Government Benefits and Its Role in Paying for Long-term Care Supports and Services

LTSS Boot Camp

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I. OVERVIEW

A. WHY IS THIS SO COMPLICATED?

In theory, access to government-funded long-term supports and services is simple – "get Medicaid." But while getting Medicaid sounds simple, it is anything but. Why is it so complicated?

- **Medicaid is both a federal and state program**. Medicaid's "original" sin is that it is a federal and state system. While the federal government creates the general rules and provides over half the funding, each state administers its own Medicaid program and is allowed significant flexibility in its rules and administration. Unlike Medicare, which is easy to talk about nationally, Medicaid has so much variation state by state that it is difficult to discuss at a national conference.

  Assume that everything said about Medicaid at this conference comes with the caveat: Check your state's rules and programs.

- **States, through their state plans and waivers, are given wide flexibility in their Medicaid programs**. Depending on the federal authority, states use various combinations of state plan amendments and waivers to deliver home and community-based services.

  A Medicaid State Plan is the formal agreement between a state and the federal government outlining how the state administers its Medicaid program. For our purposes,

state plan amendments under § 1915(i) Home and Community-Based Services and §1915(k) Community First Choice Option are the most common.

In our field, Medicaid waivers are utilized frequently to design programs to allow our clients to live outside institutional settings. The most common waivers for our clients are §1915(c) Home and Community-Based Services (HCBS) Waivers, §1915(b) Managed Care Waivers, and §1115 Demonstration Waivers.

States get federal approval for the financial eligibility requirements for their Medicaid programs through state plan amendments and waivers. It can be very helpful to read your state's waiver applications. Attached as Appendix 1 is Michigan's waiver application for its Habilitation and Supports Waiver 1915(c). Looking at this waiver application can be very helpful in understanding many of the concepts discussed below.

- **You cannot assume your state will follow the federal minimum guidelines**. While most states must be no more restrictive than the minimum SSI guidelines in their Medicaid financial eligibility requirements, it is frighteningly common for states to make up their own rules and dare advocates to challenge them. Because initial legal challenges usually occur through the state administrative system, the cost is rarely worth the fight, and states get by with breaking the rules.

- **Everything is political**. You must look no further back than the fight over Medicare expansion as part of Obamacare to understand that politics enters every part of Medicaid. Politics is why states have so much flexibility in Medicaid programs, and politics is almost always a key driver of each state's decision for its eligibility requirements.

In fairness to each state, on average, Medicaid expenditures are significant constituting an average of $20,644 per person with disabilities in 2021. But this can range from $49,015 in Minnesota to $10,838 in Tennessee.[1]

B. STATES HAVE GREAT FLEXIBILITY IN THEIR FINANCIAL ELIGIBILITY REQUIREMENTS.

On December 7, 2021, the Centers for Medicare and Medicaid Services issued a letter to State Medicaid Directors entitled "State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services" (included as Appendix 2). The letter emphasized that because of the Sustaining Excellence in Medicaid Act of 2019, states have great flexibility in determining income and resource disregards for individuals eligible for, or seeking coverage under, certain Medicaid authorities like sections 1915(c), (i), (k), and 1115. This option allows states to raise income and resource standards for HCBS recipients through state plan amendments and waivers. The goal is greater flexibility should help states rebalance their Medicaid programs from institutional to community-based care.

As states submit waivers and plan amendments under State Medicaid Director Letter (SMD #21-004), we can assume there will be even greater differences in the financial eligibility requirements for HCBS services between states.

II. SSI MEDICAID

A. SSI ELIGIBILITY EQUALS MEDICAID ELIGIBILITY IN MOST STATES.

In most states, SSI eligibility means Medicaid eligibility. But even here there is some variation.

[1] CMS Medicaid and CHIP 2023 Scorecard located at: https://www.medicaid.gov/state-overviews/scorecard/measure/Medicaid-Per-Capita-Expenditures?measure=EX.5&measureView=state&stratification=463&dataView=pointInTime&chart=map&timePeriods=%5B%222021%22%5D.

- **Section 1634 States**. Section 1634 of the Social Security Act (42 USC §1383c(a)) allows states to enter into agreements with the Social Security Administration (SSA), where SSA will determine eligibility for medical assistance. In these "1634 States," if an individual is eligible for $1 of Supplemental Security Income (SSI), that individual is automatically qualified for Medicaid in that state. If a client resides in a 1634 state, you should look if the individual is eligible for SSI and, if so, apply for SSI with the Social Security Administration. Once the individual has SSI, there will be no need for a separate Medicaid application.

  ***36 states are currently 1634 States: Alabama, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, New Jersey, New Mexico, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming*.**

- **SSI Criteria States**. In SSI Criteria States, SSI eligibility should equate to Medicaid eligibility, but the state manages their own Medicaid eligibility processes. So while a client who is SSI eligible should get Medicaid, you may be required to file a separate Medicaid application in SSI Criteria States.

  ***6 states are currently SSI Criteria States: Alaska, Idaho, Kansas, Nevada, Oregon, and Utah*.**
  POMS SI 07145.010(A)(1).

Section 209(b) States. Section 209(b) (42 U.S.C. §1396a(f)) allows states to use more restrictive eligibility criteria for Medicaid than those used for the Supplemental Security Income (SSI) program. In 209(b) States, SSI eligibility does not equate to automatic Medicaid eligibility. While Medicaid financial eligibility standards may be more restrictive in 209(b) states, clients must still have some way to "spenddown" income on

medical expenses to become eligible for Medicaid. This is called a Medicaid spenddown or, in some states, a Medicaid deductible. Thus, if you are in a Section 209(b) State, you must also know your state's specific Medicaid financial eligibility requirements.

> ***8 states are currently 209(b) States: Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, and Virginia*.** **POMS SI 07145.010(A)(1).**

B. GETTING SUPPLEMENTAL SECURITY ELIGIBILITY.

Again, one dollar ($1.00) of Supplemental Security Income equals automatic eligibility for Medicaid.

i. <u>Medical Eligibility</u>.

Social Security uses a five-step process for disability criteria, summarized here from attorney Avram Sacks' materials for last year's Stetson SSA Mechanics Boot Camp:[2]

1. Substantial Gainful Activity (SGA):

- The claimant must not be engaged in substantial gainful activity. In 2024, substantial gainful activity is $1,550/month, which is increased to $2,590/month for blind individuals.
- If earnings exceed the monthly threshold, the claim is denied, unless there are special circumstances (e.g., impairment-related work expenses, special accommodations).

2. Severity of Impairment:

- The claimant must have a severe impairment that significantly limits their ability to perform basic work tasks (e.g., walking, sitting, lifting, etc.).
- Minor health issues do not qualify. The combined impact of all impairments is considered.

[2] *See* Avram Sacks, The Nuts and Bolts of SSI and SSDI, Stetson Law 2023 SSA Mechanics Boot Camp.

3. Listed Impairment:

- The claimant may qualify if their impairment matches or equals a listed impairment in Social Security regulations at https://www.ssa.gov/OP_Home/cfr20/404/404-app-p01.htm.

- If an impairment does not meet the exact listing criteria, it can still be considered equivalent if its medical significance is similar.

4. Past Relevant Work (PRW):

- If the claim is not established by this stage, the claimant must prove they cannot perform any past relevant work done in the last 15 years.

- This includes both full-time and part-time work that meets the SGA level.

5. Vocational Adjustment to Other Work:

- If the claimant cannot perform past relevant work, the determination shifts to whether they can adjust to other work given their age, education, and residual functional capacity (RFC).

- At step 5, the burden of proof shifts to the Social Security Administration to demonstrate that the claimant can perform other jobs.

ii. <u>Income Eligibility</u>.

The SSA assesses all income types, but treats earned and unearned income differently:

- **Earned Income**. For earned income, meaning income earned while working, Social Security excludes the first $20 a month, plus disregards an additional $65 of the earned income. Then Social Security counts only half of the remaining earned income.

  Example: John has $1,000 a month in *earned* income. He would still get $485.50 in SSI calculated as follows:

  1. **Earned income:** $1,000
  2. **Apply the $20 general income exclusion** (which applies to both earned and unearned income):
     - $1,000 - $20 = $980
  3. **Apply the $65 *earned* income exclusion**:
     - $980 - $65 = $915
  4. **Divide the remaining income by 2** (since only half of earned income counts):
     - $915 ÷ 2 = $457.50
  5. **Subtract the countable income from the federal benefit rate**:

- In 2024, the SSI federal benefit rate for an individual is $943.
- $943 - $457.50 = $485.50 (John's SSI payment)

- **Unearned Income**. Unearned income includes gifts, annuities and pensions, inheritances, dividends from investments, rental income, child or spousal support, and so forth. Unearned income reduces SSI benefits dollar-for-dollar. Social Security's table of contents on unearned income can be found at POMS SI 00830.000 Unearned Income.

Example: John has $1,000 a month in *unearned* income. He would be ineligible for Supplemental Security Income calculated as follows:

1. **Unearned income:** $1,000
2. **Apply the $20 general income exclusion**:
   - $1,000 - $20 = $980
3. **Subtract the countable income from the federal benefit rate**:
   - In 2024, the SSI federal benefit rate for an individual is $914.
   - $943 - $980 = $0 (since the countable unearned income exceeds the federal benefit rate).

Importantly, Social Security Retirement and Disability benefits are considered unearned income. It is quite common for our clients to have some non-SSI Social Security and SSI as long as their non-SSI Social Security is under $963 ($943 federal benefit rate + $20 income disregard.) This can be a terrific situation for a client because this will not only entitle a client to automatic Medicaid eligibility in most states, but will make the client eligible for Medicare.

Cash distributions from a special needs trust will also count as unearned income for SSI purposes, which is a common mistake.

iii. <u>Asset Eligibility</u>.

To qualify for SSI, individuals must have countable under $2,000 for an individual and $3,000 for a couple. Countable resources include cash, bank accounts, stocks, bonds, and real estate. It does not include certain resources such as the individual's primary residence, one vehicle,

personal belongings, certain funeral expenses, ABLE Accounts, and certain special needs trusts. A full list of exempt resources is discussed in Section V, Strategies for Asset Eligibility below. .

III. NON-SSI MEDICAID

A. COMMON MEDICAID INCOME ELIGIBILITY TERMS.

To make income rules even more confusing, many income levels are set at either a percentage of the Federal Benefit Rate (FBR) *or* the Federal Poverty Level (FPL).

- **Federal Poverty Level**. The Federal Poverty Level (FPL) is calculated each year by the Department of Health and Human Services using data provided by the Census Bureau. Income limits for numerous Medicaid programs are determined as percentage of the FPL. The FPL is uniform throughout the 48 continuous states, but are different in Alaska and Hawaii. **For the 48 continuous state, the federal poverty level is $1,255/month in 2024.**

- **Federal Benefit Rate**. The Federal Benefit Rate (FBR) is the maximum monthly Supplemental Security Income benefit. Each year, increases to the FBR are tied to the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), the same index used for all Social Security benefits. Historically, the FBR typically runs at about 75% of the Federal Poverty Level (discussed above), but the FBR is not technically keyed to the FPL. **In 2024, the FBR is $943/month for individuals and $1,415/month for couples.**

- **Medically Needy Income Level (a.k.a., Protected Income Level)**. For medically needy programs, the Medically Needy Income Level "is the amount remaining after spend-down

that permits an individual to qualify for Medicaid."[3] In Michigan, this is called the protected income level and can vary by geography depending on where you live in the state (and has not been changed in over 40 years). For illustrative purposes, if the Medically Needy Income Limit is $500 and an individual's income is $1,500, the individual will have to spenddown $1,000 in medical expenses in a given month before being eligible for Medicaid.

