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Connecticut Legislative Panel Rejects Proposed Medicaid Regulations

The Connecticut Legislative Regulation Review Committee recently rejected several proposed Medicaid regulations that the Department of Social Services submitted to comply with the Deficit Reduction Act of 2005 (DRA).

The Department has operated under the proposed regulations since it published a notice of intent to adopt new regulations in April 2007, and it took almost two years to submit the regulations to the Legislative Regulation Review Committee, even though state law requires submission of the proposed regulations within 180 days of publication of notice. Casting doubt on the feasibility of the proposed regulations, the Committee in a June 9, 2009, memorandum explained that "It is questionable whether the policies in these proposed regulations are, in fact, necessary to conform to a requirement of a federal or joint federal and state program administered by the department and, thus, whether it is permissible for the department to operate under such policies before the policies are formally adopted as a regulation."

The Committee specifically cited two of Connecticut's more onerous proposed regulations as inconsistent with the DRA. The proposed regulations presume that assets returned to an applicant as part of a cured transfer were available assets for the entire time they were out of the applicant's possession. The Committee found that this provision could violate the Supremacy Clause of the U.S. Constitution because "[i]t does not appear that the DRA authorizes the treatment of transferred assets required in the proposed UPM sections." The Committee also took issue with the state's proposed undue hardship provisions, finding that the state's regulations were more narrow than the DRA and "could lead to more frequent imposition of penalties."

It is unclear what law governs the processing of Medicaid applications now that the proposed regulations have been rejected.

Trust Is an Available Resource Despite Discretionary Language

The Minnesota Court of Appeals rules that a trust's principal and income are both available resources for Medicaid purposes even though the trust's language requires only payments of income to the beneficiary and gives discretion to the trustee to distribute principal in the case of In The Matter of the Stephanie L. Wilcox Trust (May 19, 2009). Stephanie Wilcox, a woman with Down syndrome, was the beneficiary of a trust holding close to $2 million in assets. The trust, which was set up by Ms. Wilcox's father, dictates that "the net income shall be paid to [Stephanie]; provided that if the trustee determines that [Stephanie] has adequate other income, the trustee may withhold all or any part of the net income . . ." In a separate paragraph labeled "Principal," the trust states that "the trustee shall pay to any one or more of [Stephanie] and [Stephanie's] issue, such sums of principal (including all thereof) as the trustee deems advisable."

The trial court issued an order declaring the trust's income an available asset, but the court also ruled that the trust's principal was not available because it was distributed only subject to the trustee's discretion. The State appealed the ruling, arguing that the language in the trust compelled the trustee to distribute principal if Ms. Wilcox's income was not adequate to meet her needs. The trustee claimed that there was nothing in the plain language of the trust requiring such distributions.

The Minnesota Court of Appeals overruled the trial court and concluded that Ms. Wilcox does have the ability to compel distributions of principal from the trust. The court reasoned that since the language giving the trustee discretion to distribute principal follows the language requiring the trustee to provide adequate "income," the trustee must distribute principal if Ms. Wilcox's income is insufficient. The court goes on to explain that the "[u]se of 'shall' in [Ms. Wilcox's] trust does not support a finding that payment of principal is discretionary even though 'such [amounts] as the trustee[s] deem advisable' signals that the amount of such payments is discretionary, consistent with the purpose of the trust to provide 'adequate' income to [Ms. Wilcox]." (emphasis in original)

From Our Care Coordinator

Lily and Harold have been married for 62 years. They raised two sons in the home they have shared for more than half a century. Lily was diagnosed with Alzheimer's disease five years ago. Harold has been her primary care giver but recently Lily has begun to wander away from home. She has not been sleeping at night and her sons are concerned that Harold at 87 years old can no longer manage Lily's care on his own.

Mary's mother has become more forgetful and recently has experienced several falls is unsure where to get assistance. Mary is concerned that her mother is no longer safe in her current apartment but is unclear what options are available to meet her mother's needs. Mary is also concerned about how to approach her mother to discuss these concerns and possible changes needed.

The above are examples of our senior citizens aging in place and the concerns their families face. The families must make and navigate a complex system of health care and elderly services. A geriatric care manager's role is to assist families and individuals through assessment and planning. An assessment can provide information regarding the level of care needed, options for care and reimbursement. The care manager can coordinate referrals and services or direct the family in how to do this.

Czepiga Daly Dillman's Geriatric Services coordinator, Linda Worden, met with Lily and Harold. A plan was put in place to send Lily to an Adult Day Care center three days a week to provide socialization for her and respite for Harold. A safety review of the home was done and recommendations to keep Lily safe and prevent wandering were implemented. Long term planning was also discussed and applications to appropriate long term care facilitates were completed in the event that Lily was not able to safely remain in the home or something happened to Harold. An emergency response system was installed in the event that Harold needed assistance since Lily was unable to dial 911 or provide needed assistance.

After an assessment of Mary's mom, Linda Worden, our Geriatric Care coordinator, determined Lily was eligible for community based services and a referral was initiated. Her recent falls were of concern and a referral was made to a local home care agency for a physical therapy evaluation to determine functional status. The therapist was able to offer suggestions for home adaptation and arrangements for assistive devices that would help to ensure her safety. A referral was also made to a geriatric psychiatrist for evaluation of the new forgetfulness.

Geriatric care managers can help in discharge planning from hospital or nursing home, help families navigate insurance claims, reimbursement, provide education and advocate for individuals and families.

Contact our Geriatric Care coordinator, Linda Worden in our Newington office at 860-594-7998 or our Wethersfield office at 860-563-4070

Medicaid Asset Protection: Reciprocity With Other States

On March 27, 2009, Connecticut received approval from the federal government to join the National Reciprocity Compact for the granting of Medicaid Asset Protection for states with Partnership for Long-Term Care programs. The approval is retroactive to January 1, 2009. However, all Connecticut Partnership policyholders are covered under the Reciprocity Compact, regardless of when they purchased their Partnership policy.

Under the terms of the Reciprocity Compact, Connecticut Partnership policyholders who relocate to another state may be eligible to receive dollar-for-dollar Medicaid Asset Protection just as they would when they apply to Connecticut's Medicaid program. Two conditions must be met for a policyholder to be eligible for reciprocity in another state: (1) the policyholder must apply to and qualify under the other state's Medicaid program; and (2) at the time the policyholder applies to the other state's Medicaid program, Connecticut and the other state must be members of the Reciprocity Compact or Connecticut must have a separate reciprocal agreement with that state for the granting of Medicaid Asset Protection.

The Reciprocity Compact requires that any state participating in the Compact must agree to engage in reciprocity with every other state in the Compact for the purpose of

granting dollar-for-dollar Medicaid Asset Protection. In addition, the original reciprocity agreement between Connecticut and Indiana remains in effect.

PARTNERSHIP REACHES NEW MILESTONES

In the quarter ending March 31, 2009, Connecticut Partnership sales surpassed the 50,500 level with 50,562 Partnership policies purchased as of 3-31-09. In addition, the number of Partnership applications submitted reached the 62,000 level with 62,214 applications submitted as of 3-31-09.

94 percent of purchasers are under the age of seventy, with 81% under the age of 65. The average age at time of purchase is 58 and the average maximum benefit purchased is $240,827. In addition, over $60 million in Medicaid Asset Protection had been earned as of 3-31-09 by Partnership policy holders receiving benefits under their policies. 57 Partnership policyholders have accessed Medicaid after first using their Partnership benefits.

In addition, The Partnership estimates that since its inception in 1992, it has saved the Connecticut Medicaid program over $7 million in long-term care costs.