Medicaid, which provides the long overdue tobacco treatment Medicaid coverage recipients.

Connecticut should be proud of consistently remaining as one of the top ten healthiest states. We have with one of the lowest adult smoking rates at 16% in the nation; however, a desire for health equity must compel us to strive for excellent health outcomes in all populations. Research shows one of the best ways to improve health outcomes and address health disparities is to target the Medicaid population. Like the Medicaid population, smokers are disproportionately represented in lower education, income, and occupational status categories. Nationally, the Medicaid population smokes at a significantly higher rate than the overall population - 32.6 % compared with 20.4 %. Connecticut's Medicaid smoking rate is higher than the national average; 36% of Connecticut Medicaid recipients smoke over twice as high as the state smoking rate.

Comprehensive cessation services especially for our most vulnerable subpopulations in Medicaid must be available. Connecticut recognizes the importance of providing expanded Medicaid medical coverage for pregnant women, but this very important group of young women lack the smoking cessation coverage so many of them urgently need and want. 25% of pregnant Medicaid recipients are smokers and for many years the U.S. Public Health Service has recommended cessation coverage. Pregnant women on Medicaid are 2.5 times more likely than other pregnant women to smoke, according to Medicaid data collected by the Centers for Disease Control and Prevention (CDC).

(over)



**Page 2 of 2**  
**Testimony Supporting HB 5411**

Helping pregnant women to quit smoking would have enormous short and long term health benefits. These include reduced tobacco-related spontaneous abortions, lower rates of low-birth weight infants, fewer admissions to neonatal intensive care units, decreased infant deaths from perinatal disorders, and reduced rates of sudden infant death syndrome.

The next subpopulation that requires special attention in Medicaid is people who suffer with mental illnesses because 41% of people with mental health disorders are smokers. Research proves persons with mental illness can quit and want to quit. Minorities, especially Hispanics, are disproportionately represented in Medicaid population and smoke at higher rates than the State average.

Since 2003, legislation to create a comprehensive smoking cessation program and attach funding for the approximately 61,000 smokers on Medicaid in Connecticut has faltered citing budget deficits. Mere conversations about the issue will not solve the problem. Smoking costs Connecticut almost \$2 billion a year to care for people dying of lung cancer and other tobacco-related diseases. Yet, on the average, as many as two in five Medicaid beneficiaries still smoke. By passing this bill, we can help end this health disparity not only for the Medicaid recipients and save millions of taxpayer dollars in the process.

Connecticut is one of only four states that does not cover any smoking cessation treatments in its Medicaid plan. One New England neighbor, Massachusetts, has already been successful in implementing a comprehensive smoking cessation benefit for Medicaid recipients. Within just two and a half years, the group smoking rate fell 10 percentage points from 38% to 28%. Those who quit showed dramatic reductions in hospitalizations for heart attacks, emergency department visits for asthma, and acute birth complications. It is pass time for Connecticut to take this cost-effective and health promoting step.

I urge you to support Raised House Bill No. 5411, An Act Concerning the Elimination of Certain Department of Social Services Reporting Requirements with the proposed amendments as submitted by the MATCH Coalition.

Thank you.

Dawn Mays-Hardy, MS  
CT Director for Health Promotion and Public Policy  
American Lung Association in Connecticut



CONNECTICUT BUSINESS & INDUSTRY ASSOCIATION

TESTIMONY OF  
PETER M. GIOIA  
VICE PRESIDENT AND ECONOMIST  
CONNECTICUT BUSINESS AND INDUSTRY ASSOCIATION  
SUBMITTED TO THE  
HUMAN SERVICES COMMITTEE  
MARCH 11, 2010  
LEGISLATIVE OFFICE BUILDING  
STATE CAPITOL  
HARTFORD, CONNECTICUT

Good day. My name is Pete Gioia. I am the economist for the Connecticut Business and Industry Association (CBIA). CBIA represents about 10,000 firms, which employ about 700,000 women and men in Connecticut. Our membership includes firms of all sizes and types, the vast majority of which are small businesses with fewer than 50 people.

CBIA would like to comment upon the following bills: HB 5411, and HB 5245. CBIA is encouraged that the committee is calling for bills that will result in the review of high spending areas in the budget. We recommend that these efforts proceed immediately and with great urgency.

