HB 270

3480

Alaska State House of Representatives

Session:
State Capitol, Room 409
Juneau, AK 99801-1182
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Session:
State Capitol, Room 102
Juneau, AK 99801-1182
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Sponsor Statement:

Representative Cathy Munoz (R-4)
Representative Paul Seaton (R-35)
Representative Bob Herron (D-38)
Representative Max Gruenberg (D-20)

HB270 - Medicaid For Medical & Intermediate Care

"An Act amending the eligibility threshold for medical assistance for persons in a medical or intermediate care facility."

Status: PREFILE RELEASED >> (H) HSS : 2010-01-19

In 2003, the Legislature modified Alaska Statute to freeze the Medicaid long-term services income eligibility limit at that year's level ($1,656). This change created a ceiling for waiver eligibility, rather than allowing the eligibility limit to adjust annually in tandem with the Supplemental Security Income maximum benefit amount. This meant that from 2003 on, a small Social Security cost of living adjustment could put a person over the $1,656 limit, and in effect disqualify many people from the program.

The Supplemental Security Income (SSI) is a federal needs-based disability program for adults and children. For an adult, the SSI disability requirement is based on the ability to work. An adult is considered disabled if the person cannot do the work that they performed before the disability occurred or cannot do alternate work because of a severe physical or mental condition. For a child to be eligible, they must suffer from serious physical and/or mental problems. For both adults and children, the disability must last, or be expected to last for at least one year.

House Bill 270 will change the current income eligibility rate which is frozen at $1,656 a month, or 300% of the 2003 SSI benefit rate, to 300% of the current SSI rate.

Near the end of 2008 many individuals received notices that they would no longer be eligible for the waiver after the 2009 Social Security COLA went into effect. Because the waiver eligibility limits no longer adjust with changes in the cost of living, it placed some people slightly over the $1,656 monthly limit. While there are options available for preserving eligibility, such as with the creation of a Medicaid qualifying income trust, also known as a Miller trust, these options have drawbacks. To qualify for a Miller trust the individual must seek the assistance of an attorney and find a trusted individual to manage

their trust assets. In addition, the Miller trust has a number of responsibilities and restrictions that must be followed.

Medicaid services are critical to the well-being of Alaska's most vulnerable citizens. Lending support to this legislation will ensure that eligible Alaskans can continue to receive nursing home care and in-home services.

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House Majority Press: http://housemajority.org/spon.php?id=26HB270

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

January 30, 2010

Representative Cathy Muñoz
Alaska State Capitol, Room 409
Juneau, AK 99801-1182

Subject: Support Letter for HB 270

Dear Representative Muñoz:

The Alaska Commission on Aging (ACoA) is pleased to offer our support of HB 270, a bill to amend the income eligibility threshold for persons requiring nursing home level of care stated in AS 47.07.020(b)(6). This bill is authored by you and co-sponsored by Representatives Paul Seaton, Bob Herron, Max Gruenberg, and Les Gara.

ACoA supports returning the statutory income limit for this benefit from the current fixed dollar amount of $1,656 per month to 300% of Supplemental Security Income (SSI), the previous statutory limit, in order to allow the eligibility limit to adjust annually with the Supplemental Security Income maximum benefit amount. This change will ensure that eligible Alaskans can continue to receive nursing home care and in-home services provided by the State's Medicaid program when they receive cost-of-living adjustments to their Social Security and other benefit amounts.

In 2003, the Alaska Legislature changed AS 47.07.020 (b) (6) to freeze the Medicaid long-term services income eligibility limit at that year's level ($1,656). This change created a fixed ceiling for waiver eligibility, rather than allowing the eligibility limit to adjust annually in tandem with the SSI maximum benefit amount, which is tied to changes in the Consumer Price Index (CPI). The downstream impact of this freeze has been that from 2003 and into the future, a small Social Security cost-of-living adjustment could put a person over the $1,656 limit, and in effect disqualify many people from the program. Most public assistance programs in Alaska are indexed to the Alaska poverty level or other guidelines which provide flexibility as incomes rise along with living costs.

We thank you for sponsoring HB 270 to ensure that eligible Alaska seniors and other vulnerable Alaskans can maintain their income eligibility and continue to receive home- and community-based services, despite small COLA increases to their Social Security and other benefit payments. Please feel free to contact Denise Daniello, ACoA's executive director, by phone (465-4879) or email (denise.daniello@alaska.gov) should you have questions or require additional information. Thank you.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

Cc: Representative Paul Seaton
Representative Bob Herron
Representative Max Gruenberg
Representative Les Gara

AGENET Alaska Geriatric Exchange Network

Alaska's Association of Senior Service Providers
c/o 419 Sixth Street, Juneau, Alaska 99801

February 18, 2010

Representative Cathy Munoz
State Capitol, Room 409
Juneau, Alaska 99801-1182

Dear Representative Munoz:

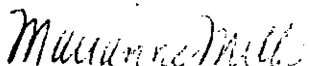
On behalf of the members of AGENET (the Alaska Geriatric Exchange Network), I am pleased to offer this letter of support for House Bill 270, "an act amending the eligibility threshold for medical assistance for persons in a medical or intermediate care facility". This bill will help older Alaskans continue their access to cost-effective home and community-based services which help them maintain their health and independent living in their own home and community.

