OFFICE OF POLICY AND LEGAL ANALYSIS

Date: May 13, 2021
To: Joint Standing Committee on Health & Human Services
From: Anna Broome, Legislative Analyst

LD 1427 An Act To Encourage Family Care of Aging Adults

SUMMARY: This bill prohibits DHHS from assessing a penalty on payments made to a family member providing personal support services within 5 years of a MaineCare member who is applying for long-term care coverage. If the caregiver provided services but was not paid prior to the applicant applying for MaineCare, that person's inheritance is exempt from the State's estate recovery in the amount equal to the fair market value of services provided.

It directs DHHS to seek a waiver pursuant to Section 1915(c) of the United States Social Security Act to allow the provision of personal support services by a relative chosen by the recipient of services in a home setting.

It requires DHHS to amend its rules on eligibility for long-term care services provided under the MaineCare program or state-funded programs to remove provisions and presumptions that disqualify some persons from eligibility for long-term care. It removes the requirement for written agreements and presumptions regarding the purpose of paying for services and certain transfers. It directs the department to adopt routine technical rules to incorporate the amendments by October 15, 2022 and to notify the Health and Human Services Committee of the completion of the rulemaking.

ISSUES FROM TESTIMONY:

- Sponsor: Three purposes to the bill.
  - An applicant of MaineCare is presumed to have made a disqualifying transfer in the 5 year lookback period if they have paid a family member for personal care. Only applicants who have executed a personal care contract are able to prove they didn't make the transfer in order to qualify for MaineCare. Want a lower standard of proof.
  - Encourage family members to take care of their family member at home by allowing them to be paid for services. As part of the MaineCare application, the applicant can have a family member take care of them in lieu of a nursing facility.

    - Allow an exemption in estate recovery for the services rendered by a family member.
- Proponents: Paying family members is common sense but is assumed to be a transfer at less than market value causing hardship. Should be encouraging this. Already a shortage of direct care staff. Barriers are in the eligibility rule.
- DHHS NFNA:
    - Federal Medicaid law requires periods of ineligibility when an individual transfers assets for less than fair market value in 5 years before application. The law requires proof of transfer for a purpose other than to qualify for Medicaid – DHHS would not be able to do this under this bill. Personal care agreements are a common form of verification used by other states. Other documentation can also be used.
    - Waiver exemption to estate recovery for personal care is limited to the member having income <200% FPL and current policy requires the individual providing care must live in the home with the MaineCare member for at least two years. Care given exemptions are limited to two years before death or entering a facility.
    - CMS is unlikely to agree to restriction the provisions regarding transfer of assets and adjusting FPL may not be possible.
    - Will be a fiscal impact.

DRAFTING ISSUES:

- May need some clarification between "reasonable services" (home care than is less expensive that institutional care), value of services is based on geographic equivalent (of home care?) and fair market value.
- Does the relative providing care have to be an heir?
- Unclear what the language on lines 19-20 mean: "this section is implemented by department staff in the department's application review procedures and in the estate recovery process." If there is law and rule, why is additional language about implementation necessary?
- No provision in the bill for CMS approval for estate recovery changes. If denied, this would come from GF?
- Sec. 2 requires a waiver for 1915(c). Unclear if this language is specific enough. Some sections of MaineCare already allow for relatives to provide personal care (see below). Are there members of MaineCare who are unable to employ a relative that are not prohibited by federal law or rule? There is no provision for denial of the waiver request by CMS.
- How does the estate recovery sections apply to state-funded programs (line 36)?

- Sec. 3 states that the department "may not presume … for the purpose of qualifying for public benefits". It doesn't increase the types of evidence that may be used. Does it mean that the department cannot seek evidence regarding the proof of transfer?
- Is the current 200% FPL for waiver exemption still in place in the rules with the Sec. 3 changes to the rules?

