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A Medicaid Primer for Housing Officials

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A. Introduction – What is this Medicaid Primer?

The most striking characteristic of housing and health care in this country is the disconnection between the two fields. Except in institutions, elders and individuals with disabilities typically obtain their housing from one source and their health care and supportive services from a completely different source. The Centers for Medicare & Medicaid Services (CMS) is committed to collaborating with the Department of Housing and Urban Development and other housing organizations to coordinate resources to improve access to affordable, accessible housing for elders and individuals with disabilities. Access to affordable, accessible housing is critical to the success of the Money Follows the Person Demonstration Program, which will provide opportunities for thousands of Medicaid beneficiaries living in institutions to relocate to the community. To build collaboration requires an understanding of the programs and resources that are available from CMS. This document describes the basic components of the Medicaid program. It is not a technical manual. Presented in a concise question and answer format, this document explains many of the features of what can be a complicated program.

Housing and health care professionals operate in totally different environments, each with their own culture, terminology, and array of programs whose details confound each other. Operating in distinct worlds, housing and health care staff generally know the other's purpose but need to work more closely and learn to integrate efforts for their mutual benefit and the benefit of the people they serve. Such understanding and coordination are essential underpinnings to the success of reforms proposed in a Report to Congress from the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century and in many other forums.

The Commission held several hearings and witness after witness testified to this problem and the consequences of its continuation. Through such exchanges, Commissioners came to appreciate that:

- Some policy disconnects have long histories and may not be easily reconciled;
- Poor communication, differing vocabulary, and few opportunities to share experiences separate professionals, policymakers, academics, and even the media in the two fields;
- Lack of coordination and integration between housing and health care is characterized by different and distinct financing systems and regulatory structures; and
- Most difficult of all, government is structured, at both legislative and administrative levels, in ways that inhibit coordination.

Language Barriers

One prominent barrier separating housing and service representatives is the language, acronyms, and definitions used by each side.

Housing providers are challenged when dealing with the health and support needs of tenants, which bring them face to face with a system that is as enigmatic and complex as the housing world is to staff who work in the health and long term care system. Medicaid services, eligibility,

income levels, waivers, aging in place, relocation from institutions, and other issues are as confusing to housing professionals as the myriad of housing programs and rules are to professionals in the long term care system. Even casual conversations with these providers begin to show the first signs of separation - language.

Housing programs are typically national. Housing professionals speak of tenants, dwelling units, turnover rates, replacement schedules, fair market rents, low income and very low income tenants, and subsidies. They want to know what a senior's income is as a percentage of area median income (AMI).

Although there is a core set of mandatory requirements, Medicaid operates as 54 different programs. Each State and territory chooses from a menu of eligibility and service choices. Medicaid staff talk about recipients, beneficiaries, and consumers. They ask about an applicant's income in relation to the Supplemental Security Income (SSI) program, the medically needy eligibility standard, or the special income level (300% of the federal SSI benefit).

Health services professionals and Medicaid staff talk about beds, length of stay, and a host of terms meaningful to Medicaid.

In 2003, the Rutgers/National Academy for State Health Policy (NASHP) Community Living Exchange and the Technical Assistance Center Inc. prepared a housing primer for use by service professionals. This primer was prepared to help housing providers understand the basics of Medicaid, the terms, rules, services and other issues that emerge when trying to find services that will meet the needs of tenants intent on living independently in their apartment for as long as possible. It is presented in a question and answer format to focus on the questions housing providers commonly ask about Medicaid. This document is intended to be changed and expanded as new questions arise or responses change over time.

B. General questions about Medicaid

The Federal Medicaid program is administered by the Centers for Medicare & Medicaid Services (CMS) which is under the Department of Health and Human Services. Other HHS agencies include the Administration on Aging and Centers for Disease Control. For the purposes of this primer CMS is the agency that is relevant to the work of housing professionals for persons needing long-term care and other health services.