Most seniors who receive Social Security benefits or retirement pensions receive a small annual cost of living adjustment (COLA) to their benefit amounts. Because the program income eligibility limits do not adjust with changes in the cost of living, each year some people receiving home and community-based (HCB) waiver services find that their adjusted incomes place them slightly over the $1,656 monthly limit. They receive notice that they are no longer eligible for HCB waiver services, their services are suddenly cut off, and their health and independent living is threatened as a result.

House Bill (HB) 270 would correct the situation by changing income eligibility as the cost of living changes, instead of the current fixed amount of $1,656 per month. The proposed change makes sense, especially since older Alaskans prefer remaining in their own homes for as long as possible rather than having to go to costly nursing homes when their health declines prematurely.

Thank you for introducing this bill and for your consistent support of services for older Alaskans. Feel free to contact me at 463-6154 if I may provide further assistance to promote passage of HB 270.

Sincerely,



Marianne Mills
AGENET President

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QUESTIONS AND ANSWERS ON AS 47.07.020 (b)(6) PROPOSED CHANGE

❖ **What is SSI?**

SSI, or Supplemental Security Income, is a federal needs-based disability program for adults and children which provides cash benefits and automatic Medicaid eligibility.

❖ **What are the eligibility requirements for SSI?**

The person must:

(1) Have limited income and resources;
(2) Be an adult or a child who is blind or disabled, or an adult who is age 65 or older;
(3) Live in the United States;
(4) Be a U.S. citizen or an eligible non-citizen (including lawful permanent residents and some other categories...)

❖ **What are the income and resource requirements for SSI eligibility?**

Monthly benefits are calculated by subtracting certain excluded amounts from the individual's monthly income, and then subtracting the remainder from the maximum SSI benefit amount (currently $674). The resulting amount will be the individual's monthly SSI benefit. In other words, an individual's income must be substantially below the poverty level (which is currently $1,127.50 per month in Alaska).

Individuals may have up to $2,000 in resources, or up to $3,000 in resources for a couple.

❖ **What is the SSI definition of disability?**

For an adult, the SSI disability requirement is based on the ability to work. An adult is considered disabled if the person cannot do the work they did before and cannot do a different kind of work because of a severe physical or mental condition.

To be eligible for SSI, a child must suffer from serious physical and/or mental problems that prevent the child from living a normal life.

For both adults and children, the disability must last, or be expected to last, for at least a year, or to result in death.

❖ **Is SSI different from Social Security Disability Insurance?**

Yes. Both programs provide assistance for people with disabilities who meet certain medical criteria, and both are administered by the Social Security Administration. However, Social Security Disability Insurance is a program for individuals (and certain family members) who are "insured," that is, they have worked long enough in jobs where they paid Social Security taxes. SSI, on the other hand, is based solely on the financial need of the disabled individual, even if that person has little or no work history.

❖ **What is the current maximum monthly benefit amount for SSI?**

In both 2009 and 2010, the maximum monthly cash benefit amount for an individual on SSI is $674 (or $1,011 for a couple). This amount normally increases from year to year based on an automatic annual cost of living adjustment (COLA) which is calculated from changes in the Consumer Price Index (CPI). However, there were no increases in any of the Social Security programs' benefits this past year due to the very low rate of inflation.

❖ **Why did AS 47.07.020 originally key Medicaid waiver eligibility to an income level three times the maximum monthly SSI benefit rate? When did this statutory limit change?**

In most states, Medicaid financial eligibility rules are more liberal for people who require long-term services. Under federal law, a state may grant Medicaid eligibility to persons who have incomes as high as three times the basic benefit standard for the SSI program. In operating a HCBS waiver program, a state may employ the same financial eligibility rules to determine eligibility as it does for institutional services. Accordingly, before 2003, AS 47.07.020 set Alaska's Medicaid long-term care (including waiver services) financial eligibility at three times the maximum SSI amount. In 2003, that amount was $552, so the income limit that year was $1,656 (three times $552).

In 2003, the Alaska Legislature changed AS 47.07.020 (b) (6) to freeze the Medicaid long-term services income eligibility limit at that year's level ($1,656). This change created a ceiling for waiver eligibility, rather than allowing the eligibility limit to adjust annually in tandem with the SSI maximum benefit amount, which is tied to changes in the Consumer Price Index (CPI). This meant that from 2003 on, a small Social Security COLA could put a person over the $1,656 limit, which no longer adjusted with the SSI rate.

Most public assistance benefits in Alaska are keyed to federal poverty guidelines or other income standards that are automatically adjusted annually.

❖ **If Alaska returns to the prior version of AS 47.07.020, what will the Medicaid waiver income eligibility limit be?**

The Medicaid waiver income eligibility limit for 2010 would be $2,022 monthly, or three times the current maximum SSI monthly benefit ($674). This would be an increase of slightly over 22 percent in the income limit, and would return waiver coverage to those earning slightly more than 175% of the federal poverty limit (FPL) for Alaska, versus the current 147% FPL.

Year	Waiver Limit	% of AK FPL	(AK FPL)
2003	$1,656	177%	$11,210
2009	$1,656	147%	$13,530
2010	$2,022*	179%	$13,530

*Result of proposed legislation

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- **What problems have been created by the 2003 change to AS 47.07.020?**

Most individuals receiving Social Security retirement or disability benefits, or retiree pensions, receive a small annual cost of living adjustment (COLA) to their benefit amounts. Because the waiver eligibility limits no longer adjust with changes in the cost of living, each year some people receiving waiver services find that their adjusted incomes place them slightly over the $1,656 monthly limit, thus ending their eligibility for the Medicaid waiver. People in this position have had to pay privately for nursing home care (thousands of dollars per month) or try to set up a Medicaid qualifying income trust, also known as a Miller trust.

