Public Initiatives That Help Elders and Individuals With Disabilities Remain at Home

Kate McEvoy, Esq.
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Overview

This document is intended to help practitioners to navigate through the complex eligibility requirements for Medicaid and other programs that provide payment for home and community-based services (HCBS). It includes the following:

- an overview of the current policy context;
- a summary of recent developments in federal policy that support Medicaid eligibility;
- a summary of Connecticut state law amendments that affect Medicaid eligibility;
- a summary of applicable Medicaid coverage groups;
- a chart showing Connecticut Medicaid covered services and coverage standards;
- a decisional schema that highlights each of the elements of eligibility;
- detailed summaries of the programs; and
- references to web-based application materials.

Policy Context

Medicaid Funding for Home and Community-Based Services (HCBS)

Generally, Medicaid funding for home and community-based services (HCBS) is very limited, covering only the "medical" home care services (e.g. skilled nursing, home health aide), subject to prior authorization and maximum service levels. Individuals who qualify for "community" Medicaid through "categorically needy" or "medically needy" status receive only the medical home care services in addition to all other Medicaid benefits.

By contrast, Medicaid "waivers", which serve individuals who meet both financial and functional eligibility criteria, provide a much broader array of HCBS. 1915(c) waivers are available to recipients who would, without benefit of waiver services, be institutionalized in a hospital or nursing facility. They are typically targeted to identified populations, which under federal law may include the following: elders, individuals with physical disabilities, individuals with mental retardation or developmental disabilities, medically fragile/technology dependent children, individuals with HIV/AIDS, and individuals with TBI/SCI. Connecticut has received approval from the Centers for Medicare and Medicaid Services (CMS) for seven 1915(c) waivers, serving the groups listed above with the exception of individuals with HIV/AIDS.

Medicaid waivers permit states to receive federal matching funds without complying with standard provisions such as "statewideness", "comparability", and income and resource rules. Further, waivers allow for imposition of enrollment caps to ensure budget neutrality. As a result of enrollment caps, all of the Connecticut waivers except the Connecticut Home Care Program for Elders are waitlisted, meaning that even where an individual can meet all eligibility criteria there is not an available slot in which he or she can be served.

HCBS Options for Residents of Nursing Facilities: Money Follows the Person (MFP)

The Money Follows the Person (MFP) Program offers individuals who may have been inappropriately institutionalized the option to transition back to independent living in the community. Applicants must be age 18 or older, must meet financial and functional eligibility requirements, and must have resided in a nursing facility for a minimum of three (**please note:** change from previous requirement of 6) months. Those found eligible may access the full range of services that are currently offered through the Medicaid "waivers". The latest available data from DSS (June, 2012) indicates that over 1,000 individuals had been transitioned to the community.

Affordable Care Act "Re-Balancing" Initiatives

The Patient Protection and Affordable Care Act[1] includes important new provisions with respect to Medicaid coverage that:

- expand the scope of Medicaid coverage for low-income, non-elderly individuals by giving states the option to cover individuals whose incomes are less than 133% of the Federal Poverty Level;
- authorize use of Medicaid state plan amendments to cover HCBS;
- authorize use of Medicaid state plan amendments to create "medical health homes" for individuals with complex care needs;
- provide an option for states to cover personal care assistance in support of individuals with disabilities who would otherwise require an institutional level of care;

[1] Pub. Law No. 111-148 (signed March 23, 2010)

- provide incentives to increase the proportion of Medicaid expenditures on HCBS: and
- provide incentives for states to cover additional preventative services.

The Department of Social Services has received approval for the first option, covering individuals whose incomes are less than 56% of the FPL under the new "Low-Income Adult (LIA)" program, and is considering its position on the others.

1915(i) Medicaid State Plan Amendment

Federal policy is trending slowly but inexorably toward a less compartmentalized system of Medicaid funding for home and community-based care, but there is some lag of implementation in most states because of budget deficits and concern about the "woodwork" effect of opening up programs to families that have traditionally cared for individuals with disabilities and chronic conditions themselves as opposed to relying on public supports.

Changes in Medicaid law and policy are ultimately expected to yield new coverage models that are based on universal functional eligibility criteria as opposed to age, diagnosis or condition. A means of achieving this result is through use of a 1915(i) Medicaid state plan amendment. The 1915(i) option is not new, but provisions of the federal Affordable Care Act[2] have made it a more attractive vehicle. Under a 1915(i) amendment, states can target specific populations, retain the rule that an individual may have income up to 300% of the Supplemental Security Income (SSI) benefit, and continue to cover a broad range of services, but may not impose enrollment caps and must serve all financially and functionally eligible individuals as an entitlement.

Obviously, this prohibition on capping enrollment is of concern to states facing budget deficits, but advocates have argued that savings associated with diverting individuals from Medicaid-supported nursing facility care and obtaining federal Medicaid match for individuals currently served exclusively through state funding could offset new costs.

In Spring, 2012, DSS submitted an application to CMS to cover participants of the state-funded tiers of the Connecticut Home Care Program for Elders (CHCPE) who were financially eligible for Medicaid but did not meet the nursing home level of care (LOC) requirements for participation in Level 3 (the Medicaid waiver). This will permit approximately 300 individuals, and others with similar profiles who subsequently apply to the program, to qualify for Medicaid coverage of their home and community-based services (HCBS).

[2] Patient Protection & Affordable Care Act (PPACA), Pub. L. 111-148 (signed March 23, 2010); Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. 111-152

Recent Federal Developments that Support Medicaid Eligibility:

Health and Human Services Administration (HHS) Position on Home Ownership by Same-Sex Couples:

Generally, federal Medicaid law treats same sex individuals who are married under the auspices of state law as single individuals for purposes of the Medicaid spousal asset protections that are afforded by the Medicare Catastrophic Coverage Act of 1988 (MCCA).[3] This is because the federal Defense of Marriage Act (DOMA)[4] defines marriage as a legal union between one man and one woman. This is the applicable definition for purposes of federal tax law and benefits, including, but not limited to federal income, gift and estate tax; federal Family and Medical Leave Act (FMLA) leave; federal and private pensions; Social Security dependent and survivors benefits, fringe and survivor benefits for federal employees, and Medicaid MCCA protections for married couples.

In a letter dated June 10, 2011[5], however, 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 homes in which any of the following reside:

- the beneficiary's spouse (as defined by DOMA);
- a child under the age of 21;
- children who are blind or have permanent disabilities; or
- 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.[6]

CMS describes these provisions 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[7], and transfers of a home to a spouse[8], 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 permissively interpret undue hardship[9] to include situations in which denial of benefits based on transfer of a home to a same-sex spouse or domestic partner would deprive the individual of "medical care such that the individual's health of life would be endangered, or the individual would be deprived of food, clothing, shelter or other necessities of life."

Finally, CMS addresses circumstances under which states are required to pursue estate recovery.[10] Federal law currently provides that Medicaid estate recovery can be made only when there is no:

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[3] Pub. L. No. 100-360

[4] Pub. L. No. 104-199, 110 Stat. 2419 (1996)

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

[6] 42 U.S.C.A. § 1917(a)(2)

[7] 42 U.S.C.A. § 1917(c)(2)(B)(i)

[8] 42 U.S.C.A. § 1917(c)(2)(A)(i)

[9] 42 U.S.C.A. § 1917(c)(2)(D)

[10] 42 U.S.C.A. § 1902(a)(18) and 42 U.S.C. § 1917(b)(1)

- surviving spouse; or
- surviving child under age 21 or surviving child who is blind or has a disability.

Notwithstanding, federal law requires that states implement procedures to waive estate recovery where it would cause undue hardship.[11] 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."

Note that consistent with state law, the Connecticut Department of Social Services (DSS) should already recognize the above exceptions. A brief history of this issue traces the evolution of the Connecticut law from recognition of civil union status to marriage equality.

Responding to a request by the Department of Social Services (DSS) for an advisory opinion on how to reconcile state law with the requirements of the Medicaid program, an opinion of the Connecticut Attorney General, dated November 14, 2007, stated that "all civil union partners and civil union families who meet state eligibility requirements are entitled to benefits under state law. The only questions were whether, and to what extent, the state was permitted use federal funds or seek federal reimbursement." The enactment of Connecticut law recognizing same sex marriages on October 1, 2010 converted civil unions to marriages[12] and therefore the opinion is applicable to current treatment of Medicaid eligibility.

The opinion recognizes two options as permissible: either to treat a same sex marriage partner as a "spouse" and to fund any applicable benefit under Medicaid by using only state funds, or to establish a parallel, state-funded program to serve such individuals. DSS elected to treat same sex marrieds as co-equal to other married individuals, and to pay 100% of their costs through state funds. On this basis, it would be consistent for DSS to recognize HHS' suggested guidelines for treatment of same sex couples.

Exemption of Federal Tax Refunds in Tax Years 2010 through 2012:

Section 728 of the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (Public Law 111-312, signed into law by President Obama on December 17, 2010) 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 EIC, CTC, other tax credits, or refund of a filer's over withheld income tax. These new rules are effective for 2010 through 2012 and are helping individuals to qualify for and 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;
- such refunds and advance payments are excluded from eligibility consideration for all federal and federally-assisted program (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:
    - when determining the eligibility of the individual's spouse or other family member;

[11] 42 U.S.C.A. § 1917(b)(3)
[12] P.A. 09-13 § 12(a)

- as income or resources to individual(s) to whom they are given;

- amounts received as refunds or advance payments:

  - that are transferred by the recipient cannot be treated as a transfer of assets for less than Fair Market Value (FMV);
  - cannot count as available resource if placed in a trust within 12 months of receipt; and
  - are not countable as income for purposes of post-eligibility treatment of income provisions applicable to institutionalized individuals.

Note that states have the option under Section 1902(r)(2) of the Social Security Act to disregard both state and local tax refunds and advance payments in the same manner as is the case above for federal payments, but this is not required.

Recent Connecticut State Law Amendments that Affect Medicaid Eligibility:

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 [effective July 1, 2011]** (the Act) reconciles Connecticut's treatment of "undue hardship" with federal law.

In summary, the Act 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[13] 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.

Notwithstanding, the law mirrors language from another statute section[14] 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 has 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 to 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:

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

- 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 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.

Treatment of Partial Returns of Assets:

Section 104 of Public Act 11-44 [effective July 1, 2011] amends the applicable Connecticut statute[15] 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:
  - services from a long-term care facility;
  - services from a medical institution that are equivalent to those provided in a long-term care facility; or
  - 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;

[15] C.G.S.A. § 17b-261a

- 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
    - 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
    - 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.