HB 5411

CBIA supports efforts to better review and reform the way Long term care services are delivered in the state. Long term care services are vital and serve often the most vulnerable and needy of our citizens. But, a key in sustaining delivery of such services in the difficult budget times is to spend dollars wisely while meeting client preferences. Recently, the Connecticut Institute for the 21<sup>st</sup>-Century released a study of LTC in the state. The study found that clients

prefer home care and alternatives to institutional nursing home care where possible. The state should focus upon providing the right care in the right place at the right price. The executive summary of the study is attached. The full study can be accessed at [http://ctregionalinstitute.files.wordpress.com/2010/02/findings\\_full.pdf](http://ctregionalinstitute.files.wordpress.com/2010/02/findings_full.pdf) . The call for the state to pursue waivers to better allow for CHOICE in LTC is a step in the right directions as it empowers the client, allows for appropriate care at the desired location and ultimately better spends scarce budget dollars. We support this effort.

In addition, we encourage the committee to call for a review of best practices in Medicaid cost savings efforts in other states with a set report date and a set date to begin IMPLEMENTATION of such recommendations. For example, Massachusetts allows for Medicaid coverage of smoking cessation projects and products. Far from being a cost the commonwealth has achieved savings in this area by creating more wellness in the client population and avoiding future costs. While one example it points out that Connecticut needs to catch up with innovation in the field.

#### HB 5245

CBIA supports efforts to increase private nonprofit provision of community living arrangements and other community services. As detailed in the attached STATECOST publication such service provision is appropriate and cost effective. In tough economic times the state needs to more effectively spend limited dollars to sustain services to needy clients. Serious enhancement of privatization in this area is long overdue.

Thank you for the opportunity to present this testimony.

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# CT21

CONNECTICUT REGIONAL INSTITUTE FOR THE 21ST CENTURY

**THE MISSION:** The Connecticut Regional Institute provides continuing opportunities for its members and other organizations to understand and discuss economic activity in the state and obstacles to its success. In 1999, the Institute released a significant study commissioned from the firm of Michael Galis & Associates, Inc. entitled "Connecticut: Strategic Economic Framework." The study defines the real-life economic markets and movement of people, goods, and ideas in the region, the nation, and the world.

The analysis in the Galis study serves as a means for Connecticut residents to

- Develop a stronger network among private and public sector leaders and a leadership structure effective in keeping this region competitive; and
- Identify issues of inter-regional scope and opportunities to strengthen the state and each of its regions as premier places to live, visit and work.

**FOR ADDITIONAL INFORMATION VISIT:**  
[ctrregionalinstitute.org](http://ctrregionalinstitute.org)

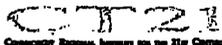
## Framework for Connecticut's Fiscal Future

Part 1: Assessment of Connecticut's Long-Term Care System



A Report of the Connecticut Regional Institute for the 21st Century

001758



The Connecticut Regional Institute for the 21<sup>st</sup> Century (the Institute) was formed in 1997 when public and private leaders in Connecticut came together to exchange ideas about increasing the state's economic growth by viewing Connecticut as part of a dynamic set of systems in the Northeast, not as a "stand-alone" political entity. The group focused on informing policymakers on key issues that hold the most potential for the state's future. Managed by a statewide steering committee, the Institute is incorporated, has not-for-profit tax exempt status, and provides continuing opportunities to discuss and study important issues regarding Connecticut's competitiveness.

- In 1999, the Institute commissioned a significant study by the firm of Michael Galis & Associates, Inc. entitled *Connecticut: Strategic Economic Framework*. The study defines the real-life economic markets and movement of people, goods, and ideas in the region, the nation and the world. That widely-recognized study is seen as a valuable policy framework, continuing to shape the Institute's initiatives.
- In 2003, the Institute turned to the issue of the link between Connecticut's future growth and responsible land use in order to draw connections between economic development, state and local planning, the trend toward sprawl, and preserving our quality of life.
- In 2007, the Institute's latest report, *Economic Vitality & Competitive Cities*, identified key features of successful cities and strategies for making all Connecticut communities attractive and productive, with recommendations for state and local actions to achieve this objective.

### *The Challenge of 2010*

For the past two years the Institute has tracked the state's continuing battle to wrestle with the growing fiscal and economic crisis. The economic downturn has created increased need for public services while sharply reducing state revenues.