Near the end of 2008, a panic ensued when dozens of individuals received notices that they would no longer be eligible for the waiver after the 2009 Social Security COLA went into effect. While they were told that they may be able to preserve their eligibility by implementing a Miller trust, this was not a workable solution for some recipients. [A Miller trust (or Medicaid qualifying income trust) makes Social Security and other income exempt from calculations of income and resources if the state is reimbursed from the trust for Medicaid expenses upon the recipient's death.]

New waiver applicants who are medically qualified for Medicaid long term services are disqualified for income reasons when they apply, even though their monthly incomes may be very modest, say, 150% of the federal poverty level.

- **What are the problems with obtaining a Miller trust to shelter excess income in order to continue Medicaid waiver eligibility?**

First, the disabled individual must locate an attorney who can assist them in creating a Miller trust (or qualified income trust). While free legal services are available, they are not readily accessible in every community in Alaska. The individual or their family must spend their time (generally around the end-of-year holidays) frantically trying to find affordable legal help. If the person is too disabled to be able to take the steps to create such a trust, and has not granted anyone else the financial power to do so, it will be necessary to go to court to obtain a conservatorship in order to create the Miller trust.

In order to create a Miller trust, the individual must have a trustworthy friend or family member whom they feel will manage the trust responsibly. Sadly, in today's world, attorneys tell us that this can be an issue – many Medicaid recipients do not know anyone they wish to put in charge of their finances. These people must either trust a stranger to manage their money or forego benefits. Other recipients risk their money by having less-than-trustworthy relatives serve as trustee. We are aware of a current case of an elder whose granddaughter has left the state with the individual's trust account funds.

Managing one's own finances is a matter of personal dignity for many older Alaskans. Being forced to give up this right can be stressful and humiliating, as well as financially risky.

Initial responsibilities of a trustee include obtaining a lawyer to draft the trust – sometimes within a 30-day window, registering the trust with the court system, obtaining an identification number from the IRS, setting up a special trust account with a bank (which not all banks will do), arranging direct deposits to that account through Social Security and other income sources, and securing approval for the trust from the Division of Public Assistance (DPA).

There are many additional details specific to management of the Miller trust, such as the requirement for the money to be placed in a non-interest-bearing account.

Once the account is set up, it is the trustee's responsibility to ensure that the trust distributes a monthly allowance to the Medicaid recipient equal to the monthly Medicaid income limit. The trustee must keep the remainder of the monthly income in the account, or purchase items on the recipient's behalf in accordance with certain restrictions. These restrictions are not always clearly spelled out under federal or state law, and are a large source of confusion for trustees. Diligent trustees often fear personal liability for spending trust money on items that turn out to be disapproved. Less-than-diligent trustees can jeopardize a recipient's Medicaid benefits by spending money without regard for the rules. Trustees also have to pass annual audits with DPA to ensure that the trusts are being managed correctly.

Money in the Miller trust can be used only for "allowable expenses," which do not include food or housing expenses. Generally, the individual has received a COLA on their Social Security or pension for the express purpose of keeping up with increased costs of food and housing. Being forbidden to use this extra money for its intended benefit places them at a disadvantage in meeting their basic needs.

Finally, a Miller trust is irrevocable. In the rare event that an individual's health improves to the degree that they are no longer medically eligible for long term services, they will not have access to the funds in the trust for their daily expenses.

Creation of a Miller trust should normally be considered a last resort when there are no other options available.

3488

ALASKA STATUTES 1962

Volume 10

TITLE 45 TO TITLE 47

NOVEMBER 2002

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Annotated and Printed by
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Under the Supervision of
JANICE COFFIELD, THOMAS D. CRANFIELD, JR.,
AND BRIAN YOST

Effective Date of Statutes

See Alaska Constitution, art. II, § 18

Annotated through Sup. Ct. Op. No. 5589. For complete scope of annotations, see preface. For detailed information on the use of the Alaska Statutes, see User's Guide in Volume 1.

LexisNexis

3489

AS 2002

[illegible] medicare [illegible] in connection with supplying prescrip- [illegible] ALR5th 390 [illegible] pharmacy [illegible]

Sec. [illegible].07.020. Eligible persons. [illegible] of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under [illegible] 1396 — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 percent of the supplemental security income benefit rate under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the Aid to Families with Dependent Children program;

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, [illegible] they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and [illegible] requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under age 21 not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 — 25.23.220;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

ALASKA STATUTES 1962

2003 SUPPLEMENT

NOVEMBER 2003

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Under the Supervision of

TERESA BUCHHOLZ, ANN GRADY, THOMAS D. CRANFIELD, JR., AND BRIAN M. YOST

Effective Date of Statutes

See Alaska Constitution, art. II, § 18

Annotated through Sup. Ct. Op. No. 5704. For complete scope of annotations, see preface. For detailed information on the use of the Alaska Statutes, see User's Guide in Volume 1 of the 2002 main set.