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 [effective January 1, 2012, $22,728]. Resumption of the minimum CSPA rule became effective July 1, 2011. **[Section 178 of P.A. 11-44]**

Medicaid Coverage Groups

Categorically needy. Individuals who are "categorically needy" receive Medicaid services by reason of poverty and age or disability. Categorically needy individuals must be age 65 or older or must have a disability that meets Social Security criteria. Disability is defined by federal law as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months, or blindness."[16] Income[17] and asset limits effective January 1, 2011 are as depicted (these are updated, but may not change, each January 1):

Region A	Monthly Income Limit	Asset Limit
Individual	$ 888.61	$1,600
Couple	$1,333.92	$2,400

Regions B& C	Monthly Income Limit	Asset Limit
Individual	$ 784.22	$1,600
Couple	$1,228.10	$2,400

Region A includes: Bethel, Bridgewater, Brookfield, Danbury, Darien, Greenwich, New Canaan, New Fairfield, New Milford, Newtown, Norwalk, Redding, Ridgefield, Roxbury, Sherman, Stamford, Washington, Weston, Westport and Wilton. **Regions B & C** comprise the rest of the state.

Categorically needy under special income level. Connecticut has extended categorical eligibility to residents of long-term care facilities and individuals who are receiving Medicaid benefits under a home and community-based waiver. An individual living in the community is eligible under this category where he or she:

- would be eligible for Medicaid if residing in a long-term care facility;
- qualifies for home and community-based services under a Medicaid waiver; and
- would, without such service, require care in a long-term care facility.[18]

The community-based individual remains eligible as long as he or she meets all eligibility criteria and is receiving services under a waiver.[19] To qualify, the individual must have income below 300% of the SSI benefit (in 2012 for an individual, $2,094 per month)[20], and non-exempt assets of $1,600 or less.[21] Working individuals with disabilities can qualify under more liberal income and asset limits[22] (see below).

Medically needy. Medicaid benefits are also available to older adults and individuals with disabilities who are considered to be "medically needy". While these individuals have incomes greater than those permitted for "categorically needy" eligibility, their out-of-pocket expenditures for medical services permit them to "spend-down" to eligibility.[23]

"Medically-needy" status emerged as a concession to the states by the federal government. Historically, Medicaid required participating States to provide medical assistance to persons who received cash payments under one of four welfare programs established by the Social Security Act: Old Age Assistance, Aid to Families with

[16] 42 U.S.C. § 416(i)
[17] U.P.M. § 4530.05 B.2.; U.P.M. § 5520.15 A.2.a.
[18] U.P.M. § 2540.92 A.
[19] U.P.M. § 2540.92 B.
[20] U.P.M. § 2540.92 C.1.; U.P.M. § 5520.15 A.3.b.
[21] U.P.M. § 2540.92 C.2.
[22] U.P.M. § 2540.92 C.3.
[23] C.G.S.A. § 17b-282

Dependent Children, Aid to the Blind, and Aid to Disabled. In 1972, the latter three programs were replaced by a new program: Supplemental Security Income for the Aged, Blind and Disabled. The SSI program continued to require that all recipients would also receive Medicaid services.

Given that eligibility standards for SSI were more lenient, however, the government responded to "woodwork" concerns of states by permitting them to opt out of automatically serving those eligible for SSI. Instead, such states could elect to serve only those who would have been eligible under the Medicaid state plan in effect on 1/1/72. A condition of electing this "209(b) option"[24] was, however, that these states were subsequently required to offer a spend-down option.

Connecticut is a 209(b) state and permits individuals whose income exceeds the established income standards to spend-down to eligibility.[25] Under spend-down, an individual must each six months show out-of-pocket medical expenses equal to or greater than the amount by which his or her income exceeds the income cap.[26] Described another way, Connecticut recognizes that individuals who have high out-of-pocket costs for medical care are effectively as poor as those who can meet the income requirements for categorically needy status.

Medicaid for Low-Income Adults (LIA). Retroactive to April 1, 2010, Connecticut became the first state in the country to receive approval from the Centers for Medicare and Medicaid Services (CMS) to cover a new eligibility group in Medicaid. This coverage, which is called "Medicaid for Low-Income Adults (LIA)", picks up individuals and couples, age 19-64, with income of up to 56% of the Federal Poverty Level (FPL). This was a gain for the state in that this population had previously been covered at 100% state expense under the State Administered General Assistance Program (SAGA) and is now eligible for federal match funds.

Income limits effective June 30, 2010 are as depicted below. Please note that individuals who live in Region A receive an additional income deduction that effective increases the income limit from 56% of the FPL, which is the standard recognized in the bulk of towns, to 68% of the FPL. The program disregards the first $150 per month of earned income, and it is permissible for individuals to "spend-down" to coverage by showing medical expenses that effectively reduce monthly income below the required limits. There is no asset limit for the program, and no recovery from liens on home property. Redetermination is required on an annual, as opposed to a six-month, basis. Regions are the same as those used for categorically needy individuals.

Region A	Monthly Income Limit
Individual	$ 617.44
Couple	$ 833.68

Regions B& C	Monthly Income Limit
Individual	$ 508.48
Couple	$ 686.56

Very significantly, a 2011 amendment to state law[27] authorized DSS to amend the Medicaid state plan to provide a more restrictive benefit package to individuals eligible for Low-Income Adult (LIA) coverage. A section of a law[28] enacted by the Connecticut legislature in 2012 specifically authorizes DSS to:

- reinstate an asset test for eligibility, of $10,000 per individual;
- count family income when determining eligibility (this is intended to address screening of families in which an up to age 26 dependent has qualified for LIA coverage);

[24] 42 U.S.C. § 1396a(f)
[25] U.P.M. § 5520.20 B.5.a.
[26] U.P.M. § 5520.25 B.
[27] Section 116 of Public Act 11-44
[28] Section 26 of 2012 Conn. Legis. Serv. P.A. 12-1

- impose a 90-day cap, per admission, on nursing facility coverage.

Note that if an individual exhausts nursing home coverage for an admission that extends beyond 90 days, he or she will be required to apply for Medicaid long-term care coverage with all associated terms of eligibility.

DSS will seek approval under an 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) for these changes. If CMS approves, the changes are slated to become effective on October 1, 2012, with current beneficiaries asked to provide documentation via self-declaration form and new applicants subject to the new terms.

Medicaid for Working Disabled.[29] Federal law establishes Medicaid coverage for certain working individuals with disabilities.[30] Correspondingly, Connecticut covers three groups of employed individuals with medically certified disabilities or blindness under its MED-Connect Program:

- the Basic Insurance Group (authorized by the federal Ticket to Work and Work Incentives Improvement Act of 1999);[31]
- the Medically Improved Group (authorized by the federal Ticket to Work and Work Incentives Improvement Act of 1999);[32] and
- the Balanced Budget Group (authorized by the Balanced Budget Act of 1997).[33]

The following income and asset criteria are applicable to all three coverage groups. An individual may qualify for the MED-Connect program if he or she has:

- gross income of no more than $6,250 per month ($75,000 per year)[34]; or
- applied income that is less than or equal to $3,082.50 per month after reducing gross income by:
    - a $20 general disregard;
    - a disregard of the first $65 in earnings;
    - income that is needed for disability-related work expenses; and
    - half of the individual's remaining earnings.[35]

Further, an individual must have assets of no more than $10,000, or $15,000 if he or she is part of a married couple that is living together.[36] For purposes of asset eligibility limits, certain retirement accounts and accounts that are maintained for the purpose of increasing the individual's employability are excluded.[37] Generally, participants must pay a monthly premium equal to 10% of their income in excess of 200% of the FPL (effective March 1, 2011, $1,816.00).[38] As between the three coverage groups, the following additional criteria apply:

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[29] C.G.S.A. § 17b-597
[30] 42 U.S.C. § 1396d(a)
[31] U.P.M. § 2540.85 A.
[32] U.P.M. § 2540.85 B.
[33] U.P.M. § 2540.85 C.
[34] U.P.M. § 2540.85 A.2.a.; U.P.M. § 2540.85 B.2.; U.P.M. § 2540.85 C.1.
[35] U.P.M. § 2540.85 A.2.b.; U.P.M. § 2540.85 B.2.; U.P.M. § 2540.85 C.1.
[36] U.P.M. § 2540.85 A.3.a.; U.P.M. § 4005.10 A.5.; U.P.M. § 2540.85 B.2.; U.P.M. § 2540.85 C.1.
[37] U.P.M. § 2540.85 A.3.b.; U.P.M. § 2540.85 B.2.; U.P.M. § 2540.85 C.1.
[38] C.G.S.A. § 17b-597(b)(7); U.P.M. § 2540.85 A.4.a.; U.P.M. § 2540.85 B.2.; U.P.M. § 2540.85 C.1.

Coverage Group	Additional Criteria
Basic Insurance Group	The individual must be between the ages of 18 and 64. Further, he or she must be engaged in substantial and reasonable work, as defined by: • receiving cash remuneration and pay stubs; or • if self-employed, making regular FICA payments; or • out of work through no fault of his/her own (e.g. by reason of a temporary health problem or involuntary termination), in which case coverage extends for up to one year from the date of loss of employment.[39]
Medically Improved Group	The individual must be between the ages of 18 and 64. Further, he or she must meet all of the criteria for coverage under the Basic Insurance Group, have lost eligibility because of a medical improvement that was determined at the time of a regularly scheduled continuing disability review[40]; but continue to have a severe, medically determinable impairment.[41] For this group, substantial and reasonable work effort is defined as earning a monthly wage greater than or equal to forty (40) times the federal minimum hourly wage [in 2012, the minimum federal hourly wage = $7.25]. Unlike individuals covered by the Basic Insurance Group, a Medically Improved Group participant must continue to be employed to receive coverage.[42]
Balanced Budget Act Group	The individual must be age 65 or older. Further, he or she must meet all of the criteria for coverage under the Basic Insurance Group, and must have a medically certified disability or blindness.[43]

[39] U.P.M. § 2540.85 A.1.
[40] U.P.M. § 2540.85 B.1.
[41] U.P.M. § 2540.85 B.3.a.
[42] U.P.M. § 2540.85 B.3.b.
[43] U.P.M. § 2540.85 C.

Medicaid Covered Services

Covered Services. Federal law enumerates a list of mandatory services that each state that elects to participate in Medicaid must cover. These include:

- inpatient hospital care;
- outpatient hospital and FQHC services;
- laboratory and x-ray services;
- nursing facility services for individuals age 21 and older who require daily nursing care or other rehabilitation services that can only be provided in a nursing facility or on an inpatient basis;
- physicians' services;
- medical and surgical services performed by dentists;
- home health services (including durable medical equipment) for individuals eligible for nursing home care; and
- clinic services.