B. NON-SSI MEDICAID CATEGORIES

If a client is not eligible for SSI, the client might still be eligible for Medicaid through other financial eligibility criteria. However, it would be impossible to talk about all the Medicaid categories and each state's eligibility criteria for each category in an hour presentation.[4] Understanding some general financial eligibility criteria that states generally use when applying for Medicaid waivers can be very helpful in understanding your own state's Medicaid eligibility criteria.

For example, I have included in Appendix 4 a sample from my law firm and select passages from Michigan's operations manual to demonstrate how complicated navigating all the Medicaid programs is in just one sample state.

- **Other "Categorically Needy" Financial Criteria**. A client with a disability is "categorically needy" if the client meets income and asset limits set by the state. A categorically eligible beneficiary is automatically eligible for Medicaid without a spenddown. As discussed above, an SSI recipient is "categorically needy" in most states.

[3] Instructions, Technical Guide and Review Criteria for a §1915(c) Home and Community-Based Waiver, Center for Medicare and Medicaid Services, page 319 (January 2019).

[4] Kaiser Family Foundation has several useful resources for state-by-state comparisons.

However, states can use financial criteria more generous than SSI for categorical eligibility. Eligibility will vary by state. In these states, that more "generous" income eligibility level is usually set at 100% of the federal poverty level (currently $1,255/month), which is $312/month higher than SSI.

According to the Kaiser Family Foundation, in 2018, 20 states allowed Medicaid eligibility for seniors and people with disabilities up to 100% of the Federal Poverty Level (FPL). These states include Arizona, Arkansas, California, the District of Columbia (DC), Florida, Hawaii, Illinois, Indiana, Maine, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Utah, and Virginia. While Arkansas, Florida, and Virginia extend Medicaid eligibility, they do not elect the full 100% FPL. Additionally, Arkansas extends coverage beyond SSI limits for seniors only.[5]

- **Medically Needy**. States can create an optional "medically needy" Medicaid category where an individual's income is otherwise too high for categorically needy coverage. Instead, "these individuals qualify for coverage by spending down (i.e., reducing their income by incurring medical expenses). States that elect to cover the medically needy populations do not have to offer the same benefit package to them as they offer to the categorically needy."[6] An individual qualifies for Medicaid in a medically needy category after "spending down" their income on certain medical expenses below the medically needy income level in a given state.

Medically Needy Eligibility occurs when Income – Medical Expenses < Medically Needy Income Level.

[5] Kaiser Family Foundation, Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings From A 50-State Survey (June 14, 2019).

[6] Instructions, Technical Guide and Review Criteria for a §1915(c) Home and Community-Based Waiver, Center for Medicare and Medicaid Services, page 319 (January 2019).

According to the Kaiser Family Foundation, in 2018, 32 states have medically needy programs for individuals with disabilities. These states include Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.[7]

- **Special Income Group ("300% of SSI Group")**. This category is for individuals needing home- and community-based services who would otherwise require institutional care but have too much income to qualify to be categorically eligible for Medicaid. There is no spenddown for this group. States can have lower income rates, but most every state with the program has capped income at 300% of SSI (i.e., the federal benefit rate). In 2024, this is $2,829/month.

The Special Income Rule is most commonly applied to home- and community-based programs targeted at keeping older adults who would otherwise be in a nursing home at home. However, as advocates, it is sometimes important to remind agencies that individuals with disabilities may qualify for Medicaid services under numerous categories. This can sometimes be problematic, however, as the agencies charged with providing services to older adults are often different than the agencies charged with providing services to individuals with disabilities. Coordinating between those different agencies can be a nightmare. To address this, Michigan just released a letter explaining how that coordination should work, which is included as Appendix 3.

- **Adult Disabled Child (formerly DAC) Medicaid Disregard**. Under 42 USC §1383c(c), states must disregard any increase in Social Security benefits in determining Medicaid eligibility when a child transfers from being an SSI recipient to receiving adult disabled child benefits on a parent's Social Security record.

[7] Kaiser Family Foundation, Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings From A 50-State Survey (June 14, 2019).

Depending on the state, this can be highly problematic if a child was never able to receive SSI because a parent died, became disabled, retired, or never had a child apply for SSI. In certain states, this can cause a child to be ineligible for SSI-related Medicaid because the increase in income due to the Social Security increase is not disregarded. This is highly unfair, and the Special Needs Alliance is attempting to make a legislative change. Other common issues can occur when a child works and loses the ADC benefit and when a child receiving the ADC benefit gets married.

- **Medicaid Buy-In Programs**. If a beneficiary has earned income (i.e., income from working), they may be eligible for a Medicaid Buy-In program. These programs typically have higher Medicaid asset and income limits to encourage individuals with disabilities to work and may require participants to pay premiums or cost-sharing based on their income. These return to work programs can vary significantly from state to state (if available at all).

***The Kaiser Family Foundation keeps a list of income and asset limits for Medicaid Buy-In programs at: https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-4*. Only six states do not have some sort of buy-in program for individuals with disabilities: Alabama, Hawaii, Missouri, Oklahoma, South Carolina, Tennessee.[8]**

IV. STRATEGIES FOR OBTAINING INCOME ELIGIBILITY

Clients over the income eligibility limits are typically much more difficult than clients over the asset limits (which is discussed in next Section V below). But there still can be successful strategies.

[8] *Id.*

- **Can you irrevocably assign income to a special needs trust?**

In any case involving excess income, your first question should be if the income can be irrevocably assigned to a special needs trust – almost always a first-party (d)(4)(A) trust. According to Social Security POMS SI 01120.200(G)(1)(d):

> **Assignment of income**
>
> A legally assignable payment that is assigned to a trust or trustee is income for SSI purposes, to the individual entitled or eligible to receive the payment, unless an SSI income exclusion applies or the assignment is irrevocable. We consider assignment of payment by court orders to be irrevocable. For example, child support or alimony payments paid directly to a trust or trustee because of a court order are considered irrevocably assigned and thus not income. Also, U.S. Military Survivor Benefit Plan (SBP) payments assigned to a special needs trust are not income because the assignment of an SPB annuity is irrevocable. For more information on SPB annuities, see SI 01120.201J.1.e.

Irrevocable assignment of income to a first-party special needs trust must be done before age 65. POMS SI 01120.203(B)(3). Whether you can assign income to a pooled trust at age 65 or over is a state and specific pooled trust question.

Assigning income to an ABLE Account generally will not work because the individual owns the ABLE Account. As such, for income purposes, it is usually treated the same as if the income hit the individual's bank account.

Common examples of income that is regularly irrevocably assigned to special needs trusts:

- **Child or spousal support** *court ordered* to be paid to the SNT.
- **Survivor Benefit Plans** through the military (made possible by the 2015 Howard P. "Buck" McKeon National Defense Authorization Act thanks to many attendees of this conference).
- **Annuities**, particularly structured settlement annuities, that are irrevocably assigned by court order.

Pension assignment is a state-by-state, pension-by-pension question. The Special Needs Alliance is working with various states to promote legislation that will allow government pensions to be assigned to a special needs trust. If you want to work on this issue in your state, please e-mail me.

The Social Security POMS are also very explicit as to what *cannot be assigned*. The following cannot be assigned:

- Temporary Assistance to Needy Families (TANF)/Aid to Families with Dependent Children (AFDC);
- Railroad Retirement Board-administered pensions;
- Veterans' pensions and assistance;
- Federal employee retirement payments (CSRS, FERS) administered by the Office of Personnel Management;
- Social Security Title II and SSI payments; and
- Private pensions under the Employee Retirement Income Security Act (ERISA) 29 U.S.C.A. § 1056(d)).

It will almost always be better to assign income to a special needs trust rather than using a Miller Trust if you can. You can use the trust money is many more ways to improve the client's quality of life.

- **Is a Miller Trust an option in your state and the Medicaid program you need?**

A Miller Trust (also known as a Qualified Income Trust or Income Assignment Trust) is a trust used in certain income cap states if an individual's income is above the income cap. This is the (d)(4)(B) trust if you were ever wondering why special needs trusts jump from (d)(4)(A) to (d)(4)(C)!

With a Miller Trust, if an individual's income exceeds the income cap, the additional funds can be deposited into the Miller Trust. The Miller Trust then can generally only be used to pay medical expenses not covered by Medicaid, and upon the individual's death must be paid over to the state's Medicaid agency.

Before you embark on using a Miller Trust, you must understand your state's rules regarding Miller Trusts!

According to the Kaiser Family Foundation, in 2018, 22 state allow the use of Miller Trusts for individuals with disabilities who need Home and Community-Based

Services (HCBS) under Medicaid: Alaska, Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Mississippi, Missouri, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, and Texas.

- **Can the client work enough to get into your state's buy-in program with higher income/asset limits?**

As mentioned above, the Kaiser Family Foundation indicates that forty-four states have a Medicaid buy-in program for individuals with disabilities, which usually comes with higher income/assets limits. If your client can work – sometimes just a few hours – you may be able to get Medicaid eligibility even with higher incomes.

In Michigan, the buy-in program has been extremely useful in getting around the otherwise draconian and burdensome spenddowns that come with medically needy eligibility.

If you think a client working could be a pathway to eligibility, but there is no obvious employment, consider working with a disability organization (e.g., a local Arc) to see if they would be willing to hire for the minimum work required.

- **Advocate or move to another state?**

As discussed above, CMS is giving states extreme flexibility to adjust their income limits for home and community-based services. It is an ideal time to advocate for higher limits in your state.

And yes, a client could always establish residency in another state with higher income limits.

V. STRATEGIES FOR OBTAINING ASSET ELIGIBILITY

Depending on your state, the following is a checklist of options to consider if a client is above assets for Medicaid eligibility.

- **Are these services available in a non-asset tested Medicaid program?**

While this might have limited value in seeking long-term care and support services, it is worth noting that due to Medicaid expansion and the Affordable Care Act, many state Medicaid programs now use only a modified adjusted gross income (MAGI) test, without considering assets. These MAGI-only programs can encompass Medicaid expansion, children's Medicaid, coverage for pregnant women, parents and caretaker relatives, and the CHIP program. As always, the availability of these programs will vary from state to state.

> ***An individual will generally not be eligible for MAGI-based Medicaid programs if the individual has Medicare.***

- **For inheritances, evaluate whether there is a way to convert first-party money to third-party money. See if you can decant the trust if there is problematic language.**

If a beneficiary received an inheritance and there are significant assets to justify doing so, scour any will or trust for boilerplate language that might allow the inheritance to be considered third-party funds. If boilerplate language in the will or trust gives the trustee or executor authority to apply a discretionary standard to a beneficiary with a disability, utilize that language.

If the language of the trust contains problematic language or the use of the boilerplate clause might cause issues, know your state's decanting statute (if any). Often, you can decant the trust into a trust that will be acceptable to your state Medicaid agency.

Decanting is a handy tool if you have a discretionary trust drafted out of state with problematic language for your state.

