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National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

WHITE PAPER

MEDICAID PAYMENT FOR ASSISTED LIVING

How Supplemental Payments Affect Assisted Living Resident's Eligibility for Medicaid and SSI:

A Resource for Advocacy and Policy Development

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The Issue

When a Medicaid-eligible assisted living resident is provided services under Medicaid waiver payment, she is required to spend virtually all of her income towards room, board and assisted living services. Additional payment for the services is provided by the Medicaid program under a Medicaid-designated reimbursement rate.

Assisted living facilities often claim that Medicaid rates are inadequate, and seek additional payment from the resident or the resident's family. This white paper recommends that facilities should not be allowed to seek such supplemental payments, and that Medicaid-authorized rates should be set at adequate levels.

The white paper examines four aspects of this issue: how states set rates, how facilities sometimes seek supplemental payments, how some states regulate or prohibit supplementation, and how supplementation can have negative impacts on a resident's eligibility for Medicaid or Supplemental Security Income (SSI).

I. Introduction

Assisted living facilities often claim—sometimes with justification—that Medicaid-authorized rates are insufficient to cover the room, board and services provided to Medicaid-covered residents. In some instances, the facilities demand extra payment from the resident or the resident's family, often characterizing payments as "voluntary contributions" rather than payment for room, board, or services.

These demands often put residents and families in a difficult or untenable position. Among other things, supplemental payments by families generally are considered income to the resident, potentially leading to termination or reduction of eligibility for Medicaid and/or SSI. To avoid benefit reductions, sometimes payments are made under the table.

Current policy should be revised both to protect residents and their families from exploitation, and to preserve the integrity of the Medicaid and SSI programs. Medicaid allocations for room, board and services should bear a reasonable relationship to facility costs and, in accord, facilities must be limited to charging only Medicaid-approved amounts.

II. State Medicaid Allocations for Assisted Living Often Do Not Reflect Facilities' Cost of Providing Room and Board.

When assisted living care is covered through a Medicaid Home and Community-Based Services (HCBS) waiver, the facility receives two primary types of payment: one for services and another for room and board.

Payment for *services* is based on a rate developed and paid by the Medicaid program. The amount paid for services at least purports to track the costs of providing those services. Depending on the resident's income, she may pay a portion of this amount.

The amount of the *room and board* payment is often set by the Medicaid program, principally through Medicaid calculations that require residents to pay a certain amount towards the assisted living services and, concomitantly, that designate a certain amount that will *not* be paid for services and will be retained by the resident to cover personal needs. The resident's remaining income is allocated for payment of room and board expenses.

The room and board allocation, however, generally does not track the real costs of room and board. Instead, a resident's "available income" (comprised of the room and board allocation plus the personal needs allowance) often is keyed to the federal Supplemental Security Income (SSI) benefit or, in some states, the federal SSI benefit plus a state supplement. If the resident has relatively little other income—the most common example of "other" income being Social Security retirement benefits—his total income will be supplemented to an amount set by the SSI and state supplement benefit levels.

Even if a resident's "other" income is high enough to disqualify him from SSI and any state supplement, his "available" income under Medicaid rules still likely will be based on the SSI and state supplement standards. He will be required to spend down that higher amount on assisted living *services* and other medical expenses, and ultimately will be allowed only to retain roughly the same amount of income he would have had if receiving SSI and/or a state supplement. In brief, the resident's designated payment for assisted living services generally will reduce his income to the amounts designated for room and board plus the personal needs allowance.

States have discretion to set the authorized amount for room and board. In 2008, states' room and board allocations commonly fell within the $500-$599 range, accompanied by personal needs allowances for the resident of between $50 to $100. Some states had smaller allocations; for example, *Maryland* only allowed a resident $420 for room and board and $68 for a personal needs allowance.[1] On the higher end, *Florida* used a room and board allocation of $715.40 but with a personal needs allowance of only $54. *California* paid a relatively high state supplement, resulting in a room and board allocation of $928 and a personal needs allowance of $121.

In most cases, these allocations were not linked to true room and board costs. This discrepancy is responsible to a significant extent for facilities' attempts to obtain supplemental payments.

1 Md. Home and Community-Based Services Waiver for Older Adults, Appendix B-5-c-2; Md. Regs. Code tit. 10, §§ 10.09.24.10(D)(2)(c), 10.09.54.03(C)(8)(a)(i).