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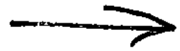
AS 2003



(12) "medical assistance record" means records required to be kept by state or federal law or regulation regarding claims to a medical assistance agency;

(13) "organization" has the meaning given in AS 11.81.900;

(14) "person" has the meaning given in AS 11.81.900;

(15) "property" has the meaning given in AS 11.81.900;

(16) "reckless disregard" means acting recklessly, as that term is defined in AS 11.81.900;

(17) "services" or "medical assistance services" means a health care benefit that may qualify for reimbursement under AS 47.07 or AS 47.08, including health care benefits provided, attempted to be provided, or claimed to have been provided to another, by a medical assistance provider, or "services" as defined in AS 11.81.900;

(18) "unconditional discharge" has the meaning given in AS 12.55.185. (§ 3 ch 66 SLA 2003)

Chapter 07. Medical Assistance for Needy Persons.

Section
10. Purpose
20. Eligible persons
30. Medical services to be provided
32. Inpatient psychiatric services for persons under 21 years of age
35. [Repealed]
36. Cost containment measures authorized

Section
42. Recipient cost-sharing
70. Payment rates for health facilities
73. Uniform accounting, budgeting, and reporting
74. Audits and inspections
110 — 190. [Repealed]
900. Definitions

Sec. 47.07.010. Purpose. It is declared by the legislature as a matter of public concern that the needy persons of this state who are eligible for medical care at public expense under this chapter should seek only uniform and high quality care that is appropriate to their condition and cost-effective to the state and receive that care, regardless of race, age, national origin, or economic standing. It is equally a matter of public concern that providers of services under this chapter should operate honestly, responsibly, and in accordance with applicable laws and regulations in order to maintain the integrity and fiscal viability of the state's medical assistance program, and that those who do not operate in this manner should be held accountable for their conduct. It is vital that the department administer this chapter in a manner that promotes effective, long-term cost containment of the state's medical assistance expenditures while providing medical care to recipients. Accordingly, this chapter authorizes the department to apply for participation in the national medical assistance program as provided for under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act). (§ 1 ch 182 SLA 1972; am § [illegible] ch 66 SLA 2003)

Effect of amendments. — The 2003 amendment, effective September [illegible] 2003, rewrote the first sentence, added the second sentence, and in the last sentence substituted "department" for "Department of Health and Social Services."

NOTES TO DECISIONS

Cited in Garner v. State, 63 P.3d 264 (Alaska 2003).

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires Medicaid coverage are eligible to receive medical assistance under 42 U.S.C. 1396 — 1396p (Title XIX, Social Security Act).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

AS 2003

(1) persons eligible for but not receiving assistance under any plan of the state approved under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act, Supplemental Security Income) or a federal program designated as the successor to the aid to families with dependent children program;

(2) persons in a general hospital, skilled nursing facility, or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under age 21 who are under supervision of the department, for whom maintenance is being paid in whole or in part from public funds, and who are in foster homes or private child-care institutions;

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act), and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under age 21 who are in an institution designated as an intermediate care facility for the mentally retarded and who are financially eligible as determined by the standards of the federal program designated as the successor to the aid to families with dependent children program;

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed $1,656 a month but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility;

(7) persons under age 21 who are receiving active treatment in a psychiatric hospital and who are financially eligible as determined by the standards of the federal program designated as the successor to the Aid to Families with Dependent Children program;

(8) persons under age 21 and not covered under (a) of this section, who would be eligible for benefits under the federal program designated as the successor to the aid to families with dependent children program, except that they have the care and support of both their natural and adoptive parents;

(9) pregnant women not covered under (a) of this section and who meet the income and resource requirements of the federal program designated as the successor to the aid to families with dependent children program;

(10) persons under age 21 not covered under (a) of this section who the department has determined cannot be placed for adoption without medical assistance because of a special need for medical or rehabilitative care and who the department has determined are hard-to-place children eligible for subsidy under AS 25.23.190 — 25.23.210;

(11) persons who can be considered under 42 U.S.C. 1396a(e)(3) (Title XIX, Social Security Act, Medical Assistance) to be individuals with respect to whom a supplemental security income is being paid under 42 U.S.C. 1381 — 1383c (Title XVI, Social Security Act) because they meet all of the following criteria:

(A) they are 18 years of age or younger and qualify as disabled individuals under 42 U.S.C. 1382c(a) (Title XVI, Social Security Act);

(B) the department has determined that

(i) they require a level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded;

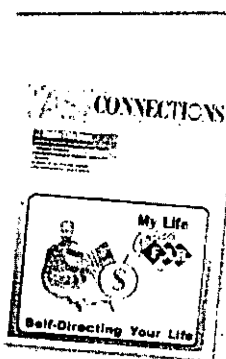
(ii) it is appropriate to provide their care outside of an institution; and

(iii) the estimated amount that would be spent for medical assistance for their individual care outside an institution is not greater than the estimated amount that would otherwise be expended individually for medical assistance within an appropriate institution;

(C) if they were in a medical institution, they would be eligible for medical assistance under other provisions of this chapter; and

Supporting Individuals and Families to Self Direct Their Lives Through the Maryland New Directions Medicaid Waiver

About the Project
MD New Directions Waiver
New Directions Fact Sheets
Person-Centered Planning
Individualized Budgeting
What is Self-Direction?
Regional Workshops
Planning Workshops
Creating an Individualized Budget
Resources and Links
Calendar of Events
Glossary of Acronyms & Terms
Position Announcement
Outreach Tools
Contact Us



Inside the March - April 2005 Issue of TASH Connections:
Self-Directing Your Life (.pdf file)

My Life: Going FAR is a project of TASH.