Optional Services. Federal law also identifies an array of optional services that states may elect to cover. Please see below a list of services that are covered under the Connecticut Medicaid program, as well as explanatory notes on coverage criteria.

Service	Sub-service	Prior Authorization Required?	Coverage Limits
Dental Note that a section of a 2012 law[44] passed by the Connecticut legislature requires that prior authorization and service limitations that attach to non-emergency Medicaid dental services apply to each client regardless of how many providers serve them.			
	Comprehensive Exam	No	Limited to one lifetime exam per client; can request an additional exam through prior authorization if client switches providers
	Cleanings	No	Limited to one per year[45] for each "healthy adult", which is defined as a person age 21 or older for whom there is no evidence indicating that dental disease is an aggravating

[44] Section 2 of Conn. Legis. Serv. P.A. 12-1

[45] 2011 Conn. Legis. Serv. P.A. 11-44, Section 81, 2011 Conn. Legis. Serv. P.A.11-61, Section 158

			factor for the person's overall health condition; if a client has a chronic condition that warrants more frequent exams, can request additional through prior authorization
	Crowns	Yes	Limited to anterior teeth upper; fixed bridgework not covered
	Dentures – complete	Yes, for replacement	Limited to one set each 7 years; if dentures are stolen or destroyed by natural
	Dentures – partial	Yes, for replacement	disaster, fire or accident, can request replacement through prior authorization; if lost through misuse, abuse or negligence, dentures will not be replaced; must document the need for replacement, which will not be done for cosmetic purposes
	Exams, periodic oral	No	Limited to one per year for each "healthy adult", which is defined as a person age 21 or older for whom there is no evidence indicating that dental disease is an aggravating factor for the person's overall health condition; if a client has a chronic condition that warrants more frequent exams, can request additional through prior authorization
	Extractions	Yes	
	Fillings		
	Oral surgery	For facial deformities	
	Prophylaxis	No	Limited to one per year for each "healthy adult", which is defined as a person age 21 or older for whom there is no evidence indicating that dental disease is an aggravating factor for the person's overall health condition; if a client has a chronic condition that warrants more frequent prophylaxis, can request additional through prior authorization
	Root canal treatment	Yes, for re-treatment	Not performed if multiple missing teeth or poor outcome
	X-rays	No	Limited to one set of bitewing x-rays per year for each "healthy adult", which is defined as a person age 21 or older for whom there is no evidence indicating that dental disease is an aggravating factor for

			the person's overall health condition
Dialysis		No	Must be medically necessary; provided in home, clinic, hospital, or institution with approved program
Durable Medical Equipment (DME) Items that 1) withstand repeated use; 2) are primarily and customarily used for medical purposes; 3) are generally not useful to individuals who are not ill or injured; and 4) are non-disposable	Non-exclusive list of covered items: wheelchairs and accessories; walking aids (walker, cane, crutches); bathroom equipment; inhalation therapy (IPPB, suction, nebulizers); hospital beds and accessories; enteral/parenteral therapy equipment Medicaid can also pay for repairs and, as approved, replacement	Yes, for some	Must be prescribed by physician; must be received from Medicaid enrolled provider; must meet the definition of DME, as well as be medically necessary and medically appropriate
Hearing Aids/Prosthetic Eyes		No	Must be prescribed after medical evaluation; a Medicaid participating vendor must test and fit; provided to individuals who live at home, in a residential care home, ICF-MR or skilled nursing facility
Home Health	Nursing (direct services including, but not limited to: enemas, dressing changes, treatments, administration and supervision of medication), home health aide (hands on care and assistance with Instrumental Activities of Daily	Yes, request must be made in advance by the agency that will be providing the care for: 1) home health aide service[47]; 2) nursing visits[48]; 3) physical therapy in excess of the initial evaluation and 2	Home Health Certification and Plan of Care (CMS-485) must be signed by a physician Covers home health aide only when providing **"hands on care"**, which is defined as assistance with Activities of Daily Living (ADLs), provided most often, but not exclusively, by home health aides, including prompting and cueing necessary for a client to perform an

[47] Note that Section 13 of 2012 Conn. Legis. Serv. P.A. 12-1 removed the specific numerical caps that were associated with prior authorization for this service.

[48] Note that Section 13 of 2012 Conn. Legis. Serv. P.A. 12-1 removed the specific numerical caps that were associated with prior authorization for this service.

	Living), physical therapy, occupational therapy, speech therapy Note that sections of a law[46] passed in 2012 by the Connecticut legislature that affect but that are not limited to Medicaid 1) permit nurses to delegate administration of non-injectable medication to homemaker-home health aides who obtain medication administration certification; 2) hold RNs who do so consistent with statutory standards harmless from liability; and 3) clarify that the Connecticut Nurse Practice Act does not prohibit homemaker-companion agency affiliated personal care assistants (PCAs) from administering medications to competent adults who direct their own care and make their own decisions pertaining to assessment, planning and evaluation.	visits per week per client; 4) speech-language therapy in excess of the initial evaluation and 2 visits per week per client; 5) occupational therapy in excess of the initial evaluation and 1 visit per week per client; 6) physical, occupational, or speech-language therapy in excess of 9 visits per therapy type per calendar year per provider per client for "mental disorders" and disorders of the spine The initial prior authorization is generally made for a 3 month period, and additional periods of up to 12 months can subsequently be approved The standard for cost effectiveness is that the total expenditure on all services (nursing, HHA, therapies) must be less than the cost of the appropriate level of nursing facility care	ADL; **"Activities of daily living (ADLs)"** include bathing, dressing, toileting, transferring and feeding **"Instrumental activities of daily living (IADLs)"** are defined as any activity related to a person's ability to function in the home, including, but not limited to, meal preparation, housework, laundry, and use of the telephone **"Home"** is defined as a place of residence, including but not limited to, a boarding home, residential care home or Community Living Arrangement, and which does not include a hospital, a nursing facility, a chronic disease hospital, an ICF-MR or other facility that receives an all-inclusive rate paid directly by Medicaid for care of the client
Hospital		Yes for all inpatient	
Independent	Audiology, physical	Yes physical therapy,	Covers one evaluation per year for

[46] Sections 11 & 12 of 2012 Conn. Legis. Serv. P.A. 12-1

Therapy	therapy, speech pathology	audiology and speech and language pathology services in excess of 2 visits, and occupational therapy in excess of 1 visit, per consecutive 7-day period (a calendar week starting Sunday and ending Saturday)	each type; must be provided by a practice that is not part of a hospital outpatient department or clinic; Medicare must be primary, if applicable
Long-Term Care in a Skilled Nursing Facility or ICF-MR		Yes, for bedhold of up to 15 days; for temporary absence for home leave of up to 21 or 36 days per calendar year	All inclusive per diem rate covering nursing, certified nursing assistant, therapy, therapeutic recreation and room and board
Medical Interpreter		To be determined	This service is authorized by statute but has not yet been implemented and was, in 2011, deferred until 2013 by the Connecticut legislature[49]
Medical/Surgical Supplies	Surgical dressings, diabetic supplies, sterile gloves, blood pressure kits, incontinence supplies	Yes for some	Provided for clients at home
Mental Health	Inpatient hospitalization, detoxification at hospital or detox facility, crisis services, day treatment, therapy, methadone treatment, medical evaluation, medications		Must be prescribed by a physician
Transportation	Non-emergency medical trips	Yes, must reserve 48 hours in advance	Must have no other means of transportation; must be to and from Medicaid-covered medical service; must be to provider that is the closest appropriate provider of the service that is being received
Orthotic/Prosthetic Devices	Corrective or supportive devices to: 1) replace a missing portion of the body; 2) prevent or correct deformity or malfunction; 3)	Yes for some	Must be prescribed by a physician; must be provided by a Medicaid-enrolled supplier

[49] 2011 Conn. Legis. Serv. P.A. 11-44, Section 85 amending C.G.S.A. § 17b-28e

	support a weak or deformed body part		
Oxygen Therapy		Yes	Must be prescribed by a licensed practitioner; must be supplied by a Medicaid-enrolled vendor/supplier; will not pay for "as needed" use
Parenteral/Enteral Supplies		Yes for some	Must be prescribed by a physician; for clients at home
Podiatry		No	Podiatry coverage for individuals age 21 and older was restored effective October 1, 2011[50] for medically necessary services performed by enrolled independent podiatrists
Prescription Drugs		Yes, for brand-name drugs and drugs not listed on Preferred Drug List Note that Connecticut law[51] requires: • DSS through its contractor HP to process PA requests from physicians or pharmacists not later than 2 hours after receipt • if the request is not granted or denied within 2 hours of receipt, it is deemed granted • if PA is required but has not been sought by the prescriber or the pharmacist is unable to contact the prescriber at the time that the prescription is presented, the pharmacist is	Does not cover drugs for sexual problems, cosmetic conditions, obesity, drugs that are experimental or enteral nutrition supplements for adults

[50] 2011 Conn. Legis. Serv. P.A. 11-44, Section 85 amending General Statutes § 17b-28e
[51] General Statutes § 17b-491a(b)

		authorized to dispense a one-time 14-day supply • an additional 5-day emergency supply is also available when no PA has been requested by the prescriber and the individual has returned to the pharmacy after depleting the 14 day temporary supply	
Rehabilitation Clinic	Physical therapy, occupational therapy, speech therapy, audiology	Yes, for PT, ST or audiology of 3 or more visits per week and for OT of 3 or more visits per week	Services must be provided by independent clinic; does not cover services in SNF, ICF or ICF-MR
Vision	Eye exam, second opinion, one pair of glasses every two years unless another pair of glasses is determined by a physician to be medically necessary[52] due to a change in the client's medical situation, including, but not limited to, cataract surgery, tumors, stroke, diabetes, or a change in vision acuity by at least 1 diopter since the last prescribed pair Contact lenses are only covered where they provide better management of a visual or ocular condition including,		Must be provided by licensed ophthalmologist, optometrist, or optician; must be provided by Medicaid-enrolled provider; may be provided in office, home, hospital, SNF, ICF, ICF-MR, CDH, RCH, institution or rest home Note that there are no exceptions for replacement of broken, lost, or stolen glass until the two year limitation is met

[52] 2011 Conn. Legis. Serv. P.A. 11-44 , Section 94, 2011 Conn. Legis. Serv. P.A. 11-48, Section 1, both amending C.G.S.A. § 17b-278g

	but not limited to, Unilateral Aphakia, Keratoconus, corneal transplant, or High Anisometropia		

Coverage standards. In order to be covered, a Medicaid service:

- must be medically necessary;
- may be subject to prior authorization requirements;
- must not be unproven, for cosmetic purposes, experimental, of a research nature or for services that are in excess of those deemed medically necessary.