The numbers in Connecticut have dramatic implications for the role and costs of government at all levels in the state:

- State budget deficits of \$12 billion to \$20 billion over the next three fiscal years, approximately 20% to 30% of the state's current services spending;

- Unemployment that is just under 9% and job recovery that is expected to be slow;
- Exploding numbers of foreclosures and personal bankruptcies;
- More than \$20 billion in unfunded liabilities for retiree pension commitments and health obligations; and
- Cutbacks to local town and city governments that will cause deficits and potential sharp municipal tax increases.

Our state's elected leaders face difficult decisions as they seek to ensure that Connecticut emerges as a competitive, caring state when the economy improves. The massive federal stimulus package in aid and loans to our state and municipal governments will not solve our structural problems or fully close our vast deficit.

If the state does not deal effectively with the current structural fiscal issues, Connecticut's economic competitiveness is questionable. It is for this reason the Institute decided to take on a series of initiatives to assist the state in addressing the current fiscal and economic crisis.

### *The Institute's Current Mission*

The Institute has resolved to look at elements of spending that account for a significant percentage of the state's budget and where shifts in approaches to service delivery could make a real difference. In doing so, the Institute engaged research firm Blum Shapiro to assist in this effort, asking them to review major budgetary program areas and to:

- Quantify savings that can be realized in the next fiscal cycle and over the long term;
- Identify opportunities to improve service;
- Identify opportunities to increase customer satisfaction; and
- Identify opportunities to increase efficiencies.

For further information about the Institute and its work, visit [www.ctregionalinstitute.org](http://www.ctregionalinstitute.org).

### *Regional Institute Steering Committee:*

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► Consolidate and Integrate State LTC Functions

- Establish consolidated, efficient all-ages, human services approach to LTC in Connecticut that maximizes the impact of Medicaid dollars and Older Americans Act funds.
- Rationale for Change:
  - ⇒ Connecticut has a fractured governance structure for providing administrative and programmatic support to older adults and persons with disabilities. A number of different state departments and agencies are responsible for services and funding for different populations and programs. This organizational complexity poses significant challenges for both consumers and providers of LTC services. Further uncertainty has been created by a legislative mandate to create new Department on Aging.

The Institute believes these recommendations, along with more specific recommendations contained within the report, to be of the highest priority.

The Institute would like to thank the Connecticut Long-Term Care Planning Committee, the University of Connecticut Health Center - Center on Aging, and the Connecticut Commission on Aging for their cooperation. This executive summary was created from the Assessment of Connecticut's Long-Term Care System report, in which appropriate references can be found for source information.

The Institute will look at two or three other areas of state government during 2010. Areas currently under consideration include efforts to reduce recidivism in our state prisons, and increased communal living and daycare services provided by non-profit agencies for the Department of Mental Health and Department of Mental Retardation clients. We encourage you to suggest other areas of state government that could benefit from this type of objective review.



## Summary of Report Findings

This report, entitled *Assessment of Connecticut's Long-Term Care System*, is the first in a series of such efforts that the Institute will undertake in 2010. The goal is to provide political leaders in the Executive and Legislative branches with tools to re-invent Connecticut's approach to state government and delivery of services.

Findings show that Connecticut's Long Term Care (LTC) System is out of balance and in dire need of restructuring if the state is to assist those in need of LTC over the next 15 years while not dramatically increasing costs.

### LONG TERM CARE IS BROAD AND AFFECTS EVERYONE

LTC covers a broad range of paid and unpaid supportive services for persons who need assistance due to physical, cognitive or mental disability or condition. LTC consists largely of personal assistance with the routine tasks of life, as well as additional activities necessary for living independently. Unlike medical care where the goal is to cure or control an illness, the purpose of LTC is to allow an individual to attain and maintain the highest reasonable level of functioning and to contribute to independent living.

### CONNECTICUT MEDICAID EXPENDITURES ON LONG TERM CARE ARE SIGNIFICANT

Providers of LTC include nursing homes (institutions), homes and community based services by formal paid caregivers, and home and community based care by informal caregivers. Informal caregivers are unpaid family and friends who serve as the primary source of LTC.

Medicaid is the primary payer of formal LTC nationally and is the United States' health program for eligible individuals and families with low incomes and resources. It is a means-tested program jointly funded by the state and federal governments, and is managed by the states.