This project is funded by the **Maryland Developmental Disabilities Council,** in cooperation with the **Maryland Developmental Disabilities Administration.**

What is a Medicaid Waiver?

This information is based on a Policy Brief of the National Center for Family Support. The entire brief can be found at www.familysupport-HSRI.org

The Medicaid program is an enormously important source of money to pay for services and supports for people with developmental disabilities. About $3 of every $4 that states spend for developmental disabilities services comes by way of Medicaid. Once, Medicaid dollars only paid for institutional services. Today, Medicaid allows more diverse services and supports for individuals in the community, by "waiving" the need to get those same services in an institution.

Why is it important to learn all about Medicaid?

Advocates need to keep in mind that states have the ability to decide who gets funded for what services (criteria for eligibility and coverage). To realize many of the opportunities afforded by federal policy, a state must elect to include an "option" or change its current policies. Medicaid policy change at the state level means convincing policy makers (governors and legislators) to take advantage of key options if they have not done so already. This is why it is important for individuals, families and other stakeholders to be "at the table" when Medicaid policy is discussed.

The Way Medicaid Works

Federal law (Title XIX of the Social Security Act) and regulations spell out the requirements that a state must meet in operating its Medicaid program. If a state meets these requirements, then the federal government pays a percentage of money (called the Federal Medical Assistance Percentage (FMAP)) of the amount of money that the state spends for services to people who are eligible for Medicaid. The FMAP rate varies, depending on income levels in each state. The lowest FMAP for high-income states is 50%; the maximum rate allowed is 83%. The highest rate currently being paid is about 77% (Mississippi).

States must use their own or local tax dollars (called "matching dollars") to meet their share of Medicaid costs. In order to expand Medicaid services, a state must provide more of their own tax dollars to get more money from the federal government. In the federal budget, Medicaid is an "open-ended entitlement" program. This means that the federal government is required by law to pay its share of state Medicaid costs regardless of the total amount. Each state spells out what is available under its Medicaid program in a document called the "state plan." The state plan describes the groups of individuals who can receive Medicaid services and the services that the state will make available to them. A state can amend its plan to change its program. State plan amendments are subject to federal review and approval. Each state must designate one of its agencies (called the "single state Medicaid agency") to administer its Medicaid program. The Medicaid

Sign up for the My Life: Going FAR email discussion group. This group is for sharing questions, ideas, and sucess stories related to self-directing support services and for supporting people to self-direct and use the Maryland New Directions Medicaid Waiver.

Individuals with developmental disabilities, families, and interested advocates or supporters are welcome and encouraged to participate.

If you or someone you know is interested in the information, but does not have regular access to email or the internet, please call us at 410-828-8274 x109 and we will add you to our regular mailing list.

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agency may enter into agreements with other state agencies (e.g., the state developmental disabilities agency) to administer specific services.

The federal agency responsible for the Medicaid program is the Center for Medicaid and State Operations (CMSO), a branch of the Health Care Financing Administration (HCFA) in the Federal Department of Health and Human Services. HCFA issues regulations and other policy guidance concerning Medicaid. It also oversees state Medicaid program operations. There are ten HCFA Regional Offices located around the country that work with individual states concerning the operation of their Medicaid programs.

Key Requirements For States

There are key requirements with which a state's Medicaid program must comply. These basic requirements govern Medicaid programs nationwide. They include:

- A state must make services available to individuals on a *comparable* basis. With some exceptions, a state may not provide services that differ in amount or type to one group of beneficiaries than others.
- A state must guarantee that recipients have *free choice* in selecting from among qualified service providers when obtaining Medicaid services. That is, a state cannot require a person to obtain services from a specific provider to the exclusion of others.
- A state must make Medicaid services are available *statewide* and provide that individuals have ready *access* to them.
- A state must accept and make a *prompt decision* concerning a person's application for Medicaid services.
- A state may not limit or ration services due to a funding shortfall. A state is obligated to provide services in its state plan to all eligible persons. If a state cannot afford to provide the services, it must change its state plan.
- A state also must permit individuals to appeal adverse decisions concerning their eligibility or the authorization of services. This is called the Fair Hearing process.

In some cases, a state may request *waivers* of some of these requirements. Medicaid home and community-based service waiver programs operate under such waivers. The HCBS waiver program will be discussed in more detail below. When a state decides to use a managed care arrangement to obtain services for individuals (thereby limit their freedom of choice), there are federal laws and regulations concerning how such arrangements must be set up in order to safeguard their interests. Medicaid services must be obtained from "qualified providers." A state must spell out the qualifications that an individual or agency must meet in order to furnish services. States have considerable latitude in specifying these qualifications. At a minimum, providers must meet requirements spelled out in state law. In addition, each provider must enter into a contract (called a "provider agreement") with the state in order to be paid for services it provides to beneficiaries.

Medicaid is a "vendor payment" program. Typically, states pay providers directly on a fee-for-service basis once the provider has furnished a service. Subject to federal requirements, a state may pay for Medicaid services through prepayment ("capitation") arrangements when services are provided by health maintenance organizations (HMOs) or similar organizations. *States have broad discretion in determining the amount of* payments for services. Federal law requires that payment rates must be

sufficient to attract enough providers so that recipients can access needed services.

Eligibility: The Portal to Medicaid Services

Medicaid services are available only to individuals determined eligible for a state's program. Eligibility is the "portal" through which people must pass in order to obtain Medicaid services. On the other side of this portal lie services that people can obtain.

