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January 2008

STATEMENT OF THE NATIONAL SENIOR CITIZENS LAW CENTER REGARDING CMS' POSITION ON SPOUSAL IMPOVERISHMENT PROTECTIONS IN HCBS WAIVER PROGRAMS

The Centers for Medicare & Medicaid Services (CMS) is taking an unfounded position regarding the applicability of the federal law's spousal impoverishment protections in home and community-based care (HCBS) waiver programs. CMS has refused to approve New York's Nursing Home Transition & Diversion Waiver because the proposed waiver would include spousal impoverishment budgeting for people who have a spend-down (the "medically needy"). The agency informed New York's Department of Health (DOH) that federal law prohibits a state from extending spousal impoverishment protections to HCBS enrollees who qualify under the medically needy income category. CMS' position has no basis in federal law and would eviscerate the purpose of the spousal impoverishment protections if applied. It would also force some frail married individuals to choose institutional care over home or community-based care. What follows is an explanation of why the agency's position is incorrect.

1. Background

DOH submitted the waiver to CMS in 2005, under which DOH proposed to move approximately 5,000 individuals from nursing homes to community settings. DOH asked that CMS approve the waiver under the authority provided to the federal agency by 42 U.S.C. §1396n, which allows CMS to waive state compliance with certain provisions of the Medicaid Act in order to permit states to provide a package of HCBS to individuals who would otherwise require nursing facility care in the absence of such services.

In its application, DOH requested that the federal law's spousal impoverishment protections extend to the spouses of all individuals qualifying for the waiver. These protections, contained in 42 U.S.C. §1396r-5, are specifically designed to ensure that the spouses of individuals who cannot afford to pay for necessary long-term care services do not have to impoverish themselves in order for their frail spouses to attain the vital assistance Medicaid coverage provides. These "community spouses" are entitled to a minimum share of the couple's combined income, called the "minimum monthly maintenance needs allowance" (MMMNA), which for 2007 must be set by all states at no lower than $1,650 (New York's MMMNA is $2,541). The community spouses are also entitled to at least half of the couple's combined resources, up to a maximum of $101,640 for 2007 (New York has set a minimum of $74,820 for the community spouse's protected resources). Federal law requires that states guarantee these financial protections to the community spouses of *all* institutionalized Medicaid applicants, and provides states the option to extend the protections to the spouses of HCBS enrollees.

CMS, however, informed DOH that the waiver could not be approved if the spousal impoverishment protections were extended to the community spouses of "medically needy" enrollees of the Diversion waiver. A medically needy individual is one whose income is over the relevant Medicaid

limit but insufficient to pay for the costs of his or her medical care. Eligibility for these individuals is attained by what is called a "spenddown"; the individuals reduce their countable income by applying amounts over the limit to their medical expenses and then qualify. In New York, where DOH has determined the average monthly cost of care in a nursing facility to be between $6,506 and $10,123,[1] *most* individuals qualify for Medicaid long-term care coverage under the medically needy category.

CMS articulated its position that spouses of medically needy HCBS enrollees may not be afforded spousal impoverishment protections in a letter sent to a New York-based advocate for people with disabilities.[2] The agency claimed that the federal law, 42 U.S.C. §1396r-5(h)(1), provides states only narrow authority to extend the protections to spouses of HCBS enrollees. This provision provides states the discretion to extend the protections to the spouses of individuals "described in section 1902(a)(10)(A)(ii)(VI)," who are:

[Individuals] who would be eligible under the State plan under this subchapter if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home and community-based services described in subsection (c), (d) or (e) of section 1396n of this title they would require the level of care provided in a . . . nursing facility . . . the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted . . . under [42 U.S.C. §1396p].

Instead of referring to HCBS enrollees generally, CMS believes this provision refers only to individuals whose income is within the nursing facility/HCBS income limit set by the state.[3] CMS bases its interpretation on the language of the provision which refers to individuals "who would be eligible . . . if they were in a medical institution." As CMS sees it, if an HCBS enrollee has $900 in monthly income in a state where the nursing facility/HCBS monthly income limit is $1,000, this person would definitely be eligible if s/he were in an institution, and his or her spouse could therefore be protected by the spousal impoverishment provisions. But if this same HCBS enrollee with $900 in monthly income lives in a state with a nursing facility/HCBS monthly income limit of $800, then it is not certain, according to CMS, that this person would be eligible if in an institution. His or her spouse may therefore not enjoy the spousal impoverishment protections.

