Unraveling the Mystery of Medicaid Eligibility for LTSS

HCBS CONFERENCE
Home & Community-Based Services

2024 Home and Community-Based Services Conference

MERCER

Unraveling the Mystery of Medicaid Eligibility for LTSS

Kim Donica

Senior Principal

Mercer Government

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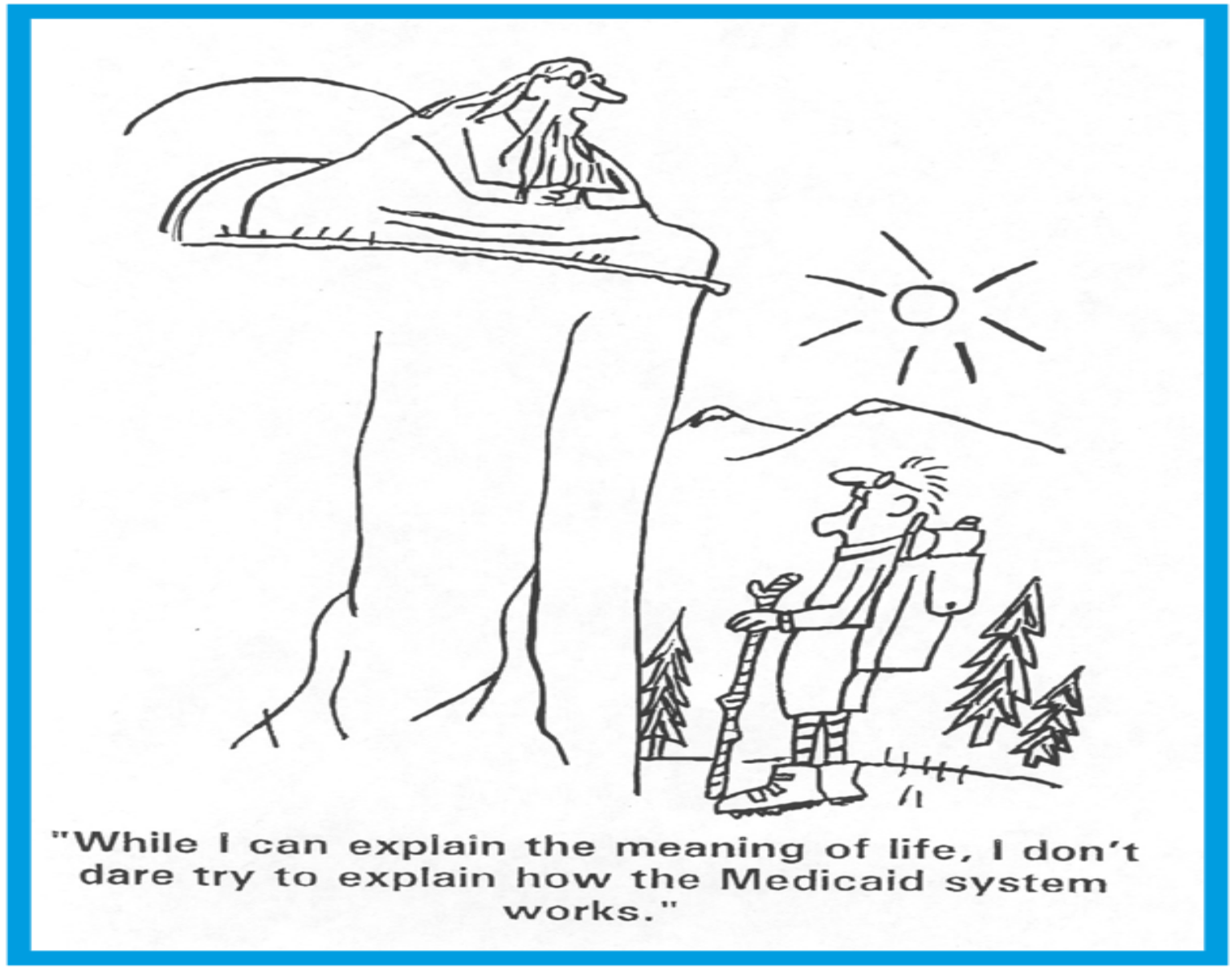
welcome to brighter



"While I can explain the meaning of life, I don't dare try to explain how the Medicaid system works."

Session Goals

1. Increase participants' knowledge of Medicaid eligibility.
2. Increase participants' knowledge regarding mechanisms to expand Medicaid eligibility for individuals who need home- and community-based services (HCBS).
3. Increase participants' basic understanding of long-term services and supports (LTSS) resource tests.
4. Increase participants' knowledge of Medicaid estate recovery.