There are two parts to Medicaid eligibility. One is *financial eligibility*. Medicaid is a *means-tested* program. To qualify for Medicaid, a person cannot have income or assets that exceed the amounts that the state has specified. *The second leg of eligibility is whether a person is a member of a "group" that recognized in federal law* (e.g., people with disabilities who receive federal Supplemental Security Income (SSI) benefits). In order to receive.Medicaid services, a person has to meet both tests. "Mandatory" groups (e.g., individuals that all states must serve) essentially include SSI recipients and children who live in very low-income households. But, there are many options or "doors" available to states to widen Medicaid eligibility beyond the mandatory groups. People with developmental disabilities qualify for Medicaid by meeting financial eligibility tests and being members of recognized but broader groups (e.g., individuals with disabilities). It is important to understand that over the past fifteen years, federal Medicaid policy has changed to permit states to offer Medicaid services to more groups of individuals who do not actually receive public assistance payments. Medicaid no longer is closely tied to "welfare." Even though the program is still means-tested, new mandates and options have been added so that individuals and families who have income above the poverty line can pass through the portal.

There are certain eligibility options that can play an important role in enabling people with developmental disabilities to qualify for Medicaid services, even though these options are not reserved exclusively for such individuals. These options revolve around children and adults who do not qualify as members of a mandatory group, generally because their or the family's income prevents them from being eligible to receive an SSI or other public assistance payment. It is helpful to discuss these options in terms of those that are relevant to children, adults and those that cut across all ages.

- **Children**. Not all children and youth with severe disabilities can qualify for an SSI payment and, thus, Medicaid. In the case of children with severe disabilities who live with their families, SSI rules require that a portion of the family's income be counted as available ("deemed") to the child. Even in the case of low-to-moderate income families, this requirement can result in the child's not qualifying for an SSI payment and, thus, make the child ineligible for Medicaid. However, if the child were placed permanently out of the family home in an institutional setting, the family's income would not be counted and the child would qualify for Medicaid. In order to correct this problem, in 1982 Congress enacted the "Katie Beckett option" (also known as "TEFRA 134"). Under this option, a state can decide not to count the family's income when the child meets SSI disability criteria and would be eligible for Medicaid if s/he were in an institutional setting. Several states have adopted this option. One state where this option is used extensively is Wisconsin. See the _ for how to obtain more information about Wisconsin's Katie Beckett program.

- Children who do not receive SSI also can qualify for Medicaid in a variety of other ways. They can qualify as members of low and moderate income households (needy families). There can be other avenues available, depending on the state. The Vermont Parent-to-Parent Network has identified six ways (including the Katie Beckett option) that children with disabilities can obtain Medicaid eligibility in Vermont. See the _ for how to access this information.

- Congress is considering a bill (the Family Opportunity Act) that would give states still another option for extending Medicaid eligibility to children with disabilities who live in higher income households eligible for Medicaid services. We discuss this bill more in the final section.
- **Adults**. Family income does not play a role in Medicaid eligibility for adults with disabilities, including when the person lives with his/her family. Only the adult individual's own income and resources are considered. As noted previously, states must extend Medicaid eligibility to individuals who receive SSI payments. SSI program rules permit individuals to earn income up to a certain level and still qualify for SSI. Recently, these earning limits were raised to $740/month. There also are special rules that continue SSI and Medicaid benefits for a period of time after a person exceeds the earned income ceiling. It is not true that having a job automatically disqualifies a person for Medicaid. But, problems can arise once the person's income climbs above levels that SSI permits.
- Not all adults with severe disabilities qualify for an SSI payment. People who receive "adult disabled child" Social Security benefits or who have other income (including employment income) that exceed SSI maximums can qualify for Medicaid under other options. A state can set higher income thresholds that permit more of these individuals to qualify even though they do not receive SSI. Many states also permit individuals to qualify as "medically needy." In a medically needy program, people who have income above the state's maximum qualify for Medicaid by "spending down" their income on health services until it reaches the state's maximum (e.g., if a state's maximum is $600 per month and a person has income of $800, the person will qualify once he or she spends $200 on health services). Recently, HCFA issued new rules that give states more options to make it easier for people to qualify as medically needy and thus obtain Medicaid eligibility. In addition, starting in 1997, Congress has added more eligibility options that permit states to extend or continue Medicaid eligibility for adults with disabilities whose employment earnings would otherwise disqualify them for Medicaid. See the _ for how to obtain information on this new options (which some states already have adopted). The rules concerning Medicaid eligibility for adults with disabilities differ considerably from state to state with the exception of the requirement that states include SSI recipients. As with children, it is important to have solid information concerning the rules in your state.
- **Long-term Services Eligibility**. In most states, Medicaid financial eligibility rules are more liberal for people who require long-term services. For example, a state may grant Medicaid eligibility to such persons who have incomes as high as three-times the basic grant standard for the SSI program (i.e., as high as $1,590 per month). In operating an HCBS waiver program, a state may employ the same financial rules to determine eligibility as it does for institutional services. For children, this yields the same result as the Katie Beckett option. However, the Katie Beckett option is broader since it

does not hinge on whether the child participates in a waiver program. In the case of adults, using institutional financial eligibility rules can make a big difference in enabling individuals to obtain Medicaid eligibility. But, again, these special provisions apply to people who qualify for long-term services.