Put simply, CMS believes that an aging individual or person with a disability whose income is insufficient when compared to the cost of community-based long-term care services nonetheless has a fair likelihood of being able to afford the private cost of care in a nursing facility. It has therefore told DOH that the Diversion waiver, a waiver designed to help aging individuals and person with disabilities function in their homes and communities instead of in medical institutions, may not be approved so long as the spousal impoverishment protections are extended to the community spouses of the medically needy waiver enrollees.

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[1] NY State Dep't of Health, GIS 07 MA/002, *Medicaid Regional Rates for Calculating Transfer Penalty Periods* (January 2, 2007), <http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/07ma002.pdf>

[2] Letter from Gale P. Arden, Director, Center for Medicaid and State Operations, Disabled and Elderly Health Programs Group, Center for Medicare & Medicaid Services, to Bruce Darling, Organizer, New York State ADAPT (November 9, 2006)

[3] States may set as their income limit for nursing facility and HCBS services an amount up to 300% of the S.S.I. benefit rate, which is $1,869 for 2007. 42 U.S.C. §1396b(f)(4)(C).

CMS' interpretation of the relevant statutory provision is incorrect. The agency fails to appropriately identify an intent behind the federal law to exclude medically needy HCBS enrollees from the spousal impoverishment protections, and flagrantly ignores the actual cost of institutional care to justify its position. CMS' interpretation is also adverse to the very policies CMS is actively promoting nationwide, and is inconsistent with the approach it has taken toward other waivers submitted by New York in the past.

2. <u>There is no intent in the federal law to exclude the community spouses of medically needy HCBS enrollees from the spousal impoverishment protections</u>

The actual scope of the spousal impoverishment provisions clearly reveals the novelty of the agency's position. From a starting point, the community spouses of *all* institutionalized individuals who qualify for Medicaid are entitled to the spousal impoverishment protections, regardless of the method by which the institutionalized spouses qualify. Spouses of those qualifying as medically needy are no less entitled to the protections than spouses of Supplemental Security Income (S.S.I.) recipients. Similarly, whether an individual attains eligibility by virtue of having income below the separate income standard set by a state, or by establishing an income cap trust (or "Miller Trust") because his or her income is *above* this standard, the individual's spouse will be afforded the protections.[4] Spouses of individuals receiving LTC coverage through a waiver approved under 42 U.S.C. §1315 or through a PACE program are also entitled to the protections.[5]

And still the federal law goes further, allowing states the discretion to extend the spousal impoverishment protections to the spouses of HCBS enrollees. But for purposes of CMS' position on the limits of the scope of this discretion, it is important to point out the different methods by which one may gain Medicaid eligibility for HCBS. First, individuals may qualify by simply having income within the limit established by the state. For those whose income is above this limit, there are two different ways eligibility may be attained, both of which are identical to the alternative methods for gaining Medicaid eligibility in a nursing facility. First, if the state is operating a medically needy program, as New York is, the individual may attain eligibility if s/he meets a spenddown. Where, however, an HCBS applicant with income over the state limit is in a state without a medically needy program, the individual may qualify by establishing a Miller Trust.[6] Because the income placed into the Miller Trust becomes "unavailable" to the individual, the trust necessarily places the HCBS applicant's income below the state's income cap, and the individual is therefore eligible for Medicaid.

But CMS does not touch upon the availability of spousal impoverishment protections to those HCBS enrollees who attain eligibility by way of a Miller Trust, and the reason for this is easily understood. Even under CMS' narrow reading of 42 U.S.C. 1396a(a)(10)(A)(ii)(VI), the HCBS applicant who establishes the Miller Trust may, at his or her state's discretion, be extended the spousal impoverishment

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[4] Because of the very high cost of long-term care services, an individual whose income is over the nursing facility and HCBS limit is still unlikely to be able to afford the cost of the necessary services. Therefore, in states that do not have medically needy programs, individuals with incomes over the states' limit have to be able to qualify through the creation of an income trust. 42 U.S.C. §1396p(d)(4)(B). All of the individual's income is placed into the trust, and the state is the remainder beneficiary. These trusts are commonly referred to as "Miller Trusts," after the federal court decision which recognized the validity of these trusts. *Miller v. Ibarra*, 746 F.Supp. 19 (D. Colo. 1990). Individuals in states with medically needy programs may not attain eligibility by establishing a Miller Trust. 42 U.S.C. §1396p(d)(4)(B)(iii).

