Key Aspects of Recent Developments in Federal and State Long-Term Care Legislation and Policy

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		Expansion	Contraction
Capsule		In the interest of achieving cost savings and honoring consumer preference, shifting of resources from institutional settings to home and community-based services.	Retraction of more expansive aspects of its long-term care coverage and imposition of increased cost-sharing obligations.
Access to services			
	Eligibility	Medicaid Undue Hardship: An individual or his/her spouse can claim that they should not be penalized for having transferred assets where denial or discontinuance of Medicaid benefits would cause an undue hardship. **Public Act 11-176 [passed by Senate and House as amended, not yet signed by Governor]** reconciles Connecticut's treatment of "undue hardship" with federal law. In summary, the law defines "undue hardship" as a situation in which: • the life or health of an applicant would be endangered by the deprivation of medical care, or the applicant would be deprived of food, clothing, shelter or other necessities of life; • the applicant is otherwise eligible for medical assistance under Connecticut law[1] but for the imposition of the penalty period, • if the applicant is receiving long-term care [LTC] services at the time of the imposition of a penalty period, the provider of LTC services has notified the applicant that such provider intends to discharge or discontinue providing LTC services because of nonpayment; • if the applicant is not receiving LTC services, a provider of services has refused to provide such LTC services due to lack of a payment source; and • no other person or organization is willing and able to provide LTC services to the applicant. The law requires DSS to impose a penalty period pursuant to statute if: • an applicant made a transfer of assets or assignment of assets to deliberately impoverish him or herself in order to obtain or maintain eligibility for medical assistance; or • a transfer of assets or assignment of assets was made by the applicant's legal representative or a joint owner.	Reversion to Minimum Community Spouse Protected Amount (CSPA): Historically, a couple applying for Medicaid coverage of long-term care in Connecticut had to prove out to DSS need for more than the minimum CSPA. For a one-year period commencing July 1, 2010 and ending June 30, 2011, a 2010 law passed by the Connecticut legislature required that the Commissioner of DSS permit the community spouse to receive the **maximum** CSPA. In 2010, the maximum CSPA was $109,560. The 2011 state budget reverted to the prior rule, under which a couple must prove out the need for more than the **minimum** CSPA of $21,912. Resumption of the minimum CSPA rule will become effective July 1, 2011. **[Section 178 of P.A. 11-44]** Treatment of Partial Returns: **Section 104 of Public Act 11-44 [effective July 1, 2011]** amends the applicable Connecticut statute[2] by stating that only a full return of transferred assets will affect a Medicaid penalty period. "An institutionalized individual shall not be penalized for the transfer of an asset if the entire amount of the transferred asset is returned to the institutionalized individual. The partial return of a transferred asset shall not result in a reduced penalty period." Further, the new law: • defines an "institutionalized individual" as an individual who is receiving:

[1] C.G.S.A. § 17b-261

		Expansion	Contraction
Access to services			
	Eligibility	**Medicaid Undue Hardship (cont.)** Notwithstanding, the law mirrors language from another statute section[3] to provide that the penalty period can be waived by reason of the applicant's dementia or having been exploited. These include situations in which: • at the time of the application, the transferor had dementia or other cognitive impairment and cannot explain the transfer or assignment that would cause the penalty period; • the transferor had dementia or other cognitive impairment at the time that the transfer or assignment was made; • the transferor had dementia or other cognitive impairment at the time that the transfer was made and was as a result exploited into making the transfer; or • the applicant's legal representative or the record owner of a jointly held asset made the transfer or assignment without the applicant's authorization. Further, the law establishes procedural requirements for review and determination of whether undue hardship exists. DSS is required issue a preliminary notice to applicant for medical assistance benefits of its intent to deny benefits based on transfer of assets, informing the applicant of his or her right to rebut the presumption that the transfer was made for the purposes of qualifying or to claim undue hardship. The applicant must respond within the following time frames: • where a long-term care provider issues notice of its intent to discharge, to refuse to provide or to discontinue services due to a penalty period, the applicant has 60 days to file an undue hardship claim; and • in all other circumstances, the applicant has an initial 15-day period from receipt of DSS' notice within which to respond. DSS is required to grant one extension of this 15-day appeal period upon request, and, if "reasonable", to grant additional extensions. Failure to claim undue hardship at this stage does not foreclose making a claim by hearing. DSS must provide an interim notice of determination not later than	**Treatment of Partial Returns (cont.)** o services from a long-term care facility; o services from a medical institution that are equivalent to those provided in a long-term care facility; or o home and community-based services under a Medicaid waiver; • requires that if there have been multiple transfers, all transferred amounts, irrespective of recipient, must be returned in order to be considered a full return; • authorizes DSS to review the circumstances under which the transfer and full return of an asset was made to determine the intent of the individual, his or her spouse or his or her legal representative; and o if DSS concludes that the purpose of the transfer and return of the transferred asset was to shift the start of the penalty period or shift nursing home costs, to require DSS to treat the entire amount of the returned asset as available to the individual from the date of transfer; or o if DSS concludes that the purpose of the transfer and return of the transferred asset was for another reason, requires DSS to treat the entire amount of the returned asset as available from the date of return of the transferred asset; and • treats the transfer and subsequent return of a transferred asset as a "trust-like" device that constitutes an available asset for purposes of determining eligibility.

