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# MEDICAID PAYMENT FOR ASSISTED LIVING:

# CURRENT STATE PRACTICES, AND RECOMMENDATIONS FOR IMPROVEMENT

**January 2010**

This issue brief is a product of a study supported by The Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health and social issues. The views presented here are those of the National Senior Citizens Law Center and not necessarily those of The Commonwealth Fund, its directors, officers, or staff.

This issue brief is an introductory document to these issues and to the study. More detailed results, analysis and recommendations will be published by the National Senior Citizens Law Center in upcoming months.

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**EXECUTIVE SUMMARY**

Many state Medicaid programs now pay for assisted living services. For facility residents, the availability of Medicaid reimbursement can be a tremendous benefit, but the design and implementation of these programs has too often led to discrimination against Medicaid-eligible residents, eviction, and other types of poor care.

For one, Medicaid eligibility standards often are not well designed for assisted living. In particular, low allocations for room and board may leave the resident or the facility, or both, in a financially untenable position.

Discrimination occurs because facilities often have the right to refuse Medicaid reimbursement. Outside of assisted living, the rule of thumb is that a Medicaid-certified health care provider must accept Medicaid reimbursement from a Medicaid-eligible patient, but this is not true in assisted living in many states. In these states, Medicaid-certified facilities commonly reserve the right to refuse a resident's Medicaid coverage, leading to the resident's eviction for being unable to pay at the private rate. Similarly, facilities in these states often condition Medicaid acceptance on the resident having paid privately for a certain number of months prior to becoming Medicaid-eligible.

Poor care results from the absence of standards. Federal Medicaid law applies very few substantive requirements on assisted living facilities, generally relying almost exclusively on state licensure. For example, although a private room is generally seen as a principal benefit of assisted living (particularly in comparison to nursing home care), Medicaid-eligible assisted living residents are almost always forced to share a room. Most state Medicaid programs will not pay to hold an assisted living room when a resident is temporarily in the hospital, and facilities commonly have wide discretion to evict residents.

## SUMMARY OF RECOMMENDATIONS

### To Make Medicaid Eligibility Standards Workable for Assisted Living Residents:

State allocations for room and board should be based generally on the cost of room and board, rather than on SSI payment levels.

Facilities should be required to accept the Medicaid-specified amount as the resident's entire room and board payment.

Facilities should not be allowed to demand or accept supplemental payments from the family members or friends of Medicaid-eligible residents.

State Medicaid programs should offer medically-needy eligibility to assisted living residents.

Spousal impoverishment protections should be designed to account for the resident's obligation to pay room and board expenses.

Spousal impoverishment protections should be available for medically-needy beneficiaries.

### To Prevent Discrimination Against Medicaid-Eligible Assisted Living Residents:

Medicaid-certified assisted living facilities should be required to accept Medicaid coverage from Medicaid-eligible residents.

If a facility is Medicaid-certified, every unit within the facility should be so certified.

A facility's withdrawal from Medicaid should not limit the rights of already-admitted residents to access Medicaid coverage.

### To Improve Quality of Care For Medicaid-Eligible Assisted Living Residents:

The federal government should develop quality of care standards for Medicaid-funded assisted living services.

Private occupancy should be made a reality in Medicaid-funded assisted living.

When a Medicaid-eligible resident is hospitalized, Medicaid programs should make payments to hold the resident's space in the assisted living facility, and the resident should have a right to return to the facility.

## DISCUSSION

### A. Introduction

Assisted living care is increasingly seen as an alternative to nursing home care. This is true both for consumers paying out of pocket and for state Medicaid programs. In recent years, the federal Centers for Medicare and Medicaid Services (CMS) has developed and promoted options for long-term care outside of nursing homes, and these options often include funding for assisted living services.

In almost all states, the Medicaid program can pay in at least some circumstances for services provided in an assisted living facility. Currently 37 states pay for assisted living services through Medicaid waivers, and 16 states pay through the Medicaid state plan. (Obviously, some states pay through both.) Waiver funding is more attractive to state governments because waivers allow the state to place a cap on the number of beneficiaries receiving Medicaid funding for assisted living services. In state-plan funding, by contrast, the funding is an entitlement for beneficiaries and thus must be made available to any person who meets eligibility standards.