[5] 42 U.S.C. §1396r-5(a)

[6] See generally, U.S. Department of Health and Human Services, *Understanding Medicaid Home and Community Services: A Primer*, at 27-29 (October 2000); Enid Kassner, AARP, Lee Shirley, National Academy of Aging Society, *Medicaid Financial Eligibility for Older People: State Variations in Access to Home and Community-based Waiver and Nursing Home Services*, at 5 (April 2000).

protections because the individual is, by virtue of creating the trust, *indistinguishable* from an individual whose income is *below* the state's income cap–they both have available income below the cap, and both therefore "would be eligible . . . if they were in a medical institution." But how could the agency justify a reading of federal law that works to deny spousal impoverishment protections to medically needy HCBS enrollees but allows them to be available to HCBS enrollees who create Miller Trusts? At least initially (i.e., before those in non-medically needy states create a trust), both have income over the state income cap, but CMS is denying the protections to medically needy individuals that it could not, based on its reasoning, similarly deny to HCBS enrollees who establish Miller Trusts (again, federal law does not permit individuals in medically needy states to qualify through a Miller Trust). The agency cannot justify the separate treatment, and consequently circumvents this issue.

But the larger, more important point to draw from the separate treatment CMS requires for these two discrete classes of HCBS enrollees is the isolation the agency imposes on the community spouses of medically needy HCBS enrollees on the whole. Within the wide and diverse universe of the Medicaid long-term care population–institutionalized S.S.I. recipients, institutionalized income-qualifying individuals, institutionalized individuals who have created Miller Trusts, HCBS-enrolled S.S.I. recipients, HCBS-enrolled individuals who have created Miller Trusts, PACE enrollees, Section 1115 waiver beneficiaries–CMS believes that the community spouses of one discrete member group are specifically denied the spousal impoverishment protections of federal law–medically needy HCBS enrollees.

Given the vital importance of these protections and the breadth of their applicability, only an identifiable congressional intent to exclude the spouses of the medically needy HCBS enrollees could possibly justify such a reading of the federal law. CMS, however, does not even suggest a congressional intent, nor does the agency even advance a *policy* justification, reasonable or otherwise, for the denial of the protections to community spouses of medically needy HCBS enrollees. There is nothing unique about the characteristics of a community spouse of the medically needy HCBS enrollee that would provide a rational explanation as to why the federal law would specifically exclude her—and only her—from the spousal impoverishment protections of the federal law. Without any identifiable congressional intent or policy justification, the denial of these protections to the medically needy HCBS enrollees is arbitrary.

3. CMS' Support for its reading of federal law is disingenuous

Unable to provide a logical explanation as to why community spouses of medically needy HCBS enrollees are somehow singled out by federal law, CMS seeks to justify its narrow reading of the relevant federal law based on assertions it does not support with data, statistics or facts. The agency argues that, because 42 U.S.C. §1396a(a)(10)(A)(ii)(VI) identifies individuals "who would be eligible if in an institution," the utter uncertainty relating to whether a medically needy HCBS enrollee would meet a spenddown in an institution puts them squarely outside this definition ("[I]t is entirely speculative that [the medically needy HCBS enrollee] would in fact meet the spenddown liability if institutionalized."[7]). The agency does not allow that it is likely, or even a legitimate possibility, that a medically needy HCBS enrollee will meet a spenddown in an institution. Instead, the agency concedes only that it is "possible to construct scenarios" under which such an individual would meet an institutional spenddown. This disingenuous assessment of the likelihood of a medically needy HCBS enrollee meeting a spenddown in an institution is the agency's sole basis of support for its position, and a closer examination of the institutional cost of long-term care exposes the inherent weakness of it.