In 2010, the Connecticut legislature enacted legislation[53] that defined "medically necessary" and "medical necessity" more stringently than had been the case historically, as:

> "those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition."[54]

While the Act reinforced that policies and guidelines should be regarded as advisory in nature[55], and not determinative of coverage, there was immediate concern on part of advocates that they would be used in a preclusive manner.

Procedurally, if DSS is denying a request for authorization of coverage for a service based on lack of medical necessity, DSS is required to provide a copy of the guideline or criteria on which its decision is based.[56]

[53] 2010 Conn. Legis. Serv. P.A. 10-3, amending C.G.S.A. § 17b-259b
[54] C.G.S.A. § 17b-259b(a)
[55] C.G.S.A. § 17b-259b(b)
[56] C.G.S.A. § 17b-259b(c)

Decisional schema for matching clients with Connecticut's Medicaid waivers and other sources of support

In light of the fact that Connecticut's current system remains reliant on specific eligibility criteria, practitioners will benefit from using a decisional schema to screen and match clients within the confines of existing approved waivers and other sources of support. There are two elements to this exercise:

- Does the applicant fit the eligibility criteria?
- Will the applicable program meet the applicant's needs?

Decisional schema: age. Historically, Connecticut's Medicaid waiver options required specific adherence to age criteria. Certain programs were limited to individuals age 18 to 64; others served only older adults. While the Connecticut Home Care Program for Elders retains a minimum age threshold (age 65), in past sessions the Connecticut legislature has liberalized age limits for the Acquired Brain Injury (ABI), the Personal Care Assistant (PCA), and Medicaid for Employed Disabled by removing the upper age limit of 64. As a result, each of these waivers now serves individuals age 18 and older.

Decisional schema: citizenship. All of Connecticut's Medicaid waiver options require that an applicant be either a citizen or an eligible non-citizen.[57]

Citizens are defined as:

1) an individual born in the continental United States, Alaska or Hawaii;
2) an individual born in an outlying United States territory including Guam, the Virgin Islands, or Puerto Rico;
3) an individual treated for administrative purposes as a citizen by the Immigration and Naturalization Service (INS), including, but not limited to, those born in American Samoa or the Northern Mariana Islands;
4) a naturalized citizen;
5) a child under the age of 18 whose parents are citizens or who have been naturalized; or
6) an individual who meets specific INS conditions for citizenship, including, but not limited to, an individual born in a foreign country with at least one parent who is a U.S. citizen, a foreign-born spouse of a citizen or a foreign-born child who has been adopted by a citizen.

Eligible non-citizens are defined as individuals who are:

1) lawfully admitted to the U.S. for permanent residence as an immigrant; or
2) permanently residing in the U.S. under color of law (PRUCOL), as determined by the INS, including, but not limited to:
    a. non-citizens who entered prior to January 1, 1972 who have resided in the U.S. continuously since then;
    b. non-citizens who have been granted political asylum by the U.S. Attorney General;
    c. refugees;
    d. parolees admitted at the discretion of the U.S. Attorney General for a definite period of time;
    e. non-citizens residing in the U.S. pursuant to an indefinite stay of deportation;
    f. non-citizens resident in the U.S. pursuant to an indefinite voluntary departure;
    g. non-citizens on whose behalf an immediate relative petition has been approved whose departure the INS does not intend to enforce;
    h. non-citizens who have filed applications for adjustment of status whose departure the INS does not intend to enforce;

[57] U.P.M. § 3005.05

i. non-citizens who have been granted a stay of deportation by court order, statute or regulation, or by determination of the INS, whose departure the INS does not intend to enforce;
j. non-citizens granted voluntary departure whose departure the INS does not intend to enforce;
k. non-citizens granted deferred action status;
l. non-citizens residing in the U.S. under orders of supervision;
m. non-citizens granted suspension of deportation whose departure the INS does not intend to enforce;
n. non-citizens whose deportation has been withheld;
o. any other non-citizens living in the U.S. with the knowledge and permission of the INS whose departure the INS does not intend to enforce.

3) classified by the INS as a newly legalized non-citizen; or
4) a North American Indian born in Canada who has maintained residence in the U.S. since entry and is at least one-half American Indian.

♦ **Practitioners take note:** a non-citizen who does not fall into one of the above categories may qualify for Medicaid benefits if she/he has an emergency medical condition.

Decisional schema: residency. Connecticut residency is also an eligibility requirement of each of the waivers.[58] There is no durational requirement, but an applicant must "intend to remain". This is satisfied where an individual 1) lives in the state not for a temporary purpose; and 2) indicates an intent to remain either permanently or indefinitely within the foreseeable future.

Decisional schema: income. To participate in a waiver, an applicant may have gross monthly income of no more than 300% of the Supplemental Security Income benefit. This amount is updated annually each January 1. In 2012, the monthly income limit is $2,094. Income includes, but is not limited to, wages, pensions, Social Security benefits, Veterans' benefits and Supplemental Security Income. Where an individual with a disability is over income, practitioners should consider use of a pooled trust.

Decisional schema: asset limit for an individual. The asset limit for an individual for the waivers is $1,600. The protections and obligations of the Medicare Catastrophic Act Coverage Act of 1988 (MCCA) apply to the waivers.[59] Generally, assets are treated in the same manner as they would be with respect to an application for nursing home coverage. The applicant/recipient of HCBS services is referred to as the "institutionalized spouse" and his or her wife or husband is referred to as the "community spouse".

Note that where a Connecticut Partnership-approved long-term care insurance policy has paid out benefits, assets equal to that figure may be excluded from the eligibility determination.

Several alternative sources of support are associated with more liberal asset guidelines. These include:

- the state-funded components of the Connecticut Home Care Program for Elders: the asset limit for an individual is 150% of the minimum Community Spouse Protected Amount (CSPA) (in 2012, $34,092.00); the asset limit for a couple (one or both receiving services) is 200% of the minimum Community Spouse Protected Amount (CSPA) (in 2012, $45,456.00);
- the Statewide Respite Program, which permits an individual to have up to $109,000 in liquid assets; and
- the Veterans Administration Aid & Attendance Benefit, which permits an individual to have up to approximately $50,000 in assets, and a couple to have up to approximately $80,000 in assets.

[58] U.P.M. § 3010.05
[59] Pub. Law No. 100-360

Decisional schema: functional criteria. To qualify for the waivers and for certain state-funded supports, an individual must demonstrate not only that s/he meets financial eligibility criteria, but also that he or she has need for assistance. Different methods and descriptors are used to assess functional eligibility for services. Among these are:

- **specific diagnosis or condition**, examples of which include:
    - acquired brain injury (please note: developmental or degenerative disorders do not qualify) (ABI Waiver)
    - mental retardation as defined by statute or Prader-Willi Syndrome (DDS Waivers)
    - "severe disability" (Katie Beckett Waiver)
    - "chronic, severe, permanent disability" (please note: those with mental illness, mental retardation, or dementia do not qualify on that basis) (PCA Waiver)
    - irreversible or deteriorating dementia (Statewide Respite Program);

- **"critical needs"** (CHCPE), which include bathing, dressing, toileting, transferring, eating/feeding, meal preparation, and medication administration;

- **"activities of daily living"** (PCA), which include bathing, dressing, eating, transferring, management of bowel and bladder; and

- **"level of care"** (DMR, Katie Beckett), which refers to the likelihood that the applicant is otherwise in need of care in nursing facility, chronic disease hospital or intermediate care facility.

Another important screening criteria is to assess the extent to which the level of care will adequately support the individual in the community.

Decisional schema: amount of coverage. The waivers cannot pay for 24-hour care. Each is associated with cost caps that reflect a percentage of what would otherwise be expended by Medicaid to support its participants in a nursing facility. In 2012, the monthly Medicaid nursing home reimbursement is $5,798.00.

- ABI: up to 200% [$11,596.00 per month]
- CHCPE Waiver: up to 100% [$5,798.00 per month]
- CHCPE State-Funded: Level 1 up to 25%, Level 2 up to 50% [$1,450.00 per month, $2,899.00 per month]
- Katie Beckett: up to 100% [$5,798.00 per month]
- PCA: percentage based on degree of impairment

The DDS waivers also impose cost caps on specific services such as specialized equipment, physical modifications to home. Further, the DDS Individual and Family Support Waiver permits expenditures of no more than $50,000 per individual annually.

The VA Aid & Attendance benefit is calculated by deducting out-of-pocket medical expenses from income and then calculating the difference between that figure and the maximum income amount.

Generally, care provided under the waivers cannot replace care provided by family members.

Decisional schema: type of coverage. Each waiver specifies a list of covered services and generally cannot deviate from these to accommodate individual needs. The most limited waiver is PCA, which provides only personal care assistant services and emergency response systems; the most expansive, those associated with DDS.

Cost sharing. It is also critical to take note of any applicable cost sharing obligations that will be borne by recipient of service.

Under the waivers, a participant whose monthly income, adjusted for medical expenses (e.g. Medicare Part B premium of $99.90 in 2012, Medigap premium), exceeds 200% of the Federal Poverty Level (FPL) (effective March 1, 2012, $1,862), must pay "applied income" of the excess. Please see p. 27 for an explanation of this calculation.

"Legally liable" relatives (spouses) may have an obligation to contribute toward the cost of care. This determination is made by DSS. First, DSS calculates the "community spouse's" LLR contribution by:

1) reducing the community spouse's adjusted net income from the previous tax year by 200% of the Federal Poverty Level (effective March 1, 2012, $1,862);
2) multiplying the result by .25; and
3) further reducing the resultant sum by the dollar value of any additional support (e.g. out-of-pocket costs of medical supplies, costs of special diet or transportation, home adaptation) that is provided by the community spouse to the applicant spouse.

DSS then compares the resultant figure with the community spouse's monthly maintenance needs allowance (MMNA). The minimum MMNA effective July 1, 2011 is $1,838.75. This amount is revised each July 1. The required contribution is amount by which the community spouse's monthly income exceeds the MMNA, or the actual amount of the LLR, whichever is less.