ADDITIONAL INFORMATION REQUESTED BY COMMITTEE:

- Why were changes made to the hardship waiver for estate recovery in 2020?
- When can family members be paid now in Maine? Are there MaineCare members/sections where this is not currently allowed and is not prohibited by federal law or rule?
  - Sec. 19 (and 63 the state funded equivalent) allows for the adult receiving services to register as a Personal Care Agency and may hire family members to provide care.
  - Adult children can be employed to take care of parents, or other family members including siblings, under certain programs including Medicaid and state-funded home and community-based services for adults with disabilities and consumer-directed programs – Sec. 19 (Medicaid) and 63 (state-funded), Sec. 12 (Medicaid) and Ch. 11 (state-funded).
  - Only in special circumstances can a family member provide nursing services in Sec. 96; cannot provide personal support services and be paid under this Section of MaineCare.
  - Others?

- **Cross-ref for Sec. 1 notwithstanding Title 22, §3174-A:**
  §3174-A. Medical coverage program for certain boarding home residents

The department shall administer a program of medical coverage for persons residing in cost reimbursement boarding homes who, but for their income, would be eligible for supplemental security income benefits on account of blindness, disability or age, and who do not have sufficient income to meet the per resident payment rate for boarding home care, including an amount for personal needs of at least $30 a month. Notwithstanding supplemental security income eligibility regulations, the department may impose a penalty for certain transfers of assets. Rules adopted pursuant to this section are routine technical rules as defined by Title 5, chapter 375, subchapter II-A.

- **Cross-refs for Sec. 2. Title 22, §7302, sub-§7:**

7. Personal care assistance services. "Personal care assistance services" means services required by an adult with long-term care needs to achieve greater physical independence, which may be self-directed and include, but are not limited to:

A. Routine bodily functions, such as bowel or bladder care;
B. Dressing;
C. Preparation and consumption of food;
D. Moving in and out of bed;
E. Routine bathing;
F. Ambulation; and
G. Activities of daily living and instrumental activities of daily living.

And Title 22, §7307:

§7307. Relatives as providers

The department may not refuse to pay a relative of an adult with long-term care needs for the provision of in-home and community support services or personal care assistance services if the relative is qualified to provide the service and the payment is not prohibited by federal law or regulation.

- **Rules excerpts (MaineCare Eligibility Manual Ch. 332, Part 15):**

Section 1.5: Fair Market Value

…

Past support for basic necessities does not include any items given as a gift or any services provided by relatives. Past support for basic necessities may include clothing, transportation or personal care provided by a relative only if this clothing, transportation or personal services were provided as part of a legally written enforceable agreement whereby the individual would transfer the asset in payment for clothes, transportation or personal services once those services have been received.

An Individual may only transfer assets for services provided by a relative if the transfer takes place at the time the service is rendered and:

I. the services must be performed after a written agreement has been executed between the applicant and provider. Other provisions stated above continue to apply.

II. at the time of the receipt of the services, the applicant may not be residing in a nursing facility or a CRBH, AFCH, or RCF.

III. at the time of the receipt of the services, the services must have been recommended in writing and signed by the applicant's physician, as necessary to prevent the transfer of the applicant to residential care or nursing facility care. Such services may not include the mere providing of companionship.

IV. at the time of application, the Department will verify the agreement by reviewing the written contract between the applicant and the provider / relative which must show the type, frequency and duration of the services being provided to the applicant and the amount of consideration (money or property) being received by the provider / relative. If the amount paid for the services is above the fair market value of the services at the time the services were delivered, then the applicant will be considered to have transferred the assets for less than fair market value. If in question, fair market value of the services may be determined by consultation with an area business which provides such services.

Section 1.6: Disproving the Presumed Transfer

Any transfer taking place will be presumed to have been made for the purpose of becoming or remaining eligible for Medicaid, unless the individual furnishes clear and convincing evidence that the transaction was for some other purpose and that there was no intent at the time to apply for Medicaid within the foreseeable future. It is the Department's responsibility to demonstrate that a transfer took place and to establish the date of the transfer. It is the individual's responsibility to prove that the transfer took place for reasons other than to gain eligibility for Medicaid.

