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National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

WHITE PAPER

MEDICAID PAYMENT FOR ASSISTED LIVING

Overview of Medically Needy Eligibility:

A Resource for Advocacy and Policy Development

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Background on Medicaid HCBS Waivers

Medicaid payment for assisted living care generally is made in one of two ways. The state Medicaid plan may provide for personal care services, or the state may have a Medicaid home and community-based services (HCBS) waiver that authorizes payment for services provided in an assisted living facility.

This white paper analyzes only the second option—Medicaid HCBS waiver payment for assisted living care—as this is by far the most common way in which Medicaid programs pay for assisted living care. Currently 37 states pay for assisted living services through Medicaid waivers, whereas only 16 states pay through a state plan program.[1] Some states use both methods.

The Medicaid HCBS waiver (also sometimes called a Section 1915(c) waiver)[2] is designed to prevent or delay nursing facility admissions. Under the waiver, Medicaid reimbursement can be provided only for a Medicaid beneficiary whose care needs would qualify her for nursing facility admission, and only for those services that enable her to remain in her home or in an assisted living facility.[3] Such services include, but are not limited to, home health aide services and personal care services.[4]

Medicaid Eligibility Categories

Federal law requires a state to provide Medicaid coverage without any charge to all Supplemental Security Income (SSI) beneficiaries, except in the relatively limited number of states (called "209(b)" states) in which eligibility is based not on SSI but instead on the inflation-adjusted state disability payment standards from 1972 (when the SSI program first became effective).[5] A state has an option to increase the ceiling for no-cost Medicaid up to the federal poverty line ($867 in 2008, which is when the study gathered most eligibility data; $903 in 2010).[6] Also, a state may provide no-share-of-cost Medicaid to all persons receiving an optional state income supplement (State Supplemental Payment, or SSP).

In addition, for long-term care—nursing facility services and HCBS waiver services—a state has a commonly-exercised option to provide coverage for persons who otherwise would be disqualified due to excess income. For these persons, a state can set a special income limit of up to 300 percent of the federal SSI rate ($1,911 in 2008, as the federal SSI rate was $637 at that time; $2,022 in 2010, based on a federal SSI rate of $674). The beneficiary does not have an obligation to spend

1 *See* Appendix, Table 2.
2 The relevant federal statute, 42 U.S.C. § 1396n(c), is Section 1915(c) of the Social Security Act.
3 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(VI), 1396n(c)(1); 42 C.F.R. § 435.217.
4 42 U.S.C. § 1396n(c)(4)(B); 42 C.F.R. § 440.180(b)(3), (4).
5 42 U.S.C. § 1396a(a)(10)(A)(i)(II), (f); 42 C.F.R. § 435.120. The "209(b)" designation comes from the fact that this eligibility category was established by section 209(b) of Public Law 92-603 (1973).
6 42 U.S.C. § 1396a(a)(10)(A)(ii)(X), (m).

down income in order to obtain eligibility, but under state Medicaid rules she likely has a similar obligation to make specified *post*-eligibility payments towards health care expenses.[7] Also, if a person has excess income, she may nonetheless be able to obtain special-income-limit eligibility by transferring away the excess income to a qualified income trust.

An additional option for a state is medically needy eligibility. A person is deemed "medically needy" if her income, while too high to qualify under the state's other Medicaid options, is inadequate to cover her actual health care expenses. She is not eligible until she pays her "excess" monthly income—calculated in reference to a standard set by the state—for health care expenses. Following this payment, the Medicaid program will cover the remaining health care expenses incurred during that month.

A Medicaid program has the authority to offer income deductions beyond those offered by SSI. This authority dates to 1988's Medicare Catastrophic Coverage Act, and is codified at Section 1902(r)(2) of the Social Security Act.[8] For special-income-limit eligibility, such an income deduction can be used in the post-eligibility process to reduce the beneficiary's payment obligation. For medically needy eligibility, the deduction can be used to loosen eligibility standards.