Federal Housing programs are administered by the Department of Housing and Urban Development (HUD), which compared to HHS and even CMS, is much smaller in size and budget. CMS employed about 4,100 staff with Discretionary Budget Authority of \$67.2 billion in FY 2006. HUD's 2006 Discretionary Budget Authority was \$28.5 billion in FY 2006.

Unlike HUD subsidized housing programs, which are largely Federally-driven by Congress and HUD, Medicaid is a Federal and State partnership. Some aspects are determined by the Federal government (Centers of Medicare & Medicaid Services) and some by the State Medicaid agency. CMS provides a minimum level of requirements via regulations and the States may choose to

promulgate additional requirements and services. The Federal-State partnership program of the Medicaid program, in this way, offers considerable flexibility to the States, unlike HUD programs, which are largely defined and budgeted by HUD. When housing professionals work within or across various States, they are likely to find variations from State to State. This is particularly the case for how Medicaid home and community-based services are funded and the range of such services provided. As an example, there are no Federal regulations governing the term “assisted living” which varies by State and is largely a for-profit, private pay industry. On the other hand, HUD Housing Choices Vouchers (Section 8), 202, 811 and Hope VI programs are standardized programs which operate consistently across States.

Q. What is Medicaid? Is it the same in every State?

Medicaid is a federally supervised, State administered partnership that provides primary, acute, and long term care services to individuals who meet income, resource requirements, and other categorical requirements (e.g., residency, citizenship). Medicaid is means tested – meaning that beneficiaries must meet income and resource guidelines (savings and other assets). Most elderly Medicaid beneficiaries and some younger adults with disabilities are dually eligible for Medicaid and Medicare. States have considerable flexibility to determine who is eligible and what services will be covered. Because of this flexibility, there are wide variations among State Medicaid programs. Who is eligible and what services they may receive vary from State to State.

Q. What is Medicare?

Medicare is a federal health insurance program for people age 65 and older and people with disabilities under age 65 who receive Social Security Disability Insurance payments. Medicare provides primary and acute medical services to older adults and some younger individuals with a disability. Although Medicare covers nursing home and home health services, they are authorized only during post acute or rehabilitative phases of an illness. Medicare services are short term and are not approved for people needing long-term, custodial care.

Q. Can a person be eligible for both Medicare and Medicaid?

Yes. These individuals are referred to as Dual Eligibles. Most low-income seniors are dual-eligible.

Q. Is Medicaid part of the Temporary Assistance for Needy Families (TANF) system?

No, it is a separate system; however, financial eligibility for Medicaid is often determined by the same State or county organization that determines eligibility for TANF and food stamp benefits.

Q. Who pays for Medicaid?

Medicaid costs are shared between the Federal government and States. A few States require that counties pay a portion of the share paid by the State. Each State's share varies depending on its relative per capita income. The Federal share for payment of services ranges from a minimum of 50% to a maximum of 83% of spending for services. For example, in Indiana the State share is 37.31 percent and the Federal share is 62.69 percent. For every dollar spent on Medicaid health and long term care services 62.69 cents are paid for by the Federal Medicaid program and 37.31 cents are paid for by the Indiana Medicaid program. The costs for administering the program are shared 50-50 between the Federal and State.

Q. What programs provide services for low-income persons?

Low income individuals may qualify for services from an array of programs including Medicare, Medicaid, the Older Americans Act, Food Stamps, and Low Income Fuel Assistance. However, Medicaid pays for a significant amount of the long term care services provided to low-income individuals.

Q. What agencies can I contact to learn more about Medicaid and other resources?

Medicaid is administered by a "single State agency" that is usually a Department or Division of a State health and human services or human services umbrella agency. The Medicaid agency is responsible for setting policy, paying bills, contracting with providers, and managing the program.