This discussion is based upon a study of those states that pay for assisted living care through Medicaid home and community-based service waivers. The study focused particularly upon five states—Arkansas, New Jersey, Oregon, Texas, and Washington—but also included the other states paying through a waiver. Although the study and this paper focus on waiver payment rather than state-plan payment, the analysis and recommendations are in large part relevant to Medicaid payment under either option.

### B. Medicaid eligibility standards are not well designed for assisted living.

<u>In most state Medicaid programs, room and board allocations are not realistic.</u>

Medicaid pays for assisted living services but not for room and board. The resident must pay for room and board out of his or her own income. To account for this, Medicaid programs allocate a certain amount of income that residents are allowed to retain to pay for room and board.

These room and board allocations are too low, putting pressure on both residents and facilities. Room and board allocations for waiver-eligible assisted living residents were commonly within the $500-$599 range, with the personal needs allowances in these states ranging from between $50 to $100. A few states, such as California and New Jersey, allocated higher amounts for room and board, while Oregon and Maryland allocated lower amounts, with the personal needs allowances of each of these states falling roughly in the neighborhood of $100.

This recommendation obviously will cost money, as will several of the following recommendations pertaining to Medicaid eligibility. The additional expense is justified by the fact that assisted living facilities generally are less expensive than nursing homes, even when assisted living room and board costs are included at a realistic level. Also, Medicaid

beneficiaries should have the option of receiving necessary long-term care services in a nursing home, an assisted living facility, or at home, as appropriate, and these options will be realistic only to the extent that the related eligibility calculations also are realistic.

Facilities often require or solicit supplemental payments, although such payments may lead to loss of eligibility or cutbacks in benefits.

Twenty states reported that they require facilities to accept the room and board allocation as payment in full for room and board. The other states generally do not address the issue in law or administrative guidance and, as a result, facilities in those states appear to have discretion to set room and board rates that exceed the Medicaid allocation. In defending this silence, respondents from some of these states argued that facilities effectively were limited to the Medicaid allocation, since it would be bad business to charge above the allocation.

In fact, facilities have sought to charge more than the allocation by requiring supplemental payments from a resident's family members or friends. This supplementation, however, violates the general rule in federal law that the specified payment from a public benefits program (such as Medicaid) must be accepted as payment in full. Also supplemental payments, if reported appropriately, will generally cause a dollar-for-dollar decrease in a resident's payment under the Supplemental Security Income Program, and often will cause a comparable limitation on Medicaid eligibility.

States are roughly split on whether to allow facilities to require supplemental payments. In some of those states that allow supplementation, it is limited appropriately to payment for items or services that are not included in the Medicaid-funded package of services.

Most states did not offer eligibility to persons over the "income cap," even if the person had long-term care expenses that exceeded available income.

Approximately two-thirds of the states imposed income caps, which were almost always set at 300 percent of the federal Supplemental Security Income (SSI) benefit. This is the maximum cap allowed by federal law for this eligibility category, which is used in many state Medicaid programs both for nursing home care and waiver services. In 2010, this maximum cap amounts to $2,022 monthly ($674 X 3 = $2,022).

In income-cap states, a person with an income even one dollar over the cap is ineligible for Medicaid coverage, even though it is likely that his or her income will be insufficient to cover assisted living expenses. A minority of states offered "medically-needy" eligibility, which provides coverage for residents over an income cap, provided that the resident pay his or her "excess" income for assisted living services.

Spousal impoverishment protections are relatively less effective in assisted living.

Federal Medicaid law requires financial protections for the at-home spouse of a Medicaid-eligible nursing home resident. From the couple's combined savings, the at-home spouse is entitled to retain whichever is greater: an amount from $21,912 to $109,560, depending

on the state, or one-half of the couple's savings up to a maximum of $109,560. (All dollar amounts are from 2010.) Also, the at-home spouse may be allowed to retain even more from savings, if the extra savings are necessary to generate adequate income.