Medically Needy Eligibility

In General

As discussed above, "medically needy" beneficiaries are persons whose incomes are too high for Medicaid categorical eligibility, but who otherwise meet eligibility requirements.[9] The most relevant example for the purposes of this white paper are persons who would be eligible for Supplemental Security Income (SSI)—due to age, disability, or blindness, along with low resources—but who have incomes that exceed the SSI standard, and also exceed the state's special income limit (if the state provides for special-income-limit eligibility).

Medically needy coverage is generally optional for states—it is allowed but not required. Medically needy coverage is mandatory, however, to the extent that a state's historical 209(b) obligation requires the state to maintain a medically needy program that was in place as of January 1, 1972.[10]

If a state offers medically needy eligibility, coverage must be extended to include at least two specified groups: pregnant women and minor children.[11] Other coverage groups are optional for

7 42 U.S.C. § 1396a(a)(10)(ii)(V); 42 C.F.R. §§ 435.236, 435.1005.

8 42 U.S.C. § 1396a(r)(2). Section 1396a of the United States Code is an equivalent citation for Section 1902 of the Social Security Act.

9 *See* 42 U.S.C. § 1396d(a) (eligibility for disabled persons and others who are not eligible for Supplemental Security Income but whose income and resources are inadequate to cover their health care expenses); 42 C.F.R. § 435.301(a)(1)(ii).

10 42 U.S.C. § 1396a(f).

11 42 U.S.C. § 1396a(a)(10)(C)(ii); 42 C.F.R. § 435.301(b)(1).

a state—for this white paper, the most relevant coverage groups are the aged (persons at least 65 years old), the disabled, and the blind.[12] A state is not allowed to offer eligibility only to subgroups—for example, only to assisted living residents.

In the case of the waivers covering assisted living care, the study found that medically needy eligibility was offered in thirteen states, as shown in Table 3 in the Appendix. These states are:

> California, the District of Columbia, Kansas, Maryland, Minnesota, Montana, Nebraska, New Hampshire, North Dakota, Utah, Vermont, Washington, and Wisconsin.

Of these, California, Montana, Nebraska, and North Dakota were anomalies in offering eligibility through a medically needy program but not through a special-income-limit program.[13]

A medically needy program can be important to ensure that waiver benefits are available on an adequately wide basis. It is easy to understand how an assisted living resident could have a monthly income over the special income limit of $1,911 but yet be unable to keep up with a facility's monthly private-pay charges. An over-income resident likely could use a qualified income trust to bring his income within the special income limit, but setting up and administering a trust is easier said than done, requiring a significant expenditure of time and money. (For information about qualified income trusts, consult this study's report on special-income-limit eligibility, to be released early in 2011.)

In any case, many consumers may be unaware even of the existence of an income limit. A survey by the New Jersey Public Advocate found that privately paying residents and their family members assumed that the resident would be Medicaid-eligible after spending down resources, even when the resident had an income level that in fact would have disqualified him or her for eligibility under New Jersey's $1,911 special income limit.[14] New Jersey does not offer medically needy eligibility but, in general, the interviewed residents and family members were unaware of an income limitation.

Also, the New Jersey Public Advocate found a significant number of assisted living residents with incomes over the special income limit. Based on interviews with former residents and their families, the Public Advocate determined that, of residents who had left certain assisted living facilities after spending down their resources, 23 percent had incomes over the $1,911 limit.[15]

A medically needy program can be valuable for assisted living residents but its value should be kept in perspective. When a state grants eligibility under both the special-income-limit and medically

12 2 C.F.R. §§ 435.301(b)(2), 435.320 (aged), 435.322 (blind), 435.324 (disabled).

13 Montana Application for HCBS Waiver, Appendix B-4.

14 N.J. Dep't of Pub. Advocate, Aging in Place: Promises to Keep, An Investigation into Assisted Living Concepts, Inc. and Lessons for Protecting Seniors in Assisted Living Facilities 19-20, 24, 28 (2009).

15 N.J. Dep't of Pub. Advocate, Aging in Place: Promises to Keep, An Investigation into Assisted Living Concepts, Inc. and Lessons for Protecting Seniors in Assisted Living Facilities 30-31 (2009).

needy categories, the special-income-limit beneficiaries generally are a much more numerous group.