[2] C.G.S.A. § 17b-261a
[3] C.G.S.A. § 17b-261a(c)

		Expansion	Contraction
Access to services			
		Medicaid Undue Hardship (cont.) 10 days after the applicant files the claim, and must issue a final decision within 10 days along with the determination of Medicaid eligibility. The law also permits a nursing facility to submit and requires DSS to accept an undue hardship claim on behalf of a resident where that resident or his her legal representative authorizes the nursing facility to do so. In recognition that an applicant or recipient may not have the capacity to file an undue hardship claim on his or her own, the law also permits a nursing facility to request an extension of time to claim undue hardship if: • the applicant is receiving long-term care in the nursing facility; • the applicant has no legal representative; and • the nursing facility provides certification from a physician that the applicant is according to Connecticut statutory standards for conservatorship of the person and/or of the estate incapable of caring or him or herself or incapable of managing his or her affairs. If these conditions are satisfied, DSS is required to grant an extension of time to permit a representative to be appointed for purposes of filing an undue hardship claim.	**State Assistance for Noncitizens (SMANC):** Consistent with the Connecticut Supreme Court decision in favor of DSS and effective from passage, **Section 118 of Public Act 11-48**, permits DSS to eliminate coverage of most medical services to low-income legal immigrants who have lived in the U.S. for less than five years under the State Medical Assistance for Noncitizens (SMANC) program, but retains coverage for older adults who are: • currently receiving home care services equivalent to those provided under the CHCPE; • receiving nursing home care as of June 30, 2011; or • receiving care and apply for SMANC prior to June 1, 2011.
		Federal Exemption of Tax Refunds: Section 728 of the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (Public Law 111-312) helps low-income individuals by excluding any federal tax refund from counting as income or assets in determining eligibility for any federally-funded public benefit program. This includes state and local programs only partially funded by federal dollars. Tax refunds can include benefits from the Earned Income Tax Credit (EITC), Child Tax Credit (CTC), other tax credits, or refund of a filer's over-withheld income tax. These new rules are effective for 2010 through 2012 and will help people retain Medicaid coverage. Note the following additional details from an information bulletin issued by the Centers for Medicare and Medicaid Services on February 2, 2011: • these protections are applicable only to refunds and advance payments that are received after December 31, 2009 and before January 1, 2013;	