Medicaid operates under a simple rule: no Medicaid card, no services. States have many options for widening the eligibility portal for both children and adults with disabilities beyond those who receive an SSI payment. Advocacy with respect to Medicaid eligibility centers on urging states broaden eligibility options to more children with severe disabilities who live with their families and adults who do not qualify for SSI.

Once a person successfully navigates through a Medicaid portal, the next question is what services they can obtain that would be valuable in meeting his or her needs? Answering this question revolves around "coverage" -- the collection of "services" or "benefits" a state offers to Medicaid beneficiaries.

Medicaid coverage also has two parts. Every state must provide all Medicaid recipients with a core set of *mandatory services* (e.g., hospital, physician, nursing facility, home health services). A state also may elect to provide additional *optional services* (e.g., personal assistance, home and community-based waiver services). See the _ for how to locate information about the all the services that a state must or may offer. States can operate Medicaid programs that have either wide or narrow benefits. Usually you can find out about all the services your state offers at the Medicaid agency's website (_). Like other health insurance programs, whether a person requires a service is based on "necessity" (medical or otherwise) criteria (e.g., does a person's condition require a treatment or service that is covered under the state plan?).

State-to-state, the basic services that are available depend on whether the person is a child or adult as well as the decisions that a state has made with respect to the services it offers. Everyone who has a Medicaid card can access the services that a state offers through its Medicaid state plan. Here, we describe some key "regular" Medicaid services (e.g., services that a state can provide without seeking special waivers). In the next section, we will discuss services that a state can over through an HCBS waiver program.

There are differences in the services that a state must or may offer children and adults. In particular:

- **Children**. For more than a decade, Congress has focused on strengthening the role that the Medicaid program plays in ensuring that children (with or without disabilities) have access to health care. In 1989, Congress extensively revamped federal Medicaid law what are labeled "Early and Periodic Screening, Diagnosis and Treatment" (EPSDT) services. States must provide EPSDT services to all children who are eligible for the Medicaid program. It is one of the mandates that states must meet in operating a Medicaid program. Through EPSDT, children must be seen periodically by health care professionals. If the child is identified as having a medical condition, further diagnoses must be performed and a state must follow through to provide all necessary treatment services. *However, needed services can be identified at any time by* professionals other than the child's own physician. The 1989 law

changes required states to step up their performance in operating EPSDT programs. It also mandated that states furnish any necessary Medicaid service (including dental care) that a child requires – regardless of whether the state specifically covers the service as part of its regular Medicaid program or not. The EPSDT mandate, for example, means that Medicaid eligible children with severe disabilities who require therapeutic services must be provided them. A state cannot restrict the services that it provides under the EPSDT mandate; it must make all types of services available, including the services that children with severe disabilities or special health care needs require. Such services can include home health services and personal assistance. However, EPSDT services do not include services (like respite) that only can be furnished through an HCBS waiver program. It is this EPSDT mandate that potentially makes obtaining Medicaid eligibility so valuable for children with disabilities.

- **Adults**. Except for the mandatory services that all states must include in their Medicaid programs, states have latitude in terms of the types of services that they make available to adults with disabilities. With respect to adults, there is no equivalent to the EPSDT mandate. States vary considerably with respect to the optional services that they make available to adults. For example, states frequently make available only very limited dental services or restrict the provision of therapeutic services only to people who need such services to "restore function," a restriction that frequently results in persons with developmental disabilities not being able to obtain such services. In addition, often states impose restrictions on optional services that can narrow their scope considerably.

There are three "regular" Medicaid services that are especially relevant to meeting the needs of people with developmental disabilities:

- One is home health, which all states must offer in their Medicaid programs. Home health services are provided to individuals at their place of residence. Home health services must include part-time or intermittent nursing services, home health aide services, and certain medical supplies and equipment. Physical, occupational therapy and speech pathology and audiology services also may be provided on an optional basis. In some states, access to home health services has been restricted to "homebound" individuals. But in July 2000, HCFA issued a policy clarification that states cannot restrict the availability of these services to people whose condition prevents them from leaving the home. This is expected to increase access to home health services by individuals who live in the community.
- The second important "regular" Medicaid service coverage is personal care (a.k.a., "personal assistance" or "attendant care"). When this service is offered, workers can provide assistance to people with disabilities in a wide variety of ways (helping with activities of daily living, grocery shopping, or getting about in the community). Once, federal rules limited the provision of these services to the person's home and described them in "medical model" terms. In 1993, Congress changed federal law so that personal assistance could be provided out in the community and "demedicalized" them. In 1999, HCFA issued new guidelines that gave states increased flexibility in providing these services, including sanctioning the use of consumer-directed personal care services (____). A state may provide personal care/assistance services without obtaining a waiver from HCFA and people do not have a

demonstrate a "need for institutional services" in order to obtain these services. Personal care is a potentially very flexible benefit that states can make available to all beneficiaries. However, fewer than 30 states offer personal care under their regular Medicaid programs and many have imposed more stringent restrictions on them than federal policy requires. A few states (e.g., Washington) make personal assistance available relatively widely.

- Another service is "targeted case management." The service is labeled "targeted" because it is one of the few regular Medicaid services that a state can cover but limit to specific groups of individuals. Many states use this coverage to fund their service coordination systems for people with developmental disabilities. States can offer these services to one or many groups of beneficiaries. Targeted case management is designed to help Medicaid beneficiaries access any of a wide range of services -- including social and educational services – not just health care services.