Basic Financial Eligibility Standards for Medically Needy Eligibility

A state's medically needy program must use the same resource and income standards for each applicant, whether the applicant is (for example) an older adult or a parent with children.[16] Furthermore, states are limited in the setting of these standards. The resource standard in non-209(b) states must be set no lower than the lowest standard used to determine eligibility under SSI, which is the cash assistance program related to medically needy eligibility.[17] For persons eligible through age, disability, or blindness, the resource standard is not allowed to be any more stringent than the SSI resource standard of $2,000.

The medically needy income standard is tied to eligibility standards for Aid to Families with Dependent Children (AFDC). AFDC was repealed in 1996—replaced with the Temporary Assistance for Needy Families program—and from that point a state's medically needy income standard has been capped at no more than 133 1/3 percent of the state's 1996 AFDC income level, as adjusted for subsequent changes in the consumer price index.[18]

In 209(b) states, as is generally the case, the applicable standards are tied to the standards effective in that state on January 1, 1972. For beneficiaries whose eligibility is based on age, disability or blindness, the income and resource standards can be no lower than the *highest* of the two following standards: the state's lowest current standard for categorical eligibility, or the inflation-adjusted standard from 1972.[19]

Regarding income standards generally, an applicant is eligible if her health care expenses reduce her available income below the state's medically needy income standard – she is deemed "needy" because her income is insufficient when taking her health care expenses into account. In calculating the necessary spend-down of income for health care expenses, a state can use a period from one to six months.[20] In addition, but only for waiver services provided to disabled or elderly adults, a state is allowed to grant eligibility based on *anticipated* medical expenses.[21] In the case of assisted living residents, estimation and anticipation of expenses is a generally uncomplicated task, as each month the resident is obligated to pay a predictable amount for assisted living services.

16 42 U.S.C. § 1396a(a)(10)(C)(i)(III) (Medicaid state plan must list "single standard to be employed in determining income and resource eligibility for all such groups"); 42 C.F.R. §§ 435.811(a) (income standard); 435.840(a) (resource standard).

17 42 C.F.R. §§ 435.811(c) (income); 435.840(b) (resources).

18 42 U.S.C. §§ 1396b(f)(1)(B)(i), 1396u-1(f)(3).

19 42 C.F.R. § 435.811(d)(2), 435.840(c)(2).

20 42 C.F.R. § 435.831(a).

21 42 U.S.C. § 1396t(b)(3).

Availability of Income Deductions under Federal Medicaid Law

As is always the case in public benefits programs, certain resources and income are considered exempt or unavailable, and thus are not counted against eligibility standards. In classifying resources or income as exempt, a state Medicaid program must offer at least the same deductions applicable in the related cash assistance program—as relevant here, SSI.[22]

Also, in a procedure fully available only since 2001, a state may offer income deductions beyond those available under SSI.[23] These deductions are available both for special-income-limit eligibility and the medically needy program. A state may provide an income deduction which effectively makes the medically needy income standard less restrictive. This is important since, as discussed above, medically needy income standards otherwise are tied to 1996 AFDC payment levels.

A state's authority to allow such deductions was solidified through a relatively torturous legislative and administrative process, which is summarized in this white paper only in part.[24] The explicit authority derives from 1988's Medicare Catastrophic Coverage Act.[25] This legislative enactment, however, proved to be insufficient vis à vis medically needy eligibility. The federal Health Care Financing Administration (HCFA) interpreted the legislation in a narrow way, continuing to refuse to authorize income deductions for determinations of whether a person would be *eligible* for federally-subsidized care—as relevant here, whether a person's income would be less than or equal to the medically needy standard of 133 1/3 percent of the state's 1996 AFDC payment level.[26] HCFA at that time only recognized income deductions for *post-eligibility* payments required to be made by persons eligible under the special-income-limit category.