Finally, remember that probate courts are generally courts of equity. As courts of equity, probate courts can sometimes use their equitable powers to fix a missed beneficiary designation or correct problematic trust provisions. This is particularly true if the settlors' intent is known, and nobody will object to the requested change.

You must do a cost-benefit evaluation before you go to court. First, know your probate court and state agency to know if this is possible relief. Second, particularly if the client is under age 65 and the sum is modest, the cost-benefit could weigh towards doing a first-party trust and avoiding the expense of court.

- **Can you convert countable resources to exempt resources?**

Particularly for small sums, you should determine if you can easily convert countable resources to exempt resources.

Below is a list of some of the major categories of exempt assets for SSI purposes. **Despite this list, there are *huge* variations from state to state**. You must know your state's rules and policy manual. Also, remember this does not need to apply for Section 209(b) States.

Start here:

- Paying down debt!

Exempt resources as found in POMS SI 01110.210:

- Home serving as the principal place of residence, including associated land (SI 01130.100). Note: There is an equity limit for long-term care Medicaid and home and community-based waivers, but not for SSI or other Medicaid categories. The equity limit will vary in each state.
- Jointly-owned real property that cannot be sold without undue hardship to other owners (SI 01130.130)
- Real property while reasonable efforts to sell it are unsuccessful (SI 01130.140)

- Restricted, allotted Indian land (SI 01130.150)
- One vehicle used for transportation (SI 01130.200)
- Burial space or plot for eligible individuals and their family (SI 01130.400)
- Household goods and personal effects (SI 01130.430)
- Stock held by native Alaskans in Alaska regional or village corporations (SI 01120.105)
- Dedicated accounts for benefits (SI 01130.601)
- Radiation Exposure Compensation Trust Fund payments (SI 01130.680)
- German reparations payments to Holocaust survivors (SI 00830.710, SI 01130.610)
- Austrian social insurance payments (SI 00830.715, SI 01130.615)
- Japanese-American and Aleutian restitution payments (SI 00830.720)
- Federal disaster assistance (SI 00830.620, SI 01130.620)
- Agent Orange settlement payments (SI 00830.730, SI 01130.660)
- Ricky Ray Hemophilia Relief Fund payments (SI 01130.695)
- Payments to Veterans' Children with Certain Birth Defects (SI 01130.681)
- State annuities for certain veterans (SI 01130.662)
- Funds in an ABLE account (SI 01130.740). As noted below, there is a $100,000 cap for SSI purposes, but no cap for Medicaid eligibility.

Exclusions with Limits on Value/Length of Time.

- Funds from the sale of a home, if reinvested in a replacement home within 3 full calendar months. (SI 01130.110)
- Life insurance up to $1,500 face. If over $1,500 face and then the cash value surrender value is counted. pending on face value (SI 01130.300)
- Burial funds for an individual and/or their spouse (SI 01130.410)
- Certain prepaid burial contracts (SI 01130.420)
- Property essential to self-support (SI 01130.500–SI 01130.504)

- Resources of a blind or disabled person necessary to fulfill a Plan for Achieving Self-Support (PASS) (SI 00870.000, SI 01130.510)
- Retained retroactive SSI or RSDI benefits for 9 months (SI 01130.600)
- Restitution payments for misused Title II, VIII, or XVI benefits (SI 01130.602)
- Cash and in-kind replacement for lost, damaged, or stolen excluded resources (SI 00815.200, SI 01130.630)
- Victims' compensation payments (SI 00830.660, SI 01130.665)
- State or local relocation assistance payments (SI 00830.655, SI 01130.670)
- Tax refunds related to Earned Income Tax Credits (SI 00830.060, SI 01130.676)
- Grants, Scholarships, Fellowships, and Gifts (SI 01130.455)

Again, despite the POMS's straightforward language on these exemptions, states put their spin on these exempt assets. While in most SSI states, you could have legal challenges if your state applies a stricter standard, it is a rare client who would want to take up that challenge – particularly if there are other avenues for Medicaid qualification.

Certain retirement assets may be exempt depending on your state and program. This is a topic that is too complicated for this presentation. Again, know your state.

- **First-Party Special Needs Trust under 42 USC § 1396p(d)(4)(A)?**

A first-party special needs trust is a standalone trust established under 42 U.S.C. § 1396p(d)(4)(A). Assets in a first-party special needs trust are exempt for Medicaid purposes. To be exempt, a first-party special needs trust must:

- Be established for individuals with disabilities *under* the age of 65;
- A parent, grandparent, legal guardian, or a court must set it up; and
- Must contain a payback clause whereupon after the beneficiary's death, the remaining assets are used to reimburse any state that provided Medicaid benefits to the beneficiary before any were received.

In many, if not most states, Medicaid paybacks cover Medicaid expenditures back to the beneficiary's birth, not the date the Trust was established. Thus, for a critically ill individual (particularly one receiving Medicare), some consideration should be given to whether establishing a trust with a payback makes sense.

Pros of a First-Party Special Needs Trust:

- A beneficiary, or the beneficiary's family, can choose the Trustee, which will often be more responsive to the beneficiary's needs and have lower ongoing administration costs.
- Trustees can also choose investment advisors and will have a wider range of investment options.
- More individualized drafting opportunities.
- Better able to manage non-cash assets.
- Allows for customized residuary distributions if residuary funds exceed a Medicaid payback.

Cons of a First-Party Special Needs Trust

- Legal fees for drafting the Trust can be expensive, and administration can be expensive if using a professional trustee.
- First-party special needs trusts tend to get frequently scrutinized by government agencies, sometimes years (or decades) later.
- Trust administration can be too complicated for an unsophisticated (e.g., family member) Trustee.
- Investment diversification may be difficult with smaller trust sizes.

 Pooled Trust under 42 USC 1396p(d)(4)(C)?

A pooled trust under 42 U.S.C. § 1396p(d)(4)(C) is the traditional alternative to a first-party special needs trust. Each beneficiary has a separate account in a pooled trust, though funds are pooled for investment purposes. A pooled trust must:

- Be managed by a nonprofit association.

- The account must be set up for the sole benefit of an individual with disabilities under Social Security's meaning.

- Remaining funds upon the beneficiary's death must either be retained by the nonprofit by the nonprofit or go to pay back Medicaid for the beneficiary's Medicaid expenditures.

> ***States and even individual pooled trusts vary in their rules regarding retained funds. In some states, pooled trusts can retain all remaining funds after a beneficiary's death, while other states require at least some percentage of the funds to go to the state for a Medicaid payback. Pooled trusts also vary in their policies as to whether a beneficiary can designate where funds go if the Medicaid lien is less than the subaccount amount.***

> ***Under 42 USC § 1396p(d)(4)(C) there is no age limit for funding a pooled trust. Yet there is significant variation among states as to whether funding a pooled trust at age 65 or over will incur a divestment penalty. But when we are talking about Medicaid programs for individuals with disabilities, many of these programs do not have divestment penalties. Funding a pooled trust at age 65 and over may be a viable strategy, but must be done with considerable care.***

Pros of a Pooled Trust

- Professionally managed by a nonprofit, which should be adept at advising on government benefits.

- Cost-effective to set up, particularly for smaller trusts.

- Economies of scale allow for greater investment diversification.

Cons of a Pooled Trust

- Limited control over distribution and investment decisions. A pooled trust's bureaucratic requirements can be frustratingly burdensome for some individuals.

- Pooled trusts vary significantly in quality.

- Ongoing administration fees can be surprisingly expensive.

ABLE Accounts?

An ABLE (Achieving a Better Life Experience) account is an exempt resource for Medicaid eligibility. An ABLE account allows the individual (if competent) to remain in control of the funds, and the funds in the ABLE Account will grow tax-free if used for qualifying disability

expenses. The disability must have begun before age 26 (to be increased to 46 in 2026). ABLE accounts may have a Medicaid payback requirement upon the beneficiary's death, although current enforcement of Medicaid paybacks varies significantly by state. Contributions to an ABLE Account are limited to the annual gift tax exclusion, which is $18,000 in 2024.

A first-party special needs and pooled trust can contribute to an ABLE account. For competent trust beneficiaries who can manage their assets but need Medicaid, special needs trusts regularly contributing to ABLE accounts can significantly lower trust administration costs and promote independence.

Remember, the disability must have simply begun before the age of 26 (46 in 2026), and you can use a doctor's certification to certify this if you do not have a Social Security Disability determination before these ages.

Pros of ABLE Accounts

- ABLE accounts offer the most independence for beneficiaries. A competent beneficiary can maintain control of their own money by managing their own ABLE account.
- ABLE Accounts are cheap, with annual fees usually $60 or under and investment fees usually around .3-.6%. This is far cheaper than pooled trusts.
- Practically, most any expenditure can qualify as a qualified disability expense. Additionally, distributions made from an ABLE account do not count as in-kind support and maintenance (ISM) for SSI.
- ABLE accounts grow tax-free if distributions are made for qualified disability expenses. This is comparable to a Roth IRA.
- Like pooled trusts, ABLE accounts allow for greater investment diversification for small sums of money.
- You can use an ABLE account in any state giving you a variety of programs to choose from (although significant consolidation of ABLE programs is occurring).
- Most ABLE programs use a TrueLink or similar type debit card, and the cost for the card is usually significantly cheaper than getting a card through a special needs trust.

Cons of ABLE Accounts

- ABLE accounts are only available to beneficiaries whose disabilities began before age 26 (46 is 2026).

- ABLE accounts are not a good option if a beneficiary is a spendthrift or vulnerable to exploitation.
- The $18,000 annual limit makes ABLE accounts a limited option for most resource planning.
- As ABLE account administrators face tight budgets, customer service with certain ABLE programs can be spotty, and many are increasingly difficult to work with, particularly for legal representatives.
- Consolidation of state ABLE programs is limiting the variety of ABLE programs to choose from.
- ABLE accounts can only handle cash.

An ABLE account is exempt for SSI purposes up to $100,000, but there is no asset limit for Medicaid purposes. In these instances, an individual is not supposed to lose SSI eligibility – SSI benefits are suspended. But be careful – this is likely a ripe area for agency error.

Is a Medicaid Buy-In Program an option?

As discussed with income above, Medicaid Buy-In Programs allow people to maintain Medicaid while working. These programs typically have asset limits (and other asset rules) that are more generous than SSI's. Thus, if your client can work at least some, that could give them a greater asset cushion.[9]

Again, in many states, the amount of work does not have to be substantial. It can be as low as a few hours a month in Michigan.

[9] The Kaiser Family Foundation keeps a list of income and asset limits for Medicaid Buy-In programs at: https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D#note-4.

- **Does it make sense to divest assets as a last resort option?**

While this would usually be the last option to consider, many Medicaid waiver programs for individuals with disabilities may not have a divestment penalty. It could be a risky last resort option.