Regarding income, the at-home spouse is entitled to retain from $1,822 to $2,739 from the couple's monthly income, depending on the state. A greater limit may be allowed if the at-home spouse can show "exceptional circumstances resulting in significant financial duress."[1]

In Medicaid home and community-based waiver programs, however, spousal impoverishment protections are not required. A state may or may not offer spousal impoverishment protections but, if protections are offered, the savings and income allocations must fall into the same federal ranges that apply in the case of nursing home residents.

A survey of the states revealed that the vast majority of states offered spousal impoverishment protections for waiver-funded assisted living residents, and that those protections were identical on their face to the protections offered to the state's nursing home residents. The most common choice was to set the savings and income allocations for both nursing home residents and assisted living residents at the minimums allowed by federal Medicaid law.

Even if set at the same levels used for married nursing home residents, however, spousal impoverishment protections in assisted living are less effective. The problem, again, is the resident's obligation to pay room and board expenses. A nursing home resident has no room and board obligation, and can allocate virtually all of his or her income to the at-home spouse. If that same resident is living in an assisted living facility, however, some significant portion of the resident's income will be required for room and board expenses, and thus will not be available to the at-home spouse.

A very few states have responded to this problem. For example, Minnesota enables a resident to take a deduction for income allocated to an at-home spouse.[2] Washington uses state-only money to pay for the resident's room and board charge, allowing the resident to save income for allocation to the at-home spouse.[3]

Federal rulings have denied spousal impoverishment protections to residents with medically-needy eligibility.

The Centers for Medicare & Medicaid Services (CMS) has ruled that spousal impoverishment protections are not available to medically-needy waiver beneficiaries. These are the beneficiaries whose incomes exceed the state's income cap (generally $2,022 in 2010) but are insufficient to cover the beneficiaries' care needs.

CMS's argument is a bit obtuse. For the purposes of a Medicaid waiver, spousal impoverishment protections can be available to persons "who would be eligible under the State plan … if they were in a medical institution."[4] CMS argues that a Medicaid program cannot be sure if a medically-needy beneficiary would spend down to eligibility levels in a nursing home, even if he is meeting the spend-down requirement for waiver services. Thus, according to CMS,

the beneficiary cannot be considered "institutionalized" and his spouse cannot be afforded spousal impoverishment protections.[5]

CMS's argument has some significant holes. Because Medicaid-covered nursing home services generally are much more expensive than Medicaid-covered assisted living services, it would seem as if a medically-needy waiver beneficiary would always be financially eligible if he were instead in a nursing home. Also, CMS's statutory interpretation is far from obvious—in fact, CMS approved and re-approved several waivers with spousal impoverishment protections for medically-needy beneficiaries, before belatedly adopting its present policy.

Perhaps most importantly, CMS's policy conflicts with legislative intent. The statutory language demonstrates congressional intent to allow states to extend spousal impoverishment protections to waiver beneficiaries. There is nothing to suggest that medically-needy beneficiaries be excluded across-the-board from spousal impoverishment protections.

### C. Current law allows assisted living facilities to discriminate against Medicaid-eligible residents.

Some facilities require private payment for a certain period of time as a condition of accepting Medicaid; such requirements would not be allowed in Medicaid-certified nursing homes.

In the past, nursing homes commonly required that a resident pay privately for a period of time before using Medicaid reimbursement. Now, however, the federal Nursing Home Reform Law prohibits such private-pay requirements in nursing homes.[6] The underlying Medicaid principle is that a Medicaid-certified provider is required to accept Medicaid reimbursement.

Evidence suggests that some assisted living facilities require a resident to pay privately for a certain period of time before the facility will accept the resident's Medicaid coverage. The study obtained disclosure statements filed by New Jersey assisted living facilities with the state, and those statements indicated that 45 percent of the facilities required private payment as a precondition for Medicaid eligibility. Furthermore, the private-pay requirements were significant: of the facilities requiring private payment, a full 82 percent required private payment for ten months or more.