Decisional schema: assignment/recovery. By applying for Medicaid benefits, an individual automatically assigns to the State any rights and claims to third-party reimbursement of services.[60] This includes claims against an insurer, a contract, other federal or state program and responsible third party. The department's claim is the lesser of the amount of Medicaid benefits paid by the department or the amount owed under the right or claim.[61]

Regulations provide that recovery will be made in certain circumstances for individuals who were age 55 and older when they received home and community-based Medicaid services.[62] Recovery from real or personal property is made only:

- after the death of the individual's surviving spouse; and
- where the individual has no surviving child who is under the age of 21 or who is either blind or has a disability.[63]

[60] U.P.M. § 7505.10 A; U.P.M. § 7520.10 A
[61] U.P.M. § 7505.10 B
[62] U.P.M. § 7525.10 A
[63] U.P.M. § 7525.10 B

Acquired Brain Injury Waiver

Waiver Information:

Waiver Type:	1915(c)
Enrollment Capacity:	369
Current Enrollment:	369
Year First Approved:	1997 (authorized in 1995 by C.G.S. Section 17b-260a)
Waitlist Status:	waitlisted; 63 as of January, 2012

Eligibility Criteria:

Age Range: 18 and older (2006 legislation removed upper age limit)

Functional status: must have acquired brain injury (developmental and degenerative disorders do not qualify) and meet the "level of care" requirement of otherwise needing care in a nursing facility, chronic disease hospital or an intermediate care facility

Income limits effective January 1, 2012:

Individual:	$2,094 (300% SSI)
Couple:	based on applicant's income
Comments:	can use a special needs trust; those eligible for Medicaid for Working Disabled not subject to income and asset restrictions

Asset limits effective January 1, 2012:

Individual:	$1,600
Couple:	MCCA rules apply
Exemptions:	MCCA rules apply (ex. primary residence, vehicle needed for employment or medical visits or modified for use of individual with disability)

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

METHOD		COMMENTS
Agency-Based		
Agency + Choice		
Self-Direct	X	Caregiver must be 18 or older, and may not be 1) spouse of client; 2) parent of client (if client is age 21 or younger); 3) the conservator of the client; or 4) related to a client's conservator.
Other		

Covered Services: case management, personal care assistance, homemaker, chore services, companion, home-delivered meals, respite care, vocational supports, housing supports, home and/or vehicle modification, personal emergency response systems, transportation, supported employment, specialized medical equipment and supplies

Cost Caps/Cost Effectiveness Standards: Waiver pays up to 200% of average monthly Medicaid nursing facility cost (in 2012, $11,596.00 per month) depending on the level of institutional care the individual would otherwise require.

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective March 1, 2012, 200% FPL = $1,862 per month; amount is updated each March 1), adjusted for medical expenses; legally liable relative may have obligation to contribute – see page 27.

To Apply: Download application from this link: http://www.ct.gov/dss/lib/dss/pdfs/w1130ABIRequestForm.pdf

Kate McEvoy, Esq.
July, 2012

CT Home Care Program for Elders Medicaid 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; Private Assisted Living Pilot is waitlisted

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)

Income limits effective January 1, 2012:		**Asset limits effective** January 1, 2012:	
Individual:	$2,094 per month (300% SSI)	**Individual:**	$1,600
Couple:	based on applicant's income	**Couple:**	effective July 1, 2011, based on P.A. 11-44, $24,328 (minimum CSPA of $22,728 + applicant's $1,600)
Comments:	may use a pooled trust; VA "homebound" benefit to surviving spouses is excluded		MCCA rules apply
		Exemptions:	MCCA rules apply

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

METHOD		COMMENTS
Agency-Based	X	Majority of clients receive services via agencies
Self-Direct	X	Where client does not require care management
PCA	X	See guidelines on pages 29-30
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, personal care assistants, and adult family living[64].

Cost Caps/Cost Effectiveness Standards: Waiver can in 2012 pay no more than $5,798.00 per month per individual (100% of the average monthly Medicaid cost). Within that cap, program can in 2012 pay for no more than $4,120.00 per month per individual for social services (all services other than skilled nursing visits and home health aide).

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective March 1, 2012, 200% FPL = $1,862 per month; amount is updated each March 1), adjusted for medical expenses (e.g. Medicare Part B premium of $99.90, medical insurance premiums); legally liable relative may have obligation to contribute – see page 27.

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

[64] 2012 Conn. Legis. Serv. P.A. 12-104

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; Private Assisted Living Pilot is waitlisted

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, 2012:
Individual: none
Couple: none
Comments:

Asset limits for Levels 1 & 2 effective January 1, 2012:
Individual: $34,092 (this equals 150% of min. CSPA)
Couple: $45,456 (this equals 200% of min. CSPA)
Exemptions: UPM 8040.35 follows MCCA rules but does not require spousal assessment or look-back

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	See guidelines on pages 29-30
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 and (operationally effective June 25, 2010) personal care assistants.

Cost Caps/Cost Effectiveness Standards: Level 1 can in 2012 pay no more than $1,450.00 per month per individual (25% of average monthly Medicaid cost). Level 2 can in 2012 pay no more than $2,899.00 per month per individual (50% of average).

Cost Sharing Requirements: 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 (effective March 1, 2012, $1,862.00 per month; amount is updated each March 1) must effective July 1, 2011 make a co-payment equal to **7%** of the cost of his or her monthly care plan; and 2) each participant whose ~~income exceeds 200%~~ of the FPL must continue to pay applied income obligations, if any, and must also make a co-payment equal to **7%** of the cost of his or her monthly care plan. **Note:** cost share increased July 1, 2011 from 6 to 7% per **Public Act 11-44**. Legally liable relative may have obligation to contribute – see page 27.

Still in Effect

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

Kate McEvoy, Esq.
July, 2012

DEPARTMENT OF SOCIAL SERVICES
CONNECTICUT HOME CARE PROGRAM FOR ELDERS (CHCPE)
Effective January 1, 2012

Service Level	Description	Functional Need	Financial Eligibility	Care Plan Limits	Funding Source
Category 1	Limited home care for moderately frail elders	At risk of hospitalization or short term nursing home placement (1 critical need deficit)	Individual Income = no limit Assets: Individual = $34,092 Couple = $45,456	<25% NH Cost ($1,450.00/mo)	STATE
Category 2A	Intermediate home care for very frail elders with some assets above the Medicaid limits	In need of short or long term nursing home care	Individual Income = no limit Assets: Individual = $34,092 Couple = $45,456	<50% NH cost ($2,899.00/mo)	STATE
Category 3	Extensive home care for very frail elders who would otherwise be in a nursing home on Medicaid	In need of long term nursing home care (deficits in 3 critical need areas or ADLs)	Individual Income = $2,094/month Assets: Individual = $1,600 Couple = (both as clients) = $3,200 (one as client) =$24,328	100% NH Cost ($5,798.00/mo) (Social Services cap = $4,120.00)	MEDICAID (state/federal)

Notes:

1. Clients with incomes of $1,816.00 (this is updated March 1 of each year) and above are required to contribute to the cost of their care.
2. There is no income limit for the State-Funded levels. The Medicaid Waiver income limit equals 300% of SSI.
3. Services in all categories include the full range of home health and community-based services.
4. Care plan limits in all categories are based on the total cost of all state-administered services.
5. Some individuals may be functionally eligible for either category 1 or 2 services and financially eligible for Medicaid. In such cases, home health services will be covered by Medicaid and other community-based services covered through state funds.
6. **Effective July 1, 2011, based on Public Act 11-44, the $24,328 asset limit reflects an assumption of minimum CSPA of $22,728 plus applicant's $1,600.**
7. Functional need is a clinical determination by the Department concerning the applicant's critical need for assistance in the following areas: bathing, dressing, toileting, transferring, eating/feeding, meal preparation and medication administration.
8. Care plan cost limits are for CHCPE fee-for-service only.

Kate McEvoy, Esq.
July, 2012

Applied Income Methodology:

Applied income is calculated in a two-step process: the first step is completed by the Access Agency, and the second by the Alternate Care Unit of DSS.

Access Agency Initial Calculation: The formula for the first calculation follows below. Please note that the figures that are listed are effective for the calendar year 2012 and:

- that the Personal Needs Allowance (PNA), which equals 200% of the Federal Poverty Level (FPL), updates each March 1; and
- the Medicare Part B premium figure updates each January 1.

Applied Income Initial Calculation:

gross monthly income	$
less Personal Needs Allowance	$ 1,862.00
less Medicare Part B monthly premium	$ 99.90
approximate Applied Incv ome amount	$
less any other monthly medical expenses	$
= adjusted approximate Applied Income	$

Alternate Care Unit Calculation:

adjusted approximate Applied Income (from above)	$
less Community Spousal Allowance (CSA) (if applicable)	$
less Community Family Allowance (CFA) (if applicable)	$
final Applied Income	$

"Legally Liable" Relative Methodology:

"Legally liable" relatives (spouses) may have an obligation to contribute toward the cost of care. This determination is made by DSS. First, DSS calculates the "community spouse's" LLR contribution by:

1) reducing the community spouse's adjusted net income from the previous tax year by 200% of the Federal Poverty Level (effective March 1, 2012, $1,862);
2) multiplying the result by .25; and
3) further reducing the resultant sum by the dollar value of any additional support (e.g. out-of-pocket costs of medical supplies, costs of special diet or transportation, home adaptation) that is provided by the community spouse to the applicant spouse.

DSS then compares the resultant figure with the community spouse's monthly maintenance needs allowance (MMNA). The minimum MMNA effective July 1, 2012 is $1,891.25. This amount is revised each July 1. The required contribution is amount by which the community spouse's monthly income exceeds the MMNA, or the actual amount of the LLR, whichever is less.

DSS Information Bulletin on the Use of Pooled Trusts:

♦ **Practitioners take note:** A bulletin issued by the Centers for Medicare and Medicaid Services (CMS) dated May 12, 2008 stated that transfers to (d)(4)(C) trusts by individuals age 65 and older may be subject to penalty for transfer of assets for less than fair market value.

In response, the Connecticut Department of Social Services issued an Information Bulletin, No. 09-02, on April 15, 2009 indicating:

- that it had interpreted the CMS bulletin to read that "exemption from the transfer of assets rules applies only to disabled individuals **under the age of 65** who transfer assets into a pooled trust";
- that individuals with disabilities may, however, continue to make transfers of assets (defined by federal law as including income or assets or both) into pooled trusts without penalty if:

    - such transfers are made exclusively for reasons other than qualifying for Medicaid;
    - the individual receives, or is expected to receive, fair market value (FMV) for the transfer;
    - the individual transfers an amount that is less than one day's stay in a long-term care facility at private pay rates [through June 30, 2008, $311.14; this changes each July 1]; or

      DSS example: Mr. Jones, age 65 and disabled, is applying for Medicaid under the CHC [sic: Connecticut Home Care Program for Elders] program. He meets all eligibility criteria, except that his gross income is $2,200 (the income [in 2009] for CHC is currently $2,022 per month). However, he assigns $179 of his monthly income into a pooled trust. We now compute his income to be $2,021.00, which would make him eligible to the program.

