Leveraging SMD Letter 21-004 to Expand HCBS Eligibility

HCBS CONFERENCE
Home & Community-Based Services

2023 Home and Community-Based Services Conference

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Agenda

- Overview of the ARPA HCBS Technical Assistance Collective
- Overview of ARPA HCBS TA Collective Support of Michigan
- Presentation from Gene Coffey, CMS
- Presentation from Kristina Leonardi, Michigan DHHS
- Presentation from Eric Carlson, Justice in Aging
- Questions

Overview of ARPA HCBS TA Collective

- The ARPA HCBS TA Collective is comprised of
  - ADvancing States
  - NASDDDS
  - Alissa Halperin of Halperin Health Policy Solutions
  - Anne Jacobs of Riverstone Health Advisors and
  - Brian Burwell
- The ARPA HCBS TA Collective formed with 2021 with the generous support of charitable foundations to provide free technical assistance to states around their ARPA HCBS Spending Plan activities.
  - Round 3 of rapid-fire foundation funding is made possible by: The John A. Hartford Foundation, The SCAN Foundation, The CARE Fund, and The Milbank Memorial Fund. Earlier rounds of funding included: Arnold Ventures and The Peterson Center on Healthcare

Overview of ARPA HCBS TA Collective Support for Michigan

- Michigan applied for and was selected for ARPA HCBS TA Collective Phase 3 technical assistance.
- Its technical assistance request related to its ARPA HCBS initiative designed to leverage the SMD Letter 21-004 to expand HCBS Eligibility in the state.
- As MI will discuss in more detail, ARPA HCBS TA Collective members Alissa Halperin from Halperin Health Policy Solutions and Anne Jacobs from Riverstone Health Advisors helped MI:
  - Research other state activities to leverage this SMD letter
  - Summarize a kitchen sink of possible strategies for leveraging SMD 21-004 to expand HCBS eligibility
  - Strategize about next steps for stakeholder engagement, CMS conversations, and evaluation of potential options for leveraging the SMD letter to expand HCBS eligibility

Gene Coffey

Centers for Medicare and Medicaid Services (CMS)
CMCS
Division of Medicaid Eligibility Policy

Expanding eligibility for HCBS: Leveraging SMDL 21-004 to Increase Accessiblity of HCBS

Gene Coffey, CMS

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Introduction

- This presentation provides information on state authority to target less restrictive financial methodologies to Medicaid applicants and beneficiaries in need of home and community-based services (HCBS).
- CMS State Medicaid Director letter "State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services" (SMD #21-004, December 7, 2021) provides implementation guidance.
- This authority gives states an additional tool to use in efforts to "rebalance" their Medicaid coverage of long-term services and supports (LTSS) from institutional to community-based care.

Basics of section 1902(r)(2)-based disregard authority

- Section 1902(r)(2)(A) of the Social Security Act (the Act) directs that states use financial methodologies that are no more restrictive, and which may be less restrictive, than those applied under non-MAGI methodologies (e.g., SSI-based methodologies).

  Reminder: Disregards may not be applied in MAGI-based eligibility determinations.

Basics of section 1902(r)(2)-based disregard authority, cont'd

- "Less restrictive" methodologies typically involve disregarding a certain amount or type of income or resources.

  For example:
  - $100 in monthly unearned income
  - An amount of income above an income eligibility threshold (e.g., countable income between 100 percent and 150 percent of the federal poverty level)
  - Census Bureau income
  - $5,000 in countable resources
  - A second vehicle

Exception: Rule of Construction Enacted in 2019

- Section 3(b) of the Sustaining Excellence in Medicaid Act of 2019 (Pub. L. 116-39) authorizes states to target disregards at individuals who need or are receiving HCBS without having to also apply the disregard to individuals who need or are receiving institutional services.
- This means that states may target disregards at individuals seeking eligibility in the special HCBS waiver-related eligibility group (described at 42 C.F.R. § 435.217) or at individuals who need HCBS authorized under section 1915(c), (i), or (k), or under section 1115 of the Act but are seeking eligibility under another eligibility group.

Authority to target section 1902(r)(2) disregards based on need for HCBS

The authority enacted in 2019 permits a state to target a less restrictive methodology at only individuals within an eligibility group who are in need of HCBS. For example:

- A state may target a disregard exclusively at individuals in an eligibility group who need 1915(c), (i), or (k) services without applying the disregard to other individuals in the group
- A state that offers 1915(i) and (k) services under its state plan could target a disregard at individuals who need 1915(i) services
- A state that operates more than one 1915(c) waiver could target a disregard at individuals who meet the coverage criteria for one particular waiver
- A state may target a disregard exclusively to individuals eligible in the group described at 42 C.F.R. §435.217

Additional Information

- The new authority is available to states now.
- To implement income or resource disregards using this authority, states must submit a state plan amendment (SPA) to CMS.
- CMS staff is available to provide technical assistance.