The "regular" services that a state offers through its Medicaid state plan make up a "core" benefit package available to all Medicaid beneficiaries. Federal policy is very liberal with respect to the range of benefits that states may offer. But, many states are reluctant to add more services to their Medicaid programs or loosen up the restrictions that apply to the services that they presently offer. It is not surprising that concerns about increased spending lie behind this reluctance. Once a service is included in the core benefit package, it becomes an entitled service that might be very costly to provide. Nonetheless, advocates should be vigilant for opportunities to urge states to take advantage of opportunities to add services that are important to people with disabilities or remove overly stringent restrictions.

This information is based on a Policy Brief of the National Center for Family Support. The entire brief can be found at www.familysupport-HSRI.org

My Life: Going FAR is a project of TASH.
This project is funded by the Maryland Developmental Disabilities Council,
in cooperation with the Maryland Developmental Disabilities Administration.

01/24/05

Waiver Programs

The Medicaid Program is responsible for the implementation and ongoing administration of home and community-based services waivers and targeted case management programs for special population groups. The Program studies, plans, and implement services relating to the needs of special populations such as the elderly, the mentally ill, and the physically and mentally disabled.

- Waiver Programs Overview
- Reportable Event Information
- Provider Billing Forms and Instructions
- Registry Policy for Closed Waivers
- Older Adults Fact Sheet Updated
- Autism Waiver Fact Sheet
- Model Waiver Fact Sheet
- TBI Waiver Fact Sheet
- Living at Home Waiver Program
- Frequently Asked Questions List
- Estate Fact Sheet
- Estate Fact Sheet - Spanish Version
- Medical Day Care Waiver Fact Sheet NEW!
- Medical Day Care Waiver Application NEW!
- Medical Day Care Services Waiver NEW!
- Residential Treatment Center (RTC) Waiver NEW!
- Waiver Program Updates
  - Autism Waiver Application
  - Approved Living at Home Waiver Application
  - 1915 (b)(4) waiver application for Living at Home Case Management. Submitted July 2009

What is a waiver?

Under Section 1915(c) of the Social Security Act, Medicaid law authorizes the Secretary of the U.S. Department of Health and Human Services to waive certain Medicaid statutory requirements. These waivers enable States to cover a broad array of home and community-based services (HCBS) for targeted populations as an alternative to institutionalization. Waiver services may be optional State Plan services which either are not covered by a particular State or which enhance the State's coverage. Waivers may also include services not covered through the State Plan such as respite care, environmental modifications, or family training.

The four basic types of 1915(c) HCBS waivers available for states based on the target population's level of alternative long-term institutional care are:

- intermediate care facility-mental retardation (ICF-MR) level of care for mentally retarded and/or developmentally disabled individuals;
- chronic or rehabilitative hospital level of care for individuals who are medically fragile, chronically ill, or severely disabled;
- psychiatric hospital level of care for individuals who are severely or chronically mentally ill; and
- nursing facility level of care for individuals who are elderly, physically disabled, and/or cognitively impaired.

To be a waiver participant, an individual must be medically qualified, certified for the waiver's institutional level of care, choose to enroll in the waiver as an alternative to institutionalization, cost Medicaid no more in the community under the waiver than he or she would have cost Medicaid in an institution, and be financially eligible based on their income and assets.

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FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **HB270**
() Publish Date:

Identifier (file name): HB270-DHSS-SDMS-03-18-10
Dept. Affected: Health & Social Services
Title: Medicaid for Medical and Intermediate Care
RDU: Senior and Disability Services
Component: Senior and Disability Medicaid Services
Sponsor: Munoz
Requester: House HSS
Component Number: 2662

Expenditures/Revenue (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITU	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURE							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipt							
1037 GF/Mental Health							
Other Interagency Receipt							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2010) c

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if nece*

This bill would increase the Medicaid income eligibility standard for individuals who reside in medical institutions, typically nursing facilities. This standard is also used for people who receive home and community-based waiver services. Currently, this standard is fixed at $1,656 per month. The bill would increase the amount to 300 percent of the federal Supplemental Security Income (SSI) monthly benefit, which is currently $674, adjusted for cost of living each year. Initially, the new standard for Medicaid nursing facility residents and waiver recipients would be $2,022 per month.

DHSS does not anticipate that increasing the monthly standard for this eligibility category will increase the number of Medicaid recipients receiving services. While this is contrary to DHSS expectations when the Legislature fixed the standard at a set dollar amount in 2003, experience shows that as individuals receive cost of living increases in pensions or Social Security payments that raise their incomes over $1,656 per month, they use Medicaid qualifying income trusts to reduce their countable income below that amount and continue to qualify for Medicaid.
(Continued on Page 2).

Prepared by: William J. Streur, Deputy Commissioner
Phone 269-7827
Division: DHSS Health Care Services
Date/Time 2/3/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date 3/18/2010

(Revised 11/6/2009 OMB)

ANALYSIS CONTINUATION

Another consideration is that Medicaid recipients who qualify under this institutional income standard are required to make a contribution toward the cost of the Medicaid institutional or waiver services they receive if their countable income exceeds the personal needs allowance established for their living arrangement. The personal needs allowance for people on waivers has historically been set in regulation and the amount varies depending on the person's living situation, and is not linked to the institutional income standard. DHSS has not assumed an increase to the personal needs allowance. Therefore, DHSS does not anticipate an increase in Medicaid spending as a result of this legislation. If DHSS increased the personal needs allowance in conjunction with increasing the income eligibility standard, it would increase Medicaid expenditures.