    - the individual transfers an amount equal to or greater than one day's stay in a long-term care facility at private pay rates [through June 30, 2008, $311.14; this amount changes each July 1] and DSS approves a plan for use of the funds.

      DSS example: Mrs. Smith, age 65 and disabled, is applying for Medicaid under the CHC program. She meets all eligibility criteria, except that her gross income is $2,500 per month. She assigns $590 of her monthly income into a pooled trust. The trust pays out $290 per month on her behalf for additional waiver-type services that are not covered under Medicare or Medicaid. Mrs. Smith expends this $290 in its entirety every month. The remaining amount, $300, is less than the one-day penalty amount of $311.14 described above. Mrs. Smith is eligible for the CHC program.

♦ **Practitioners take note:** A DSS comment in the Information Bulletin underscores that it is permissible to transfer up to $311.14 in income to a pooled trust, even if a lesser amount would qualify an individual for income eligibility. As DSS notes, this will potentially reduce the individual's applied income obligation (cost-sharing requirements of participation in the CHCPE).

♦ **Practitioners take note:** Another DSS comment notes that it is permissible to transfer a larger amount of income or assets into a pooled trust if DSS approves a plan for its expenditure. In the case of income, this requires submission of an Income Plan (Attachment A to the DSS Information Bulletin) that details how the individual will spend the excess within six months. A cited example is payment of property taxes. In the case of assets, this requires submission of an Asset Plan (Attachment B to the DSS Information Bulletin) that details how the assets will be spent over the course of the individual's lifetime. The cited examples are payment for accessibility modifications to a home, and payment of services provided by a caregiver or care manager.

CHCPE ALSA Options:

I. Moderate and Low-Income ALSA Demonstration Project – C.G.S. Section 17b-347e

First authorized through Public Act 98-239, and then expanded to 300 units by Public Act 99-279, the Moderate and Low-Income ALSA Demonstration Project has underwritten construction of new, stand-alone Managed Residential Communities (MRC's) through which residents who 1) are age 65 and older; 2) are at risk of nursing home placement; and 3) meet CHCPE financial eligibility criteria receive ALSA services. This project is a partnership involving the Department of Social Services (DSS), the Department of Economic and Community Development (DECD) and the Connecticut Housing Finance Authority (CHFA). Please see table for a listing of the involved sites.

Site Name	Address	Telephone:	# of Units	ALSA
Herbert T. Clarke House	25 Risley Road Glastonbury	860-652-7623	45	Utopia
The Retreat	90 Retreat Avenue Hartford	860-560-2273	95	Community Outreach Program for Elders
Smithfield Gardens	32 Smith Street Seymour	203-888-4579	56	Utopia
Luther Ridge at Middletown	628 Congdon Street Middletown	860-347-7144	45	Employs own staff

II. ALSA in State-Funded Congregate Housing – C.G.S. Sections 8-119m & 17b-342(c)

In 2000, the Legislature extended the CHCPE to residents of state-funded congregate housing. This project also represents a partnership between DSS and DECD. The sites that are participating include: Augustana Homes Bishop Curtis (Bethel), Bacon Congregate (Hartford), D.J. Komanetsky Estates (Bristol), Ella B. Scantlebury Senior Residence (New Haven), Herbert T. Clark House (Glastonbury), Mount Carmel Congregate (Hamden), Luther Manor (Middletown), Mystic River Homes (Noank), Ludlow Commons (South Norwalk), Prospect Ridge (Ridgefield), Seeley Brown Village (Pomfret), Silverbrook Estates (Orange), Virginia Connolly Congregate (Simsbury), St. Jude Common (Norwich), The Marvin (Norwalk), and F.J. Pitkat Congregate Living (Rockville). Utopia is providing assisted living services at most of these sites.

III. State Assisted Living Demonstration in Federally Funded Elderly Housing – C.G.S. 8-206e(d)

Authorized by Public Act 00-2, then expanded in scope by Public Act 01-2, the Demonstration provides assisted living services to residents of designated buildings.

Site Name	Address	Telephone:	ALSA
Immanuel House	15 Woodland Street Hartford	(860) 525-4228	Utopia.
Juniper Hill Village	1 Silo Circle Storrs/Mansfield	(860) 429-9933	Utopia
Tower One/Tower East	18 Tower Lane New Haven	(203) 772-1816	Utopia

IV. Private Assisted Living Pilot – C.G.S. Sections 17b-365 & 17b-366 *** NEW ***

This pilot assists individuals who have spent down resources while living in private managed residential care (MRC's) with payment for assisted living services (this excludes payment for room & board). Mid-term budget adjustments passed by the Connecticut legislature in the 2012 session expand the pilot from a maximum of 75 individuals to a maximum of 125 individuals.[65] There is currently a substantial wait list. DSS indicates that MRC participation is very changeable.

[65] Sections 9 & 10 of 2012 Conn. Legis. Serv. P.A. 12-1

will pay assisted living

Kate McEvoy, Esq.
July, 2012

CHCPE Personal Care Assistant (PCA) Guidelines:

Personal care assistants are a covered service of the program subject to the following qualifiers and limitations:

- per statute, personal care assistance services are covered to the extent that "such services are not available under the Medicaid state plan and are more cost effective on an individual client basis than existing services covered under such plan"[66];
- recipients of the service must:
    - be CHCPE eligible;
    - require hands-on assistance with one or more activities of daily living (ADLs), including bathing, dressing, eating, transfer, and/or toileting (bladder, bowel care); and
    - not already be receiving assisted living services under the pilot.

CHCPE participants who receive approval for PCA service may either:

- hire their own PCA(s) and utilize Allied as the fiscal intermediary for employment paperwork and payroll services – this is known as the "common law employer" option; or
- hire their PCA(s) from a pool associated with a home health agency or homemaker/companion agency – this is known as the "co-employer" option.

Allied or the agency performs the following functions:

- counseling on the rights and obligations of the client as employer or co-employer;
- obtaining an employer identification number (EIN) for the client;
- processing of PCA time sheets; and
- payroll and required payroll deductions.

A personal care assistant is defined for this purpose as "one or more persons assisting an elder with tasks that the individual would typically do for him or herself in the absence of a disability."

The client has employer authority and is responsible for directing the activities that are provided.

PCAs must be:

- at least age 18;
- able to understand and carry out the client's directions;
- physically able to perform the involved duties;
- willing to receive training;
- able to handle emergencies;
- able to maintain an effective working relationship with the client and to operate any special equipment that is needed by the client to assist with ADLs; and
- willing to submit to a criminal background check.

Anyone <u>other than</u> the following may be approved as a PCA:

- the client's spouse;
- the client's conservator or legal guardian; or

[66] C.G.S.A. § 17b-342(c)

- a relative of the client's conservator or legal guardian.

Note that attorneys-in-fact are not specifically prohibited from serving as PCAs, but DSS has indicated that it will review the individual circumstances of cases to determine if this is suitable.

Please note that if a criminal background check reveals results, a client may still choose to hire that individual but must sign and submit to the DSS Alternate Care Unit an Acknowledgment and Release of Liability Form (Form W-989).

Personal care assistant services should focus on physical or verbal assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Note that transportation is not a covered element of PCA service, and that medical transportation is otherwise covered as a separate service under Medicaid. A CHCPE client may receive approval on the basis of clinical assessment of unmet need for both PCA and the following additional services:

- care management;
- emergency response system (ERS);
- meals-on-wheels;
- skilled nursing;
- adult day care;
- skilled chore; and
- the Medicaid "medical" services (e.g. home health aide, physical therapy, occupational therapy, speech therapy).

PCA clients cannot receive the following services:

- homemaker;
- chore; or
- companion.

PCAs are per DSS "intended to supplement, not supplant, existing informal voluntary supports", and therefore family members or others who have been providing such support will not be approved to be paid as PCAs for providing the same service(s).

A requirement for receiving approval for PCA service is that the client or his/her representative identify a viable back-up plan in the event of PCA absence. DSS has indicated that this plan must be specific and cannot rely upon calling 911.

Each individual PCA can be approved to work up to 25.75 hours per week. Where clients obtain and can document current workers compensation coverage, each individual PCA can be approved to work up to 40 hours per week.

The total amount of service, including PCA and any of the additional services listed above, may not exceed the cost cap for the level (Level 1, 2 or 3) of service for which the CHCPE client has been approved. Within an identified range, the client decides what rate to pay his or her PCAs, and can either pay at the maximum (in 2011, $13.80 per hour) or pay at a lesser hourly rate. Note that the rate is a gross wage from which the employer's share of FICA, FUTA and unemployment compensation must be deducted.

CT Home Care Program for Disabled Adults

Waiver Information:

Waiver Type:	N/A (state-funded pilot)
Enrollment Capacity:	50 (serves fewer because of budget constraints)
Current Enrollment:	program began accepting applications in October, 2007
Year First Approved:	2007 (authorized by Section 29 of Public Act 07-2, effective 7/1/07)
Waitlist Status:	waitlisted

Eligibility Criteria:

Age Range: 18-64

Functional status: must have a degenerative neurological condition (including, but not limited to, Multiple Sclerosis, Alzheimer's disease, Parkinson's, Huntington's, ALS, Pick's or Creuztzfeldt-Jakob) and must 1) require assistance in three or more of the following: bathing, dressing, toileting, transferring, eating, meal preparation or administering medication; or 2) have made 4 or more errors on the Mental Status Questionnaire and require assistance with two of the areas listed in 1)

may not participate if 1) eligible for Medicaid; or 2) primary diagnosis is mental illness or mental retardation; individuals who are waitlisted for the PCA Waiver may be considered for the CHCPD on a case-by-case basis

Income limits effective January 1, 2012:

Individual: none
Couple: none

Asset limits effective January 1, 2012 (program uses the same asset limits as are used for Levels 1 & 2 of the CHCPE):

Individual: $34,092
Couple: $45,456

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

METHOD		COMMENTS
Agency-Based	X	Majority of clients will receive services via agencies
Agency + Choice		
Self-Direct		
PCA		
Other		

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

Cost Caps/Cost Effectiveness Standards: Program can in 2012 pay no more than $2,899 per month per individual (50% of average monthly Medicaid cost).