Needless to say, any private-pay prerequisite—but particularly one of ten months or more—could make Medicaid coverage illusory for many beneficiaries in need of assisted living services. Medicaid eligibility would be usable only for those residents with enough money to pay privately for the specified number of months prior to becoming eligible. Poorer residents—specifically, those with inadequate savings to pay for the required number of months—might become Medicaid eligible, but their Medicaid will be refused by the assisted living facility.

In any state, a consumer might challenge a facility's private-payment prerequisite as a violation of federal Medicaid law. To this point, however, there has evidently been no such challenge made. Broad change likely will not occur unless and until the federal or state governments explicitly address the topic.

Some Medicaid-certified assisted living facilities refuse Medicaid reimbursement from existing residents at the facility's discretion.

Nursing home law provides much more protection than assisted living laws in relation to a Medicaid-certified facility's obligation to accept Medicaid reimbursement, although even the nursing home protections are limited. Under the federal Nursing Home Reform Law, a federally-certified nursing home may not require residents or potential residents to waive rights to Medicare or Medicaid.[7] Thus, a nursing home cannot turn down Medicaid reimbursement or establish additional preconditions (such as private payment of a certain duration, as discussed above). This principle is complicated by partial certification, i.e., certification of only a certain percentage of a facility's beds. Although some states' Medicaid programs demand complete certification for nursing homes, a significant number of other states authorize partial certification as allowed by federal law. Partial certification can lead to hardship for nursing home residents; a facility can refuse to accept Medicaid reimbursement even after a resident spends down to Medicaid-eligible levels.

Assisted living facilities tend to operate with few explicit legal requirements regarding the acceptance of Medicaid reimbursement from a particular resident. A recent New Jersey report highlighted an assisted living facility chain that as a business practice decided to refuse Medicaid reimbursement from existing residents, even if those residents already had been utilizing Medicaid eligibility.[8]

The harm to residents is substantial. A resident is spending down his or her life savings on assisted living services, assuming reasonably that Medicaid coverage will be there when savings run out. But when the resident becomes Medicaid-eligible, the rug is pulled out from under him or her whenever a Medicaid-certified facility refuses to accept Medicaid. The resident will be unable to pay and will be forced to find another Medicaid-certified facility.

In a survey given by this study to each state with an assisted living Medicaid waiver, the state respondent was asked, "Is a certified facility required to retain a private-pay resident who spends down to Medicaid eligibility levels while living in the facility?". Answers of "yes" were submitted only by Illinois, New Hampshire, and Oregon.

When an assisted living facility withdraws from the Medicaid program, existing facility residents lose any ability to use Medicaid eligibility in that facility.

A comparison with federal nursing home law again is instructive. If a nursing home is Medicaid-certified when a particular resident is admitted, Medicaid reimbursement in that facility always is an option for that resident, whenever her finances qualify her for Medicaid coverage. A withdrawing facility's Medicaid certification continues for residents present in the facility at the time withdrawal is requested, and is available to those residents as long as they reside in the facility, whenever they become Medicaid-eligible.

Currently, there is no comparable federal law for assisted living. State laws typically require only that adequate notice be given. Oregon and Washington, however, have laws somewhat comparable to the federal nursing home protections.[9]

**D. Medicaid certification has minimal quality of care standards.**

Waivers generally do not set quality of care standards for assisted living, and instead defer to state licensure standards.

In general, Medicaid assisted living waivers defer to the state's assisted living licensure regulations. CMS' standard waiver template requires that a state assure the quality of the waiver-funded services, and in general the state's assurance relies heavily on the existence of the licensure regulations.

This reliance is problematic for residents, for at least two reasons. First, state licensure rules often are vague, frequently deferring themselves to whatever might be the terms of a facility's admission agreement. Second, Medicaid waivers are limited to Medicaid beneficiaries who need the equivalent of nursing home care, but licensure regulations generally are written for a "typical" assisted living population with relatively lesser care needs.