		Expansion	Contraction
Access to services			
		Federal Exemption of Tax Refunds (cont.): • such refunds and advance payments are excluded from eligibility consideration for all federal and federally-assisted programs (including Medicaid) as both income and resources for a period of twelve months after the month in which received; • payment of refunds and advance payments is also not counted: o when determining the eligibility of the individual's spouse or other family member; o as income or resources to individual(s) to whom they are given; • amounts received as refunds or advance payments: o that are transferred by the recipient cannot be treated as a transfer of assets for less than Fair Market Value (FMV); o cannot count as available resource if placed in a trust within twelve months of receipt; and o are not countable as income for purposes of post-eligibility treatment of income provisions applicable to institutionalized individuals.	
		CMS Guidance on Medicaid Eligibility and Home Ownership by Same-Sex Couples In a letter dated June 10, 2011[4], the Centers for Medicare and Medicaid Services (CMS) notified states that they may elect to provide same-sex spouses and domestic partners of long-term care Medicaid beneficiaries certain of the asset protections regarding home ownership that are recognized for opposite sex couples. These include protection from liens, recognition that denial of eligibility for transfer of a home can result in undue hardship, and exemption from estate recovery. Federal law currently provides that liens for medical assistance benefits paid may not be imposed on 1) the beneficiary's spouse (as defined under the federal Defense of Marriage Act, DOMA); 2) a child under the age of 21; 3) children who are blind or have permanent disabilities; or 4) siblings who have equity interest in the home and have been residing in the home for at least one year immediately preceding the date on which the beneficiary was institutionalized.[5] CMS	

[4] *Available at: http://www.cms.gov/smdl/downloads/SMD11-006.pdf*

		Expansion	Contraction
Access to services			
		CMS Guidance on Medicaid Eligibility and Home Ownership by Same-Sex Couples (cont.) describes this as a "floor of protection", and provides that "States can have a policy or rule not to pursue liens when the same-sex spouse or domestic partner of a Medicaid beneficiary continues to lawfully reside in the house." Further, CMS references federal law that exempts both transfers of assets to a beneficiary's spouse or to another person for the spouse's sole benefit[6], and transfers of a home to a spouse[7] , but states that "the exemptions for transferring assets to a spouse cannot be directly applied to same-sex spouses or domestic partners as a result of DOMA." A solution, suggests CMS, is that states can permissively interpret undue hardship[8] to include situations in which denial is based on transfer of a home to a same-sex spouse or domestic partner. Finally, CMS addresses circumstances under which states are required to pursue estate recovery.[9] Federal law currently provides that Medicaid estate recovery can be made only when there is no 1) surviving spouse; or 2) surviving child under age 21 or surviving child who is blind or has a disability. Federal law requires that states implement procedures to waive estate recovery where it would cause undue hardship.[10] Similar to its suggestion concerning treatment of transfer of the home, CMS states that "States have flexibility to design reasonable criteria for determining what constitutes an undue hardship" and that "this may include establishing reasonable protections applicable to the same-sex spouse or domestic partners of a deceased Medicaid recipient."	
	Availability	**CHCPE Open Admission:** The CHCPE continues to be open to intake on a rolling basis, and the 2011 funding level is expected to continue to support open admission.	**Waiver/Pilot Waitlists:** • the legislature did not pass the bill that sought to require DSS to seek a 1915(i) state plan amendment, under which all waiver-eligible individuals would be required to be served as an entitlement • there is no new funding for ABI or PCA waivers or assisted living pilot, all of which remain waitlisted

[5] 42 U.S.C. § 1917(a)(2)
[6] 42 U.S.C. § 1917(c)(2)(B)(i)
[7] 42 U.S.C. § 1917(c)(2)(A)(i)
[8] 42 U.S.C. § 1917(c)(2)(D)
[9] 42 U.S.C. § 1902(a)(18) and 42 U.S.C. § 1917(b)(1)
[10] 42 U.S.C. § 1917(b)(3)

		Expansion	Contraction
Program Structure			

Expansion

Medicare Cost-Sharing Programs (MSP):
Effective October 1, 2009, there was a dramatic expansion in eligibility criteria for the Medicare Cost Sharing Programs (CT calls this Medicare Savings Plan Plus):

Program	Income Limits (singles/ couples)	Covers (2011 figures)
QMB	$1,778.9/ $2,393.55	Part A premium (if applic.) = $248/$450 per month Standard Part B premium = $115.40 per month Annual deductibles = $1,132 hospital, $162 Part B Co-payments
SLMB	$1,959.51/ $2,636.55	Part B premium = $115.40 per month
ALMB	$2,091.67/ $2,816.67	Part B premium = $115.40 per month