Finally, in 2001 HCFA capitulated to pressure from the states and others, issuing a regulation that explicitly authorized deductions in determining eligibility issues. HCFA cited among other things the 1996 legislation that had replaced AFDC with TANF, noting a Congressional intent "to sever the link between cash assistance and Medicaid."[27]

In the discussion accompanying the regulation's release, HCFA notably emphasized the flexibility given states by the new regulation. For one, HCFA cited the troubling situation in which a state's medically needy income standard is significantly lower than its SSI-linked income standard, and pointed out how an income deduction could be used to make these standards consistent. Also, HCFA noted that waiver participants are handicapped financially by the Medicaid program's

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22 42 U.S.C. § 1396a(a)(10)(C)(i)(III); 42 C.F.R. §§ 435.831(b), 435.845(b).

23 42 U.S.C. § 1396a(r)(2); 42 C.F.R. § 435.1007(e), (f).

24 During the 1980's, Congress had imposed moratoria in an attempt to prevent the federal Health Care Financing Administration from imposing penalties against states for using more lenient resource and income standards. *See* 66 Fed. Reg. 2,316, 1,316-17 (Jan. 11, 2001).

25 Pub. L. No. 100-360, Tit. III, § 303(e) (adding subsection (2) to 42 U.S.C. § 1396a(r)).

26 66 Fed. Reg. 2,316, 2,316-17 (Jan. 11, 2001).

27 66 Fed. Reg. 2,316, 2,317 (Jan. 11, 2001); *see* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. 104-193.

inability to pay for room and board costs (contrasted to Medicaid's payment for room and board for nursing facility care), and explained how an income deduction might allow a beneficiary to retain more income to better cover room and board expenses.[28] Each of these scenarios, in fact, was encountered by this study, and these two suggestions by HCFA have been followed by (for example) Washington and California, respectively, as discussed subsequently in this white paper.

This flexibility, however, is not unlimited, particularly as to the targeting of income deductions. Guidance from the Centers for Medicare and Medicaid Services (CMS, the successor to HCFA) specifically states that a state may not limit deductions only to waiver beneficiaries, or only to persons in institutions (or outside of institutions, for that matter). Targeting can only be based on eligibility groups such as the medically needy aged (at least age 65) or medically needy disabled persons. These eligibility groups can be combined so that, for example, an income deduction might apply to medically needy persons whether aged or disabled.[29]

At least initially, these targeting rules appear to significantly limit the viability of income deductions. The problem, from a state's perspective, is financial. It is one thing, for example, to offer a $200 income deduction to each of a state's 2,000 waiver beneficiaries. It is quite another for that same deduction to be offered to every aged or disabled person with medically needy eligibility.

On the other hand, a state is allowed to employ a deduction that necessarily will apply exclusively (or almost exclusively) to specific waiver settings. CMS has stated that a state can choose to disregard specific kinds of income—CMS's examples are Social Security Disability income or interest from savings accounts. Also, and of more relevance to a waiver setting, a state may disregard income used for a particular purpose. CMS offers the examples of income put into a medical savings account, or used to maintain or repair a home.[30] Under this type of deduction, a state could choose to deduct a certain portion of a resident's income paid for room and board in an assisted living facility.

Calculations Used in Specific States for Determining Medically Needy Eligibility

California

The study found that, like Montana (see below), California offered a medically needy program without offering eligibility through a special-income-limit category. California, however, was not as heavily dependent on the medically needy category. In addition to offering eligibility without a share of cost to persons eligible for SSI and/or the optional state supplement, California extended

28 66 Fed. Reg. 2,316, 2,320 (Jan. 11, 2001).

29 CMS, Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers (May 11, 2001).

30 CMS, Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers (May 11, 2001).

no-share-of-cost eligibility to persons whose available income did not exceed the total of the federal poverty rate plus $230. In 2008, this meant that no-share-of-cost eligibility for Medicaid generally was provided to persons with countable incomes up to $1,097 ($867 federal poverty rate + $230).