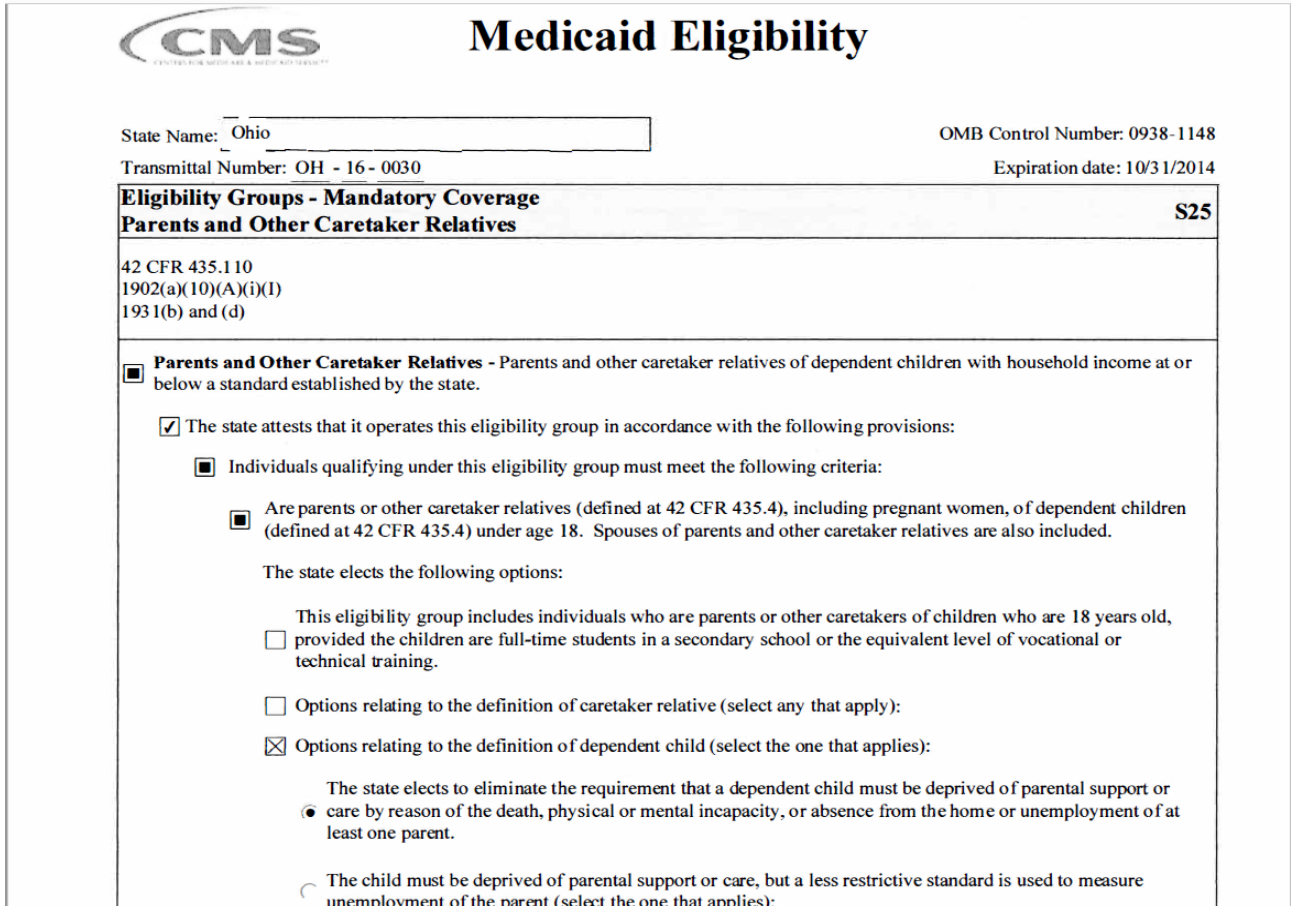
Federal Medicaid Statute and Regulations

- Medicaid eligibility statutory requirements
  - Primarily 1902 of Social Security Act
- Medicaid eligibility regulations
  - 42 CFR § 435

https://www.macpac.gov/reference-guide-to-federal-medicaid-statute-and-regulations/

State Plan

Section 2: Eligibility and Coverage



CMS

Medicaid Eligibility

State Name: Ohio

OMB Control Number: 0938-1148

Transmittal Number: OH - 16 - 0030

Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Parents and Other Caretaker Relatives **S25**