Assisted living waivers generally do not require private units, even though private occupancy is regarded as one of the principal benefits of the assisted living model.

Assisted living originally was proposed as a single-occupancy model, and much private-pay assisted living is provided on a single-occupancy basis. Regardless, single occupancy generally is not required by licensure rules or by Medicaid certification standards. Medicaid waivers often state that rooms are shared only by a beneficiary's choice, but evidence suggests that the "choice" of a shared unit may be more rule than exception.

In New Jersey, for example, the assisted living waiver has provided for shared occupancy only by choice, but this presumption is belied by facility disclosure statements filed with the state. In disclosure statements obtained from the state by the study, 77 percent of the facilities stated that Medicaid-eligible residents shared a room.

A small minority of states requires private occupancy for Medicaid-funded assisted living. In Washington, for example, the waiver rules require apartment-like living units.[10] This exceeds the standards set by the licensing rules, which allow for shared occupancy by two residents.[11]

California's waiver also requires private occupancy, although state licensing rules otherwise accept shared occupancy. All waiver beneficiaries must be offered a private unit, and any request to share a unit must be initiated by the resident. In order, presumably, to limit a facility's ability to push residents into shared occupancy, such a request must be submitted to the state's care coordinator, who then forwards the request to the facility operator.[12]

In Nebraska, a waiver-certified facility must provide a private room including a bathroom with at least a toilet and sink. The regulations state that "Semi-private rooms shall be considered

on an individual basis (e.g., couples), and require prior approval of the [Nebraska Department of Health and Human Services]."[13] This represents a significant upgrade from the licensing requirements, which for new construction allow for two residents per bedroom with only 80 square feet per resident.[14]

Medicaid programs generally do not pay to hold a resident's assisted living unit during the resident's hospitalization, subjecting residents to unnecessary evictions.

In many states, an assisted living resident can lose his or her residence simply due to a short hospitalization. During the hospitalization, the Medicaid program makes no payments to the facility and, after the hospitalization, the facility then refuses to readmit the resident.

This is another area in which assisted living residents have fewer rights than do nursing home residents. In nursing homes, federal Medicaid law allows a Medicaid program to pay to hold a room during a resident's hospitalization, and many state Medicaid programs do exactly that.[15] Also, the federal Nursing Home Reform Law requires a nursing home to offer readmission to the next available bed following the hospitalization of a Medicaid-eligible resident, and to notify residents of its room hold policies.[16]

In assisted living, on the other hand, Medicaid programs generally do not pay for room holds. Study respondents perceived the problem as a fundamental one based on the characterization of Medicaid assisted living payment: waiver payment is for home and community-based services, rather than institutional care, so it is assumed that a Medicaid program cannot pay to hold a "room" or a "bed." As discussed above, payment for room and board is the resident's responsibility, not Medicaid's.

A limited number of states provide some resident protections. In Ohio, a room hold evidently requires only payment of the room and board rate: a state-issued consumer guide explains that residents must pay their room and board obligations even when absent from the facility, and that the Medicaid program does not pay for days in which the resident has been absent.[17]

In a limited number of states, Medicaid programs authorize payments designed to hold assisted living residents' rooms during the resident's hospitalization. The study identified two state Medicaid programs—Washington and Illinois—that pay for assisted living room holds with state-only money.[18] Colorado also makes such payments but a state respondent was unclear whether the state's room hold payments included federal financial participation or were comprised solely of state-only money.[19]

The Georgia and Montana Medicaid programs received federal financial assistance for their payments to assisted living facilities during residents' absences.[20] Authority for federal participation comes from federal guidance designed to promote alternatives to institutionalization. This guidance authorized "personal assistance retainer payments" for payment to waiver service providers during a beneficiary's temporary absence.[21]

## RECOMMENDATIONS

### To Make Medicaid Eligibility Standards Workable for Assisted Living Residents:

State allocations for room and board should be based generally on the cost of room and board, rather than on SSI payment levels.