Effective 10/1/09, the asset limit for the program was removed and effective 1/1/10, it ceased to be subject to estate recovery. Individuals who qualify for MSP are also eligible for Medicare D "Extra Help" benefits as follows:

- **for individuals with incomes up to 135% of the FPL** (in 2011, individual income ≤ $14,620.50, couple income ≤ $19,669.50) and limited assets (in 2011, less than or equal to $8,180 for an individual, less than or equal to $13,020 for a couple), full subsidy of 1) standard monthly premiums up to the "benchmark" premium amount [in 2011, $33.66 per month];[11] 2) deductibles; 3) drug coverage during the "gap" period, and 4) co-insurance during the catastrophic period.

These individuals remain obligated, depending on income level and unless institutionalized, to make co-pays of $1.10 to $3.30 per prescription.[12]

- **for individuals with incomes greater than 135% of the FPL, but less than or equal to 150% of the FPL** (in 2011 individual income ≤ $16,245, couple income ≤ $21,855) and limited assets (in 2011, less than or equal to $12,640 for an individual, less than or equal to $25,260 for a couple) are eligible for sliding scale assistance with monthly premiums.

These individuals remain obligated to pay a deductible of $63, initial co-insurance of 15% per prescription, and co-insurance of $2.50 per generic/$6.30 per brand name during the catastrophic period.[13]

Contraction

Phase-out of ConnPACE:

Sections 88-90 of Public Act 11-44 [effective 7/1/11] phase out the ConnPACE program for all participants except for approximately 110 individuals who are ineligible for Medicare.

ConnPACE is being phased out because Connecticut has liberalized eligibility standards for the Medicare Cost-Sharing Programs (MSP) to the extent that almost all ConnPACE participants qualify for not only assistance with the out-of-pocket costs of participating in Medicare, but also for the federal Part D "Extra Help" or Low-Income Subsidy (LIS) benefit.

ConnPACE will continue to serve a small number of individuals who are otherwise eligible and who do not qualify for Medicare. Additionally, ConnPACE will accept applications from such individuals as follows:

- within 31 days of their 65th birthdays or within 31 days of qualifying for federal Social Security income benefits, as applicable; or
- during an annual open enrollment period from November 15 through December 31 of each year.

These individuals must meet income eligibility criteria (for an individual, income of less than $25,100 per year/$2,092 per month; for a couple, income of less than $33,800 per year/$2,817 per month) must pay a $45 annual enrollment fee, and must pay $16.25 per prescription, or the actual cost of the drug, whichever is less. Note that there is no asset eligibility limit and that ConnPACE recipients are not subject to estate recovery.

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[11] 42 U.S.C. § 1395w-114(b)(1)
[12] 42 U.S.C. § 1395w-114(a)(1)

		Expansion	Contraction
Scope/mode of services		**New Medicaid Options Related to Federal Health Care Reform:** Effective from passage, **Section 110 of Public Act 11-44** authorizes DSS to establish medical homes (a mechanism for comprehensive care management) for participants of Medicaid (including waivers) who have 1) two chronic conditions; 2) one chronic condition and a risk of developing a second; or 3) a serious and persistent mental health or substance abuse condition. Further, this section permits DSS to implement ACA initiatives an incentive program to prevent chronic diseases, a "mental disease" demonstration program, a dual eligible demonstration program, the Balancing Incentive Payments Program (funds in support of re-balancing goals), and the Community First Choice (personal care assistant) option.	**Retraction of Medicaid Low-Income Adult (LIA) Coverage:** **Section 116 of Public Act 11-44** permits DSS to amend the Medicaid state plan to provide a more restrictive benefit package to individuals eligible for Low-Income Adult (LIA) coverage. This could include limitations on any or all of the following: office visits, therapy, ER services, hospital services, DME, pharmacy, nonemergency transportation and home care).
		Medicaid Podiatry: Effective October 1, 2011, **Section 85 of Public Act 11-44** restores podiatry as a covered Medicaid service. **Medicaid Medication Therapy Management:** Effective July 1, 2011, **Section 143 of Public Act 11-44** requires DSS to contract with a pharmacy organization to offer Medicaid therapy management services, including: • review of medical and Rx history of recipients; and • development of medication action plans to improve care outcomes. **Medicaid Smoking Cessation:** Effective effective January 1, 2012 and July 1, 2011, respectively, **Sections 106 and 107 of Public Act 11-44** remove the requirement that Medicaid smoking cessation treatment be ordered by a health care professional, permitting Medicaid to cover of over-the-counter drugs and counseling in support of smoking cessation.	**Medicaid Vision Coverage:** Effective July 1, 2011, **Section 81 of Public Act 11-44** limits Medicaid non-emergency adult services for "healthy adults" (those age 21 and older for whom there is no evidence that dental disease is an aggravating factor to the individual's overall health condition) to one cleaning, one exam, and one set of x-rays per year. **Medicaid Dental Coverage:** Effective July 1, 2011, **Section 94 of Public Act 11-44** restricts Medicaid coverage for eyeglasses to one replacement pair every other year (as opposed to current restriction of once per year). **Note**, however, that **Section 1 of Public Act 11-48** provides that glasses can be replaced more often where "a Medicaid recipient's health care provider determines that such eyeglasses are necessary because of a change in the recipient's medical condition." **Medicaid Medical Interpreter Coverage:** **Section 85 of Public Act 11-44** further defers implementation of Medicaid medical interpreter coverage until July 1, 2013.