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective March 1, 2012, 200% FPL = $1,862 per month; amount is updated each March 1), adjusted for medical expenses (e.g. Medicare Part D premium, medical insurance premiums); legally liable relative may have obligation to contribute – see page 27.

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

Kate McEvoy, Esq.
July, 2012

Department of Developmental Services Comprehensive Supports Waiver

Waiver Information:

Waiver Type:	1915(c) – for individuals who live in community living arrangements, community training homes, and managed residential communities
Enrollment Capacity:	6,700
Current Enrollment:	approximately 4,765
Year First Approved:	2005
Waitlist Status:	as of September, 2011, 960 individuals were on the residential waitlist (this list includes applicants for both DDS waivers)

Eligibility Criteria:

Age Range:	18 and older
Functional status:	Individual must have been assessed to have 1) mental retardation as defined in C.G.S. Section 1-1g; or 2) Prader-Willi Syndrome. Further, must have need for ICF/MR level of care and show need for at least one of the waiver services.

Income limits effective January 1, 2012:		**Asset limits effective** January 1, 2012:	
Individual:	$2,094 (300% SSI)	**Individual:**	$1,600
Couple:	based on applicant's income	**Couple:**	MCCA rules apply
Comments:	can use a special needs trust; those eligible for Medicaid for Working Disabled not subject to income and asset restrictions	**Exemptions:**	MCCA rules apply

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

METHOD		COMMENTS
Agency-Based	X	Services must be provided by "qualified vendors"
Agency + Choice	X	Agency offers the individual a choice of providers
Self-Direct	X	Individual hires and manages caregivers
Other	X	Waiver permits a blend of the above options

Covered Services: licensed residential services (community living arrangements, community training homes, assisted living), residential and family supports (supported living, personal support, adult companion, respite, personal emergency response systems, home and vehicle modifications), vocational and day services (supported employment, group day activities, individualized day activities), specialized and support services (behavior and nutritional consultation, specialized equipment and supplies, interpreters, transportation, family consultation and support)

Cost Caps/Cost Effectiveness Standards: Certain services come attached with specific, annual cost caps (e.g. specialized equipment has a cap of $750 per year; physical modifications to home can cost no more than $10,000 over three-year waiver term); cannot replace services already being provided by family members.

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective March 1, 2012, 200% FPL = $1,862 per month; amount is updated each March 1), adjusted for certain expenses.

To apply: Call DDS Eligibility Unit at 1-866-433-8192 to request eligibility determination documents.

Kate McEvoy, Esq.
July, 2012

Department of Developmental Services Individual and Family Support Waiver

Waiver Information:

Waiver Type:	1915(c) – for individuals who live in their own or family homes
Current Enrollment:	approximately 3,997
Year First Approved:	2005/three years
Waitlist Status:	as of September, 2011 960 individuals were on the residential waitlist (this list includes applicants for both DDS waivers)

Eligibility Criteria:

Age Range:	18 and older
Functional status:	Individual must have been assessed to have 1) mental retardation as defined in C.G.S. Section 1-1g; or 2) Prader-Willi Syndrome. Further, must have need for ICF/MR level of care and show need for at least one of the waiver services.

Income Limits effective January 1, 2012:

Individual:	$2,094 (300% SSI)
Couple:	based on applicant's income
Comments:	can use special needs trust; those eligible for Medicaid for Working Disabled not subject to income and asset restrictions

Asset Limits effective January 1, 2012:

Individual:	$1,600
Couple:	MCCA rules apply
Exemptions:	MCCA rules apply

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

METHOD		COMMENTS
Agency-Based	X	Services must be provided by "qualified vendors"
Agency + Choice	X	Agency offers the individual a choice of providers
Self-Direct	X	Individual hires and manages caregivers
Other	X	Waiver permits a blend of the above options

Covered Services: residential and family supports (supported living, personal support, adult companion, respite, personal emergency response systems, home and vehicle modifications), vocational and day services (supported employment, group day activities, individualized day activities), specialized and support services (behavior and nutritional consultation, specialized equipment and supplies, interpreters, transportation, family consultation and support)

Cost Caps/Cost Effectiveness Standards: Waiver generally will not spend more than $50,000 per year per individual; certain services come attached with specific, annual cost caps (e.g. specialized equipment has a cap of $750 per year; physical modifications to home can cost no more than $10,000 over three-year waiver term); cannot replace services already being provided by family members.

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective March 1, 2012, 200% FPL = $1,862 per month; amount is updated each March 1), adjusted for certain expenses.

To Apply: Call DDS Eligibility Unit at 1-866-433-8192 to request eligibility determination documents.

Kate McEvoy, Esq.
July, 2012

Katie Beckett Waiver

Waiver Information:

Waiver Type:	1915(c)
Enrollment Capacity:	200 (current funding only supports 180 slots)
Current Enrollment:	180
Year First Approved:	1983 (authorized by C.G.S. Section 17b-283)
Waitlist Status:	waitlisted

Eligibility Criteria:

Usually very complex case profiles.

A section of a law passed by the Connecticut legislature in the 2012 session eliminates the 125-person enrollment cap, limits its spending to available appropriations, and clarifies that the Katie Beckett waiver serves individuals who are institutionalized or at risk of institutionalization and who 1) are age 21 or younger; 2) have physical disabilities and may also have co-occurring developmental disabilities; and 3) meet waiver financial eligibility criteria.[67]

Age Range:	age 21 and younger
Functional status:	physical disability (and co-occurring developmental disability)

Cuts off @ 21; closest parallel is move up → fam Care waiver

Income limits effective January 1, 2012:		**Asset limits effective** January 1, 2012:	
Individual:	$2,094 (300% SSI)	**Individual:**	$1,600
Couple:	based on applicant's income	**Couple:**	MCCA rules apply
Comments:	can use a special needs trust	**Exemptions:**	

If 3+ mos. inpatient, Can get MFP

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

METHOD		COMMENTS
Agency-Based	X	
Agency + Choice		
Self-Direct		
Other		

Covered Services: case management, home health services

Cost Caps/Cost Effectiveness Standards: Waiver care plan costs cannot exceed average monthly Medicaid nursing facility cost (in 2012, $5,798 per month)

Cost Sharing Requirements: not applicable unless applicant's income exceeds 200% FPL (effective March 1, 2012, $1,862)

To apply: Contact DSS for application materials.

[67] Section 2 of 2012 Conn. Legis. Serv. P.A. 12-119

Medicare Home Care Benefit

Eligibility Criteria:

Age Range: N/A

Functional status: Physician must sign a plan of care for an individual who 1) has need for at least one skilled service (intermittent skilled nursing care, physical or occupational therapy, speech/language therapy); and 2) is homebound (an individual is considered homebound if leaving home requires a "considerable and taxing effort", and if the absences are infrequent or of relatively short duration)

Service Delivery Method(s)

METHOD		COMMENTS
Agency-Based	X	Agency must be Medicare certified
Agency + Choice		
Self-Direct		
Other		

Covered Services: Part-time or intermittent skilled nursing care by RN or LPN; part-time or intermittent home health aide services (personal care) only where also receiving nursing care; physical, speech/language or occupational therapy; medical social work; durable medical equipment.

Cost Caps/Hour Limits/Cost Effectiveness Standards: An individual can receive no more than 8 hours per day or 28 hours per week of nursing care and home health visits, combined, unless the doctor indicates that there is need for up to 35 hours and there is a "finite and predictable end" to the need for the additional hours.

Cost Sharing Requirements: N/A (except for DME)

Face-to-Face Encounter Requirement: Effective January 1, 2011 amendments to the federal regulation[68] that governs eligibility for home health coverage require that the certifying physician or a "non-physician practitioner" (NPP)(nurse practitioner, clinical nurse specialist working in collaboration with a physician, or physician assistant) conduct and document a face-to-face encounter with each beneficiary of home health services not more than 90 days prior to, or within 30 days of, the home health start of care date. This regulation fulfills provisions of the Affordable Care Act[69] that were intended to "achieve greater physician accountability in certifying a patient's eligibility and establishing a patient's plan of care." The physician's documentation must:

- confirm that the condition for which the beneficiary is being treated is related to the beneficiary's primary reason for requiring home health care; and
- include clinical findings that support the beneficiary's homebound status and need for skilled service.

Note that the encounter can occur via tele-health. In the event that an NPP conducts the face-to-face encounter, he or she must document clinical findings of the encounter and communicate the findings to the certifying physician. Note that failure to meet this requirement leaves the provider ineligible for payment, but should not be the basis for ineligibility for the beneficiary.

Practice Tips: For consult on eligibility or denials, call the Center for Medicare Advocacy at 1-860-456-7790

[68] 42 CFR § 424.22
[69] Pub. L. 111-148 (signed March 23, 2010)

Kate McEvoy, Esq.
July, 2012

Money Follows the Person Program

Transitional Program - gets housing assistance + other waiver programs 1 yr Max

Waiver Information: "MFP"

Waiver Type:	N/A – this is a federal grant of enhanced Medicaid match funds
Enrollment Capacity:	5,000 over three years
Current Enrollment:	over 1000 individuals had been transitioned as of June, 2012
Year First Approved:	2008 (authorized in 2006 by Section 44 of Public Act 06-188; maximum participation expanded from 100 to 700 by Section 5 of Public Act 07-2; maximum participation expanded from 700 to 5,000 by Public Act 08-180)
Waitlist Status:	N/A

Eligibility Criteria:

Age Range:	18 and older
Other criteria:	individual must have resided in a nursing home or other health care facility for **three** (***PLEASE NOTE:*** reduced from six) months or more, must wish to live in a community-based setting, and must meet functional/diagnostic criteria for the Medicaid waiver (e.g. ABI, CHCPE, DDS, PCA) that will provide services ongoing (e.g. an individual age 65 who meets financial eligibility criteria must evidence three "critical needs" for services)

Income limits effective January 1, 2012:

Individual:	$2,094 (300% SSI)
Couple:	based on applicant's income
Comments:	can use a special needs trust; those eligible for Medicaid for Working Disabled not subject to income and asset retrictions

Asset limits effective January 1, 2012:

Individual:	$1,600
Couple:	MCCA rules apply
Exemptions:	MCAA rules apply

Service Delivery Method(s) (X indicates available): service delivery method depends on the Medicaid waiver for which the individual qualifies

Covered Services: The list of covered services is governed by the Medicaid waiver for which the individual qualifies. MFP can assist individuals with certain costs of transitioning from a nursing facility to a community-based living situation, including rental assistance and home adaptation.