Evidence suggests that most states' room and board allocations are not based on the costs of providing room and board, but instead on federal Supplemental Security Income (SSI) levels. Unfortunately, there is nothing about the SSI rate that assures its adequacy to cover assisted living room and board costs or a resident's personal needs allowance. Inadequate room and board allocations hurt providers, residents, and (often) residents' family members and friends. Also, those inadequate allocations have created a system which is too often reliant on facilities soliciting inappropriate payments from residents, family members, and friends.

Facilities should be required to accept the Medicaid-specified amount as the resident's entire room and board payment.

Facility charges for room and board should be limited to the allocation set by Medicaid calculations. A resident's available income consists only of minimal allocations for room, board, and a personal needs allowance. Without an explicit limit on room and board charges, a resident might be forced to expend some or all of her personal needs allowance on the room and board charges.

Facilities should not be allowed to demand or accept supplemental payments from the family members or friends of Medicaid-eligible residents.

When a public benefits program makes a payment designated for a service provider, the program generally expects the provider to accept the specified amount as payment in full. It is not fair to the facility, resident or resident's family to have a model that assumes ad hoc payments from family members. HCBS waivers aim to provide a cost-effective alternative to a nursing home, and for the sake of fairness the resident's obligation should be fixed.

State Medicaid programs should offer medically-needy eligibility to assisted living residents.

It is a matter of simple math to understand that private-pay expense for assisted living services often exceeds or approaches the common Medicaid income cap of $2,022 (for 2010). Medically-needy eligibility is needed to cover those persons who otherwise would be over the income cap but without sufficient income or assets to pay for assisted living services.

Spousal impoverishment protections should be designed to account for the resident's obligation to pay room and board expenses.

If a married Medicaid beneficiary needs long-term care services, the couple has a financial incentive for the beneficiary to live in a nursing home rather than an assisted living

facility, in order to have more income available for the at-home spouse. Spousal impoverishment protections should be designed to eliminate this disparity.

Spousal impoverishment protections should be available for medically-needy beneficiaries.

Based on both law and fairness, the at-home spouse of a medically-needy beneficiary should receive the same spousal impoverishment protections available to an at-home spouse of a resident with a different type of Medicaid eligibility.

**To Prevent Discrimination Against Medicaid-Eligible Assisted Living Residents:**

Medicaid-certified assisted living facilities should be required to accept Medicaid coverage from Medicaid-eligible residents.

Medicaid eligibility exists in order to provide necessary health care to low-income persons who otherwise could not afford it. But this protection is weakened, and to a certain extent eviscerated, when a Medicaid-certified provider is allowed to refuse Medicaid coverage.

This recommendation includes, but is not limited to, a prohibition on a facility requiring private payment for a certain number of months as a prerequisite for accepting Medicaid.

If a facility is Medicaid-certified, every unit within the facility should be so certified.

In order to implement the previous recommendation, Medicaid certification must apply to every bed in a facility. Otherwise, if facilities are partially certified, a private-pay resident who becomes Medicaid-eligible may not be able to access Medicaid coverage.

A facility's withdrawal from Medicaid should not limit the rights of already-admitted residents to access Medicaid coverage.

If an assisted living facility withdraws from the Medicaid program, the facility subsequently should be required to accept Medicaid reimbursement on behalf of any Medicaid-eligible resident who lived in the facility at the time of withdrawal, even if the resident did not become Medicaid-eligible until after the withdrawal.

**To Improve Quality of Care For Medicaid-Eligible Assisted Living Residents:**

The federal government should develop quality of care standards for Medicaid-funded assisted living services.

Medicaid waiver funding is only available for beneficiaries with care needs that would justify nursing home care. Given these high needs, and the substantial federal investment in assisted living services, the federal government should develop certain standards for Medicaid-funded assisted living services. The first priority is establishing standards that prohibit facilities from discriminating against Medicaid-eligible residents.

Private occupancy should be made a reality in Medicaid-funded assisted living.

Currently, in too many states the claim of private occupancy is a fiction, belied by the status quo of double occupancy in Medicaid-funded assisted living. States should take steps through Medicaid reimbursement rates, eligibility standards, and facility standards to provide private occupancy for Medicaid-eligible assisted living residents.