[13] 42 U.S.C. § 1395w-114 (a)(2)

		Expansion	Contraction
Cost-sharing		Historically, the legislature has rejected calls for Medicaid co-payments for medical services and prescription drugs. In 2006, a comprehensive package of prescription drug protections to "wrap-around" Medicare D benefits was enacted.	**Elimination of Coverage for Non-Formulary Drugs:** **Section 178 of Public Act 11-44** repeals various statute sections, including the section that enacted the Medicare Part D Supplemental Needs Fund (§ 17b-265e). In the 2010 session, the Fund, which provided failsafe coverage of non-formulary drugs, was eliminated.
			Nursing Home Residents Personal Needs Allowance Effective July 1, 2011, **Sections 78 and 79 of Public Act 11-44** reduce the Personal Needs Allowance for residents of long-term care facilities from $69 to $60 per month and eliminate the cost-of-living indexing provision.
		In past years, Connecticut used a uniform cost-sharing method ("applied income") for all participants of the CHCPE.	**Cost Sharing for Participants of State-Funded Tiers of CHCPE:** Effective January 1, 2010, participants of the <u>state-funded tiers</u> of the CHCPE were required to make co-payments as follows: except for individuals who reside in an affordable assisted living demonstration project, 1) each participant whose income is at or below 200% of the FPL (in 2010, $1,806 per month) was required make a co-payment equal to 15% of the value of his or her care plan; and 2) each participant whose income exceeded 200% of the FPL was required to make a co-payment of 15% of the value of his or her care plan, and also to continue to pay any applicable applied income obligations. **[Section 66 of Public Act 09-5, effective 10/13/09]** Effective **July 1, 2010**, the co-payment percentage was reduced from **15** to **6%** of the value of each participant's care plan. Effective July 1, 2011**, Section 86 of Public Act 11-44** will increase the co-payment percentage from **6** to **7%** of the value of each participant's care plan. Individuals who fail to make the required co-payment are considered ineligible for services, and are discontinued without prejudice from the program.