California's medically needy income limit has been and remains only $600 monthly, but various income deductions make medically needy coverage more accessible to assisted living residents than might be expected. A resident has a choice of two income deductions. The first is based on the amount that a resident pays for basic services in an assisted living facility. Federal Medicaid law requires a medically needy disregard for cost incurred "for medical care or for any other type of remedial care recognized under State law."[31] In accord, the corresponding federal regulation refers to "necessary medical and remedial services," and the statutory definition of "medical assistance" includes personal care services provided outside of a hospital, nursing facility, or other medical institution.[32] The end result is that basic assisted living services are recognized as a deductible cost under federal law. In accord, California since 2000 has offered an income deduction of $315 monthly for assisted living residents.[33]

The other deduction is comprised of the difference between the $600 medically needy income limit, and the actual monthly cost of assisted living care (including room, board and services, but not waiver services).[34] The effect of this deduction is to allow the resident to retain enough income to cover the facility's monthly charge. Assume, for example, that a facility's basic charge is $1,500. The resident will receive a $900 income deduction ($1,500 - $600), and can retain a total of $1,500 ($900 income deduction + $600 medically needy level).

As assisted living fees have risen, this second income deduction (based on the monthly cost for basic services) has become more usable than the first deduction (a set deduction for $315). If the facility's charge for basic services is $916 or more, the deduction based on the basic-service charge will exceed the designated deduction for personal care services ($916 - $600 = $316).

<u>Minnesota</u>

Minnesota's medically needy eligibility standard is set at 75 percent of the federal poverty level for a single person. This poverty level was $867 in 2008, so the medically needy income standard was $650. Also, the state offered no-share-of-cost Medicaid for all those elderly or disabled persons with incomes at the federal poverty level or below. Thus, a person with a monthly countable income of $850 would have no payment obligation, but a person with a countable income of $875 would be required to pay $225 monthly ($875 - $650) for health care as a precondition for

31 42 U.S.C. § 1396b(f)(2)(A).

32 42 U.S.C. § 1396d(a)(24); 42 C.F.R. § 435.831(e).

33 The deduction was added in response to a court order brought by an aggrieved assisted living resident. *See* Pettit v. Bonta, Order on Petition for Writ of Mandamus, Case No. 99 CS 01150, Sacramento County Superior Ct. (Feb. 10, 2000); Cal. Dep't of Health Services, All County Welfare Directors Letter No. 00-56 (Nov. 15, 2000).

34 Cal. Code Regs. tit. 22, § 50515(a)(3).

medically needy coverage.

A Minnesota state respondent reported that individuals meeting medically needy eligibility standards accounted for approximately seven percent of waiver beneficiaries.

Montana

Montana was a state in which medically needy beneficiaries constituted a notably high percentage of waiver beneficiaries overall—approximately 43 percent. This was less of function of generous eligibility standards, and much more the result of the state not offering special-income-limit eligibility. The medically needy income level was $545 and the personal needs allowance was $100, leaving the resident with no more than $445 monthly to pay for room and board.[35]

Utah

Utah's medically needy income standard was $382. The state employs an income deduction to raise this amount to 100% of the federal poverty line, which was $867 in 2008.

Vermont

Vermont offered medically needy eligibility with an income deduction. Vermont is in many ways a special case: its Medicaid program operated under a demonstration waiver from 1994 through 2000, and its long-term care programs since 2005 have operated under the Choices for Care demonstration waiver (*not* an HCBS waiver).

In 2008, Vermont set its medically needy standard at $950 in an urban area and $883 in a rural area. In each case, the standard was far higher than what would be allowed under the 133 1/3-percent-of-AFDC requirement. Part of this discrepancy is due to the fact that Vermont had operated under a waiver during the late 1990's, and the subsequent medically needy income standard was approved via grandfathering. But more relevant to the discussion here, and to other states' Medicaid programs, is the fact that an additional part of the discrepancy is attributable to the state's use of an income deduction. In essence, the state deducts an amount of money equal to the amount by which the 1996 AFDC payment amount would have increased from then until the present, if increases based on the consumer price index had been applied annually. The end result is that the medically needy standard has been effectively raised to account for inflation from 1996 through the present.

A Vermont state respondent estimated that approximately 25 percent of its waiver beneficiaries obtain eligibility through the medically needy program.