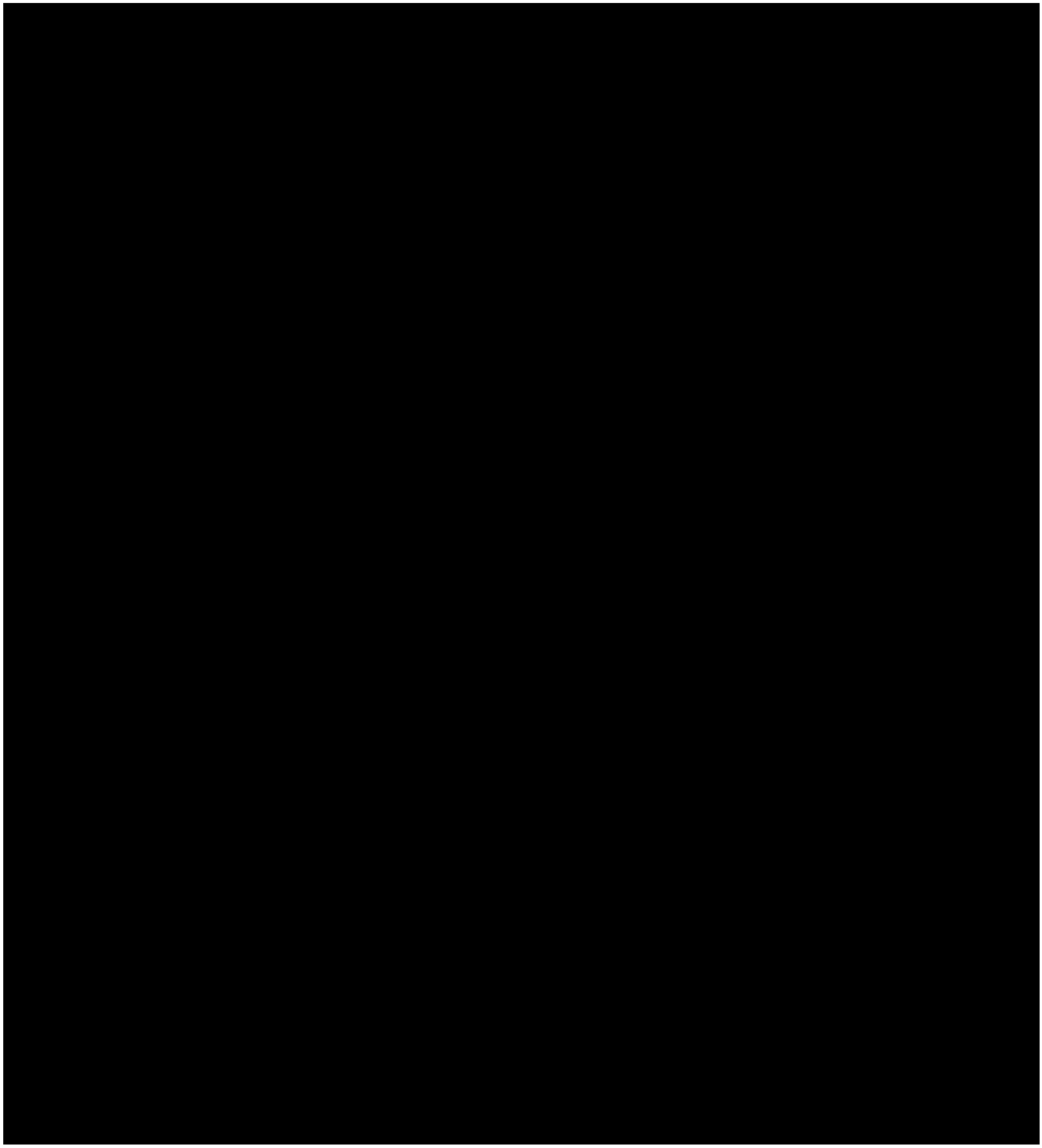
You must check your state's waiver and plan before advising. And, of course, SSI has a 3-year divestment penalty, Home and Community-Based Services 1915(c) Waivers have a 5-year divestment penalty, and HUD Housing generally has a 2-year divestment rule. So even if a current Medicaid program does not have a divestment penalty, a client may need a Medicaid service in the future where a divestment would apply.

> ***In addition to this being a last resort option, it is clearly an option you never want to take with someone with little or questionable capacity without getting court approval.***

- **Move to California?**

This is mostly facetious, but a main point of this presentation is the wide flexibility that states now have in setting financial eligibility criteria for home and community-based services. California went so far as to eliminate any asset test for its Medi-Cal program. Thus, while it is probably not practical, another last resort option could be establishing residency in a different state.

APPENDIX 1



Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

◉ **§1634 State**

○ **SSI Criteria State**

○ **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

◉ **No**

○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

☐ **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☒ **Optional state supplement recipients**

☒ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

◉ **100% of the Federal poverty level (FPL)**

○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Parents & caretaker relatives
42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

Pregnant Women
42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

Infants and Children
42 CFR 435.118
1902(a)(10)(A)(i)(III)(IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- (●) **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- ( ) **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

  Select one and complete Appendix B-5.

  - ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**
  - ( ) **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

    Check each that applies:

    - [ ] **A special income level equal to:**

      Select one:

      - ( ) **300% of the SSI Federal Benefit Rate (FBR)**
      - ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

        Specify percentage: [ ]
      - ( ) **A dollar amount which is lower than 300%.**

        Specify dollar amount: [ ]
    - [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
    - [ ] **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
    - [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
    - [ ] **Aged and disabled individuals who have income at:**

      Select one:

      - ( ) **100% of FPL**

APPENDIX 2

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD# 21-004

RE: State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services

December 7, 2021

Dear State Medicaid Director:

This letter provides guidance to states on a "rule of construction" of the Medicaid Act under section 3(b) of the Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39, which has been included in several subsequent federal laws (hereafter the "construction rule").[1] The construction rule provides that states have the option to target and tailor income and resource disregards at individuals who are eligible for, or seeking coverage of, home and community-based services (HCBS) authorized under section 1915(c), (i), (k) and 1115 authorities.[2]

This new option permits states to adopt higher effective income and resource eligibility standards for people who need HCBS, either for all such individuals or for a particular cohort of such individuals. The option affords states with broad discretion in selecting the cohorts of individuals needing HCBS for whom the state will apply higher effective income or resource standards. States could, for example, effectively raise the resource standard for all individuals eligible for HCBS, or for individuals eligible for a particular 1915(i) or 1915(k) 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. This option presents states with a critical tool to use in their efforts to "rebalance" their Medicaid coverage of long-term services and supports (LTSS)

[1] *See* The Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Division N, Title I, Section 204(b); Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, Division A, Title III, Subtitle E, Part II, Section 3812(b); Continuing Appropriations Act, 2021, Pub. L. No. 116-159, Division C, Title III, Section 2302(b); Further Continuing Appropriations Act, 2021, and Other Extensions Act, Pub. L. No. 116-215, Division B, Title I, Section 1105(b); Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Division H, Title II, Section 205(b). CMS does not interpret the construction rule in these provisions or the Sustaining Excellence in Medicaid Act rule of construction provision to be time-limited, notwithstanding its inclusion in multiple federal laws.

[2] The construction rule in the Sustaining Excellence in Medicaid Act provision and in the provisions described in footnote 1 reads: "Nothing in section 2404 of Public Law 111-148, section 1902(a)(17) or 1924 of the Social Security Act shall be construed as prohibiting a State from applying an income or resource disregard under a methodology authorized under section 1902(r)(2) of such Act (1) to the income or resources of an individual described in section 1902(a)(10)(A)(ii)(VI) of such Act (including a disregard of the income or resources of such individual's spouse); or (2) on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act or under section 1115 of such Act."

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from institutional to community-based care. The purpose of this letter is to provide information on how states can utilize the construction rule to expand coverage of HCBS under their Medicaid programs.

Background

In order to understand the new flexibility under the construction rule to expand eligibility for individuals seeking HCBS, it is helpful to review certain requirements and state options regarding the financial methodologies applied in determining eligibility for individuals seeking Medicaid based on their need for long term services and supports, eligibility groups for individuals seeking coverage of HCBS, and spousal impoverishment protections for married individuals receiving institutional care or HCBS.

Section 1902(r)(2)-based disregard authority

Section 1902 of the Social Security Act (the Act) contains two broad mandates for state Medicaid agencies in their determinations of financial eligibility for individuals who are excepted from the use of modified adjusted gross income (MAGI) methodologies.[3] First, section 1902(a)(17) of the Act requires that states use comparable financial methodologies in determining eligibility for categorical populations (e.g., individuals who are 65 years old and older, 21 years old or younger, or who have disabilities).[4] Second, section 1902(r)(2)(A) of the Act requires that states use financial methodologies in Medicaid that are no more restrictive than those applied in the most closely related cash assistance program.[5] However, section 1902(r)(2)(A) of the Act allows states to adopt income and/or resource methodologies which are less restrictive than the applicable cash assistance program. Typically, less restrictive methodologies adopted by states involve disregarding a certain amount or type of income or resources in determining applicants' and beneficiaries' countable income or resources.

CMS regulations implementing the states' authority to apply less restrictive methodologies than the corresponding cash assistance program's methodologies under section 1902(r)(2)(A) of the

[3] Section 1902(e)(14)(A) of the Act requires that states use MAGI-based methodologies in determining financial eligibility for Medicaid, subject to the exceptions described in subparagraph (D) of the same provision. Populations excepted from MAGI-based methodologies generally include, but are not limited to, individuals who seek Medicaid on the basis of being 65 years old or older, or having blindness or a disability, individuals who seek coverage for long-term services and supports, and individuals who seek Medicaid on the basis of being "medically needy." *See* 42 C.F.R. §435.603(j).

[4] *See* section 1905(a).

[5] Certain states have elected the authority provided under section 1902(f) of the Act to apply financial methodologies more restrictive than the SSI program in determining eligibility for individuals 65 years old or older or who have blindness or a disability, subject to certain conditions. *See* 42 C.F.R. §435.121. These states are referred to as "209(b)" states, after the provision of the Social Security Act Amendments of 1972, Pub. L. No. 92-603, section 209(b), which enacted what became codified at 1902(f) of the Act.

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Act require that such less restrictive methodologies be comparable for all individuals in an eligibility group, consistent with section 1902(a)(17) of the Act.[6] In other words, targeting disregards at selected individuals in the same group is not permitted. For example, if a state elects to disregard $100 in income for individuals seeking coverage under an eligibility group for individuals 65 years old and older, $100 must be disregarded in determining the income eligibility of all 65 and older individuals applying for the group.[7]

Individuals eligible for the "217" group

In operating HCBS programs authorized under section 1915(c) of the Act, states commonly extend eligibility to individuals described in section 1902(a)(10)(A)(ii)(VI) of the Act. This section authorizes Medicaid coverage for individuals who: would be eligible for Medicaid if they were in a medical institution; would require an institutional level of care in the absence of the provision of HCBS; and will receive 1915(c) services. This eligibility group is further described in 42 C.F.R. §435.217 and is commonly referred to as the "217 group."

Determining whether the 217 group applicants satisfy the requirement in section 1902(a)(10)(A)(ii)(VI) of the Act that they "would be eligible . . . if they were in a medical institution" involves the hypothetical assumption that the applicant *is* in an institution and the concomitant identification of an eligibility group under which the individual would be eligible under the state's plan assuming such institutional status.[8] Treating a 217 group applicant as institutionalized can facilitate eligibility because: (1) the income standards of eligibility groups for institutionalized individuals covered under a state's plan may be higher than those serving noninstitutionalized individuals; and (2) the income and resources of other individuals (i.e., a spouse or parent) are not included in an institutionalized individual's eligibility determination.[9]

In order to adopt a 217 group, the state selects a group that is already covered under the state plan. We refer to this group as the "principal group." The principal group is identified in the state's section 1915(c) waiver. [10] In evaluating an applicant's financial eligibility for the 217 group, his or her income and resources are determined based on the hypothetical assumption that the applicant is institutionalized and then compared to the income and resource standards of the principal group.