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

■ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☐ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☐ Options relating to the definition of caretaker relative (select any that apply):

☒ Options relating to the definition of dependent child (select the one that applies):

◉ The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

○ The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

Medicaid Eligibility

- Defined in terms of:
  - Populations covered (categorical eligibility)
  - Income levels at which populations can be covered (financial eligibility)

Medicaid Eligibility

- Categorical Eligibility
  - Individuals must fit into pre-defined categories
    - Children
    - Pregnant women
    - Parents
    - Older adults
    - People with disabilities
    - Childless adults (under the age of 65 years) (Affordable Care Act [ACA] Expansion)
  - 26 mandatory categories
  - 32 optional categories

Other ABD Pathways

- Most individuals who receive LTSS qualify for Medicaid through a pathway that does not use the MAGI methodology.
  - Many individuals who receive LTSS qualify for Medicaid through one of the SSI-related eligibility groups.
- States can use one or more optional eligibility categories designated in federal statute to provide eligibility to people with a need for LTSS.
- These categories, called “Other ABD Pathways,” allow states to extend Medicaid coverage to older adults and individuals with disabilities who have higher levels of income or resources than SSI program rules permit.
- Not all individuals eligible for Medicaid through an “Other ABD Pathway” category of Medicaid eligibility receive LTSS.

Other ABD Pathways

- Other ABD pathways allow states to offer Medicaid eligibility to individuals receiving LTSS either in an institution or a home' and community-based setting; working individuals who may need LTSS to support employment; and individuals with high medical expenses who "spend down" or deplete their income and resources. These optional eligibility pathways include the following:
  - Poverty-Related
  - Special Income Level
  - Special HCBS Waiver Group (§435.217 Group)
  - HCBS State Plan (1915(i))
  - Katie Beckett

Other ABD Pathways

- Buy-In Groups
  - Balanced Budget Act of 1997 (BBA 97) Group
  - Ticket to Work (TWWIIA) Basic Eligibility Group
  - Ticket to Work (TWWIIA) Medical Improvement Group
    - As of 2022: 48 states offer these pathways
  - Family Opportunity Act
    - As of 2022: 8 states currently offer this pathway
  - Medically Needy
    - As of 2022: 44 States offer this pathway

Other ABD Pathways

- Poverty-related:
  - Allows the state to cover individuals with incomes up to 100% of the FPL who have disabilities or are over age 65 years
  - Uses the SSI age and disability eligibility criteria
  - These enrollees are entitled to full Medicaid benefits, including State Plan LTSS if the individual meets the state's level of care (LOC) or targeting criteria for State Plan HCBS
  - In general, uses the SSI requirements and rules for determining income and resources
  - Offered by most states.
  - The level of income and resources that qualify an individual for the poverty related pathway vary by state.

Other ABD Pathways

- Special Income Level
  - Allows states to cover individuals who meet LOC criteria for certain institutions and have incomes up to 300% of the federal benefit rate (FBR).
  - Individuals must require care provided by a nursing facility or other medical institution for no less than 30 consecutive days.
  - Functional eligibility for this pathway is determined using the state-established LOC criteria that typically require enrollees to need institutional-level services and supports.
  - In 2022, 41 states and DC had a special income level eligibility pathway. There are nine states that do not provide this option in their State Plan.
  - Most states with a special income level eligibility pathway set the income level at 300% of the FBR.
  - States also apply an asset limit under the special income rule, usually the SSI amount of $2,000 for an individual and $3,000 for a couple.

Other ABD Pathways

- Special HCBS Waiver Group (§435.217 Group)
  - Allows states to extend Medicaid to individuals receiving HCBS under a waiver program who require the LOC provided by a nursing facility or other medical institution with income up to 300% of the FBR.
  - Sometimes referred to as the “217 group.”
  - In 2019, 43 states and DC had a special income level eligibility pathway.
  - All but two states reported setting the eligibility standard at 300% of FBR.
  - States also apply an asset limit under the special income rule, usually the SSI amount of $2,000 for an individual and $3,000 for a couple.