Kristina Leonardi

Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration
Aging and Community Services Division

Eric Carlson

Justice in Aging

State May Want to Prioritize HCBS Over Nursing Facility Care

- CONSUMER PREFERENCE: Consumers prefer care in community.
- COST: HCBS is less expensive than nursing facility care.
- LEGAL REQUIREMENT: Americans with Disabilities Act (through *Olmstead v. L.C.)* prohibits unnecessary segregation of persons with disabilities.

- For all these reasons, states have incentive to rebalance systems through increased HCBS use.

One Potential Strategy: Loosen HCBS Eligibility Standards

- But Medicaid rules generally constrain states' ability to loosen HCBS eligibility standards.
- Specifically, Medicaid rules often require equivalent (or substantially similar) eligibility standards for HCBS and nursing facility care.
  - CLINICAL ELIGIBILITY: Clinical eligibility often is tied to need for nursing facility care.
  - FINANCIAL ELIGIBLITY: Under comparability requirements, financial eligibility determinations for HCBS and nursing facility care must follow same methodology (although HCBS recipient will have greater income allocation, in order to meet room and board expenses).

Additional Issue: How to Handle Financial Resources of Spouse

- Nursing facility Medicaid determinations apply spousal impoverishment protections.
  - Couple's resources and income are considered together to a significant extent, and "community" spouse is entitled to allocations:
    - Right to retain income from Medicaid-eligible spouse to raise community spouse's income to (roughly) $2,500 to $3,700 monthly, depending on state.
      - Also, community spouse has right to retain all of his or her income, regardless of state-designated income level.
    - Maximum resource allocation from couple's joint resources of (roughly) $30,000 to $150,000, depending on state.

Spousal Impoverishment Protections in HCBS Eligibility

- For HCBS, spousal impoverishment protections were originally optional for states.
- But Affordable Care Act of 2010 (ACA) made spousal impoverishment protections mandatory for HCBS through 2018.
- ACA requirement has been extended several times; current expiration is September 2027.
  - Consolidated Appropriations Act (Public Law 117-328; Dec. 29, 2022); CMCS Informational Bulletin, Further Extension of the Spousal Impoverishment Rules for Married Applicants and Recipients of Home and Community-Based Services (Aug. 15, 2023).

Spousal Impoverishment Protections Generally Positive for HCBS Recipients

- Protections generally live up to name, by preventing impoverishment of spouse.
- But in some circumstances, community spouse would fare better without spousal impoverishment protections.
  - Prior to spousal impoverishment protections, eligibility of nursing facility resident was considered without regard to spouse's finances.
  - Under prior system, advantageous for resources and income to be allocated to community spouse, so they would not be considered in Medicaid eligibility determination.

- Post-ACA, Minnesota and New Hampshire expressed desire to return to system that would allow HCBS recipient's eligibility to be considered separate from spouse's finances.

Possible State Policy Changes Under CMS Guidance (1 of 6)

- Targeting income or resource disregards to HCBS programs.
  - Disregard would not apply to non-HCBS recipients within the same eligibility group.
    - So disregard could affect HCBS eligibility but not nursing facility eligibility.

Possible State Policy Changes Under CMS Guidance (2 of 6)

- Disregard could be limited to only some of state's HCBS programs.
- Guidance refers to disregards being applied differently to
  - HCBS waivers (Section 1915(c));
  - HCBS State Plan option (Section 1915(i));
  - Community First Choice program (Section 1915(k)); and
  - Medicaid demonstration waivers (Section 1115).
- Disregards might be used to:
  - Favor one program over another, or
  - Try to equalize financial eligibility standards across HCBS programs.
- For example, disregards could apply to some but not all of state's HCBS waivers.

Possible State Policy Changes Under CMS Guidance (3 of 6)

- Disregards could be limited to:
  - Types of income or resources, or
  - Income or resources set aside for particular purposes.
    - Potentially the “set aside” income or resources could support the recipient’s life in an HCBS setting.

Possible State Policy Changes Under CMS Guidance (4 of 6)

- Two potential changes relating to married HCBS recipients.

- First potential change: disregarding finances of community spouse.
  - Underlying "rule of construction" explicitly references disregarding "income or resources of such individual's spouse."
  - Guidance accordingly allows states to disregard all or a portion of community spouse's income or resources:
    - "… and therefore permits states to apply institutional deeming rules to married individuals (i.e., not count the community spouse's income or resources) who seek to participate in 1915(c) waivers as medically needy."

Possible State Policy Changes Under CMS Guidance (5 of 6)

- Second potential change related to married HCBS recipient: retaining spousal impoverishment protections, but applying disregard to community spouse's resources.
  - Language from CMS Guidance: "In other words, in pooling the spouses' resources … under the spousal impoverishment rules, states can elect to disregard all or a portion of the resources of the community spouse."