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[6] *See* 42 C.F.R. § 435.601(d)(4).
[7] Id.
[8] *See* 50 F.R. 10013, 10016-17 (March 13, 1985).
[9] Id., at 10020-21.
[10] "CMS Application for a §1915(c) Home and Community-Based Waiver [Version 3.5, Includes Changes Implemented through November 2014], Instructions, Technical Guide, and Review Criteria," pages 81-83 (Release Date: January 2015).

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For example, many states that cover the 217 group also cover the "special income level group" (the SIL group) for institutionalized individuals, described in section 1902(a)(10)(A)(ii)(V) of the Act and 42 C.F.R. § 435.236. States establish the income eligibility for the SIL group, which may be up to 300 percent of the supplemental security income federal benefit rate (SSI FBR) ($2,382 a month in 2021).[11] This means that, for an individual seeking Medicaid through the 217 group in a state that: (1) has selected the SIL group as the principal group in its section 1915(c) waiver, and (2) has elected an income standard of 300 percent of the SSI FBR for the SIL group, the individual can have income up to 300 percent of the SSI FBR and be income-eligible for the 217 group (as the individual would be income-eligible under the principal SIL group if institutionalized). If the individual meets the other eligibility requirements for coverage under the 217 group (e.g., meets the level of care defined by the state and resource standard), then the individual can receive HCBS covered under the state's 1915(c) waiver.

Historically, CMS has required that states use not only the same income and resource standards of the principal group to determine eligibility for a 217 group applicant, but the same financial methodologies as well.[12] In practice, this has meant that states have applied section 1902(r)(2)-authorized disregards to the 217 group only to the extent that the same disregards are applied in determining eligibility for the principal group.

The spousal impoverishment rules

Section 1924 of the Act, commonly referred to as the "spousal impoverishment statute," requires that financial eligibility determinations for "institutionalized" spouses be determined consistent with the spousal impoverishment statute's methodology. Section 1924(h)(1) of the Act defines an "institutionalized spouse" as a married individual who is in a medical institution or, at state option, is eligible for the 217 group, and is married to an individual who is not in a medical institution or nursing facility. However, section 2404 of the Affordable Care Act (ACA), as amended by the Consolidated Appropriations Act, 2021, P.L. 116-260,[13] requires that section 1924(h)(1)'s definition of an "institutionalized spouse" include, through September 30, 2023, married individuals who are in need of HCBS authorized under section 1915(c), (i), or (k) of the Act, or a comparable package of HCBS available under section 1115 authority.

The spousal impoverishment statute generally ensures that the "community spouse" of an institutionalized beneficiary is permitted to keep a share of the couple's combined income and resources to meet the individual's own community needs, up to certain maximum standards established under section 1924(c) of the Act. In determining the amount of the couple's combined resources to set aside for a community spouse (referred to as the "community spouse resource allowance," or CSRA), the spousal impoverishment statute requires that all resources

[11] Sections 1902(a)(10)(A)(ii)(V) and 1903(f)(4)(B) of the Act.
[12] *See* 50 F.R., at 10021.
[13] *See* Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Division H, Title II, Section 205(a) ("Extension of the spousal impoverishment protections").

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owned by either spouse, jointly or solely, be pooled. The CSRA is then subtracted from this amount and the remainder is deemed to be available to the institutionalized spouse and counted in determining whether the value of his or her resources is at or below the resource standard for eligibility.

Targeting disregards on the basis of need for certain HCBS

The construction rule directs that nothing in certain statutory provisions, including section 1902(a)(17) of the Act, "shall be construed as prohibiting a state from applying an income or resource disregard" under the authority of section 1902(r)(2)(A) of the Act "on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act or under section 1115 of such Act."

As described above, CMS's regulation implementing section 1902(r)(2)(A) of the Act requires that income and resource disregards adopted by a state must be comparable for (i.e., applied to all) individuals seeking coverage under a given eligibility group. CMS interprets the construction rule to create a narrow exception to that rule, such that states may target income and resource disregards at individuals within an eligibility group based on their need for certain HCBS described in sections 1915(c), (d), (i) and (k) or authorized under a section 1115 demonstration.

For example, if a state covers the optional categorically needy eligibility group authorized in section 1902(a)(10)(A)(ii)(X) of the Act, which serves individuals who have incomes up to the federal poverty level (FPL) and who are either 65 years old or older or have disabilities ("FPL group for individuals age 65 and older or who have a disability"), a state could apply an income and/or resource disregard in determining financial eligibility for the group exclusively to those individuals 65 or older who have a need for 1915(c), (i), or (k) services, or HCBS authorized under a section 1115 demonstration. Similarly, in a state that covers the medically needy, as authorized in section 1902(a)(10)(C) of the Act, the state could target an income or resource disregard at all prospective medically needy individuals who need the HCBS described in the construction rule, or even more narrowly at medically needy individuals who need HCBS and who are, for example, 65 years old and older, or under the age of 21.

CMS also interprets the construction rule to permit states to target a disregard based on an individual's need for a particular HCBS. For example, in a state that operates a 1915(c) waiver and also offers coverage for both 1915(i) and (k) services, the state could limit application of the disregard to individuals who need 1915(i) services. Furthermore, if a state operates multiple 1915(i) benefits, it could choose to apply a disregard exclusively for individuals who need one of the 1915(i) benefits. We also note that CMS has long permitted states to disregard types of income or resources, income or resources used or set aside for a particular purpose, or the

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income and resources of a spouse. Per the construction rule, such disregards also may be targeted to individuals receiving HCBS or particular HCBS.[14]

We note that the construction rule refers to an individual's "need" for HCBS available under various authorities. Generally, CMS would consider it reasonable for a state to define "need" in terms of satisfying the eligibility requirements for these services; i.e., based on an individual meeting the level-of-care and coverage criteria applicable to the relevant HCBS. In the context of 1915(c) services, however, an individual's eligibility to receive such services is contingent not only on the individual meeting the level of care and coverage eligibility criteria, but also on the availability of a slot in the relevant 1915(c) waiver. It would be permissible for states to target a disregard at individuals who need 1915(c) services; i.e., individuals who meet the level-of-care and coverage criteria for a 1915(c) waiver, but may not be enrolled in and receiving those services because of a waiting list for available waiver slots.

For example, in a state that covers the 217 group in a 1915(c) waiver and uses the SIL group as the principal group (and has selected 300 percent of the SSI FBR as the income standard), an individual who meets the financial eligibility requirements for the 217 group and the clinical and coverage requirements for the waiver is ineligible for Medicaid so long as the individual is on a waiting list for the waiver and is not eligible under a separate group. This is because, as noted above, an eligibility requirement for the 217 group is that the individual will receive 1915(c) services; i.e., that there is a slot in a 1915(c) waiver in which the individual will be placed and through which the individual will receive coverage for 1915(c) services that have been included in an individual's approved plan of care.

However, an individual could still qualify for Medicaid coverage under certain circumstances. Specifically, if a state separately covers under its state plan the FPL group for individuals age 65 and older or who have a disability and elect to apply to this group, under the authority of the construction rule, an income disregard above the FPL and below 300 percent of the SSI FBR for all individuals who meet the level-of-care criteria for the relevant 1915(c) waiver. In this instance, individuals who meet such criteria but are on the waiting list for the 1915(c) waiver and who otherwise would be eligible under the 217 group can alternatively qualify for Medicaid in the FPL group for individuals age 65 and older or who have a disability and will receive coverage for other state plan services, possibly including home health care services, personal care services, and 1915(i) services (if otherwise available under the state plan) while the individual is on the waiting list for the 1915(c) waiver.

Targeting less restrictive income and resource disregards at the 217 group

[14] *See* "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources Questions and Answers," May 11, 2001, at page 6, 7.

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As noted above, CMS has historically required states to apply section 1902(r)(2)-authorized disregards to the 217 group to the same extent they are applied in determining eligibility for the principal group.[15] However, the construction rule directs that nothing in sections 1902(a)(17) or 1924 of the Act or section 2404 of the ACA shall be construed to prohibit a state from applying income or resource disregards to an individual "described in section 1902(a)(10)(A)(ii)(VI) of the Act" (i.e., the 217 group) or such individual's spouse.

Section 1902(r)(2) of the Act authorizes states to apply income or resource disregards to, among others, individuals described in section 1902(a)(10)(A)(ii) of the Act, of which the 217 group is a part. Furthermore, the implementing regulation at 42 CFR 435.601(d)(1)(ii) authorizes the use of less restrictive income and resource methodologies to "[o]ptional categorically needy individuals under groups established under . . . section 1902(a)(10)(A)(ii) of the Act." Neither the statute nor regulation limit application of income or resource disregards in determining eligibility for the 217 group.[16] While it has been the historical CMS policy to limit less restrictive methodologies for the 217 group to the extent of their application to the principal group, this policy was not mandated by the plain language of section 1902(r)(2) of the Act.

While neither sections 1902(a)(17) nor 1924 of the Act have imposed a barrier on a state's targeting of income or resource disregards at the 217 group, we interpret the specific reference in the construction rule regarding the use of section 1902(r)(2)-based disregards and the 217 group to confirm the states' authority to do so. Accordingly, states may now apply less restrictive methodologies, including income and resource disregards, exclusively to individuals seeking eligibility for a 217 group, even if such less restrictive methodologies are not applied to the principal group for which the individual would be eligible if living in an institution.[17]

As noted above, the language in the construction rule relating to the 217 group specifically references the "disregard of the income or resources of [the 217 group enrollee's] spouse." Generally, the income and resources of other third parties are not deemed available to (and therefore would have no need under the authority of section 1902(r)(2) of the Act to be disregarded for) 217 group applicants and enrollees. However, where a married individual who is a 217 group applicant or enrollee is considered an "institutionalized spouse,"[18] as defined under section 1924(h)(1), states must include the community spouse's resources in the married 217 group applicant's financial eligibility determination, consistent with the resource eligibility

[15] *See* "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources Questions and Answers," May 11, 2001, at page 22.
[16] 42 C.F.R. § 435.601(d)(1)(ii).
[17] Disregards that apply to a principal group will continue to apply to the 217 group. As noted further in this letter, states will need to submit state plan amendments to exercise the authority provided by the rule of construction provision. However, as it relates to the 217 group, such amendments will only be necessary for disregards that states wish to target exclusively at the 217 group.
[18] *See* footnote 10, above.

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formula mandated by section 1924(c) of the Act.[19] In determining resource eligibility under the spousal impoverishment statute, however, for a married 217 group enrollee, CMS interprets the construction rule to permit the disregard of a community spouse's resources. In other words, in pooling the spouses' resources for a 217 group applicant or beneficiary under the spousal impoverishment rules, states can elect to disregard all or a portion of the resources of the community spouse under section 1902(r)(2)(A) of the Act.