The Medicaid agency may manage home and community-based services directly or through interagency agreements with other State agencies that implement specific programs and services. Links to each State's Medicaid agency are available at http://www.nasmd.org/links/State_medicaid_links.asp. However, the web pages may not list their telephone number or a contact. Information about home and community-based service options may be more quickly obtained from the State Unit on Aging (SUA), a local Area Agency on Aging (AAA), an Independent Living Center, a Medicaid regional or field office if the State decentralizes long term care functions, or a State agency serving people with disabilities, mental retardation, or developmental disabilities. Medicaid home and community-based waiver services programs for elders are often managed by the SUA. SUAs may operate the programs with their own staff, or through contracts with AAAs or other community based organizations. For a list of SUAs and AAAs, go to: http://www.aoa.gov/eldfam/How_To_Find/Agencies/Agencies.asp Individuals with mental retardation or developmental disabilities are usually served by a separate State agency. Links to State MR/DD agencies are available at <http://www.nasdds.org/MemberAgencies/index.shtml>. Phone numbers are listed.

Agencies in some States serve elders and adults with physical disabilities. Adults with disabilities may also receive support from a national network of Independent Living Centers (ILCs). For a list of ILCs and contact information, go to <http://www.ilru.org/html/publications/directory/index.html>.

Medicare is administered by the Federal Department of Health and Human Services.

C. Questions about eligibility

Two important points to remember when comparing Medicaid services and HUD housing eligibility methods are: 1) the two programs use very different methods to determine financial eligibility; and 2) Medicaid eligibility is extremely complicated and even health care professionals and service providers have difficulty understanding the Medicaid eligibility requirements.

HUD housing eligibility measures income in relation to the percentage of median area income, while Medicaid eligibility considers income in relation to the thresholds used for the Federal Supplemental Security Income (SSI) program, State supplements to the SSI program, poverty and medically needy (spend down) thresholds. Therefore, a person can be eligible for a housing program, but not may be eligible for the Medicaid program, or vice versa. Housing professionals do not need to understand all the different eligibility categories, but do need to know how to connect a person with the Medicaid eligibility process and the meaning of some of the commonly used terms.

Q. Is everyone entitled to receive Medicaid services?

Only applicants whose income and assets fall within the guidelines for specific eligibility groups are eligible for Medicaid. Eligible beneficiaries are “entitled” to all mandatory and optional services the State covers under the regular Medicaid program (referred to as the “State plan”) provided that they meet the medical necessity criteria to receive the service. Home and community-based waiver services may be available, but they are not an entitlement. States may create waiting lists when they reach the maximum amount that has been approved for the waiver program.

A shortage of home and community-based services (HCBS) waiver slots for Medicaid beneficiaries is a problem in some waivers. A report by the Kaiser Commission on Medicaid and the Uninsured found that 34 States had waiting lists in 2004 for individuals who applied for waiver services and were Medicaid eligible. However, the existence and size of the waiting list varies by the group served by the waiver. Twenty of the 34 States had waiting lists for elders or adults with disabilities. About 65% of these individuals on waiting lists were in one State. Waiting lists exist because there may be too few waiver slots or the State lacks funding to match

Federal Medicaid dollars. The average time on a waiting list for elders and adults with physical disabilities was 5-6 months.

Q. Who is eligible for Medicaid?

There are many different groups of individuals who may be eligible for Medicaid. Some must be covered and others may be covered at the option of the State.

There are three primary eligibility categories for persons applying to Medicaid:

- Mandatory eligibility groups such as individuals who receive benefits under the Federal Supplemental Security Income (SSI) program are automatically eligible in most States (applicants in 11 States are not automatically eligible because these States have lower income, resource, or disability requirements than SSI)¹.
- Optional categorically needy such as individuals who receive payments under a State Supplement to the federal SSI program are eligible.
- Medically needy group. States may extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under mandatory or optional categorically needy groups. The “medically needy” program allows individuals to “spend down” to Medicaid eligibility by incurring medical or remedial expenses to offset their excess income and reduce it to a level below the maximum allowed by the State plan. If a State elects to cover the medically needy under the State plan, it must cover certain individuals. However, a State with a medically needy program may but is not required to cover other medically needy persons, including aged, blind, and/or disabled persons.