In SFY 2009, Connecticut's Medicaid program spent \$2,498 billion on LTC, accounting for 13% of total expenditures - and the demand for LTC in Connecticut is growing.

Over the next 15 years (2010 to 2025), Connecticut's total population is projected to increase by 3%. Although this increase is modest, there are two additional, extraordinary trends occurring:

- The number of adults between the ages of 18 and 64—the primary, unpaid caregivers of family members—will actually decrease by 5%.
- The number people over 65 years of age will increase by 40% (207,745), due to aging of the Baby Boomer Generation.

The increasing population of residents 65+ years of age and the reduction in number of family members who will care for them will drive a significant increase in demand for LTC in Connecticut. Under the current LTC model in Connecticut, annual Medicaid LTC spending will increase by more than \$3 billion by 2025.

While Connecticut can avoid a significant portion of this cost increase, in order to do so, the LTC system must change. It is fundamentally out of balance. Traditionally, in Connecticut and nationwide, Medicaid has made access to institutional care easier than to home and community-based care, largely the result of federal Medicaid rules and regulations. Consequently, residents who could be properly cared for in their home, and bear some of their room and board costs, are instead directed towards more expensive institutions.

Projections of Connecticut Medicaid Long-Term Care Expenditures by Current and optimal Client Rates of Community and Institutional Care SFY 2009 and SFY 2025.

	Current Client Rate SFY 2009	SFY 2009 Actual Expenditure (billions)	2025 Expenditure with current Client Rate (billions)	Expenditure from 2009 to 2025 (billions)	Optimal Client Rate (A)	2025 Expenditure with optimal Client Rate (billions)	Expenditure from 2009 to 2025 (billions)
Community-based Care	57%	\$ 658	\$2,073	\$1,415	72%	\$2,720	\$2,062
Institutional Care	43%	\$1,840	\$1,774	\$1,142	28%	\$2,010	\$198
<b>Total</b>		<b>\$2,498</b>	<b>\$3,847</b>	<b>\$1,348</b>		<b>\$4,730</b>	<b>\$2,260</b>

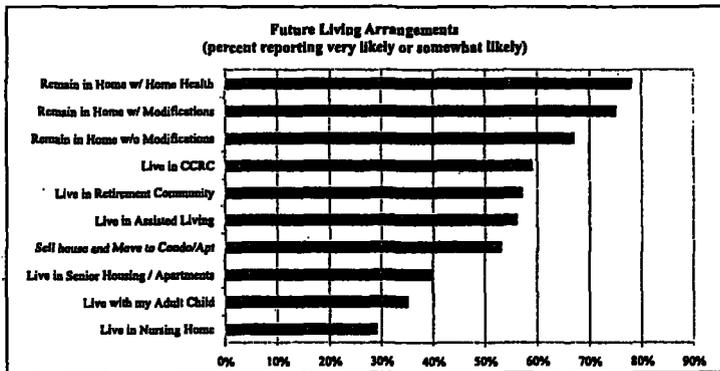
1998 million Annual Cost Avoidance      643 Clientless per.

**CONNECTICUT'S LONG TERM CARE SYSTEM MUST REBALANCE**

"Rebalancing" is the term used to describe efforts to provide recipients of LTC with a greater choice and more options; particularly the expansion of appropriate community and home-based options. Providing greater choice and access will create a more favorable ratio of people receiving home and community based care versus institutional/nursing home care. Currently, the state's system balance is 53% home and community based care and 47% institutional care. Connecticut's stated goal of a more-balanced system is 75% home and community based care and 25% institutional care, which would avoid more than \$900 million in annual LTC costs in 2025, and produce two other major benefits:

- **Connecticut Residents Prefer to Receive LTC at Home**  
The challenges of Connecticut's LTC system and its institutional bias affect much more than the cost of care. Almost 80% of state residents would prefer to continue living in their homes, with home health or homemaker services being provided.
- **Rebalancing can Significantly Slow Growth of LTC Spending**  
On average, Connecticut Medicaid dollars can support more than two older people and adults with physical disabilities in a home and community-based setting for every (one) person in an institutional setting.