[7] Letter from Arden to Darling of 11/09/06, at 3.

All states participating in the Medicaid program must apply eligibility penalties against Medicaid applicants seeking long-term care coverage who have made transfers for less than fair market value before applying. The "penalty period" is determined by dividing the uncompensated value of the assets transferred by the average monthly cost to a private patient of nursing facility services in the state, or the community in which the individual lives (as the average cost may be different between one area of the state and another). 42 U.S.C. §1396p(c)(1)(E). New York's Medicaid agency has determined the average cost of nursing facility care for six different "communities," or regions, the lowest of which is in the Central New York region. The average cost in this area is $6,506 a month.

Therefore, from a starting point, every single medically needy HCBS enrollee in New York whose monthly income is less than *$6,506* will meet a spenddown in a facility, as the cost of the individual's medical care will exceed his or her available income. It is important to note that this figure does not refer to *household* income, but *individual* income, as federal law prohibits a state from deeming a community spouse's income to an institutionalized spouse. 42 U.S.C. §1396r-5(b)(1). With regard to New York, most individuals with *higher* monthly incomes will also meet a spenddown; between the New York City, Long Island and Northern Metropolitan regions, the lowest average monthly cost of nursing facility care is *$9,074*. These figures hardly make it "entirely speculative" that a medically needy HCBS enrollee would meet an institutional spenddown.

The agency refuses to acknowledge this high cost of care and the miniscule percentage of New York residents age 65 years or older or with disabilities who have individual income this high. Instead, CMS relies on the bald assertions that determining whether a medically needy HCBS enrollee would meet a spenddown in a facility is nothing but sheer guesswork. This assessment is not supported with any data or facts, and is not in harmony with the real-life state of affairs of which the agency is well aware. The fact that this unsupported, wholly inaccurate assessment of the ability of a medically needy HCBS enrollee to meet a spenddown in a nursing facility is the agency's *sole* justification for denial of the spousal impoverishment protections to this group, the absurdity of the agency's position becomes even more clear.

4. <u>CMS' Position is adverse to agency policy</u>

Before executing President Bush' New Freedom Initiative in 2001, one of the broad aims of which is to "rebalance" the delivery of long-term care services from institutions to the community, the U.S. Department of Health & Human Service conducted a self-evaluation to determine what barriers existed to the performance of this goal.[8] Among other things, the 2002 report concluded that eliminating the bias in HHS programs (including Medicaid) required "greater flexibility for states . . . under Medicaid home and community-based services (HCBS) waivers."[9] Since then, CMS officials have publicly touted the agency's accomplishments in rebalancing Medicaid's delivery of LTC services.[10] However, former CMS Administrator Mark McClellan conceded less than two years ago that the agency "still ha[s] a ways to go" in reaching the rebalancing goal to which it has committed itself.[11] Indeed, the Medicaid Commission established by HHS recommended that changes be made to Medicaid long-term policy that

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[8] U.S. Department of Health and Human Services, *Delivering on the Promise: Self-Evaluation to Promote Community Living for People with Disabilities*. (April 21, 2002).
[9] Id. at 8.
[10] See Dennis Smith, former Acting Administrator, Centers for Medicare & Medicaid Services, Testimony on the New Freedom Initiative before the U.S. Senate Finance Committee (April 7, 2004); Mark McClellan, former Administrator, Centers for Medicare & Medicaid Services, Remarks before the CMS 2006 New Freedom Initiative Conference (April 10, 2006).
[11] Mark McClellan, former Administrator, Centers for Medicare & Medicaid Services, Remarks before the CMS 2006 New Freedom Initiative Conference (April 10, 2006).

"address institutional bias and reflect what seniors and persons with disabilities say they want and need, which is to stay at home in their communities."

The agency's refusal to allow a state to extend spousal impoverishment protections to the community spouses of medically needy HCBS enrollees represents a major step backward. Though recognizing the role of state flexibility in the enhancement of HCBS programs, the agency is taking a *statutory grant* of flexibility in HCBS programs and imposing an artificial limitation on it.

The following example illustrates how the agency's refusal to grant states the discretion to extend spousal impoverishment protections to community spouses of medically needy HCBS enrollees virtually eliminates a community-based option for low-income elderly families.

