



Report to the Legislature

**Application for Medicaid
Medically-Needy Waiver**

C 7 L01 E2, Section 206(8)(d)

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Executive Summary

ESSB 6153 Section 206(8)(d), passed by the 2001 Legislature, required that the Department of Social and Health Services (DSHS) track and report to the legislative health care and fiscal committees, on the types of long term care support a sample of waiver participants were receiving prior to their enrollment in the waiver, how those services were being paid for, and an assessment of their adequacy.

SHB 1341 was passed during the 2001 legislative session. This bill stated, "to the extent of available funds...the department may provide one or more home and community-based waiver programs in accordance with §1915 of the Social Security Act 42 CFR 435.217 for Washington residents who have a gross income in excess of three hundred percent of the federal Supplemental Security Income benefit level." Funding for these programs was approved in ESSB 6153 (2001).

However, the 2002 Legislature removed funding for the Medically Needy In-Home waiver in the 2002 supplemental budget. DSHS is proceeding with the residential waiver. The number of clients (potentially) served by this waiver was reduced to 50 clients in fiscal year 2002 and 600 clients in fiscal year 2003.

The DSHS Aging and Adult Services Administration (now ADSA, Disabilities and Long Term Care Administration) submitted a waiver application to the federal government for approval of the Medicaid waiver program approved in ESSB 6153 on June 22, 2001. Although various attempts and communications have been made and are ongoing with the Centers for Medicare and Medicaid Services (CMS), approval for the amendment to implement these waiver programs has not been received as of November 15, 2002.

Specific areas of dispute between DSHS and CMS include application of spousal impoverishment rules and spend down requirements. Once a resolution with CMS is reached, DSHS will then have to update the Washington Administrative Code (WAC), update the ACES financial eligibility system, update DSHS policy and train staff before implementing the Medically Needy waiver program.

Enclosed in this report is a summary of the waiver application process and the various communications DSHS has had with CMS.

Section 1

Waiver Application Background

On June 22, 2001, the Department of Social and Health Services (DSHS) submitted two 1915 C waivers to the Center for Medicare and Medicaid Services (CMS) to provide services to individuals who meet the Community Options Program Entry System (COPEs) functional eligibility but have income over the 300% of the federal benefit rate, currently \$1,635. If approved, these waivers would have provided coverage under the Medically Needy (MN) program.

The intent was to serve individuals in community residential settings, who meet nursing home levels of care requirements and would otherwise only have nursing home placement as a Medicaid care option. These individuals do not currently qualify for the COPEs program due to excess income, but they would qualify for nursing home services. Under current DSHS programs, nursing home placement is the only long-term care Medicaid option for these individuals.

Under the original waiver proposal, married individuals also had the benefit of the spousal impoverishment rules for MN clients if the spouse is in the nursing home. Spousal impoverishment rules allow for a more generous treatment of income for married couples to prevent unnecessary hardship to the non-institutionalized spouse. Specifically, income that belongs to a community spouse is not considered when determining eligibility, part of the institutionalized spouse's income may go to the community spouse, and there is a more generous resource standard.

These initial waivers were submitted to CMS on June 22, 2001. One waiver was for individuals receiving services in in-home settings and the other was for individuals in community residential settings. Two applications were required according to the state budget allocation. The in-home waiver would serve 150 clients in the first year and a total of 200 clients in the following two years. The residential waiver would serve 500 clients in the first year and a total of 900 clients in the following two years.

CMS responded that DSHS could only use spousal impoverishment rules, §1924 of the Social Security Act 42 CFR 435.217, if the client qualifies for the Medically Needy program without spend down. "Spend down" is a process through which excess income is assigned to the client's cost of care. Under spend down, the client must incur medical expenses equal to the excess amount of money above eligibility limits before medical benefits can be authorized. The Medically Needy income standard is less than the 300% of the federal benefit rate/SSI that DSHS uses for COPEs; under this standard a client would qualify for COPEs

before they qualify for Medically Needy programs. The spousal impoverishment rules in §1924 of the Social Security Act do not specify that the rules only apply to Categorically Needy or Medically Needy without spend down, but CMS has determined otherwise. The CMS interpretation would eliminate providing MN waiver services to clients with spouses.