	SFY 2009 Medicaid LTC Clients Monthly Average	SFY 2009 Medicaid LTC Expenditures (millions)
Community-based Care	21,275 (53%)	\$ 886 (35.5%)
Institutional Care	18,822 (47%)	\$1,612 (64.5%)
Total	40,097 (100%)	\$2,498 (100.0%)



**REBALANCING IS DIFFICULT**

The Federal Medicaid program was implemented when institutions were the only real care alternative, enabling people to get institutional care as easily as possible. With the growing preference, availability, and cost of home and community based care for LTC, Medicaid adjustments, called waivers, were created to enable home and community based care for people with specific needs. In Connecticut, each LTC waiver is managed separately, creating a challenging environment for persons seeking to learn of and acquire home and community based care when it is appropriate. Implementation of rebalancing requires improvement in the ability of people to acquire home and community based care at a level on par with institutional care, giving people a choice when home and community based care is an appropriate option.

**CONNECTICUT HAS TAKEN STEPS - BUT NOT ENOUGH**

Despite challenges, other states have successfully rebalanced, resulting in ratios today that meet or exceed Connecticut's 2025 goal. Connecticut ranks 34<sup>th</sup> among the states and is below the national average and many New England states in its rebalancing efforts.

*Money Follows the Person*, an important Connecticut Initiative designed to promote personal independence and achieve fiscal efficiencies, was recently funded by the U.S. Centers for Medicare and Medicaid Services and the State of Connecticut as part of a national effort to rebalance LTC systems, according to the needs of all persons with disabilities. Successful early program results show an average monthly cost decrease from \$2,651 for institutional care to \$983 for home and community based care. These early results may not be indicative of all the results as the program expands.

**NOW IS THE TIME FOR LEADERSHIP AND A STRATEGY**

Rebalancing works in other states and has shown good results in Connecticut, but leadership, commitment and an implementation strategy are needed in order to accelerate rebalancing efforts and achieve program goals. We have no choice: the issue is not *how* we achieve this; it is that we *must* achieve it.

The Governor should call for the Legislature to pass legislation that creates a commission to review state government operations, top to bottom, making LTC a top priority.

As part of that review, the Institute recommends:

- ▶ **Provide Strong Leadership**
  - The Governor and the Legislative leadership must make Connecticut's LTC System a priority
  - Rationale for Change:
    - ⇒ LTC affects everyone.
    - ⇒ The system is expensive and will get worse.
    - ⇒ Connecticut is behind other states.
  - Potential Implementation Approaches:
    - ⇒ Appoint a cabinet level position to lead and manage LTC.
    - ⇒ Create and support legislation that does not allow short-term budget pressures to interrupt investments in the LTC system.
    - ⇒ Strengthen OPM's role as a point of coordination for LTC.
    - ⇒ Aggressively pursue additional federal funding.

State	Percent	U.S. Rank
New Mexico	72.9	1
Oregon	72.7	2
Arizona	64.0	3
Maine	51.4	11
Rhode Island	45.6	14
U.S.	41.7	
New Hampshire	39.6	25
Massachusetts	38.7	28
Connecticut	35.5	34

- ▶ **Create a Strategy and Align the LTC System**
  - Under the governor's leadership a LTC strategy must be developed. The implementation of this strategy must align all aspects of the LTC system with the existing statute.
  - Rationale for Change:
    - ⇒ The existing system was created prior to the emergence of HCBS and has a bias towards institutions.
    - ⇒ HCBS capacity must grow to support increasing demand for LTC.
    - ⇒ A comprehensive strategy that incorporates all elements of the system is not apparent.
    - ⇒ The Connecticut LTC Plan has good ideas that are a guide but without accountability for implementation.
  - Key Elements that should be addressed in a Connecticut LTC Strategy are:
    - Organization Structure
    - Clearly Defined Goals
    - Process and Technology

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## There is a better way: Cost-effective social services through nonprofit providers

by Pete Gioia

CBIA Vice President and Economist

The state of Connecticut administers hundreds of programs that provide much-needed and generally high quality services for many people with disabilities and special needs, including children, people with mental illness and intellectual disabilities, former inmates transitioning to society, people with addictions and others. These are people who probably wouldn't survive without some kind of lifeline or safety net, and state government is helping to fulfill its responsibility to care for them.

But these people, and Connecticut's taxpayers, deserve to have much-needed social services provided in a way that can be sustained as cost effectively as possible over time. With the state facing a steep budget deficit, it is critically important to explore every viable option.

Obviously, the state provides quality services for many of its clients. It is startling, however, how much more expensive state-run programs are, compared with the same or similar services provided by nonprofit organizations.