Washington

For one or two persons respectively, the medically needy income standards are $467 and $592;

35 Montana Application for HCBS Waiver, Appendix I-5.

these figures represent 133 1/3 percent of the state's 1996 AFDC payment. Regardless, Washington is able effectively to use a medically needy standard that is equivalent to the federal SSI benefit rate, by disregarding any income between the medically needy standard and the federal SSI benefit level for an individual. The relevant Medicaid state plan amendment is entitled "More Liberal Method of Treating Income Under Section 1902(r)(2) of the Act," and states as follows:

> Effective January 1, 2005, disregard the difference between the medically needy standard … and the SSI benefit for an individual …. This applies to all medically needy groups: children, pregnant women, and the aged, blind and persons with disabilities."[36]

Thus, for either a single person or a married couple, Washington's medically needy calculations are based upon the single-person SSI federal benefit rate, which in 2008 was $637. The income deduction in effect serves to replace the AFDC-linked income standard with an income standard based on the SSI federal benefit rate.

Eligibility calculations for assisted living are based upon the facility's Medicaid-contracted rate over an average month of 30.42 days.[37] Assume, for example, that a facility's contracted rate in 2008 was slightly under $50 per day, so that the monthly rate multiplied out to $1,500 ([daily rate] X 30.42 days = $1,500). A resident would be automatically eligible under medically needy eligibility as long as his income was no more than $2,137 monthly ($637 + $1,500 = $2,137). If his income exceeded that amount, he could become eligible by incurring other health care expenses. Alternatively, he would become eligible if his assisted living expenses were to increase by the necessary amount, owing to a corresponding increase in his care needs.

In enrollment, Washington's Medically Needy Residential (MNR) waiver is much smaller than the special-income-limit COPES waiver. ("COPES" is an acronym for Community Options Program Entry System.) For the 12 months running roughly from Spring 2006 until Spring 2007, the COPES waiver covered 12,313 residents, as opposed to only 584 residents for the MNR waiver.[38] Similarly, for roughly the following 12 months, the state allocated funding for 12,681 facility residents reimbursed through the COPES waiver, as opposed to only 1,627 facility residents through the MNR waiver.[39]

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36 Washington State Medicaid Plan, Attachment 2.6-A, Supplement 8a, at 8. Section 1902(r)(2) of the Social Security Act is codified at 42 U.S.C. § 1396a(r)(2).

37 Wash. Admin. Code § 388-515-1540(6)-(10).

38 Washington's Annual Report on Home and Community-Based Services Waivers (CMS Form 372), COPES Waiver, April 1, 2006 – March 31, 2007, Lag Report; Washington's Annual Report on Home and Community-Based Services Waivers (CMS Form 372), MNRW Waiver, May 1, 2006 – April 30, 2007, Lag Report.

39 COPES Waiver, Appendix G-2; MNRW waiver, Appendix G-2. For the period April 2007 through March 2008, the COPES waiver estimated payment for 4,457 persons receiving adult family home care, 1,857 persons receiving enhanced adult residential care, and 6,367 persons receiving assisted living care. For a similar 12-month period (May 2007 through April 2008), the MNRW waiver estimates for the same types of facility care were 737, 120 and 770, respectively.

Wisconsin

Wisconsin, by contrast, did not provide any additional income deduction for medically needy eligibility, so a medically needy beneficiary was required to spend down income all the way to $591.67 monthly. This has been the state's medically needy income standard since at least 2001.[40] A state respondent reported that the medically needy category accounts for relatively few waiver beneficiaries—specifically, the medically needy beneficiaries constituted only 2.01 percent of the persons receiving assisted living services through the waiver. Broken out, medically needy beneficiaries constituted 0.7 percent of waiver beneficiaries in Adult Family Homes, 2.99 percent of beneficiaries in Community Based Residential Facilities, and 4.74 percent of beneficiaries in Residential Care Apartment Complexes.