III. Facilities Seek Supplemental Payments From Families; Regulators Respond

Because Medicaid-eligible residents have limited income available for room, board and services, some assisted living facilities have sought supplemental payments from residents' family members or friends, sometimes claiming that the resident cannot stay without a supplemental payment.

State responses have varied. Seventeen states allow supplementation, sixteen prohibit the practice (sometimes with exceptions, as noted below), and four have no policy. See Table 1, below.

Table 1

State Policy towards Supplementation by Family Members or Friends[2]

Allows	Prohibits	No Policy
Arizona	Alaska	Arkansas
Colorado	California	District of Columbia
Connecticut	Delaware	Mississippi
Florida	Illinois	Wyoming
Georgia	Indiana	
Idaho	Maryland	
Iowa	Montana	
Kansas	Nebraska	
Minnesota	New Hampshire	
Nevada	Ohio	
New Jersey	Oregon	
New Mexico	Rhose Island	
North Dakota	South Dakota	
Tennessee	Texas	
Utah	Vermont	
Washington	Virginia	
	Wisconsin	

2 Information in table drawn in part from Robert Mollica, et al., Residential Care and Assisted Living Compendium: 2007, Public Financing of Services, Medicaid Financing for Services in Residential Care Settings, Limiting the Amount Facilities Can Charge for Room and Board, and from Pa. Gen. Assembly, Legislative Budget & Finance Comm., State Efforts to Fund Assisted Living Servs., at 49 (June. 2008).

Many states that prohibit supplementation allow some exceptions, the most common of which allows for additional payments for a private room, since SSI and Medicaid rates are generally based on double-occupancy.

In other states, the prohibition is absolute. For example, an *Ohio* guide for providers explicitly states that a facility is not allowed to charge a higher rate for a larger unit, and cannot accept supplementation of the Medicaid rate for assisted living services.[3] *Texas* regulations also prohibit supplementation for a private room, as a private room is part of the Medicaid-covered package.[4]

Almost universally, states allow families to pay for such non-covered incidental items as phone bills, beauty shop services (above and beyond a routine haircut), newspapers, and cable television services.[5] These exceptions are generally noncontroversial, as payments are being made for goods and services that are neither room and board nor part of Medicaid-covered assisted living services.

Some state law attempts to distinguish between "payments" and "voluntary contributions" made by family members or friends. For example, in reference to SSI-eligible residents, *California* regulations state that a limitation on room and board charges "shall not preclude the acceptance by the facility of *voluntary contributions* from relatives or others."[6] Most likely, the regulation was written to condone a strategy in which a payment is claimed as a "voluntary contribution" in order to avoid a reduction in the resident's SSI payment.[7] (See discussion below.)

Also in the case of an SSI-eligible resident, *Florida* law allows a third party (presumably a family member or friend) to make a payment to the facility. The payments are described as "contributions" that "shall be entirely voluntary and shall not be a condition of providing proper care to the client." The monthly contribution must not exceed two times the provider rate under the state supplementation program; this provider rate in 2008 was $78.40 monthly.[8]

IV. Impact of Supplementation on a Resident's Eligibility for Public Benefits

Supplementation can cause ineligibility or reduced benefits under SSI and/or Medicaid.

Impact on SSI: An SSI payment is reduced when the beneficiary receives "in kind" support, e.g.,

3 Ohio Dep't of Aging, Ohio's Assisted Living Medicaid Waiver Program: Provider Certification Guide, at 18-19 (Nov. 2008).
4 40 Tex. Admin. Code § 46.15.
5 *See*, e.g., 40 Tex. Admin. Code § 46.15; Cal. Code Regs., tit. 22, § 87464(e); Ohio Dep't of Aging, Ohio's Assisted Living Medicaid Waiver Program: Provider Certification Guide, at 14 (Nov. 2008).
6 Cal. Code Regs., tit. 22, § 87464(e)(1) (emphasis added).
7 *See* California Department of Social Servs., Community Care Lic. Div., Handbook Guidance for Cal. Code Regs., tit. 22, § 87590(e)(1). During a 2008 regulatory reorganization, section 87590 was reissued without revision as section 87464. Cal. Regulatory Notice Register 2008, No. 11-Z, at 387 (Mar. 14, 2008).
8 Fla. Stat. Ann. § 409.212(4).

when a third party (generally a family member or friend) provides the beneficiary with food or shelter.[9] In an assisted living facility or other residential facility, a third party's payment for the resident's food and/or shelter is considered in-kind income to the resident.[10]

The reduction for in-kind income is made on a dollar-for-dollar basis, up to one-third of the federal SSI benefit ($212 in 2008). In the assisted living context, the one-third reduction is a presumed maximum value, and the beneficiary retains the right to show that in-kind income actually was less.[11] No reduction will be assessed if the supplemental payment is designated towards an item or service other than food or shelter, e.g., payment of the phone bill by a family member.

