Written Testimony before the Aging Committee
Department of Social Services
February 6, 2025

Good morning, Chairs Hochadel and Garibay, Ranking Members Hwang and Bolinsky; and distinguished members of the Aging Committee. I am Andrea Barton Reeves, Commissioner of the Department of Social Services. I am pleased to offer remarks on two of the bills on today's agenda.

House Bill 6773: AN ACT ALLOWING TRAINED NURSE'S AIDES AND ASSISTED LIVING AIDES TO ADMINISTER MEDICATION TO NURSING HOME AND ASSISTED LIVING RESIDENTS.

This bill would expand the administration of medication for nursing home residents to additional staff within a skilled nursing facility. While the Department of Social Services (DSS) appreciates the intent to alleviate staffing shortages and costs in nursing facilities, DSS has concerns that this bill, as written, will undermine the Department's goals of quality of care and resident safety.

Specifically, individuals residing in skilled nursing facilities – who are some of our most vulnerable Medicaid members – rely on properly trained and licensed staff to administer medication in a safe and reliable manner. Were this bill to pass, DSS would be concerned that the staff providing such medication would not have the requisite expertise to ensure that the medications are always administered in a safe manner. Proper medication administration requires pharmacologic and medical knowledge to understand potential drug interactions, contraindications, and side effects as well as patient-specific needs for medically complex patients who require a skilled level of care.

With the transition to acuity reimbursement in 2024, nursing homes are now incentivized to care for more complex residents and support right-sizing goals to ensure community settings are available for less complex residents. For example, a residential care home (RCH) is a non-medical setting and supports residents who are more independent. In comparison, a nursing home is considered a medical setting and cares for more acute residents. An RCH may provide services such as prompting residents to take their own medication or assisting with opening medication bottles. However, RCH staff do not administer medication such as topical or injectable medications. If an RCH resident needs more skilled assistance with medication administration, a visiting nurse will provide support to the that resident.

The Department does not have the same level of concern for residents receiving assisted living services or, home health services, because both of those types of facilities are considered community settings. DSS does provide services to a limited number of individuals in assisted living under the Connecticut Home Care Program for Elders (CHCPE) waiver and those services have specific rules around nursing services that would be separate from this bill.

However, residents in a skilled nursing facility are often unable to monitor their medication dosage or schedule. DSS relies on the expertise of a nurse to ensure these vulnerable residents, often taking more complex medications than individuals at an RCH or in a home health setting, are safely taking the appropriate medications and are monitored as needed.

DSS notes that there may be increased cost as a result of increased hospital utilization due to medication errors.

Lastly, the Department believes this bill would have the unintended consequence of fewer nurses available at nursing homes since some of their duties could be delegated to certified nurse aide or non-licensed support staff. Under the current acuity-based reimbursement system, DSS reimburses and supports costs for higher staffing levels such as registered nurses, which lead to better outcomes for member care. This bill would result in a shift in staffing, which runs counter to the Centers for Medicare and Medicaid Services' (CMS) recently issued final rule to increase the availability of nursing staff within nursing homes based on their concern of inadequate skilled nursing staff available. In April 2024, CMS issued a final rule that provides for staggered implementation over the next two years of minimum staffing standards for long-term care (LTC) facilities, including nursing homes, with the goal of improving the quality of clinical care within LTC facilities. The final rule establishes a total nurse staffing standard of 3.48 hours per resident day, which must include at least 0.55 hours per resident per day of direct registered nurse (RN) care and 2.45 hours per resident day of direct nurse aide care. Any combination of nurse staff (RN, LPN or nurse aide may be used to account for the remaining 0.48 hours per resident day. In addition, CMS will also require nursing facilities to have an RN onsite 24 hours a day, seven days a week to provide skilled nursing.

For the reasons stated above, and to ensure continued focus on resident safety and care, particularly in skilled nursing facilities, DSS cannot support this legislation.

HOUSE BILL 6775: AN ACT CONCERNING COST-OF-LIVING ADJUSTMENTS TO LONGTERM CARE FACILITY RESIDENTS' PERSONAL NEEDS ALLOWANCE.

This will provide for annual increases to the personal needs allowance in an amount equal to 25% of the annual cost of living adjustment to Supplemental Security Income.

The Department appreciates the intent and impact of this legislation, but due to the expected costs to implement that are not currently contemplated in the Governor's budget, DSS cannot support this bill at this time.

In 2021, Connecticut increased the personal needs allowance from $60 to $75. Currently, the State of Connecticut's personal needs allowance is as high, or higher, than the majority of the states in the Northeast and is significantly above the federal minimum of $30:

State	Monthly PNA
Connecticut	$75
Maine	40
Massachusetts	73
New Hampshire	74
New Jersey	50
New York	50
Pennsylvania	45
Rhode Island	75
Vermont	80
Northeast Average	$62

DSS expects that raising the personal needs allowance, and indexing it to annual increases, will have significant impacts on the Department's budget. Using data from the past five years, DSS estimates that increasing the personal need allowance would lead to a cost increase of approximately $1.5 million to the Medicaid program in the first year, of which the state share will be approximately $800,000. This cost is expected to increase progressively each year, with an estimated total cost of $22.5 million over the next five years, of which the state share will be approximately $12 million.

For this reason, the Department cannot support this proposal. In addition, it is important to note that most Medicare Advantage plans now offer an over-the-counter benefit, which can be used to purchase common drugstore items that contribute to an individual's health such as toothpaste, vitamins, allergy medicine, cold and flu medication, pain relievers, personal care (sunscreen, face wash, hand sanitizer), nicotine replacement and smoking cessation support, etc. While the amount can vary by plan, the average plan offers $100 per quarter, which is significant.