Written Testimony before the Aging Committee
Submitted by the Department of Social Services
February 9, 2021

S.B. 813 AN ACT CONCERNING RETROACTIVE MEDICAID ELIGIBILITY FOR HOME CARE SERVICES.

This bill proposes to provide up to three months of retroactive Medicaid eligibility to individuals applying for home and community-based services (HCBS) provided such applicant has not made a transfer of assets for less than fair market value.

Medicaid programs must provide coverage for up to three months prior to the month of application for any time during the three months prior that the applicant met the eligibility requirements, however the Centers for Medicare and Medicaid Services (CMS) does not allow retroactive coverage when an applicant requests coverage of HCBS.

For Medicaid provided pursuant to a HCBS waiver, coverage is prospective-only from the date on which the state Medicaid program approves a HCBS service plan. There are provisions in the waiver that require, for example, the completion of a criminal background check for providers under the waiver. If retroactive payment were possible, there could be no assurance that this CMS requirement was met. In addition, there are specific rates and approved providers in a waiver. Private services that clients/families arrange prior to the determination of financial eligibility may be provided by a non-Medicaid provider at any range of rates. Neither of these would be permissible under a waiver program.

A waiver, such as the Connecticut Home Care Program for Elders waiver, specifies to CMS that clients are provided a choice of providers and that they receive care management services that include ongoing monthly monitoring of the clients' status and the effectiveness of the person-centered plan. This standard cannot be met retroactively. In addition, federal financial participation cannot be claimed for waiver services that are furnished prior to the development of the service plan or for waiver services that are not included in an individual's service plan. A service plan cannot be backdated.

Federal law requires the imposition of a penalty when individuals transfer assets for less than fair market value for the purpose of obtaining Medicaid payment of long-term care services. Long-term care services include home and community-based services under a Medicaid waiver, as well as services provided in an institutional setting. The penalty period begins on the date when Medicaid would otherwise pay for long-term care services had the improper transfer not occurred. Medicaid does not pay for long-term care services during the penalty period as the individual could have paid for his or her care had the improper transfer not occurred. As transfer

of asset penalties cannot begin until Medicaid would otherwise pay for waiver services and since waiver services cannot begin until the application is processed, transfer of asset penalties cannot begin until the application is processed.

Because CMS guidance and federal law does not allow for the changes sought by this proposal, the Department cannot support this bill.

S.B. 818 AN ACT PERMITTING THE COMMUNITY SPOUSE OF AN INSTITUTIONALIZED MEDICAID RECIPIENT TO RETAIN THE MAXIMUM AMOUNT OF ALLOWABLE ASSETS.

This bill proposes to allow the spouse of an institutionalized person who is applying for Medicaid (referred to hereafter as the "community spouse") to retain marital assets up to the maximum allowed under federal law. Effective January 1, 2021, this amount is $130,380.

This proposal intends to increase the amount of assets the community spouse is allowed to keep. Under current statute, community spouses of long-term care Medicaid recipients are allowed to keep one-half of the couple's countable assets up to the federal maximum of $130,380. If total assets are under $26,076, the minimum allowed by federal law, the community spouse may keep all the assets. The couple's home and one car are excluded from the assessment of spousal assets. The federal amounts are adjusted annually based on increases in the Consumer Price Index.

The Department continues to maintain that the current policy, which has been in place since 1989 (with the exception of FY 2011), is fair and reasonable and supports the original intent of the 1988 Medicare Catastrophic Coverage Act, which sought to prevent the impoverishment of spouses of those applying for Medicaid coverage for long-term care. Furthermore, the department's current policy is in line with most other states.

For the reasons noted above and the fact that increasing the minimum community spouse protected amount will result in a significant unfunded fiscal impact to the state, the Department cannot support this bill.

H.B. 6353 AN ACT INCREASING FINANCIAL ASSISTANCE FOR GRANDPARENTS AND OTHER NONPARENT RELATIVES RAISING CERTAIN CHILDREN

This bill would increase the payment standard for child-only assistance units in the Temporary Family Assistance (TFA) program to seventy-five percent of the foster care rate paid by the Department of Children and Families.

While the department appreciates the goal of achieving equity in these benefits, based on SFY 2020 data, we estimate the cost of such a change to be approximately $8.4 million. Due to the significant unfunded costs associated with providing such an increase, we cannot support this bill.