DSHS is trying to target the population of aged, blind, and disabled individuals who are currently unable to receive services in the community and whose only option is to be placed in a nursing facility. Individuals with income less than 300% of the federal benefit rate/SSI can receive services under our COPES waiver. The CMS interpretation defeats the purpose of the MN waiver, which is to provide services to clients who are not eligible for COPES because they have income over the 300% of federal benefit rate/SSI and provide options other than nursing facility placement. DSHS reapplied for waivers without the spend down provisions, which were approved. DSHS has since applied for a State Plan amendment to disregard a portion of the client's income in order to reduce their income and allow them to qualify for medically needy without spend down.

The only clients DSHS can serve under the CMS' interpretation of the MN waiver are: 1) Single or married clients with income below the Medically Needy income level (these individuals qualify for COPES), and 2) Single or married clients with income over the Medically Needy income level (currently \$571) but the spousal impoverishment rules would not be applied. The clients would have to meet a spend down and DSHS would not be able to use projected expenses to meet spend down. This would mean all income over \$571 would make them ineligible. The spouse would not be allocated money from the client's income to assist with their community expenses.

The 2002 Legislature removed the funding for the Medically Needy in-home waiver in the 2002 supplemental budget. DSHS is proceeding with the residential waiver. The number of clients was reduced significantly to 50 clients in fiscal year 2002 and 600 clients in fiscal year 2003.

As of November 15, 2002, CMS has not made a final decision as to whether the State Plan amendment would be approved. In the event the State Plan amendment is denied, DSHS has prepared "Appendix C version III" which amends the current approved residential waiver to include Medically Needy with spend down and use projected expenses to meet spend down requirements. DSHS will not be able to meet the saving objectives proposed by the Legislature, as the only population able to be served would be single individuals. There is no incentive for a client with a spouse to use the MN waiver if they cannot utilize the spousal

impoverishment rules. If these proposals are not approved by CMS, DSHS will not be serving the target population and meeting the legislative intent of these waivers.

Section 2

Medicaid Waiver Application Timeline

06/22/01: DSHS submits original waiver requests to implement HB1341.

08/29/01: The two waivers were not approved due to a federal interpretation of 42 CFR 435.217 and the spousal impoverishment rules.

08/29/01: DSHS submitted a revised Appendix C to both waivers following two conference calls with CMS. The revisions included the removal of the income cap of \$3,000 and the reduction of the maintenance allowance for at home individuals. DSHS remained firm on its interpretation of the spousal impoverishment rules and asked for further consideration to apply the rules in 42 CFR 435.217 to the MN population.

08/20/01: Bill Moss, DSHS Home and Community Programs Office Chief, sent an email to Teresa Trimble, Associate Region Ten Administrator, CMS. The email stated DSHS concerns regarding the two 1915 C waiver applications pending and the continuing institutional bias evidenced by CMS interpretation of federal rules.

08/27/01: Dennis Braddock sent a letter to Tommy Thompson, CMS, in Baltimore with an outline of the fundamental disagreement between Washington and the CMS central office. DSHS found the policy interpretation that CMS has taken with regard to the waiver applications truly astonishing against the background of President Bush's New Freedom Initiative, which provided for more than \$8.6 billion for home and community-based services, and in light of the recent Olmstead U.S. Supreme Court decision.

09/13/01: DSHS submitted a letter to CMS providing them with additional information. An e-mail from Bill Moss to CMS stated that DSHS didn't want to "stop the clock" on the waiver applications as suggested by CMS and requested a written response to our inquiries. To "stop the clock" refers to when states submit a waiver or state plan amendment, the state can request to stop the clock and have CMS hold the waiver and not act on it. CMS typically has 90 days to respond to a waiver or state plan amendment request.

09/24/01: DSHS received a letter from CMS requesting additional information regarding the use of spousal impoverishment and our waiver applications. CMS also requested some additional changes to the waiver application.

09/24/01-11/5/01: Three conference calls occurred between the September letter and the two revised waiver applications to CMS on

November 5, 2001. These revisions included the additional information and updated versions of the waiver. DSHS remains firm in the belief that 42 CFR 435.217 applies to all waiver applicants and the intent of the Social Security Act is to apply spousal impoverishment to all institutional individuals including waiver applicants. DSHS requested approval of Appendix C as it was drafted, or be given a written denial from CMS on these waivers.

10/29/01: CMS conference call. CMS declared that a state may not apply spousal impoverishment rules (SSA §1924) for MN waiver recipients unless they are eligible without spend down. CMS also stated that DSHS must use the Medically Needy income level as the income standard.