If the individual wants to disprove the presumption that the transfer was made to establish Medicaid eligibility, the burden of proof rests with the individual. The individual must demonstrate that the transfer was specifically and solely for some other purpose than to receive Medicaid. Statements and evidence to disprove the transfer must be contained in the individual's record.

The statement should cover, but not necessarily be limited to the individual's:

I. purpose for transferring the asset;

II. attempts to dispose of the asset for fair market value;

III. reasons for accepting less than the fair market value for the asset;

IV. plans for and ability to provide financial support after the transfer;

V. relationship, if any, to the persons to whom the asset was transferred; and

VI. belief that the fair market value was received.

In addition to the individual having to prove that the transfer was made specifically and solely for a purpose other than to be Medicaid eligible, other factors to be considered include:

I. a sudden onset of a disability or blindness after the asset was transferred;

II. the diagnosis of a previously undetected disabling condition after the transfer occurred;

III. unexpected loss of other assets following the transfer;

IV. unexpected loss of income after the transfer occurs; and

V. court ordered transfers.

- Overview of the estate recovery exemptions: https://mainecenterforelderlaw.com/global_pictures/Estate-Recovery-October2019.pdf

- **MBM Ch. VII: Estate recovery (marked up version showing the changes from old rule; now adopted):**

B. **UNDUE HARDSHIP WAIVER BASED ON CARE GIVEN EXEMPTION**

MaineCare may exempt a portion of a Member's estate from estate recovery for health maintenance activities and personal care services performed for the Member by one individual who has a beneficial interest in the Estate. If the current income level of the waiver applicant is below two hundred percent (200%) of the current Federal Poverty Income Level, adjusted for the person's household size, MaineCare may designate a portion of a Member's estate as exempt from its estate recovery efforts if a person can demonstrate that health care maintenance activities or personal care services have been provided to a Member, as outlined below:

1. The applicant requesting the care given exemption provided health maintenance activities or personal care services as defined herein to the decedent during part or all of the two (2) years immediately prior to the Member's death or institutionalization, enabling the decedent to remain at home and avoid institutionalization for an equivalent period of time. The person requesting the exemption must provide corroborating statements from the decedent's primary care physician or other approved medical care provider acceptable to MaineCare.

2. Any care given exemption granted will not exceed the value of MaineCare benefits paid on the behalf of the Member, which would otherwise be subject to Estate Recovery. Following the approval of the undue hardship waiver based on a care given exemption, the Department will use one of the following formulas to determine the exempt amount:

    a. If the decedent received 24 hour a day care including health maintenance and personal care activities defined in Sections 5.02-6 and 5.02-121, that enabled the decedent to remain at home and avoid placement in institutionalized care as described in Section 5.02-87, and MaineCare was not paying for in home services at the time, the Department may grant an exemption not to exceed thirty-two thousand dollars ($32,000) per year, prorated for each month of approved care given; or

    b. If the decedent received care including personal care services and/or health maintenance activities less than those services he or she would have received in institutionalized care as described in Section 5.02-87, the Department may grant an exemption not to exceed twelve thousand dollars ($12,000) per year, pro-rated for each month of approved care given; or

    c. If the decedent received approved care for three (3) or more health maintenance or personal care activities defined in Section 5.02 everyday, the maximum exemption of twelve thousand dollars ($12,000) per year may be granted; or

    d. If the decedent received approved care for three (3) or more health maintenance or personal care activities defined in Section 5.02 at least three (3) times per week, a maximum exemption of six thousand dollars ($6,000) per year may be granted.

    These allowances are in place to assist the Member in maintaining independent living at home and reduce overutilization of institutional services. In circumstances where an

applicant may qualify for more than one level of care, the highest amount for one application will be granted.

3. Health care maintenance activities or personal care services previously used during the application process to reduce a transfer of assets cannot be counted again toward a care given exemption or a claim reduction.
4. All care given exemptions will be based on and limited to the two (2) year time period immediately prior to the Member's death or institutionalization.
5. An applicant may not be granted a waiver pursuant to this section for any services rendered to a Member and for which the applicant received compensation, either monetary or non-monetary.

FISCAL IMPACT:

Not yet received from OFPR.