When a Medicaid-eligible resident is hospitalized, Medicaid programs should make payments to hold the resident's space in the assisted living facility, and the resident should have a right to return to the facility.

There is some confusion among federal and state officials about the availability of payments under federal waiver law. CMS should resolve this confusion by clearly articulating that payments are permissible. Also, state Medicaid officials should use existing authority to provide payments during a "hold" and, at a minimum, guarantee a resident's right to return to an assisted living facility after a hospitalization.

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[1] 42 U.S.C. § 1396r5(e)(2)(B).

[2] Minn. Dep't of Hum. Servs., Bulletin 07-25-01C, at 21 (July 27, 2007).

[3] Columbia Legal Services, Questions and Answers on the COPES Program, July 2008, p. 4; *see also* COPES Waiver, Appendix C-2 ("Waiver clients not living with CS [community spouse] will receive the same PNA as defined under regular post-eligibility.").

[4] 42 U.S.C. § 1396a(a)(10)(A)(ii)(VI).

[5] Letter from Gale P. Arden, CMS Center for Medicaid & State Operations, to Bruce Darling, New York State ADAPT, Nov. 9, 2006 (letter on file with NSCLC); *see also* Wash. Dep't of Soc. & Health Servs., Report to the Legislature: Application for Medicaid Medically-Needy Waiver, at 3-4 (Nov. 15, 2002).

[6] 42 U.S.C. § 1396r(c)(5)(A)(i).

[7] 42 U.S.C. § 1396r(c)(5)(A)(i).

[8] N.J. Dep't of Pub. Advocate, Aging in Place: Promises to Keep, An Investigation into Assisted Living Concepts, Inc. and Lessons for Protecting Seniors in Assisted Living Facilities (2009), *available at* www.state.nj.us/publicadvocate/seniors/pdf/alc_report.pdf.

[9] Or. Dep't Hum. Servs., Div. of Seniors & People with Disabilities, Information Memorandum Transmittal, SPD-IM-08-018, Gradual Withdrawal Contracts for Assisted Living Concepts (Feb. 25, 2008); Gradual Withdrawal Contract List (2007), available at www.dhs.state.or.us/spd/tools/cm/facility_lists/grad_with_cont.pdf; Wash. Rev. Code Ann. § 18.20.440; *see also* Washington Health Care Ass'n v. Arnold-Williams, 601 F. Supp. 2d 1224 (W.D. Wash. 2009) (limiting enforcement of Washington law).

[10] Wash. Admin. Code § 388-110-140(1).

[11] Wash. Admin. Code § 388-78A-3010(1)(c).

[12] State Of California Assisted Living Waiver Pilot Project: HHA Provider Handbook § 3(C)(1).

[13] 480 Neb. Admin. Code 5-005(B)(4)(c).

[14] 175 Neb. Admin. Code §§ 4-007.3I2(2), 4-007.03I3(2).

[15] 42 C.F.R. § 447.40(a)

[16] 42 U.S.C. § 1396r(c)(2)(D).

[17] Ohio Dep't of Aging, Understanding the Assisted Living Waiver Program: A Consumer's Guide, at 19-20 (Aug. 2008), *available at* aging.ohio.gov/resources/publications/al_consumer_guide.pdf.

[18] Wash. Rev. Code § 18.20.290(1), (2); Wash. Admin. Code §§ 388-105-0045(1), (2), (5), 388-110-100(6); Ill. Admin. Code tit. 89, § 146.225(f).

[19] 10 Colo. Code Regs. 2505–10, §§ 8.495.1 (definitions), 8.495.6.C, 8.495.7.D (leaves in assisted living).

[20] Mont. Dep't of Public Health & Human Servs., Home and Community Based Waiver Manual § 410; Georgia Elderly & Disabled Waiver, Appendix C-1/C-3 (Alternative Living Services).

[21] HCFA, Olmstead Update No. 3 (July 25, 2000), *available at* www.cms.hhs.gov/smdl/downloads/smd072500b.pdf.