§ 300ll–4. Benefits

(a) Determination of eligibility

(1) Application for receipt of benefits

The Secretary shall establish procedures under which an active enrollee shall apply for receipt of benefits under the CLASS Independence Benefit Plan.

(2) Eligibility assessments

(A) In general

Not later than January 1, 2012, the Secretary shall—

(i) establish an Eligibility Assessment System (other than a service with which the Commissioner of Social Security has entered into an agreement, with respect to any State, to make disability determinations for purposes of title II or XVI of the Social Security Act [42 U.S.C. 401 et seq., 1381 et seq.]) to provide for eligibility assessments of active enrollees who apply for receipt of benefits;

(ii) enter into an agreement with the Protection and Advocacy System for each State to provide advocacy services in accordance with subsection (d); and

(iii) enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with subsection (e).

(B) Regulations

The Secretary shall promulgate regulations to develop an expedited nationally equitable eligibility determination process, as certified by a licensed health care practitioner, an appeals process, and a redetermination process, as certified by a licensed health care practitioner, including whether an active enrollee is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance with the sliding scale established under the plan).

(C) Presumptive eligibility for certain institutionalized enrollees planning to discharge

An active enrollee shall be deemed presumptively eligible if the enrollee—

(i) has applied for, and attests is eligible for, the maximum cash benefit available under the sliding scale established under the CLASS Independence Benefit Plan;

(ii) is a patient in a hospital (but only if the hospitalization is for long-term care), nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases; and

(iii) is in the process of, or about to begin the process of, planning to discharge from the hospital, facility, or institution, or within 60 days from the date of discharge from the hospital, facility, or institution.

(D) Appeals

The Secretary shall establish procedures under which an applicant for benefits under the CLASS Independence Benefit Plan shall be guaranteed the right to appeal an adverse determination.

(b) Benefits

An eligible beneficiary shall receive the following benefits under the CLASS Independence Benefit Plan:

(1) Cash benefit
A cash benefit established by the Secretary in accordance with the requirements of section 300ll–2 (a)(1)(D) of this title that—

(A) the first year in which beneficiaries receive the benefits under the plan, is not less than the average dollar amount specified in clause (i) of such section; and

(B) for any subsequent year, is not less than the average per day dollar limit applicable under this subparagraph for the preceding year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) over the previous year.

(2) Advocacy services

Advocacy services in accordance with subsection (d).

(3) Advice and assistance counseling

Advice and assistance counseling in accordance with subsection (e).

(4) Administrative expenses

Advocacy services and advice and assistance counseling services under paragraphs (2) and (3) of this subsection shall be included as administrative expenses under section 300ll–2 (b)(2)² of this title.

(c) Payment of benefits

(1) Life independence account

(A) In general

The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

(B) Use of cash benefits

Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of their choice in the community, including (but not limited to) home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. Nothing in the preceding sentence shall prevent an eligible beneficiary from using cash benefits paid into a Life Independence Account for obtaining assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions.

(C) Electronic management of funds

The Secretary shall establish procedures for—

(i) crediting an account established on behalf of a beneficiary with the beneficiary’s cash daily benefit;

(ii) allowing the beneficiary to access such account through debit cards; and

(iii) accounting for withdrawals by the beneficiary from such account.

(D) Primary payor rules for beneficiaries who are enrolled in Medicaid

In the case of an eligible beneficiary who is enrolled in Medicaid, the following payment rules shall apply:

(i) Institutionalized beneficiary
If the beneficiary is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall retain an amount equal to 5 percent of the beneficiary’s daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary’s personal needs allowance provided under Medicaid), and the remainder of such benefit shall be applied toward the facility’s cost of providing the beneficiary’s care, and Medicaid shall provide secondary coverage for such care.