In Connecticut, state-employee caregivers are providing services at double the cost of comparable programs provided by people in nonprofit agencies.

How big is the discrepancy? Here are some examples, according to the latest data (2007) from the state Department of Developmental Services (DDS):

### Community living arrangements for disabled people Annual rates, per client

	Nonprofit Providers	State programs
Average	\$87,221	\$238,624
Low	\$43,800	\$190,924
Median	\$99,278	\$240,228
High	\$158,77	\$250,193

### B. Day programs

Annual rates, per client

	Nonprofit providers	State employee provider
Average	\$20,052	\$85,298

As can be seen, average rates for community living arrangement are 2.7 times higher when provided by state employees vs. nonprofit provider services; worse, rates for day programs are 4.2 times more expensive when the state provides the services.

It's important to note that these nonprofit programs are vigorously monitored by the state agencies that have hired them. Nonprofit agencies would not be providing services under contract to the state if their quality was unacceptable.

What then is the advantage of high-cost state agencies providing these services? Wouldn't the state find exceptional savings for taxpayers if it were to make more use of reputable nonprofit social services providers?

Connecticut also continues to maintain institutional services at four regional facilities at very high rates--even though clients with similar disabilities and needs, who were deinstitutionalized years ago at the Mansfield Training School, are now being served at community-based programs.

Here are annual per-client costs, based on fiscal year 2009 annual interim rates:

**Nonprofit average: \$87,221**

**Southbury Training School: \$347,480**

**West Regional Center: \$266,450**

**North Regional Center: \$268,275**

**South Regional Center: \$386,900**

Again, these programs are costing far more than those being provided by community-based services.

Certainly, any kind of change with such vulnerable clients would need careful planning to make sure people's needs are met. However, these cost discrepancies are so clear and Connecticut's fiscal crisis so enormous that continuing to do business as usual is just fiscally unsound. The state should immediately investigate options to provide quality, lower-cost services.

Ultimately, it comes down to deciding whether we simply want to keep doing things in the same high-cost way, or choosing to make the very best use of taxpayers' dollars. People in Connecticut have already voted, saying in two recent Quinnipiac University Polls that they want state government to become smaller and more effective. This is an area in which the state could start making some significant progress.



To: The Connecticut General Assembly,

From: Alfred M. Vagnini, 1171 Straits Turnpike, Middlebury, CT 06762

Date: March 10, 2010

Re: CGA Bill No. 5399

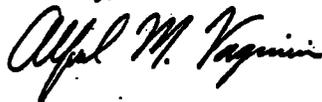
My name is Alfred Vagnini, age 49, and I am a life-long resident of Connecticut. I wish to address the above-referenced Bill regarding repayment for services to the Department of Social Services: Specifically, I want to address the notification of any potential liability to third parties. Below are some facts regarding my particular situation:

- I have one son, Christopher (Hutchinson) Vagnini.
- His mother is Melony Hutchinson.
- Melony and I were never married.
- Christopher was born June 14, 1987.
- I began paying Melony child support in 1988, retroactively from Christopher's birth.
- I paid the court-ordered amount in full until Christopher came to live with me at age 15.
- At that time the order was vacated and I did not seek support from Melony going forward.
- It was upon attempting to refinance my home I found a lien had been placed on my property.
- My attorney looked into the source of the lien and found it to be from the State of CT DSS in an amount in excess of \$11,000.
- I had no idea as to the basis for the lien and when my attorney received the information from DSS, he told me it was to reclaim State assistance monies that had been paid to Melony.
- I had absolutely no knowledge, before or after the fact, of Melony applying for or receiving State assistance or that any potential liability on my behalf existed. As far as I knew, my court-ordered support obligation for my son had been completely fulfilled.

The above summary illustrates the simple fact that, under current law, I am being held liable for a debt of which I had absolutely no knowledge. I cannot think of another example in American life where someone is liable, or even potentially liable for a debt that they are not informed of when it is incurred. This is a disheartening and unsettling prospect. I feel that this practice is unconstitutional and it is my hope that the law could be changed to fairly inform any and all parties of potential liability for repayment to DSS at the time of said liability's inception.

Thank you for the opportunity to address this matter to the lawmakers of our great State and I look forward to seeing this law changed in fairness to all parties involved.

Sincerely,



Alfred M. Vagnini  
203-598-0335  
alvags@mac.com