11/05/01 & 12/14/01: Conference calls were held with CMS. At this time, CMS was still insistent that DSHS may not use spousal impoverishment rules for MN individuals unless they are eligible without spend down. The 90th day of the request was February 7, 2002. CMS stated that if DSHS didn't change the waiver application by the 60th day, CMS would start preparing the formal disapproval.

01/07/02: CMS indicated that they could see the value of the DSHS proposal and would like more time to review the proposal. They requested that DSHS "stop the clock" on these waivers. DSHS submitted a letter requesting the clock be stopped. The clock was stopped on these waivers in collaboration with CMS while they researched federal rules to assess the impact of this change in the interpretation and the use of the spousal impoverishment with the MN population related to spend down.

01/08/02: WAC filing and ACES change request were stopped pending the review of two new waiver applications.

01/02: DSHS contacted the law offices of Covington & Burling in Baltimore and spoke with Chuck Miller to discuss the DSHS concerns with the CMS interpretation of 42 CFR 435.217. The law offices agreed with the DSHS interpretation and agreed to talk with CMS attorneys in Baltimore.

01/10/02: Conference call between DSHS and CMS. CMS indicated that our initial waivers would not be approved.

01/11/02: DSHS applied to CMS for two additional 1915 C waivers for the medically needy without spend down provisions, to serve in-home and residential clients. If CMS approved the new waivers, DSHS planned on submitting a State Plan amendment to disregard income to allow clients to qualify for MN programs without spend down.

01/23/02: Conference call with CMS regarding possible WACs for these waivers and language that would be acceptable.

02/26/02: DSHS contacted Chuck Miller of Covington & Burling in Baltimore through his associate, Carolyn Brown, to check on the status of the General Counsel's decision regarding the application of spousal impoverishment and the 42 CFR 435.217 Medicaid group. Brown informed DSHS that she had not received any additional information at that time and CMS attorneys were still working on the issue.

02/27/02: DSHS received a letter from Jackie Wilder & Pat Helphenstine to Vicky Wallace with comments on Appendix C and the executive summary in the waiver.

03/01/02: DSHS called Vicky Wallace at CMS to respond to her questions. She stated that DSHS and CMS needed another conference call.

03/05/02: DSHS held a conference call with CMS to discuss the use of the Medically Needy income limit in the waiver is less than the 300% of the federal benefit rate/SSI and removing the reference to 42 CFR 435.217 in the executive summary.

03/12/02: DSHS submitted a letter to CMS clarifying the intent of the waiver to serve MN clients without spend down and the revised pages of the waiver applications. DSHS requested a revised effective date of 5/1/02.

04/12/02: DSHS sent an e-mail to the Region 10 CMS office checking on 90-day status.

04/15/02: DSHS conference call with CMS updating status of decision. CMS stated that they would be reviewing our last proposal and would be making a decision soon. DSHS discussed moving the implementation date to 5/1/02 as the 1/1/02 had passed.

05/02/02: DSHS received approval for the second set of waivers effective 5/1/02 by fax on 5/2/02. DSHS then had to amend the Medicaid State Plan in order to implement the plan, serve the target population and to meet savings assumptions outlined in HB 1341.

05/30/02: DSHS submitted a State Plan amendment to CMS. The amendment requested use of §1902(r)(2) of the Social Security Act to disregard income between the Medically Needy income level and the state-contracted rate in a residential facility for the purposes of eligibility only. Under this amendment, clients would be eligible for services without spend down.

06/11/02: CMS Region 10 requested a conference call with staff from DSHS's Medical Assistance Administration (MAA) and from the Aging and Adult Services Administration (AASA- now the ADSA)

06/24/02: DSHS had a conference call with CMS to discuss the requested State Plan amendment. CMS requested the background and intent behind the State Plan amendment. CMS stated there was a comparability problem. "Comparability" refers to the federal requirement that states provide the same treatment for all individuals who are aged, blind or disabled. The State Plan amendment was based on the client's living arrangement and income. CMS indicated they would probably have to deny the State Plan amendment request. Without the State Plan amendment, the waivers that were approved will make very few of the intended target population eligible for services.

06/26/02: DSHS contacted the Region 10 CMS office. Region 10 CMS wanted DSHS to withdraw the State Plan amendment. DSHS refused and requested a formal denial in writing.

07/30/02: DSHS received an e-mail from Maria Garza (CMS) requesting DSHS submit a definition of "Alternate Living Facility."