(ii) Beneficiaries receiving home and community-based services

(I) 50 percent of benefit retained by beneficiary

Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for home and community based services, the beneficiary shall retain an amount equal to 50 percent of the beneficiary’s daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

(II) Requirement for State offset

A State shall be paid the remainder of a beneficiary’s daily or weekly cash benefit under subclause (I) only if the State home and community-based waiver under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n), or the State plan amendment under subsection (i) of such section does not include a waiver of the requirements of section 1902(a)(1) of the Social Security Act [42 U.S.C. 1396a (a)(1)] (relating to statewideness) or of section 1902(a)(10)(B) of such Act [42 U.S.C. 1396a (a)(10)(B)] (relating to comparability) and the State offers at a minimum case management services, personal care services, habilitation services, and respite care under such a waiver or State plan amendment.

(III) Definition of home and community-based services

In this clause, the term “home and community-based services” means any services which may be offered under a home and community-based waiver authorized for a State under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n) or under a State plan amendment under subsection (i) of such section.

(iii) Beneficiaries enrolled in programs of all-inclusive care for the elderly (PACE)

(I) In general

Subject to subclause (II), if a beneficiary is receiving medical assistance under Medicaid for PACE program services under section 1934 of the Social Security Act (42 U.S.C. 1396u–4), the beneficiary shall retain an amount equal to 50 percent of the beneficiary’s daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

(II) Institutionalized recipients of PACE program services

If a beneficiary receiving assistance under Medicaid for PACE program services is a patient in a hospital, nursing facility, intermediate care facility for the mentally
retarded, or an institution for mental diseases, the beneficiary shall be treated as in institutionalized beneficiary under clause (i).

(2) **Authorized representatives**

(A) **In general**

The Secretary shall establish procedures to allow access to a beneficiary’s cash benefits by an authorized representative of the eligible beneficiary on whose behalf such benefits are paid.

(B) **Quality assurance and protection against fraud and abuse**

The procedures established under subparagraph (A) shall ensure that authorized representatives of eligible beneficiaries comply with standards of conduct established by the Secretary, including standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest, and do not misuse benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

(3) **Commencement of benefits**

Benefits shall be paid to, or on behalf of, an eligible beneficiary beginning with the first month in which an application for such benefits is approved.

(4) **Rollover option for lump-sum payment**

An eligible beneficiary may elect to—

(A) defer payment of their daily or weekly benefit and to rollover any such deferred benefits from month-to-month, but not from year-to-year; and

(B) receive a lump-sum payment of such deferred benefits in an amount that may not exceed the lesser of—

(i) the total amount of the accrued deferred benefits; or

(ii) the applicable annual benefit.

(5) **Period for determination of annual benefits**

(A) **In general**

The applicable period for determining with respect to an eligible beneficiary the applicable annual benefit and the amount of any accrued deferred benefits is the 12-month period that commences with the first month in which the beneficiary began to receive such benefits, and each 12-month period thereafter.

(B) **Inclusion of increased benefits**

The Secretary shall establish procedures under which cash benefits paid to an eligible beneficiary that increase or decrease as a result of a change in the functional status of the beneficiary before the end of a 12-month benefit period shall be included in the determination of the applicable annual benefit paid to the eligible beneficiary.

(C) **Recoupment of unpaid, accrued benefits**

(i) **In general**

The Secretary, in coordination with the Secretary of the Treasury, shall recoup any accrued benefits in the event of—

(I) the death of a beneficiary; or

(II) the failure of a beneficiary to elect under paragraph (4)(B) to receive such benefits as a lump-sum payment before the end of the 12-month period in which such benefits accrued.

(ii) **Payment into CLASS Independence Fund**

Any benefits recouped in accordance with clause (i) shall be paid into the CLASS Independence Fund and used in accordance with section 300ll–5 of this title.
(6) **Requirement to recertify eligibility for receipt of benefits**

An eligible beneficiary shall periodically, as determined by the Secretary—

(A) recertify by submission of medical evidence the beneficiary’s continued eligibility for receipt of benefits; and

(B) submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary during the preceding year.