Other categories of eligible individuals are:

- States may cover aged or disabled individuals with income up to 100% of federal poverty level.
- States may cover individuals living in an institution who have income below 300% of the federal SSI payment, \$1,869 a month in 2007.
- Low income families with children (replacement for the Aid to Families with Dependent Children program).
- People with disabilities who are employed and have income below specified levels may be covered at the option of the State.

¹ These States include CT, HI, IL, IN, MN, MO, ND, NH, OH, OK and VA

Q. Which States have Medically Needy programs that cover elders and people with disabilities?

Arkansas	Maine	Pennsylvania
California	Maryland	Puerto Rico
Connecticut	Massachusetts	Rhode Island
District of Columbia	Michigan	Tennessee
Florida	Minnesota	Utah
Georgia	Montana	Vermont
Hawaii	Nebraska	Virginia
Illinois	New Hampshire	Washington
Iowa	New Jersey	West Virginia
Kansas	New York	Wisconsin
Kentucky	North Carolina	
Louisiana	North Dakota	

Q. How do you qualify for Medicaid?

In order to qualify for Medicaid, a person must meet the following basic requirements:

- Be a member of a group (e.g., mandatory, optional, medically needy) covered by the State’s Medicaid plan.
- Common characteristics and requirements which include non-financial (e.g., State residence, citizen, or qualified alien, etc.) and financial (e.g., income/resource requirements).
- States must use the rules and processes of: The SSI program to determine Medicaid eligibility for aged, blind, or disabled people or the AFDC program to determine Medicaid eligibility for all other groups.
- All eligibility groups tie back to the SSI or AFDC rules and processes.

Applicants must meet income and resource standards that vary by eligibility groups. SSI beneficiaries have monthly income, after exemptions, below \$623 for one person and \$934 for an eligible couple in 2007 and resources of less than \$2,000 for an individual and \$3,000 for a couple. States also cover individuals in other categories with different income levels.

Medicaid income eligibility levels have no relation to standards used by subsidized housing programs. Individuals may be eligible for a housing subsidy but do not qualify for Medicaid.

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Applicants must complete a financial application to a designated agency – usually the agency that determines financial eligibility for Temporary Assistance for Needy Families (TANF) and food stamps. It may be a State or county agency.

Q. What income is exempt?

Medicaid and housing programs allow applicants to exempt income. The Medicaid exemptions differ from those used by HUD programs and they allow State Medicaid programs to cover individuals whose gross income is higher than the SSI benefit payment or AMI threshold.

Medicaid follows the SSI rules for counting and exempting income. Some of more common sources of income applicants are allowed to exclude are:

- \$20 a month;
- \$65 a month of earned income;
- Earned income used to pay for impairment- related work expenses;
- 50% of the remaining work-related income;
- The value of housing subsidies;
- Certain Veterans benefits; and
- Assistance from State or local sources that is based on need.

Q. How does SSI compare to the Area Median Income levels used by housing programs?

On annual basis, an individual with no other income would receive \$623 a month or \$7,476 a year in Federal SSI benefits. Some States supplement the federal payment.² The federal SSI benefit varies as a percentage of the very low income standard for a one person household depending on the Metropolitan Statistical Area (MSA). The table below presents the highest and lowest very low income AMI threshold for a one person household in each State; the Federal SSI benefit as a percentage of AMI; and 300% of the Federal SSI benefit as a percentage of the highest and lowest AMI. Three hundred percent of the Federal SSI benefit is a common Medicaid eligibility standard for home and community-based waiver services.

Note: States may cover individuals in the community with income up to 300% of the federal SSI benefit only:

- Under 1915 (c) home and community based services waivers;

² The amount of the State supplement can vary for elders and adults with disabilities as well as by living arrangement.

- If such individuals are eligible in an institution (nursing home, ICF-MR or hospital); and
- The person meets the criteria to be admitted to an institution.

The SSI as a percent of AMI column would apply to tenants who may not meet the criteria for receiving waiver services since they do not meet the criteria for admission to a nursing home. This group may need some support for activities of daily living which could be paid by Medicaid programs that cover personal care under the State plan. The 300% column applies to eligibility for waiver services. Remember, the SSI benefit is not the only income standard that may be used in a State.