08/01/02: DSHS conference call with CMS regarding the State Plan amendment. CMS indicated they weren't likely to approve the request. The CMS central office in Baltimore stated they would send DSHS a letter with alternatives and possible language that DSHS could use. CMS understood that this population was not currently being served but thought that there was a problem with using the living arrangement as an eligibility factor.

08/27/02: DSHS received an e-mail from CMS with a copy of a letter dated 8/28/02, requesting additional information on the State Plan amendment request. At this point, it appeared the CMS might deny the State Plan amendment if DSHS limits income disregard to individuals residing in alternate care facilities on the basis of comparability. CMS does not believe DSHS could only target individuals in residential facilities for this disregard. CMS requested additional information on the targeted population and indicated that CMS will not provide DSHS with possible language that DSHS could be used as discussed in the August 1, 2002 conference call. CMS stated that DSHS cannot target a disregard to only Medically Needy individuals with income over 300% of the federal benefit rate/SSA. CMS had 90 days after the DSHS response to make a decision on this issue.

09/20/02: DSHS conference call with Caroline Brown of Covington & Burling to discuss State Plan amendment submitted by DSHS and to ask for their review of what we sent to the CMS central office in Baltimore.

09/27/02: DSHS conference call with Caroline Brown and Maura Dalton of Covington & Burling to discuss their interpretation of the initial verbal rejection of the State Plan amendment by CMS. The attorneys agreed with DSHS and said that there was plenty of room for argument with the conclusion reached by CMS regarding spousal impoverishment rules was contrary to Congress' intent. However, the attorneys also stated that there was a basis in the wording of the statute to support the CMS opinion. The attorneys also informed DSHS that CMS had been consistent in their interpretation of SSA §1902(r)(2) holding that comparability can't be based on living arrangement. Caroline suggested that we address the waiver of comparability issue in pre-eligibility using SSA §1915(c)(3) which states that a waiver granted under this subsection may include a waiver of the requirements relating to comparability.

11/01/02: DSHS responded to the CMS request for additional information on the State Plan amendment. The amendment was modified. The initial request for the income disregard for individuals residing in alternate care facilities was not changed. DSHS anticipates CMS will deny the State Plan amendment request.

Section 3 Program Implementation (If approved by CMS)

If the State Plan amendment is approved by CMS, DSHS will be required to take the following steps before the program could be implemented:

1. Develop and maintain a statewide waiting list for these services. There is no current mechanism for these services;
2. Set up a notification and tracking system of open slots on waiver services for use by field staff statewide;
3. Submit WAC and ACES revisions that cannot be submitted until this issue is resolved; the CR101 remains open at this time;
4. Individual client financial eligibility would not be determined until after a Comprehensive Assessment has been completed and information sent to financial services from the social services case worker completing the assessment; field staff must be trained to implement this change from regular program requirements;
5. Development of training packets for financial and social service staff;
6. Development of Social Services Payment System (SSPS) payment codes for program;
7. Budget and Finance adjustment to track waiver costs for 372 reports to CMS;
8. Notifications to residential providers regarding change in application of these services for financial eligibility;
9. Updating current DSHS program forms with new waiver information;
10. Updating DSHS program and policy materials with new waiver information.

Section 4

Medicaid Terminology Glossary

Spousal Impoverishment-Federal law for special treatment for institutionalized spouses

More generous treatment of income for married couples:

- Income that belongs to the community spouse is not considered when determining eligibility for the institutionalized spouse
- Part of the institutionalized spouse's income may go to the community spouse to bring the community spouse's income up to standards established by the federal government.

More generous resource standard for married couples:

- Institutionalized spouse is allowed \$2,000
- Community spouse is allowed additional resources (\$89,280)
- If the community spouse obtains resources or the value of existing resources increases after institutional care is authorized, the department disregards the increased value or resource as long as the institutional spouse continues to be eligible for benefits.

Spend down

Process through which excess income is assigned to the client's cost of care. The client must incur medical expenses equal to the excess amount (spend down) before medical benefits can be authorized. Spend down is like an insurance deductible.

Comparability

Requires same treatment for all individuals who are aged, blind, disabled.

Income Disregard

Income that is not counted when determining financial eligibility for medical benefits.

Stop The Clock

When states submit a waiver or State Plan amendment, CMS has 90 days to act on it. Action can be to approve, deny, or request additional information. The state can request that CMS hold the waiver and not act on it. This is called "stopping the clock".