A state supplemental payment—made by some states on top of federal SSI benefits—is not necessarily affected by payment from a family member or friend. Policies on this issue vary from state to state.

Impact on Medicaid: The impact of supplementation on Medicaid benefits is more complex and state-specific.

Indeed, state variations can be significant. This study's five focus states provide examples of the range of state Medicaid policy on payments by family or others. Washington and New Jersey follow SSI rules relatively closely, with the *Washington* rules explicitly referencing SSI rules.[12] *New Jersey* regulations specifically address the issue in the context of residential care, stating that a resident is receiving in-kind income "[w]hen a proprietary (private for-profit) or private nonprofit facility provides support and maintenance to [the resident] because a third party pays the facility on that [resident's] behalf."[13]

Interestingly, Arkansas and Texas exempt waiver beneficiaries at least in part from in-kind income rules. *Arkansas* generally follows SSI rules, and specifically states that a third-party payment to a non-medical residential facility is considered to be the resident's income.[14] These rules, however, are overridden for waiver beneficiaries.[15]

Texas regulations contain two relevant exemptions. One exemption is waiver-focused; the other exemption broadly waives in-kind income rules if the Medicaid beneficiary "lives in a commercial room-and-board establishment."[16]

Oregon changed its policy during 2008. For the first part of the year, the Oregon Medicaid program

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9 20 C.F.R. § 416.1102.
10 20 C.F.R. § 416.1145.
11 20 C.F.R. § 416.1140.
12 *See* Wash. Admin. Code §§ 388-450-0005(7), 388-475-0600, 388-475-0700(4).
13 N.J. Admin. Code tit. 10, § 71-5.4(a)(13)(iii)(2).
14 Arkansas Medical Services Policy Manual § 3347.2.
15 Arkansas Medical Services Policy Manual § 3347.
16 1 Tex. Admin. Code § 358.455(b)(1)(A), (E).

used rules similar to the SSI rules to evaluate in-kind income. As of October 1, 2008, however, the state Medicaid program disregards in-kind income, including shelter-in-kind.[17]

Ways in Which Supplementation Might Affect Medicaid Eligibility

In states that count family payments as in-kind income, there are several ways in which family supplementation could negatively affect a resident's Medicaid coverage, depending on how the resident qualifies for Medicaid.

1. Beneficiary's only income is SSI.

SSI eligibility brings with it automatic eligibility for Medicaid with no share of cost. If supplementation leads to reduction but not termination of SSI benefits, the resident continues to receive Medicaid coverage with no share of cost.

Example: A resident's income consisted entirely of SSI benefits ($637 monthly in 2008). Receipt of in-kind income could cause at most a one-third reduction in the SSI benefit, and the resident's Medicaid eligibility would continue with the reduced SSI monthly benefit of $425.

2. Beneficiary receives other income, as well as SSI.

When SSI is supplemental to other income, supplementation by family or friends can cause the beneficiary to lose SSI eligibility and, in turn, no-share-of-cost Medicaid eligibility.

Example: In 2008, an assisted living resident received $520 from Social Security retirement benefits and only $137 from SSI. (Since the first $20 of "other" income is disregarded, the resident overall received $657, rather than $637.) In this case, a $200 payment by a family member for food and/or shelter would result in loss of the $137 SSI benefit, and, as a result would terminate no-share-of-cost Medicaid also. Depending on the state, the resident might be eligible for Medicaid through a different eligibility group, but with a payment obligation.

3. Beneficiary's Medicaid eligibility is based on his income being under the long-term care special income limit.

A family member's supplemental payment could result in Medicaid termination if the resident's eligibility had been based on his income being under the long-term care special income limit—in most states, $1,911 in 2008. A Medicaid program generally follows the same income-counting rules as the corresponding public benefits program, which in this case is SSI.[18]

Example: A resident's available income was $1,800 monthly. A family member's payment of $200

17 Oregon Medicaid State Plan, Supplement 12 to Attachment 2.6-A.
18 42 C.F.R. § 42 CFR 435.601(b).

towards food or shelter would constitute in-kind income that would push the resident over the Medicaid limit.