The same outcome may now be achieved for married medically needy individuals. Prior to the ACA's mandatory application of the spousal impoverishment rules for married 1915(c) waiver participants, states could permit the spouses of medically needy 1915(c) waiver participants to keep more resources than otherwise permitted under section 1924(c) of the Act. Section 1915(c)(3) permits a waiver of section 1902(a)(10)(C)(i)(III) of the Act, which governs the income and resource methodology rules for the medically needy, 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.[20]

Thus, before the ACA's enactment, if a married individual seeking section 1915(c) services as a medically needy individual in a 1915(c) waiver in which section 1902(a)(10)(C)(iii) of the Act had been waived, only the resources (and income) in the name of the married applicant would be included in his or her financial eligibility determination; resources exclusively in the other spouse's name, even if in total exceeding the CSRA, would not be deemed available to the married applicant.

However, by mandatory application of the spousal impoverishment rules, the resource eligibility determination requires that all of the resources owned by either spouse, separately or jointly, be pooled, and the amount exceeding the CSRA deemed available to the "institutionalized" spouse. CMS is aware that a few states preferred the pre-ACA method of effectively permitting a couple to keep all resources when one spouse needs 1915(c) waiver services, but that options for accomplishing this have generally been unavailable, with both the ACA's spousal impoverishment provision being in effect and there being no exceptions to the comparability mandate in a state's use of 1902(r)(2)-based disregards. Now, however, the construction rule permits the targeting of resource (and income) disregards at married medically needy individuals who are eligible for 1915(c) (or other HCBS) services, such that states may ultimately permit such couples to keep all resources.

---

[19] Section 1924(a)(1) of the Act mandates that its provisions supersede other provisions of the Medicaid statute that are inconsistent with the former. While not relevant here, CMS has opined that section 1924 of the Act does not supersede section 1902(e)(14)(A) of the Act, which mandates the use of MAGI income methodologies for certain Medicaid eligibility populations. *See* SMDL #15-001, "Affordable Care Act's Amendments to the Spousal Impoverishment Statute," pages 5-6.

[20] *See* 50 F.R. at 10021.

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Other related provisions of federal law

As noted, the construction rule that is the subject of this letter is contained in several recently-enacted federal laws.[21] Also included as a component of this construction rule in some of these federal laws, and independently in others, is additional language referring to home and community-based services and spousal-related income and asset disregards for individuals who qualify for Medicaid by reducing their income based on their incurred medical or remedial care expenses.[22] This letter does not address those provisions, and CMS continues to review their impact on program policies.

Conclusion

States that are interested in electing the new flexibility authorized by the construction rule must submit a state plan amendment in order to effectuate a new income or resource disregard. CMS is prepared to offer technical assistance to states that are interested. Questions about this letter may be directed to Gene Coffey, Technical Director, Division of Medicaid Eligibility Policy, CMCS, at Gene.Coffey@cms.hhs.gov.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

[21] *See* Footnote 1, above.

[22] *See* Medicaid Extenders Act of 2019, Pub. L. No. 116-3, Section 3(b)(1); Medicaid Services Investment and Accountability Act of 2019, Pub. L. No. 116-16, Section 2(b)(1); Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, Division N, Title I, Section 204(b)(2); Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, Division A, Title III, Subtitle E, Part II, Section 3812(b)(2); Continuing Appropriations Act, 2021, Pub. L. No. 116-159, Division C, Title III, Section 2302(b)(2); Further Continuing Appropriations Act, 2021, and Other Extensions Act, Pub. L. No. 116-215, Division B, Title I, Section 1105(b)(2); Consolidated Appropriations Act, 2021 Pub. L. No. 116-260, Division H, Title II, Section 205(b)(2).

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APPENDIX 3

Michigan Department of Health and Human Services
Program Policy Division PO Box 30809
Lansing MI 48909

Michigan Department of Health & Human Services
GRETCHEN WHITMER, GOVERNOR | ELIZABETH HERTEL, DIRECTOR

September 11, 2024

<Provider Name>
<Provider Address 1>
<Provider Address 2>
<City> <State> zipcode5-zipcode4

Dear MI Choice and Medicaid Behavioral Health Providers:

RE: Guide to Coordinate Services for Medicaid Behavioral Health and MI Choice

The purpose of this document is to clarify when Medicaid Behavioral Health services and MI Choice home and community-based waiver (MI Choice) services can and cannot be provided together. It should be used as a guide to develop a coordinated, person-centered, plan of services for individuals to ensure they get the support they need regardless of which program(s) serve them.

It is important to note, when a service is available through both the Habilitation Supports Waiver (HSW) and the Behavioral Health 1915(i) State Plan Amendment (SPA) service array, it is described in this document as a Community Mental Health (CMH) service. If someone is enrolled in the HSW, they would get services available from the HSW and could receive services from Behavioral Health 1915(i)SPA as long as the individual is enrolled, and medical necessity is met.

For more information on the requirements of any of the programs mentioned in this Letter, please refer to the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual. Information on Behavioral Health programs is found in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. Information on the Home Help and MI Choice programs are found in their respective chapters with the program name.

Background

Michigan has several Medicaid programs that offer home and community-based services and supports that allow individuals to live in their own homes and receive assistance. These programs include Medicaid State Plan benefits and Medicaid waivers. Medicaid requires that services and supports be coordinated so there is no duplication of service.

The primary program that provides home and community-based support is the State Plan personal care program, called Home Help. This program is administered by MDHHS. An individual cannot be enrolled in a Medicaid waiver if their service and support needs can be fully met through Home Help services.

There are also several waivers that support people to live in the community. Two waivers, MI Choice and the HSW, serve individuals who could receive services and supports in an institutional setting. Additionally, the Behavioral Health 1915(i)SPA provides supports and services and serves many people who use the community mental health system.

With the exception for Home Help services described below, when someone enrolls in either waiver program, Medicaid rules require that the waiver program assure the services and supports necessary to maintain the individual in their preferred home or community-based setting are authorized without duplication.

The 1915(c) MI Choice and Habilitation Supports Waivers (HSW)

Some Medicaid beneficiaries may be eligible for both the MI Choice waiver and the HSW. These individuals must choose from which waiver to receive services and supports. An individual cannot be enrolled in or receive services from both waivers at the same time. While the array of services on the waivers is similar, it is not identical. For example, Enhanced Pharmacy is not a service through the MI Choice Waiver but is an HSW service. See the crosswalk at the end of this document for a listing of services available in each program. Please refer to the MDHHS Medicaid Provider Manual for a description of services. Individual choice may be based on the services available, access to providers, availability of a waiver slot or other unique factors. For persons who are eligible for both waivers, the waiver selected by an individual is not as important as providing clear communication that the individual must choose only one of the waivers.

The MI Choice Waiver provides home and community-based services and supports to the elderly and adults with disabilities who are otherwise eligible for nursing facility services. Twenty waiver agencies administer the MI Choice Waiver program throughout the state. To be eligible for MI Choice, applicants must meet the nursing facility level of care criteria, be eligible for Medicaid, and have a need for and agree to receive supports coordination and at least one other MI Choice service monthly. MI Choice offers expanded financial eligibility to its participants. The income limit is 300% of SSI ($2,829 per month, gross in 2024), and special asset protections for spouses apply. Persons who enroll in MI Choice do not have a spend-down. When enrolling in MI Choice, participants choose to receive MI Choice services instead of personal care available through the Home Help program.

The HSW provides support to people who have a developmental disability (a severe chronic condition attributable to a mental or physical impairment that has manifested before the age of 22 and impairs three or more major life activities), are Medicaid eligible, require and receive at least one habilitative service each month, reside in a community setting and are eligible to receive services available at an intermediate care facility for individuals with intellectual and developmental disabilities (ICF/IID). The HSW is administered by Prepaid Inpatient Health Plans (PIHPs) through the community mental health system. Habilitation services under the HSW cannot duplicate services that are otherwise available to an individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973. Individuals enrolled in the HSW must have their personal care needs met through the Home Help program up to the limits of that program.

When a beneficiary requires a transition from the HSW to MI Choice or from MI Choice to the HSW the initial step is to contact the MDHHS specialist for the waiver in which the beneficiary is currently enrolled. All HSW enrollments start on the first day of a month and may end on any day of a month. This is different for MI Choice. MI Choice enrollments can start on any day of the month and may end on any day of the month. The coordination of the start date and disenrollment date is essential when transitioning from one 1915(c) waiver to another.

Steps to follow to transfer between HSW and MI Choice:

1. The MI Choice waiver agency or PIHP must contact the MDHHS specialist for the waiver in which the beneficiary is currently enrolled. The purpose of this contact is to provide justification for a transfer and supporting documentation for MDHHS review.
2. If the MDHHS specialist agrees that a transfer is appropriate, the MDHHS specialist for the current waiver program will contact the specialist for the receiving waiver program.
3. If the MDHHS specialist does not agree that a transfer is appropriate, they will contact the MI Choice waiver agency or PIHP to discuss their concerns and next steps.
4. To proceed with program transfer, MDHHS will coordinate a teleconference with the MI Choice waiver agency or PIHP.
5. The MDHHS specialist of the receiving program will notify the appropriate MI Choice waiver agency or PIHP of the potential transition.
6. The receiving MI Choice waiver agency or PIHP completes the evaluation of eligibility.
7. Upon confirmation of the individual's eligibility and their approval to transfer to the new program, the MI Choice waiver agency and PIHP coordinate the individual's disenrollment and enrollment dates.
8. Disenrollment from the current waiver must occur on the last day of a month, with the start date of the new waiver occurring on the 1st of the following month.
9. Once known, the disenrollment date and start date must be communicated to the MDHHS waiver specialist to ensure a smooth transition between waivers.

Coordination with the Behavioral Health 1915(i)SPA

People who are eligible for either MI Choice or HSW may be eligible for Behavioral Health1915(i)SPA and additional State Plan services available through the community mental health system. These services are available to people with intellectual disabilities, developmental disabilities, or serious mental illness. Some people with serious mental illness may be eligible for MI Choice Waiver services because of a physical disability and for Behavioral Health 1915(i)SPA services because of their serious mental illness.

MI Choice participants may receive Behavioral Health 1915(i)SPA and State Plan services that do not duplicate MI Choice services. This includes services such as Skill-Building and Supported Employment. A person with an intellectual or developmental disability or serious mental illness who is enrolled in the MI Choice Waiver could access Behavioral Health State Plan and Behavioral Health 1915(i)SPA services through the community mental health system.

Since Behavioral Health State Plan, HSW and the Behavioral Health 1915(i)SPA services are administered through the community mental health system, coordination of those services is common. Coordination of Behavioral Health State Plan and Behavioral Health1915(i)SPA services with the MI Choice waiver is more challenging since they are administered by different agencies. Such coordination involves regular communication between the two agencies. MI Choice enrollees must receive supports coordination from MI Choice as a condition of enrollment. However, it may be necessary for a MI Choice participant to also have a CMH case manager to help them access and manage the behavioral health services they require.

Coordination of CLS and Personal Care

Coordination of services and supports issues also arise for people on the HSW and people only receiving Behavioral Health 1915(i)SPA and State Plan services who need more personal care than is available through the Home Help program or other programs. The MDHHS Medicaid Provider Manual has addressed how the CLS services are coordinated with State Plan personal care services for individuals served by the mental health system:

> "For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping may be used to complement Home Help services when MDHHS has determined the individual's needs for this assistance exceeds Home Help service limits. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help."
>
> "If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision."
>
> See the MDHHS Medicaid Provider Manual for more information.