		Expansion	Contraction
Consumer Protections			
Note: a bill that sought to require "long-term care facilities" to conducted "criminal history and patient abuse background searches" was not acted upon before the end of the session.		**Notice of Rights and Obligations to Employers of PCA's:** **Public Act 11-230 [passed by Senate and House as amended, not yet signed by Governor]:** • define as a "registries" entities that supply or refer individuals to provide homemaker/companion service on a self-directed basis (either compensated directly by the consumer or considered to be an independent contractor); and • requires issuance of a notice to consumers informing them that they may be considered an employer under law and, if that is the case, may be held responsible for the payment of federal and state taxes and other payments required by law, and may wish to consult a tax professional.	
Note: bills that sought to 1) establish a "senior citizen bill of rights"; 2) expand the permissible duties of a conservator of the person to include authority to draft a disposition of remains form for a conserved person; and 3) adopt the Connecticut Uniform Adult Protective Proceedings Act were not acted upon before the end of the session.		**Penalty for Fraudulent or Malicious Elder Abuse Reports:** **Public Act 11-224 [passed by both Senate and House, not yet signed by the Governor]** makes it a class A misdemeanor, punishable by imprisonment of up to one year, a fine of up to $2,000, or both, to: • wilfully make a fraudulent or malicious elder abuse report to DSS; • conspire with another person to make or cause such a report to be made; or • wilfully testify falsely in any administrative or judicial proceeding arising from a report concerning abuse, neglect, abandonment or need for protective services of an older adult. While the law retains existing provisions that require DSS to interview the putative victim alone unless the individual does not consent or where DSS determines that it is not in the individual's best interests, the law additionally prohibits DSS from interviewing an elderly victim of alleged abuse alone as part of an investigation if a doctor who has examined the individual within 30 days prior or after the date on which DSS receives the report states in writing that is medically contraindicated. Finally, in light of the fact that the law imposes criminal liability, it also eliminates an exception from immunity from civil liability for bad faith and malicious elder abuse reports.	

		Expansion	Contraction
Consumer Protections			
Note: bills that sought to 1) require nursing facilities to establish grievance policies and grievance committees; 2) require nursing facilities to disclose receivership and bankruptcy to applicants and residents; 3) enhance the nursing home bill of rights with additional notice provisions concerning surety contracts; and 4) require nursing facilities to provide training on residents' fear of retaliation, were not acted upon before the end of the session.		**Protections for Hospitalized Nursing Home Residents:** **Public Act 11-236 [passed by House and Senate, not yet signed by the Governor]** amends various aspects of nursing home transfer, bedhold and discharge law. The bill re-defines key terms as follows: "**Transfer**" means movement of a resident from one facility to another facility or institution, including, but not limited to, a hospital emergency department, in which facility or institution a resident is either admitted or receives care for more than 24 hours. "**Discharge**" means movement of a resident from a facility to a non-institutional setting. Also significant is that the bill provides new protection for hospitalized nursing home residents. Where a nursing facility has received notice from a hospital that a resident is medically ready for discharge, but the facility has concerns about its ability to meet the resident's care needs or regards the resident as a danger to him or herself or others, the facility is required as soon as is practicable but not later than 3 days after the nursing facility requests to consult with the hospital, the resident and his/her legal representatives to develop a plan of care and readmission date. This process requires 1) consideration of the resident's wishes and the hospital's recommendations; 2) that the resident's bed be reserved until completion of the consult; and 3) that the hospital participate and disclose medical records in support of the consult. A nursing facility is prohibited from refusing to re-admit a resident except where: • it cannot meet the resident's care needs; • the resident no longer needs a nursing facility level of care because of improvement in his or her health; or • the health or safety of individuals in the nursing facility would be endangered because of the readmission of the resident. Further, the bill provides In situations in which the nursing facility is refusing to re-admit a resident following a hospitalization, DSS is required to hold a hearing within required time frames and has the authority to require the nursing facility to readmit the resident to a semi-private, or if medically necessary a private, room.	

Note also the following <u>structural matters</u>: **Sections 145-146 of Public Act 11-44** defer implementation of the Department on Aging until July 1, 2013. **Section 178 of Public Act 11-44** repeals the statute section that established the Long-Term Care Reinvestment Account. There are no rate increases for home care except for a $4 per day increase in the ADC rate. **Note also the following** <u>**tax matters**</u>: **Sections 84-87of Public Act 11-6** lower the estate and gift tax threshold from $3.5 m. to $2.0 m., and extend the existing 7.2% rate to estates and gifts valued at between $2.0 m. and $3.5 m. **Sections 102-103 of Public Act 11-6** eliminate the sunset of the municipal conveyance tax rate, increase the state conveyance tax by 0.25% and require DRS to deposit revenue from the increase to the state tax into the Municipal Revenue Sharing Account. **Section 110 of Public Act 11-6** establishes an Earned Income Tax Credit (EITC) equal to 30% of the Federal credit.