When the supplemental payment does not push the resident over the special income limit, supplementation under SSI income-counting rules would cause a corresponding increase in a resident's obligation to make payments towards his health care expenses. Under special-income-limit eligibility in particular, a resident generally has a post-eligibility obligation to make a specified payment towards his health care expenses. Similarly, a resident with medically needy eligibility must pay a certain amount in health care expenses (including assisted living expenses) before the Medicaid program will cover waiver services and other health care expenses. In either of these situations, supplementation would translate to an increase to a resident's payment obligation on a virtual dollar-for-dollar basis.

Policy Responses: Facilities Should Be Required to Accept Designated Amounts as Payment in Full, Without Supplementation

Both regulatory action and vigorous oversight are needed to protect Medicaid-eligible residents. States should adopt clear policies that protect residents and their families from demands for payments above limits. Clear federal guidance to the states in the form of statute, regulations and/or waiver approval criteria would assure uniform treatment of assisted living residents in all states.

Facility Charges For Room and Board Should Be Limited to Allocation Set By Medicaid Calculations.

State law should explicitly limit a facility's room and board charges to the amount allocated to the resident for room and board by Medicaid calculations. Without an explicit limit on room and board charges, a resident might be forced to expend some or all of her personal needs allowance on the room and board expenses. Older adults can be in a vulnerable position when needing assisted living services, and a facility might require payment of all or virtually all of a resident's available income, including the personal needs allowance. Indeed, some residential care facilities have required payment of personal needs allowances even when the allowance is protected by law.[19]

19 *See, e.g.,* Elder v. Fischer, 717 N.E.2d 730 (Ohio Ct. App. 1998) (residential care facility illegally obtaining payment of residents' personal needs allowances); Dworkin v. Dombrowski, 761 N.Y.S.2d 245, 2003 N.Y. App. Div. LEXIS 6286 (N.Y. App. Div. 2003) (same); Cortigiano v. Oceanview Manor Home for Adults, 227 F.R.D. 194, 199-200 (E.D.N.Y. 2005) (residential care facility denying or restricting residents' access to personal needs allowances).

Facilities Should Not Be Allowed to Request or Accept Supplemental Payments From a Resident's Family or Friends.

Public benefits programs should be based on consistent rules. It is not fair to the facility, resident or resident's family to have a model that assumes ad hoc payments from a resident's family members. HCBS waivers have been set up to provide a cost-effective alternative to nursing facility care, and for fairness' sake the resident's obligation should be fixed. This gives the facility and resident the same level of certainty that they have in a nursing facility setting, and allows state Medicaid programs to more accurately compare waiver services with nursing facility services.

When a public benefits program makes a payment designated for a service provider, the program generally expects the provider to accept the specified amount as payment in full. Medicaid law, for example, explicitly requires that a Medicaid-certified provider accept the authorized payment—the Medicaid payment along with any specified contribution from the beneficiary—as payment in full.[20] These Medicaid provisions should be enforced in assisted living.

The most rational state policy on this issue is one that explicitly limits a facility to receipt of the applicable public benefits payments (SSI, the state supplement, and/or Medicaid, as the case may be) and whatever contribution is required from the resident under those programs.

State Allocations for Room and Board Should Be Based on Reasonable Facility Costs, Rather than Federal SSI Payment Levels

The Medicaid rate for assisted living *services* is often based in some way on the costs of providing those services. By contrast, most states' room and board allocations are not based on the costs of providing room and board, but instead are based on SSI benefit levels. The amount of the SSI rate, unfortunately, has little empirical link to the real monthly costs of room and board, or of a resident's personal needs.

Because, in large part, room and board is *not* a covered service under Medicaid, room and board allocations have received much less attention than the Medicaid rates for providing services. This should change. Inadequate room and board allocations hurt providers, residents, and residents' family members and friends. Also, those inadequate allocations have created a system which is all too reliant on facilities soliciting inappropriate payments from residents, family members, and friends.

20 42 C.F.R. § 447.15.

The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation and the education and counseling of local advocates, we seek to ensure the health and economic security of older adults with limited income and resources, and access to the courts for all.

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, examining how public policies can protect assisted living residents when facilities attempt to charge low-income residents excessive amounts, or require families to pay on top of Medicaid-authorized payments. 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.

The study and the development of this paper were supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the author and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.

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.