Clarification of Similar Services

- **Individual or Group Therapy (CMH service) versus Counseling (MI Choice service)**

  CMH offers Individual or Group Therapy while MI Choice offers counseling services. Individual or Group Therapy is more intense and focused on treatment whereas Counseling is less intense and focused on assisting the person with adjusting to life changes.

Individual or Group Therapy is defined in the Behavioral Health and Intellectual and Developmental Disability Supports and Service chapter under the Covered Services section of the MDHHS Medicaid Provider Manual as:

> "Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships.
>
> Evidence based practices such as integrated dual disorder treatment for co- occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice or a limited licensed master's social worker supervised by a full licensed master's social worker."

Counseling is defined in the MI Choice chapter of the MDHHS Medicaid Provider Manual as:

> "Counseling services seek to improve the participant's emotional and social well- being through the resolution of personal problems or through changes in a participant's social situation. Counseling services must be directed to participants who are experiencing emotional distress or a diminished ability to function. Family members, including children, spouses or other responsible relatives, may participate in the counseling session to address and resolve the problems experienced by the participant and to prevent future issues from arising. Counseling services are typically provided on a short-term basis to address issues such as adjusting to a disability, adjusting to community living, and maintaining or building family support for community living. Counseling services are not intended to address long-term behavioral or mental health needs."

- **Community Living Supports**

Both HSW and MI Choice offer Community Living Supports (CLS), which is also a Behavioral Health 1915(i)SPA service.[1] These services are similar in many ways, but often delivered differently because of the differing emphases among the programs. Both programs provide guidelines for the provision of the CLS services, without being too descriptive, to allow individuals some flexibility.

When both the CMH and MI Choice waiver agency are providing CLS services to the same person, it is essential to have a coordinated person-centered service plan that specifically delineates exactly what each entity is doing for the individual to avoid any duplication of services. The person-centered service plan should also describe why the service is not available from the other entity. For instance, the CMH may provide CLS that includes transportation to and from community classes as well as assistance during the class while the MI Choice waiver provides CLS in the morning to assist with bathing, dressing, and meal preparation to get the individual ready to attend the class. MI Choice cannot provide CLS during the class because skill building is not a MI Choice service.

It is also important to note that the CMH service cannot duplicate nor replace personal care services available through the Home Help Services program. Individuals enrolled in MI Choice cannot also use Home Help Services. Therefore, it may be necessary for the MI Choice program to cover services such as assistance with ADLs that would otherwise be covered through the Home Help program.

- **Services in Residential Settings**

Both the HSW and MI Choice programs can offer services in Residential Settings. According to Section 11 of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of the MDHHS Medicaid Provider Manual, the CMH can only authorize personal care services in a "licensed foster care setting with a specialized residential program certified by the state." MI Choice may provide services in licensed Adult Foster Care Homes or Homes for the Aged and in unlicensed Assisted Living Facilities. Section 4.1 of the MI Choice chapter of the MDHHS Medicaid Provider Manual states that services in a licensed setting "cannot be provided in circumstances in which they would duplicate services available elsewhere or are available under the State Plan." Therefore, MI Choice services are not available to persons who are being served by CMH in a specialized residential program certified by the state.

CMH provides "Personal Care in Licensed Specialized Residential Settings" and offers additional assistance to meet the ADL and IADL needs of the individual. The MI Choice program offers Community Living Supports or Residential Services to provide additional services to participants who live in a residential setting and require more services and supports than would be normally offered to a resident.

- **Environmental Modifications (Environmental Accessibility Adaptations or Home Modifications)**

The Environmental Modifications are also known as Environmental Accessibility Adaptations and Home Modifications. Regardless of the title of the service, the definitions are very similar for both CMH and MI Choice. One notable difference is that MI Choice will never cover central air conditioning, but CMH will under certain well-defined circumstances. If a participant is using the services of the CMH and those services are meeting their needs, it is not appropriate to make a referral to the MI Choice program solely because the person requires an environmental modification.

- **Respite Care Services**

The Respite Care Services definitions are very similar for both CMH and MI Choice. Both provide intermittent services to relieve a family member or other (unpaid) caregiver. The CMH will allow a licensed nurse to provide respite. In the MI Choice program, only non-licensed persons furnish respite services. If a nurse is providing services, then the service is called either Private Duty Nursing or MI Choice Nursing services. Additionally, the CMH definitions allow respite to be provided at a Licensed Camp, which is not allowed in MI Choice.'

Services that CANNOT Be Used Simultaneously

- Persons can never be enrolled in both the MI Choice Waiver program and the HSW at the same time. The process to transition from one 1915(c) waiver to another is explained above and requires careful planning and coordination.

- When respite is needed, a single agency (either the CMH or the Waiver Agency) should authorize all respite services.

- Persons living in a licensed foster care setting with a specialized residential program certified by the state cannot also enroll in the MI Choice program.

- Persons receiving CMH Therapy services should not also have MI Choice counseling services authorized. MI Choice counseling is NOT a replacement for CMH Therapy.

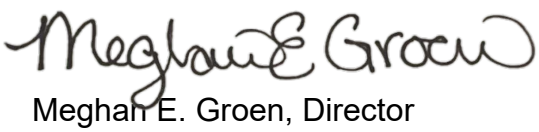
Conclusion

To ensure individuals with long-term services and supports needs can address those needs and access the full array of services and supports available, coordination between service systems is crucial. Refer to the table below to learn more about the services offered in each program. Coordination is key to implementing the individual's person-centered service plan that clearly delineates the services and supports authorized by each program or system, how those services differ from similar services available elsewhere, and why each system must furnish the services authorized. The goal is to assure individuals receive the services and supports he or she needs to have a full life in the community within each programs' requirements and parameters without duplication.

An electronic version of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

NOTE: For current service definitions, please refer to the appropriate policy bulletins and MDHHS Medicaid Provider Manual chapters.

Sincerely,



Meghan E. Groen, Director
Behavioral and Physical Health and Aging Services Administration

MI Choice, Habilitation Supports Waiver (HSW) and Behavioral Health 1915(i)SPA Crosswalk

	MI Choice 1915(c)	Habilitation Supports Waiver 1915(c)	Behavioral Health 1915(i)SPA
Program Eligibility ***Can only be enrolled in one 1915(c) Waiver at a time**	• Meets Nursing Facility Level of Care Criteria • Eligible for Medicaid (expanded eligibility rules apply) • Is either elderly (aged 65+) or aged 18 or older and has a disability. • Needs and agrees to receive at least one MI Choice service, in addition to supports coordination monthly • Resides in a home and community-based setting • Can be concurrently enrolled in Behavioral Health 1915(i)SPA services	• Has an intellectual or developmental disability (as defined by Michigan law) • Eligible for Medicaid • If not for HSW services, would require ICF/IID level of care services; and chooses to participate in the HSW in lieu of ICF/IID services. • Resides in a community setting • Must require and receive at least one HSW habilitative service per month • Can be concurrently enrolled in Behavioral Health 1915(i)SPA services	• Eligible for Medicaid • Available to beneficiaries with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability who are currently residing in a HCBS setting and meet the needs-based criteria. **Needs based criteria:** • Have a substantial functional limitation in one or more areas of major life activity AND • Without Behavioral Health §1915(i)SPA services, at risk of not increasing or maintain a sufficient level of functioning in order to achieve their individual goals of independence, recovery, productivity, and/or community inclusion and participation.
Private Duty Nursing	Available for qualified participants aged 21+	Available for qualified adults with IID age 21+	N/A
Level of Care	Nursing Facility	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	N/A
Medicaid Health Plan Enrollment	Exempt	Exempt	Exempt

Services Requirement	Must receive at least one MI Choice waiver service in addition to supports coordination per month	Must receive one habilitative service each month. Habilitative services include the following: 1. Community Living Supports 2. Out of Home Nonvocational Habilitation 3. Prevocational Services 4. Supported Employment	Must receive at least one Behavioral Health 1915(i)SPA service every three months, in addition to monthly monitoring, as documented in the person-centered service plan
Available Services	• Adult Day Care • Assistive Technology • Chore Services • Community Health Worker • Community Living Supports • Community Transportation • Counseling • Environmental Accessibility Adaptations • Fiscal Intermediary • Goods and Services • Home Delivered Meals • Nursing Services • Personal Emergency Response System • Private Duty Nursing/Respiratory Care • Residential Services • Respite • Specialized Medical Equipment & Supplies • Supports Brokerage • Supports Coordination • Training • Vehicle Modifications	• Community Living Supports • Enhanced Medical Equipment & Supplies • Enhanced Pharmacy • Environmental Modifications • Family Training • Fiscal Intermediary • Goods and Services • Non-Family Training • Out-of-Home Nonvocational Habilitation • Overnight Health and Safety Supports • Personal Emergency Response Systems • Prevocational Services • Private Duty Nursing • Respite Care • Supports Coordination • Supported Employment	• Community Living Supports • Enhanced Pharmacy • Environmental Modifications • Family Support & Training • Fiscal Intermediary • Housing Assistance • Respite • Skill Building • Specialized Medical Equipment & Supplies • Supported/Integrated Employment • Vehicle Modification

Home Help Program	Cannot receive Home Help Services when enrolled in MI Choice. The MI Choice service of Community Living Supports will fulfill personal care service needs.	Must use Home Help (through MDHHS) as eligible.	Must use Home Help (through MDHHS) as eligible.
Other	• If aging out of State Plan private duty nursing services, usually enroll on 21st birthday. (May enroll sooner if you need MI Choice services other than private duty nursing.) • Cannot enroll before the initial assessment by a waiver agency. • Can still receive all Medicaid State Plan services including mental health services, however careful coordination must occur.	• May enroll at any age if eligibility criteria are met and a slot is available • May back-date enrollment under specific circumstances • Can still receive all Medicaid State Plan services • Must use Home Help for personal care services • Can choose an agency to deliver services or hire your own workers (self- determination)	• Can still receive all Medicaid State Plan services • Must use Home Help for personal care services • Can choose an agency to deliver services or hire your own workers (self- determination) • Can be enrolled in a C-Waiver and the BH 1915(i)SPA

NOTE: For current service definitions, please refer to the appropriate policy bulletins and MDHHS Medicaid Provider Manual chapters.

APPENDIX 4

MEDICAID PROGRAM SCREENING QUESTIONS:

Who Can Qualify for Medicaid in Michigan?