Other ABD Pathways

- HCBS State Plan (1915(i))
  - First enacted in the Deficit Reduction Act and amended under the ACA
  - Created a new eligibility pathway
  - Extends Medicaid coverage along with a targeted package of HCBS State Plan services to:
    - Individuals who meet needs-based criteria but who do not meet an institutional LOC.
    - Generally, states use the SSI income counting methodologies but have discretion to apply alternative methodologies.
    - Individuals whose incomes are up to 150% of FPL, but, with the use of Section 1902 (r)(2), are up to 300% of the FBR.
  - As of 2022: **5** states use this as an independent Medicaid coverage pathway: AL, CT, IN, MD, OH

Section 1902(r)(2) of the Social Security Act

- Under normal eligibility rules, states are required to use the processes (methodologies) of the cash assistance programs (SSI and the old Aid to Families with Dependent Children program) in determining eligibility for Medicaid.
- This allows states to use less restrictive income and resource methodologies in determining Medicaid eligibility for most groups than would normally be permitted under the cash assistance program rules.
- In other words, section 1902(r)(2) permits states to disregard (i.e., “not count”) additional kinds and amounts of income and resources beyond what is allowed under the cash assistance programs.
- This can be used for all other ABD pathways except for Katie Beckett and Medically Needy pathways.

State Medicaid Directors Letter #21-004

- Issued on December 7, 2021.
- Interprets a provision in the Sustaining Excellence in Medicaid Act of 2019 that permits states to tailor income and resource standards for individuals who need HCBS.
- Section 1902(r)(2) provides that States may use eligibility methods that are “less restrictive” than the methods in the corresponding cash assistance program for certain populations but implementing regulations “require that such less restrictive methods be comparable for all individuals in an eligibility group, consistent with section 1902(a)(17) of the Act,” such that “targeting disregards at selected individuals in the same group is not permitted.” State Medicaid Directors Letter (SMDL) at 2-3 (citing 42 CFR § 435.601(d)(4)).
- Historically, the Centers for Medicare & Medicaid Services (CMS) has required states to apply 1902(r)(2) disregards for the 217 group* to the same extent that they are applied to the principal group (generally the special income level group).

* Individuals receiving Section 1915(c) services who would be eligible for Medicaid if they were in a medical institution.

State Medicaid Directors Letter #21-004

- States:
  - Have broad discretion in how to apply and target the new authority.
  - Have the option to target and tailor **income and resource disregards** at individuals who are eligible for, or seeking coverage of, HCBS, including under section 1915(c), (i), and 1115 authorities.
- Examples:
  - Apply less restrictive methodologies, including income and resource disregards, exclusively to 217 group, even if those methodologies are not applied to the principal group.
  - Implement a disregard to effectively raise the resource standard for all individuals eligible for HCBS, or for individuals eligible for a 1915(i)-benefit approved under a state's plan, or for individuals eligible for one or more of the eligibility groups covered under a state's section 1915(c) waiver.
  - Disregard all or a portion of the resources of the community spouse in determining eligibility for the 217 group.

Other ABD Pathways

- Katie Beckett
  - Allows states to count only the income and financial resources of child with a disability.
  - To be eligible, the child must:
    - Be 18 years of age or younger and live at home
    - Meet the applicable SSI definition of a disability
    - Require the LOC provided in an institution
    - Have needs that can be met outside of a facility
    - Have care needs that cost no more than institutional care
  - Most states set income standard up to 300% of the FBR, with a $2,000 asset limit.
  - **44** states and DC offer this pathway under their State Plan

1115 Demonstrations

- To expand LTSS coverage, states may use Section 1115 of the SSA to waive certain State Plan requirements.
  - States have used Section 1115 waivers to expand eligibility to groups beyond those the statute allows.
  - States have also used Section 1115 waiver programs to modify the income- and resource-counting rules and methodologies for specified groups. For example, they can be used to encourage participation in managed LTSS, and to otherwise liberalize or limit income-counting rules for specified subpopulations.
  - Moreover, states have used Section 1115 waiver authority to modify spend-down requirements, and to modify periods of retroactive eligibility and/or periods for eligibility redeterminations.

Other Eligibility Groups and LTSS

- Medicaid enrollees in other mandatory or optional eligibility pathways may also be eligible to receive LTSS if they meet the LOC criteria and meet other LTSS eligibility tests.
- This includes, in Medicaid expansion states, individuals eligible for the Adult Group, as well as other individuals in other eligibility groups where the MAGI methodology is used for determining financial eligibility.
- States may include LTSS in their Alternative Benefit Plans and may choose to enroll individuals enrolled in the Adult Group into their 1915 (c) waivers.
- Individuals who receive LTSS and whose eligibility was determined using a MAGI methodology are not subject to asset limits or post-eligibility treatment of income. Certain resource tests do apply.
- Individuals still must meet appropriate LOC.