Cost Caps/Cost Effectiveness Standards: The maximum dollar amount of services per month is governed by the Medicaid waiver for which the individual qualifies.

Cost Sharing Requirements: Participants must pay applied income and any other cost sharing that is required by the Medicaid waiver through which they receive services.

To apply: Call 1-888-99-CTMFP (1-888-992-8637) to apply.

Big Initiative

Kate McEvoy, Esq.
July, 2012

Personal Care Assistance Waiver

Waiver Information:

Waiver Type:	1915(c)
Enrollment Capacity:	748
Current Enrollment:	748
Year First Approved:	1996 (authorized in 1995 by C.G.S. Section 17b-605a)
Waitlist Status:	waitlisted; 103 as of January, 2012

Eligibility Criteria:

Age Range: 18 and older (2006 legislation removed upper age limit). Note, however, that mid-term budget adjustments passed by the Connecticut legislature in 2012 require all individuals age 65 and older who are being served by the Personal Care Assistant (PCA) waiver to transition to the Connecticut Home Care Program for Elders (CHCPE) Waiver. This is intended to free up slots in the PCA waiver for individuals who are on the waitlist.[70]

Functional status: chronic, severe, permanent disability that results in limitations in at least two activities of daily living (bathing, dressing, eating, transferring, management of bowel and bladder); those with mental illness, mental retardation or dementia do not qualify on that basis; DSS either accepts Social Security disability determination or performs analogous review of disability status; must wish to and be able to self-direct care

Income limits effective January 1, 2012:		**Asset limits effective** January 1, 2012:	
Individual:	$2,094 (300% SSI)	**Individual:**	$1,600
Couple:	based on applicant's income	**Couple:**	MCCA rules apply
Comments:	can use a special needs trust; those eligible for Medicaid for Working Disabled not subject to income and asset restrictions	**Exemptions:**	MCCA rules apply (ex. primary residence, vehicle needed for employment or medical visits or modified for use of individual with disability)

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

METHOD		COMMENTS
Self-Direct	X	PCA must be 18 or older, and may not be either 1) the spouse of the client; 2) the conservator of the client; or 3) related to the conservator.

Covered Services: Personal care assistance (bathing, dressing, companion), independent support brokers, ERS

Cost Caps/Cost Effectiveness Standards: Waiver pays up to a percentage of the average monthly Medicaid nursing facility cost (in 2012, $5,798), depending on level of ADL impairment: 1) 60% of cost for those with at least 2 ADL impairments; 2) 80% of cost for those with 3 or 4 ADL impairments; 3) 100% of cost for those with impairments in all ADL areas. Currently cannot hire PCA for more than 25.75 hours per week.

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective March 1, 2012, 200% FPL = $1,862 per month; amount is updated each March 1), adjusted for medical expenses; legally liable relative may have obligation to contribute- see page 27.

To apply: Download application from this link: http://www.ct.gov/dss/lib/dss/pdfs/W-982.pdf

[70] Section 15 of 2012 Conn. Legis. Serv. P.A. 12-1

Statewide Respite Program

Eligibility Criteria:

Age Range: N/A

Functional status: diagnosed with an irreversible and deteriorating dementia (dementias may include, but are not limited to: Alzheimer's Disease, multi-infarct dementia, Parkinson's Disease with dementia, Lewy Body dementia, Huntington's Disease, normal pressure hydrocephalus and Pick's Disease)

Waitlist Status: program was re-opened to new applicants on May 1, 2010

Annual Income Limits established by statute:

Individual: $41,000
Couple: based on applicant's income

Asset Limits established by statute:

Individual: $109,000 (liquid assets)
Exemptions: home

Please note: Individuals who are eligible for the Connecticut Home Care Program for Elders are not eligible for services under this program. 2007 legislation removed the prior restriction on serving Medicaid-eligible individuals under the age of 65.

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

METHOD		COMMENTS
Agency-Based	X	
Agency + Choice		
Self-Direct	X	
Other		

Covered Services: adult day care, home health aide support, homemaker, companion, skilled nursing visits and/or short-term stays in a nursing or assisted living facility

Cost Caps/Cost Effectiveness Standards: Total grant may not exceed $7,500 per individual per calendar year.

Cost Sharing Requirements: Eligible individuals must pay a 20% co-payment of the cost of each service received under the program. Where a hardship can be demonstrated, this co-pay can be waived.

To apply: Contact the Area Agencies on Aging at 1-800-994-9422 for application materials. This number automatically directs the caller to the AAA in greatest geographic proximity. AAA staff review and approve applications, and conduct in-home visits to assess the needs of both the caregiver and care recipient.

Practice Tip: Advocates should also explore whether clients are eligible for the $500 per family annual benefit from the Alzheimer's Association Connecticut Chapter's Respite Fund. The fund, originally established by a $50,000 bequest, makes grants for purchase of respite services including adult day programs, home health aides, homemaker/companion, skilled nursing care or short-term nursing home care. There is no age limit with respect to the diseased person or caregiver. Applications are available by calling 1-800-356-5502. A doctor's certificate and medical release are required.

Kate McEvoy, Esq.
July, 2012

Veterans Administration Aid & Attendance Benefit

Eligibility Criteria:

Age Range: N/A

Functional status: a veteran or the surviving spouse of a veteran who meets certain service requirements and 1) is determined by a physician to need "aid and attendance" with activities of daily living (eating, dressing, toileting); 2) is blind; or 3) is, by reason of having a physical or mental disability, a resident of a nursing facility

Income Limits effective December 1, 2011:

Individual veteran:	$1,704 per month
Surviving spouse:	$1,094 per month
Couple:	$2,020 per month
Comments:	benefit is determined by deducting out-of-pocket medical expenses from income and then calculating the difference between that figure and the maximum income amount

Asset Limits effective December 1, 2011:

Individual:	$50,000
Couple:	$80,000
Exemptions:	home; see below for guidance on treatment of jointly owned assets and asset transfers

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

METHOD		COMMENTS
Agency-Based	X	
Agency + Choice		
Self-Direct		
Other		

Covered Services: Individuals can use benefit to pay for home care as well as assisted living services in a managed residential community.

Cost Caps/Cost Effectiveness Standards: Capped by amount of benefit; must prove expenditures at each annual re-evaluation.

Cost Sharing Requirements: N/A

Guidance on Jointly Owned Assets and Asset Transfers: In Part IX – Net Worth section of VA Form 21-526, applicants are now asked to provide information on jointly owned assets as well as transfers of assets. Guidance in the instruction section of the form indicates the following:

- a gift of property or a sale below the property's value to a relative residing in the same household does not reduce net worth; and
- a gift of property to someone other than a relative residing in the applicant's household does not reduce net worth unless it is clear that the applicant has relinquished all rights of ownership, including the right to control the property.

Practice Tip: Contact the CT Department of Veteran's Affairs at 860-594-6604 with questions.

Kate McEvoy, Esq.
July, 2012

WISE Program (*Working for Integration, Support and Empowerment)*

NEW (2011)
DMHAS Administered

Waiver Information:

Waiver Type:	1915(c)
Year First Approved:	2009
Waitlist Status:	no wait list

Eligibility Criteria:

Age Range: 22 and older

Functional status: Individuals must:

- be Medicaid eligible
- have a diagnosis of serious mental illness
- meet one of the following residence profiles:
  - currently reside in a nursing facility
  - live in the community, have an active psychiatric disorder and be under consideration for placement in a nursing facility; or
  - already discharged from a nursing facility under Money Follows the Person
- have two or more serious life problems due to mental illness (ADL), queue
- not be in need of emergency psychiatric hospitalization
- need rehabilitation and professional assistance in developing and implementing a plan for recovery

Income limits effective January 1, 2012:		**Asset limits effective** January 1, 2012:	
Individual:	$2,094 (300% SSI)	**Individual:**	$1,600
Couple:	based on applicant's income	**Couple:**	MCCA rules apply
Comments:	those eligible for Medicaid for Working Disabled subject to different eligibility rules	**Exemptions:**	MCCA rules apply

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

METHOD		COMMENTS
Agency-Based	X	
Agency + Choice		
Self-Direct	X	

Covered Services: assertive community treatment (ACT), community support program (CSP), peer support, recovery assistant, short-term crisis stabilization, supported employment, transitional case management, non-medical transportation, specialized medical equipment, and home accessibility adaptations

Cost Caps/Cost Effectiveness Standards: Waiver uses an aggregated cap analysis that requires that the total of each client's annual service package must be no greater than the amount that the State would otherwise spend on nursing home care.

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective March 1, 2012, 200% FPL = $1,862 per month; amount is updated each March 1), adjusted for medical expenses; legally liable relative may have obligation to contribute – see page 27.

To Apply: Call DMHAS at 1-866-548-0265.

Kate McEvoy, Esq.
July, 2012

Links to Brochures and Applications:

Acquired Brain Injury Waiver

Brochure

http://www.ct.gov/dss/lib/dss/pdfs/abi_brochure.pdf

Application

http://www.ct.gov/dss/lib/dss/pdfs/w1130ABIRequestForm.pdf

Connecticut Home Care Program for Elders:

Brochure

http://www.ct.gov/dss/LIB/dss/pdfs/chcpe_052002.pdf

Application

http://www.ct.gov/dss/LIB/dss/pdfs/w-1487.pdf

DDS Waivers:

Fact Sheet

http://www.ct.gov/dds/cwp/view.asp?a=2050&q=382310

Guidebook for Consumers and Families

http://www.ct.gov/dds/lib/dds/waiver/hcbs_guidebook.pdf

Medicaid for the Employed Disabled

Brochure

http://www.ct.gov/dss/lib/dss/pdfs/whatismedicaidfortheemployeddisabled.pdf

Medicare Home Health Benefit

Summary by the Center for Medicare Advocacy, Inc.

http://www.medicareadvocacy.org/FAQ_HomeHealth.htm

Personal Care Assistant Waiver:

Brochure

http://www.ct.gov/dss/lib/dss/pdfs/pcapam06.pdf

Application

http://www.ct.gov/dss/lib/dss/pdfs/W-982.pdf

Statewide Respite Program:

Brochure

http://www.ct.gov/agingservices/cwp/view.asp?a=2513&q=313026

Veterans Administration Aid & Attendance Benefit

Summary of Eligibility Requirements and Application Process

http://www.veteranaid.org/apply.php

DMHAS WISE Program:

http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=425724