Table 1

States Offering Medically Needy Eligibility (2008)

State	Income Standard (2008)	State Policy
California	$600	Additional deduction for basic services ($315 in 2008) or for room and board expenses exceeding $600.
District of Columbia	$554	
Kansas	$727	
Maryland	$350	
Minnesota	$650	Income standard set at 75% of federal poverty line.
Montana	$645	No special income limit eligibility.
Nebraska	$637	
New Hampshire	Room and board costs plus $56	
North Dakota	$500	
Utah	$867	Income deduction to raise income standard to 100% of federal poverty line.
Vermont	$950 urban; $883 rural	1996 AFDC rate adjusted for inflation.
Washington	$637	Income deduction setting income standard at SSI federal benefit level.
Wisconsin	$591.67	

40 Wis. Dep't of Health Servs. Medicaid Manual § 39.4.1.

Evaluation of Income Deductions Used By States for Medically Needy Eligibility

In most states, the medically needy income level is relatively low even for persons living in the community, and is particularly low when compared to the likely cost of room and board in an assisted living facility. As a practical matter, if medically needy eligibility is to be usable, the state must provide an income deduction that brings the effective income level closer to what a facility might charge as payment for room and board.

As discussed above, Medicaid law allows a state to provide an income deduction that allows an assisted living resident to retain additional income. The Washington deduction is tied to the federal SSI benefit level; the end result is that a resident ultimately is able to retain the same amount of income under each of the paths to eligibility: whether he 1) is SSI-eligible and receives Medicaid with no share of cost; 2) is eligible under the special income limit and has to pay down income pursuant to post-eligibility payment obligations; or 3) obtains medically needy eligibility by spending down income. In all cases, he "retains" monthly income equivalent to the federal SSI benefit, although most of that income is then paid to the facility for room and board, with the resident retaining the remainder as a personal needs allowance. This type of structure has the advantage—or disadvantage, arguably—of leaving each Medicaid-eligible person in essentially the same position financially. The argument is whether the SSI benefit level is adequate to cover room and board expenses, and the answer in most cases probably is "no."

As discussed, California provides an income deduction based on the facility's monthly charges. From a resident's point of view, this type of strategy has the obvious advantage of tracking the resident's expenses for room and board. The Medicaid income allocation rises as the facility's charge increases. It is difficult to evaluate the impact of this rule, since the California waiver remains quite small compared to the state's size. The waiver originally was authorized for three years—2006 through 2008—and then was renewed for an additional five years, effective March 1, 2009. Throughout most of this time, the waiver has been limited to only three counties—Los Angeles, Sacramento, and San Joaquin—with intentions to expand the program to four additional counties. Currently there are only 66 certified facilities statewide.[41]

41 *See* Assisted Living Waiver (ALW), www.dhcs.ca.gov/services/ltc/Pages/ALWPP.aspx.

APPENDIX

Table 2

State Options for Covering Assisted Living Services through Medicaid (2008)

State	Medicaid Waiver	Medicaid State Plan
Alabama	---	---
Alaska	Yes	---
Arizona	Yes	---
Arkansas	Yes	Yes
California	Yes	---
Colorado	Yes	---
Connecticut	Yes	---
Delaware	Yes	---
District of Columbia	Yes	---
Florida	Yes	Yes
Georgia	Yes	---
Hawaii	---	---
Idaho	Yes	Yes
Illinois	Yes	---
Indiana	Yes	---
Iowa	Yes	---
Kansas	Yes	---
Kentucky	---	---
Louisiana	---	---
Maine	---	Yes
Maryland	Yes	---
Massachusetts	---	Yes
Michigan	---	Yes
Minnesota	Yes	Yes
Mississippi	Yes	---
Missouri	---	Yes
Montana	Yes	Yes
Nebraska	Yes	---
Nevada	Yes	---

State	Medicaid Waiver	Medicaid State Plan
New Hampshire	Yes	---
New Jersey	Yes	---
New Mexico	Yes	---
New York	---	Yes
North Carolina	---	Yes
North Dakota	Yes	Yes
Ohio	Yes	---
Oklahoma	---	---
Oregon	Yes	---
Pennsylvania	---	---
Rhode Island	Yes	---
South Carolina	---	Yes
South Dakota	Yes	---
Tennessee	Yes	---
Texas	Yes	---
Utah	Yes	---
Vermont	Yes	Yes
Virginia	Yes	---
Washington	Yes	Yes
West Virginia	---	---
Wisconsin	Yes	Yes
Wyoming	Yes	---