Questions

Spousal Impoverishment

- Purpose of spousal impoverishment is to help ensure that, when one spouse is in an institution or receiving home- and community-based waiver services, the other spouse still living in the community will not be impoverished.
- Ensures a certain amount of the couple's income and resources are preserved for the community spouse.
- In general, states must establish income and resource amounts that the community spouse may retain within federal limits. These amounts are not applied toward the qualifying spouse's Medicaid eligibility determination or LTSS costs.
- Applies to individuals whose Medicaid eligibility is determined using a MAGI and a non-MAGI methodology.

Post-Eligibility Treatment of Income

- Post-Eligibility Treatment of Income is also known as patient liability, share of cost, cost of care, and more.
- Individuals whose eligibility is based on non-MAGI rules are subject to post-eligibility treatment of income if they are in an institutional setting or determined eligible for Medicaid through the 217 group.
- Individuals whose eligibility is based on MAGI rules are **not** subject to post-eligibility treatment of income.
- Calculated by subtracting certain specific items from the individual's income, such as a personal needs or maintenance needs allowance, an allowance for a spouse and family if appropriate, and amounts the individual paid for medical care that were not subject to payment by a third party, such as medical insurance.
- Any income remaining after these amounts are subtracted from the individual's total income and are available to contribute to the cost of care.
- The state reduces its payment to the provider by that amount.
- The provider collects that amount from the individual to cover the remaining cost of care.

Miller Trusts/Qualified Income Trusts

- Federal law allows for the establishment of certain trusts that may not be counted for the purposes of determining Medicaid eligibility, thereby, allowing individuals with higher incomes or resources to qualify for Medicaid LTSS.
  - Miller Trusts are also known as Qualified Income Trusts.
  - They are offered by states that do not have a medically needy program to individuals gaining eligibility through the special income level pathway.
  - States need to indicate they allow this option in the State Plan, as well as the 1915(c)-waiver application.
  - **25** states allow for Miller Trusts for individuals in institutional settings; 22 allow for HCBS

LTSS Coverage Checks

- Annuities
- Transfer of Assets
- Home Equity
  - These are not factors in determining Medicaid eligibility but are factors in determining Medicaid coverage of LTSS.
  - If an individual is found to have an improper transfer of assets or exceeds home equity limits, individual may have non-LTSS Medicaid services covered.
  - These coverage checks are applicable to all individuals who need LTSS, regardless of the methodology used to determine eligibility (MAGI vs. non-MAGI).

LTSS Coverage Checks

- Annuities
  - Individuals requesting Medicaid LTSS (either as a new applicant or current beneficiary) must disclose any ownership interest in an annuity by him or herself, or by a community spouse.
  - An annuity belonging to an individual or community spouse can be treated as income and/or resources that are available to the individual when determining his or her eligibility for Medicaid.
  - Applies to individuals whose Medicaid eligibility is determined using a MAGI and a non-MAGI methodology.
  - Failure to disclose an interest in an annuity can subject the individual to a penalty.
    - Penalty is non-payment for the individual's LTSS
      OR
    - At the state's option, denying eligibility for Medicaid entirely

LTSS Coverage Checks

- Transfer of Assets
  - Individuals are subject to the transfers of assets for less than fair market value rules, regardless of whether their eligibility is based on MAGI rules or non-MAGI rules if they are in an institutional setting or determined eligible through the 217 group.
  - The state must determine whether the individual or the individual's spouse has transferred any assets for less than fair market value.
    - The state can look back 60 months prior to the point when the individual:
      - Applied for eligibility
      - Became an inpatient in an institution (or began receiving waiver services)
  - If an improper transfer has occurred, a penalty is imposed.
    - The penalty is a non-payment of the individual's LTSS services for a period of time directly related to the value of the assets transferred.

LTSS Coverage Checks

- Home Equity
  - A primary residence, regardless of value, is not a countable resource for the purposes of Medicaid eligibility; however, the equity value of a home may affect whether an individual receives coverage for LTSS services.
  - Equity interest in the home must be less than $595,000, with states having the option of raising this limit to $893,000.
  - This does not apply to individuals who have a spouse, a child under the age of 21 years, or a child with a disability of any age residing in the home.

Estate Recovery

- State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee.
- For individuals ages 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, HCBS, and related hospital and prescription drug services.
- States have option to recover funds spent on other items or services covered under the Medicaid State Plan, except for Medicare cost-sharing paid on behalf of Medicare Savings Program beneficiaries.
- Estate recovery is limited to the amounts paid by Medicaid for services received by an individual and is limited to only those assets owned by the beneficiary at the time of recovery.
- Applicable to individuals whose eligibility is determined through both a MAGI and a non-MAGI methodology.

Questions

Contact Info:
Kim Donica
Senior Principal
Mercer Government
Kimberly.donica@mercer.com