(7) **Supplement, not supplant other health care benefits**

Subject to the Medicaid payment rules under paragraph (1)(D), benefits received by an eligible beneficiary shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other Federally funded program that provides health care benefits or assistance.

(d) **Advocacy services**

An agreement entered into under subsection (a)(2)(A)(ii) shall require the Protection and Advocacy System for the State to—

(1) assign, as needed, an advocacy counselor to each eligible beneficiary that is covered by such agreement and who shall provide an eligible beneficiary with—

(A) information regarding how to access the appeals process established for the program;

(B) assistance with respect to the annual recertification and notification required under subsection (c)(6); and

(C) such other assistance with obtaining services as the Secretary, by regulation, shall require; and

(2) ensure that the System and such counselors comply with the requirements of subsection (h).

(e) **Advice and assistance counseling**

An agreement entered into under subsection (a)(2)(A)(iii) shall require the entity to assign, as requested by an eligible beneficiary that is covered by such agreement, an advice and assistance counselor who shall provide an eligible beneficiary with information regarding—

(1) accessing and coordinating long-term services and supports in the most integrated setting;

(2) possible eligibility for other benefits and services;

(3) development of a service and support plan;

(4) information about programs established under the Assistive Technology Act of 1998 [29 U.S.C. 3001 et seq.] and the services offered under such programs;

(5) available assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions; and

(6) such other services as the Secretary, by regulation, may require.

(f) **No effect on eligibility for other benefits**

Benefits paid to an eligible beneficiary under the CLASS program shall be disregarded for purposes of determining or continuing the beneficiary’s eligibility for receipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles II, XVI, XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq., 1395 et seq., 1396 et seq., 1397aa et seq.), under the laws administered by the Secretary of Veterans Affairs, under low-income housing assistance programs, or under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

(g) **Rule of construction**
Nothing in this subchapter shall be construed as prohibiting benefits paid under the CLASS Independence Benefit Plan from being used to compensate a family caregiver for providing community living assistance services and supports to an eligible beneficiary.

(h) Protection against conflict of interests

The Secretary shall establish procedures to ensure that the Eligibility Assessment System, the Protection and Advocacy System for a State, advocacy counselors for eligible beneficiaries, and any other entities that provide services to active enrollees and eligible beneficiaries under the CLASS program comply with the following:

(1) If the entity provides counseling or planning services, such services are provided in a manner that fosters the best interests of the active enrollee or beneficiary.

(2) The entity has established operating procedures that are designed to avoid or minimize conflicts of interest between the entity and an active enrollee or beneficiary.

(3) The entity provides information about all services and options available to the active enrollee or beneficiary, to the best of its knowledge, including services available through other entities or providers.

(4) The entity assists the active enrollee or beneficiary to access desired services, regardless of the provider.

(5) The entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries received services from the entity or another entity.

(6) If the entity provides counseling or planning services, the entity ensures that an active enrollee or beneficiary is informed of any financial interest that the entity has in a service provider.

(7) The entity provides an active enrollee or beneficiary with a list of available service providers that can meet the needs of the active enrollee or beneficiary.

Footnotes

1 So in original. Probably should be followed by “with”.
2 See References in Text note below.
3 So in original. Probably should be “an”.
4 So in original. Probably should be “title”.


References in Text

The Social Security Act, referred to in subsecs. (a)(2)(A)(i) and (f), is act Aug. 14, 1935, ch. 531, 49 Stat. 620. Titles II, XVI, XVIII, XIX, and XXI of the Act are classified generally to subchapters II (§ 401 et seq.), XVI (§ 1381 et seq.), XVIII (§ 1395 et seq.), XIX (§ 1396 et seq.), and XXI (§ 1397aa et seq.), respectively, of chapter 7 of this title. For complete classification of this Act to the Code, see section 1305 of this title and Tables.

Section 300ll–2 (b)(2) of this title, referred to in subsec. (b)(4), was in the original section “3203(b)(3)”, and was translated as meaning section 3203(b)(2) of act July 1, 1944, to reflect the probable intent of Congress.
