Aging Committee
JOINT FAVORABLE REPORT

Bill No.: SB-566
Title: AN ACT CONCERNING RETROACTIVE MEDICAID ELIGIBILITY FOR HOME CARE SERVICES.
Vote Date: 2/20/2019
Vote Action: Joint Favorable
PH Date: 2/14/2019
File No.:

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SPONSORS OF BILL:

Aging Committee

REASONS FOR BILL:

The bill directs the Commissioner of Social Services to provide payments for Medicaid eligible home care services retroactive to not more than three months from the date an eligible person applied for Medicaid. This would mirror the retroactive Medicaid eligibility that is afforded to institutional care. It also provides that the applicant has not made a transfer of assets for less than fair market value for the purpose of obtaining or maintaining Medicaid eligibility in the sixty months before applying.

RESPONSE FROM ADMINISTRATION/AGENCY:

Connecticut Dept. of Social Services submitted testimony in opposition to this bill. Medicaid programs must provide coverage for up to three months prior to the month of application for any time during the 3 months prior that the applicant met the eligibility requirement; however Centers for Medicaid Services (CMS) policy does not allow retroactive coverage when an applicant requests coverage of Home and Community-Based Services (HCBS). For Medicaid provided pursuant to a home and community-based services waiver, coverage is prospective-only from the date on which the state Medicaid program approves a home and community-based service plan.

If retroactive payment was possible there is no assurance that the requirement of a criminal background check for providers could be met. Additionally, there are specific rates and approved providers in a waiver 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. Federal law requires a penalty when

individuals transfer asset for less than fair market value for the purpose of obtaining Medicaid payment of long-term care services. These include home and community-based services under a Medicaid waiver and those in an institutional setting. 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. 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 and a service plan cannot be backdated.

A waiver, such as the Connecticut Home Care Program for Elders waiver, specifies that clients are given a choice of providers and that they receive care management services that include ongoing monthly monitoring of the client's status and the effectiveness of the person-centered plan. This standard cannot be met retroactively. A 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.

CMS guidance and federal law does not support the changes sought by this legislation.

Mairead Painter, Dept. of Rehabilitation Services, State Long-Term Care Ombudsman: She testified in support of this legislation. They support the opportunity for a person who is both functionality and financially eligible for services, to apply for Medicaid and receive coverage for Medicaid-eligible home care services retroactive for three months, as they would if they were in a skilled nursing facility for institutional care. Currently there is no mechanism for a resident, who could otherwise choose to return to their home and receive home care services to apply for Medicaid and await or "pend" approval while receiving these home care services in the community. They have to stay in the nursing home to receive these long-term care services and supports while waiting for approval of their Medicaid.

If they have staff caring for them in the community prior to the hospital/nursing home stay and then are required to "pend" Medicaid in the facility while waiting for Medicaid approval, they can lose their staff and this makes it more difficult to return to the community. Finding a high-quality nursing home that accept as person that is pending Medicaid or eligible for retroactive Medicaid is increasingly more difficult and they may have to choose a home out of their area or one that does not have the high quality standards that they are seeking.

They do know that once a person is in a nursing home for 90 days they are far less likely to return to their home.

NATURE AND SOURCES OF SUPPORT:

Ms. Mag Morelli, President, LeadingAge Connecticut: They support this bill that would provide Medicaid coverage retroactively for eligible homecare clients in accordance with federal law.

Ms. Linnea Levine, LLC, Member of the Legislative Policy Committee of the CT Chapter of the National Academy of Elder Law Attorneys and a member of the Elder Law Section of the CT Bar Association: She testified in support of this bill. She points out the very high cost of home health care services in Fairfield County that could be as high as

$292,000 for a two year period. ($25 an hour, 16 hours a day, 7 days a week for 104 weeks.) She believes that the gap in home health services is happening every day in our state because there is no retroactive Medicaid eligibility even though Federal Medicaid regulation 42 CFR 435.915 mandates that all Medicaid Plans, including Waivered Medicaid Plans, provide Medicaid services to eligible persons up to three months before the date of application. The purpose of SB 566 is to make sure that there is no gap in care from the date a person runs out of money to pay privately for home care and the date the home health care aid is paid by Medicaid.

She concludes that this legislation would assure that the impoverished, ill and elderly population can receive care in their home without a dangerous gap in the provision of essential home health care services and Assist. the Dept. of Social Services in moving forward with its rebalancing efforts to provide quality care at home for more elders at a lower cost to Connecticut than Connecticut's cost for similar services in a nursing home.

Connecticut Area Agencies on Aging (C4A): They point out that they are on a task force with the CT Association for Healthcare at Home and the Dept. of Social Services. They are hopeful that a continued solution-based discussion will decrease the period between application and enrollment for home care services. Another potential solution would be a thoughtful process of Presumptive Eligibility as it would serve the purpose of expedited access to home care services while maintaining compliance and maximizing cost sharing with Medicaid.

NATURE AND SOURCES OF OPPOSITION:

Ms. Deborah Hoyt, President and CEO, The Connecticut Association for Healthcare at Home: She testified in opposition to this bill stating that it will complicate the provider's ability to accept Medicaid beneficiaries and create access issues for the beneficiary.

The Association is in discussions with the DSS about addressing eligibility and authorization process improvements and believes that progress can be made through discussion as opposed to a legislative approach. The Association and the DSS have engaged in a public-private LEAN Process Improvement initiative with the goal of reducing cost, waste and duplication in the administrative workflow around eligibility, authorization, billing and provider payment in Medicaid home health care delivery. In the absence of a Medicaid provider reimbursement rate increase, they believe that cost savings can be achieved and the use of provider staff time and resources improved through this effort.

Reported by: Gaia McDermott, Clerk **Date: 2/27/19**
Richard Ferrari, Assistant Clerk