Assume Mr. and Mrs. Smith live in New York City. Mr. Smith's monthly income is $1,400 and Mrs. Smith's is $600, making their household total $2,000. If Mr. Smith entered a nursing facility and qualified for Medicaid, he would be entitled to a personal needs allowance of $50. The remaining portion of his monthly income must first be made available to Mrs. Smith to raise her income to the MMMNA mandated by federal law.[12] New York has set its MMMNA at the maximum allowed by federal law, which is $2,541 for 2007. Because Mrs. Smith's monthly income is $1,941 below this amount, she is entitled to this much of her husband's income, or all of her husband's income if his available income, after his personal needs allowance (PNA), is less than this amount. Mr. Smith's income after his PNA is deducted is $1,350, so Mrs. Smith may receive all of this, raising her income in the community to $1,950.[13]

If Mr. Smith wants to remain in the community through the HCBS program, the result under the CMS interpretation would be significantly different. Mr. Smith's PNA in the community would be $200.[14] However, the remaining portion of his income would be made available for his medical providers in the community, not Mrs. Smith. Without the benefit of spousal impoverishment protections, Mr. and Mrs. Smith's household income will be $800 (Mr. Smith's $200 PNA + Mrs. Smith's $600 monthly income). This is a remarkably different outcome than if Mr. Smith were in an institution. For this couple, institutional care for Mr. Smith may actually be the better, if not only, choice.

Therefore, in addition to irrationally isolating community spouses of medically needy HCBS enrollees from all other community spouses of Medicaid LTC beneficiaries, CMS' reading of the relevant statutory provision creates the perverse incentive for some couples to choose institutional care for the frail member of the couple over HCBS. This approach betrays the agency's own stated goal of expanding community-based options for aging individuals and person with disabilities.

5. CMS has been inconsistent in its position

Finally, the credibility of the agency's position is furthered eroded by the fact that it has historically *allowed* New York to extend the spousal impoverishment protections to medically needy

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[12] Federal law mandates the order of the post-eligibility deductions from an individual's income. A personal needs allowance is deducted first, then the spousal allowance, a family allowance, and then payment for incurred medical expenses. 42 U.S.C. §1396r-5(d)(1).

[13] If Mr. Smith were single, the remaining portion of his income after his PNA deduction would be paid to the facility; his PNA in the facility is not increased in the absence of a community spouse.

[14] The PNA in the waiver setting is different than in a nursing home. The current levels were set as the result of litigation in *Evans v. Wing*, 716 N.Y.S.2d 269 (4th Dept. 2000), *rearg. den'd,* 724 N.Y.S.2d 143 (2001), with cost of living increases annually. Current levels are at Line 9 in NYS Dept't of Health GIS 07 MA/001. http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/07ma001.pdf

HCBS enrollees. Since 1989, New York has opted to extend these protections to the medically needy in HCBS waiver programs,[15] including the proposed Nursing Home Transition and Diversion Waiver. These waivers have been approved and *re-approved* with these protections included for the medically needy community spouses. Time and again courts have held that a factor in the evaluation of the credibility of an informal agency position is the consistency with which the agency has applied it. CMS does not explain in the letter what prompted the change in its position, and its consistent approval of past New York HCBS waivers that have contained the protections the agency is now insisting may not be allowed yet again exposes the weakness of the agency's position.

Conclusion

The importance of the spousal impoverishment protections for the spouses of Medicaid long-term care recipients cannot possibly be underestimated. They were specifically designed to ensure that a frail spouse who meets Medicaid's eligibility requirements can receive care without exposing the other spouse to financial hardship. The HCBS program, meanwhile, aims to allow individuals in need of long-term care to receive it in the home instead of an institution. Clearly, spouses wish to stay together, and the availability of the spousal impoverishment protections for the community spouse of a frail person for whom HCBS is an option makes this possible. Unfortunately, CMS is seeking to impose an unsupportable reading of federal law that will force the separation of certain spouses and require a frail individual to move into a facility where HCBS is an option. This policy would eviscerate the purpose of *both* federal laws. The agency should change its position in order to diminish the institutional bias of the Medicaid program, a goal to which the agency itself has declared its dedication.

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[15] New York Social Services Law § 366-c.