Table 3

Eligibility Through Special Income Limit Program and Medically Needy Program (2008)

State	Medically Needy Eligibility? Yes/No	If Yes, Medically Needy Income Standard	Special Income Limit Eligibility? Yes/No	If Yes, Special Income Limit
Alaska	No	---	Yes	$1,656
Arizona	No	---	Yes	$1,911 (300% of federal SSI rate)
Arkansas	No	---	Yes	$1,911
California	Yes	$600	No	---
Colorado	No	---	Yes	$1,911
Connecticut	No	---	Yes	$1,911
Delaware	No	---	Yes	$1,593 (250% of federal SSI rate)
District of Columbia	Yes	$554	Yes	$1,911
Florida	No	---	Yes	$1,911
Georgia	No	---	Yes	$1,911
Idaho	No	---	Yes	$1,911
Illinois	No	---	Yes	$1,911
Indiana	No	---	Yes	$1,911
Iowa	No	---	Yes	$1,911
Kansas	Yes	$727	Yes	$1,911
Maryland	Yes	$350	Yes	$1,911
Minnesota	Yes	$650	Yes	$1,911
Mississippi	No	---	Yes	$1,911
Montana	Yes	$645	No	---
Nebraska	Yes	$637	No	---
Nevada	No	---	Yes	$1,911
New Hampshire	Yes	Room & Board plus $56	Yes	$1,250
New Jersey	No	---	Yes	$1,911
New Mexico	No	---	Yes	$1,911
North Dakota	Yes	$500	No	---

State	Medically Needy Eligibility? Yes/No	If Yes, Medically Needy Income Standard	Special Income Limit Eligibility? Yes/No	If Yes, Special Income Limit
Ohio	No	---	Yes	$1,911
Oregon	No	---	Yes	$1,911
Rhode Island	No	---	Yes	$1,911
South Dakota	No	---	Yes	$1,911
Tennessee	No	---	Yes	$1,734 (200% of federal poverty line)
Texas	No	---	Yes	$1,911
Utah	Yes	$867, plus housing costs up to $300 and utility allowance	Yes	$1,911
Vermont	Yes	$950 urban; $883 rural	Yes	$1,911
Virginia	No	---	Yes	$1,356
Washington	Yes	$637	Yes	$1,911
Wisconsin	Yes	$591.67	Yes	$1,911
Wyoming	No	---	Yes	$1,911

The Assisted Living Policy Issue Brief Series

With support from the Commonwealth Fund, the National Senior Citizens Law Center (NSCLC) recently undertook an extensive study of federal and state Medicaid policies for assisted living coverage, focusing on how those policies impact the lives of assisted living residents.[1]

The results of this study are laid out in a series of policy issue briefs being released by NSCLC from Fall 2010 through Spring 2011. Each of these policy issue briefs discusses problems with the status quo, and makes recommendations for change. In many instances, a policy issue brief has a companion white paper that discusses the same or related issues in greater detail.

This paper is one of the companion white papers, providing more detail on how medically needy eligibility works, and how states are using and could use medically needy eligibility to expand access to assisted living care. This paper is designed to be used as a resource by advocates, state Medicaid officials, facility operators, and others with an interest in developing or improving Medicaid payment for assisted living. Both this paper and the accompanying policy issue brief are available at NSCLC's website, www.nsclc.org.

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1 The research included a survey of respondents in the 37 states that pay for assisted living services through a Medicaid Home and Community-Based Services waiver, as well as more in-depth research of policies and practices in five of those states: Arkansas, New Jersey, Oregon, Texas, and Washington. The research was conducted in cooperation with the University of California at San Francisco. This paper, however, is written by the National Senior Citizens Law Center, which is solely responsible for the findings, opinions, and recommendations expressed herein.