	Is the person age 19-64 *and* not qualified for and not enrolled in Medicare or Medicaid with modified adjusted gross income at or below 138% of the Federal Poverty Level ($20,120 in 2023)?	If YES, eligible under the Healthy Michigan Plan BEM 137
If NO,	Is the person on SSI?	If YES, eligible under BEM 150
If NO,	Is the person a former SSI recipient who lost SSI eligibility due to receipt of or an increase in RSDI benefits in the past?	If YES, possible eligibility under BEM 155 (503 Individuals) BEM 157 (Early Widow(er)s) BEM 158 (Disabled Adult Children)
If NO,	Is the person under 65 with a disability?	If YES, possible eligibility under BEM 170 (Home Care Children) BEM 171 (Children's Waiver) BEM 174 (Freedom to Work) BEM 163 (AD-CARE) BEM 164 (Extended Care - LTC, MI Choice & PACE) BEM 166 (Group 2 "Medically Needy")
If NO,	Is the person under age 65 and blind, but with no determination of disability?	If YES, possible eligibility under BEM 164 (Extended Care - LTC, MI Choice & PACE) BEM 166 (Group 2 "Medically Needy")
If NO,	Is the person age 65 or over?	If YES, possible eligibility under BEM 163 (AD-CARE) BEM 164 (Extended Care - LTC, MI Choice & PACE) BEM 166 (Group 2 "Medically Needy")

Is the person a Medicare beneficiary who needs help paying for Medicare premiums, coinsurances and deductibles?	Possible eligibility under BEM 165 for the Medicare Savings Programs (QMB, SLMB, ALMB or NMB) or BEM 169 for Qualified Disabled Working Individuals (QDWI)

MEDICAID PROGRAM TERMINOLOGY

503 Individuals **BEM 155**	Former SSI recipients who lost SSI eligibility due to an increase in Social Security Retirement Survivors Disability Insurance (RSDI) benefits. Medicaid eligible if the person would be eligible for SSI if the RSDI cost-of-living increases paid since SSI eligibility ended were excluded.
AD-CARE **BEM 163**	People age 65 or over and people under age 65 with a disability. Net countable monthly income cannot exceed 100% of the Federal Poverty Level (in 2024, $1,275 for one person).
Children's Waiver **BEM 171**	A child under age 18 who requires care in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/ID) but can be cared for at home for less cost.
Disabled Adult Children (DAC) **BEM 158**	A person age 18 or older who received SSI and ceased to be eligible for SSI on or after July 1, 1987 because she or he became entitled to receive DAC RSI benefits or because of an increase in such RSI benefits and is currently receiving DAC RSI benefits and would be eligible for SSI without such RSI benefits.
Early Widower(s) **BEM 157**	A person entitled to Medicare Part A and who receives RSDI benefits some or all of which are early Social Security widow(er)'s benefits and was terminated from SSI because of the receipt of those benefits and was receiving SSI in the month the early widow(er)'s benefits began and would be eligible for SSI if all the widow(er)'s benefits were excluded.
Extended Care **BEM 164**	A Medicaid eligibility category available to nursing home patients and persons seeking MI Choice waiver program and PACE services who are age 65 or older or who are under age 65 and have a disability. If the person has too much income to qualify for AD-CARE, Medicaid eligibility may be secured if gross monthly countable income does not exceed 300% of the SSI Federal Benefit Rate ($2,829 in 2024).

Freedom to Work **BEM 174**	Available to a person with a disability (according to Social Security's disability standards) who is aged 16 through 64 and who is employed with earned income. The asset and income standards for eligibility are more generous than other categories of Medicaid eligibility.
Group 2 Medically Needy **BEM 166**	Available to persons age 65 or older, persons who are blind or persons with a disability who have too much countable income to qualify for other categories of Medicaid. Eligibility for Medicaid is secured in any month in which a person incurs health care costs that equal or exceed a person's excess income, *a.k.a.* "the deductible".
Healthy Michigan Plan **BEM 137**	Available to persons age 19-64 who do not qualify for and are not enrolled in Medicare or Medicaid and have a modified adjusted gross income of 138 percent of the Federal Poverty Level ($20,782 in 2023). There is no asset test.
Home Care Children **BEM 170**	Available to a child under age 18 who is unmarried and has a disability who requires institutional care but can be cared for at home for less cost.
Medicare Savings Programs **BEM 165**	Programs that pay for a Medicare beneficiary's premiums, deductibles and coinsurances. The asset limits are more generous than other Medicaid programs.
MI Choice Waiver **BEM 106**	A program for persons age 65 or older and for persons with a disability that pays for home and community-based services to prevent an individual's admission to a nursing facility. To qualify a person's monthly gross income cannot exceed 300 percent of the federal SSI benefit level ($2,829 in 2024).
PACE **BEM 167**	The Program for All Inclusive Care for the Elderly. A managed care program for persons age 65 or older and for persons under age 65 with a disability that pays for home and community-based services to prevent an individual's admission to a nursing facility. To qualify a person's monthly gross income cannot exceed 300 percent of the federal SSI benefit level ($2,829 in 2023).

EXHIBIT I - LIST OF SSI-RELATED MA CATEGORIES

MA Category	BEM Item	Unique Nonfinancial Eligibility Factor	Program Code	Financial Eligibility Group	Automatic MA Eligibility
SSI Recipients	150	Aged, blind or disabled	A, B, E	1	Yes
Appealing SSI Termination	150	Appealing SSI termination	M, O, P	1	No
503 Individuals	155	Aged, blind or disabled	M, O, P	1	No
Early Widow(er)s	157	Blind or disabled	O, P	1	No
DAC	158	Aged, blind or disabled	M, O, P	1	No
AD-Care	163	Aged or disabled	M, P	1	No
Extended-Care	164	Aged, blind or disabled	M, O, P	1	No
Medicare Savings Programs	165	Medicare Part A	M, O, P	-	No
Group 2 Aged, Blind and Disabled	166	Aged, blind or disabled	M, O, P	2	No
QDWI	169	Type of Medicare	P	-	No
Home Care Children	170	Disabled	P	1	No
Children's Waiver	171	Disabled	P	1	No
Breast and Cervical Cancer Prevention and Treatment Program	173	Health department cancer screening	O	1	No

EXHIBIT II - SSI-RELATED MA CODING

Eligible for:			Case		Recipient	
Regular MA	BEM	MSP	PT *	SC *	PT *	ES *
AD-Care	163	Full QMB	0	1F	4	4
AD-Care	163	None	0	1F/1E	5	4
Extended-Care	164	Full QMB	8	1F	0	4
Extended-Care	164	Limited QMB (SLMB)	1	1F	1	4
Extended-Care	164	None	1	1F/1E	0	4
Group 2	166	Full QMB	9	2F	0	3
Group 2	166	Limited QMB (SLMB)	0	2F	2	3

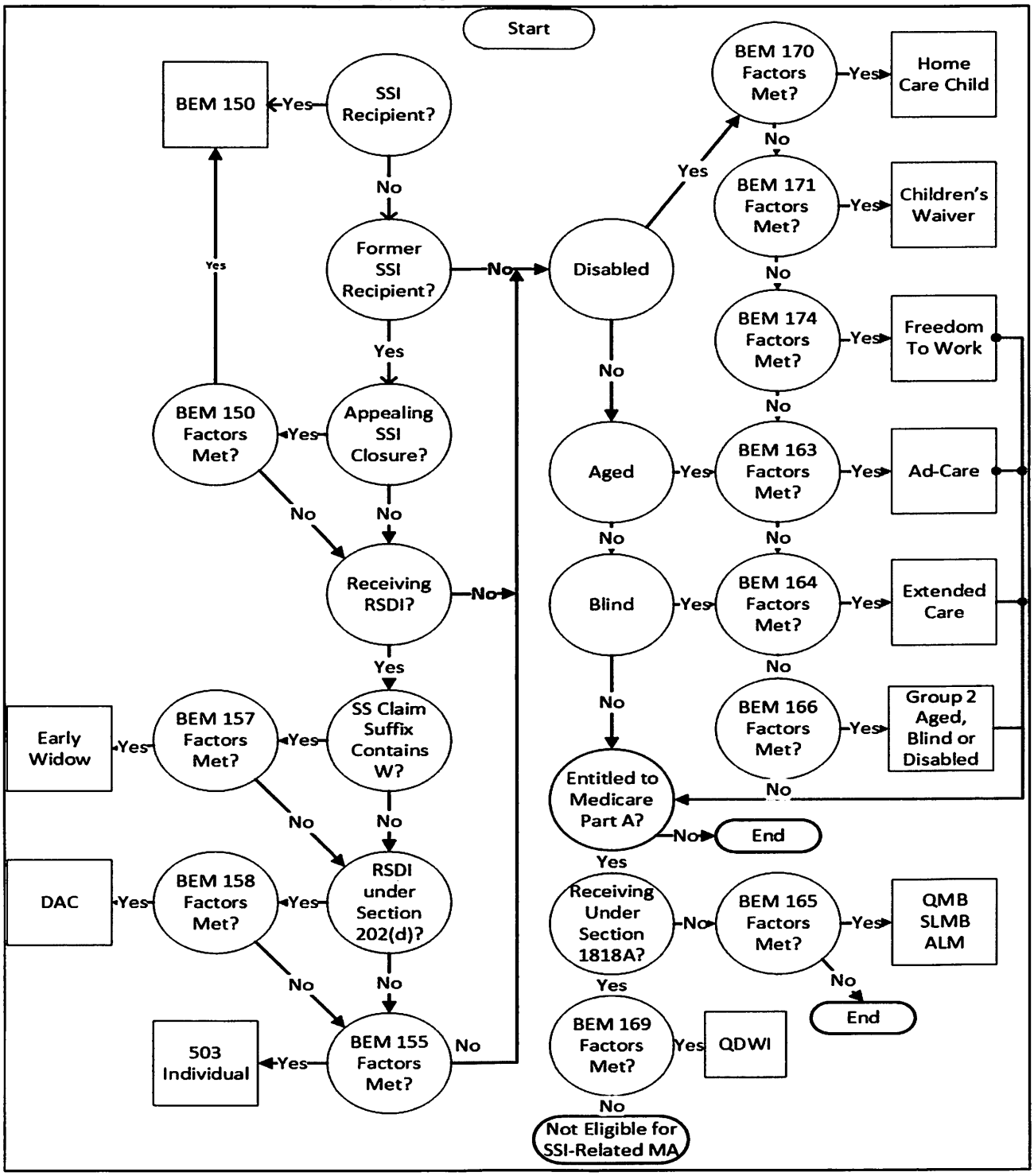
Eligible for:			Case		Recipient	
Regular MA	BEM	MSP	PT *	SC *	PT *	ES *
Group 2	166	None	0	2F/2E	0	3
Active Deductible	545	Full QMB	9	2B	0	7
Active Deductible	545	Limited QMB (SLMB)	0	2C	2	7
Active Deductible	545	None	0	20	0	7
Active Deductible	545	Full ALMB	0	2H	0	7
None	**NA**	**Full QMB**	**9**	**2B**	**0**	**3**
None	**NA**	**Limited QMB** (SLMB)	**0**	**2C**	**2**	**3**
Appealing SSI termination	150	**	0	1F	0	4
503 Individual	**155**	**	**5**	**1F**	**0**	**4**
Early Widow(er)	**157**	**None**	**7**	**1F**	**0**	**4**
DAC	**158**	**	**4**	**1F**	**0**	**4**
Home Care Child	**170**	**	**0**	**1F**	**0**	**4**
Children's Waiver	**171**	**	**0**	**1F**	**0**	**4**
QDWI	**169**	**None**	**0**	**1Q**	**0**	**4**
Freedom to Work (FTW)	174	None	0	1D	0	4
Freedom to Work (FTW)	174	Full QMB	8	1D	0	4
Freedom to Work (FTW)	174	Limited QMB (SLMB)	0	1D	2	4
Freedom to Work (FTW) premium level	174	None	0	1K	0	4
None	NA	Full ALMB	0	2H	0	3

DATA ELEMENT KEY

- **Case level Program Type (PT) on format page one.**
- **Scope/Coverage (SC).**
- **Recipient level Program Type (PT) starting on format page two.**
- **Eligibility Status (ES).**

Note: When adding coverage to an active deductible case, the ES remains 7.

EXHIBIT I - SSI-RELATED MA CATEGORIES



LEGAL BASE

MA