Possible State Policy Changes Under CMS Guidance (6 of 6)

- Construction rule authorizes disregards for persons with “need” for HCBS.
- Thus, state can target disregards for persons on HCBS waiting lists.
- Disregard can make it easier for persons to be eligible for state plan services while on waiting list.
- Not aware of any examples at this point (although guidance is still relatively new).
  - Utility is unclear, since state plan benefits may be of limited use to person already receiving Medicare.
  - The best way to help someone on waiting list is to get them off waiting list and into HCBS benefits.

Recent New Hampshire Legislation

- House Bill 2-FN-A-LOCAL (signed by Governor Sununu on June 20, 2023).
- Includes provisions to
  - Expand systems of care for healthy aging, and
  - Increase access to HCBS.

- Thanks to Cheryl Steinberg and Judith Jones of New Hampshire Legal Assistance for info, and for their advocacy on these issues.

N.H. Law Modifies Medicaid Eligibility Standards

- For HCBS waiver eligibility for married persons, law reverts to pre-ACA standards.
  - Resources of community spouse are not included.
    - "For married individuals, revert to the standard in place prior to the passage of the Affordable Care Act, so that only the resources in the name of the applicant, and not the resources in the name of the applicant's spouse are counted for purposes of determining Medicaid resource eligibility."

- Also, for single HCBS waiver recipients, disregard $6,000 in resources (establishing effective resource limit of $7,500).
  - N.H. Stat. § 167:4-f(I).

Pros and Cons of Reverting to Previous Methodology

- Ignoring resources of community spouse is useful when community spouse has most of couple's resources.
- But if HCBS recipient has most of couple's resources, spousal impoverishment allowances may be preferable.
  - Alternatively, under previous methodology, couple might transfer resources from one spouse to another.

Reduction of Transfer-of-Assets Lookback Period

- Reduced from 5 years to 3 years.
  - But with State having discretion to use 5-year lookback "if deemed necessary … based upon case specific information or extenuating circumstances."
    - N.H. Stat. § 167:4, I(b).

Presumptive Eligibility

- By 9/30/24, must seek CMS waiver (or implement alternative method) to establish "robust presumptive eligibility process for Medicaid [HCBS], including a mechanism for third party participation."
  - N.H. Stat. § 151-E:25(V).

Common Problem: Delay in HCBS Coverage

- Medicaid law generally requires coverage up to three months prior to month of application, for all months in which person met eligibility standards.
  - 42 U.S.C. § 1396a(a)(34).
- But CMS policy does not allow HCBS waiver coverage to begin until service plan is in place.
- CMS relies on requirement that HCBS waiver services are provided "pursuant to a written plan of care."
  - 42 U.S.C. 1396n(c)(1).
  - *Price v. Medicaid Director*, 838 F.3d 739 (6th Cir. 2016).
- Also, other logistical issues cause delays during HCBS eligibility determinations.

Problem with Delay

- Delay in coverage may lead to unnecessary nursing facility admissions.
- Assume eligible person with immediate need for long-term services and supports, e.g., person in hospital following stroke:
  - Nursing facility will be willing to provide services immediately, since services eventually covered back to date of admission.
  - But HCBS provider likely will not be willing to provide services until service plan is finalized.

Potential State Strategies to Address Problem

- Presumptive eligibility.
  - Note that HCBS State Plan Option (Section 1915(i) provides for presumptive eligibility, but it is limited to payment for 1) determining clinical eligibility and 2) developing service plan.
    - 42 U.S.C. § 1396n(i)(1)(J).
- Provisional written plan of care that "identifies the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility," while comprehensive care plan is being developed.
  - Olmstead Letter No. 3, Attachment 3-a (July 25, 2000).

Making the Case for Expanding Eligibility

- Develop cost neutrality calculations, comparing HCBS expense to nursing facility expense.
- CMS guidance gives states significant discretion to target (and limit) resource and income disregards.
- New Hampshire provides example of state utilizing CMS guidance.

But HCBS Benefits Go Far Beyond Cost Savings

- Persons prefer to reside in community-based settings.
- Plus, Americans with Disabilities Act (through *Olmstead v. L.C.*) establishes legal requirements.

- Money spent on HCBS is money well spent.

Developing Support

- New Hampshire example: Sharing stories of consumers and providers on-line through The Care Paradox, careparadox.org.
  - Collective of in-home care agencies, healthcare providers, nonprofits, and others.
  - Launched in 2022, the Care Paradox speaks to the stark reality that thousands of NH residents are in desperate need of care in their homes, juxtaposed with the reality of an extreme shortage of caregivers."

Questions?

This has been session:

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Thank you!