MSAs with low area median incomes will have Medicaid waiver participants at 300% of SSI who exceed the very low income levels. As AMI increases, the lower the SSI benefit and 300% of SSI benefit as a percentage of the AMI. For example, SSI beneficiaries have income equal to 33% of the highest AMI in Alabama and 47% of the lowest AMI. This means that tenants with incomes above these percentages of AMI who do not need Medicaid waiver services may not be eligible for Medicaid.³ Tenants with income below these levels who do not need waiver services would be eligible for other Medicaid services covered by the State Plan.

A State that elected the 300% option under a home and community based services waiver would cover nearly everyone with very low income in the highest AMI communities and all tenants in areas with the lowest AMI in Alabama.

Comparison of Area Median Income and Supplemental Security Income Levels⁴						
State	Highest AMI	SSI as % of AMI	300% of SSI as % of AMI	Lowest AMI	SSI as % of AMI	300% of SSI as % of AMI
AL	\$22,700	33%	99%	\$15,800	47%	142%
AK	\$31,300	24%	72%	\$23,850	31%	94%
AZ	\$26,500	28%	85%	\$14,350	52%	156%
AR	\$19,800	38%	113%	\$14,150	53%	159%
CA	\$39,600	19%	57%	\$18,050	41%	124%
CO	\$34,150	22%	66%	\$18,850	40%	119%
CT	\$40,700	18%	55%	\$26,550	28%	84%
DE	\$25,250	30%	89%	\$19,300	39%	116%
DC	\$33,100	23%	68%	\$33,100	23%	68%
FL	\$24,450	31%	92%	\$15,450	48%	145%
GA	\$24,900	30%	90%	\$16,200	46%	138%
HI	\$26,100	29%	86%	\$21,800	34%	103%
ID	\$24,900	30%	90%	\$16,700	45%	134%

³ Note that individuals with income above SSI levels may be eligible for Medicaid under other categories such a medically needy, optional poverty level category or because they receive an SSI State supplement.

⁴ Data obtained from the US Department of Housing and Urban Development web site: <http://www.huduser.org/datasets/il/il07/index.html>. Click on the Section 8 program income limits excel spreadsheet.

Comparison of Area Median Income and Supplemental Security Income Levels⁴						
State	Highest AMI	SSI as % of AMI	300% of SSI as % of AMI	Lowest AMI	SSI as % of AMI	300% of SSI as % of AMI
IL	\$29,350	25%	76%	\$18,050	41%	123%
IN	\$22,800	33%	99%	\$18,450	41%	122%
IA	\$22,400	29%	88%	\$18,750	40%	120%
KS	\$23,950	31%	93%	\$17,450	43%	129%
KY	\$22,600	33%	99%	\$14,050	53%	160%
LA	\$19,950	37%	112%	\$14,000	53%	160%
ME	\$25,700	29%	87%	\$17,250	43%	130%
MD	\$33,100	23%	66%	\$22,450	33%	99%
MA	\$32,850	23%	68%	\$25,100	30%	89%
MI	\$31,100	24%	72%	\$17,900	42%	125%
MN	\$27,500	27%	82%	\$19,300	39%	116%
MS	\$18,700	40%	120%	\$13,600	55%	165%
MO	\$23,950	31%	93%	\$15,550	48%	144%
MT	\$21,000	36%	107%	\$17,100	44%	141%
NE	\$23,300	32%	95%	\$18,800	42%	125%
NV	\$23,500	32%	96%	\$20,650	42%	109%
NH	\$30,100	25%	75%	\$22,050	36%	102%
NJ	\$33,400	22%	67%	\$19,750	34%	114%
NM	\$33,400	22%	67%	\$13,900	54%	161%
NY	\$32,850	23%	68%	\$17,800	42%	126%
NC	\$25,050	30%	90%	\$16,500	45%	136%
ND	\$23,650	32%	95%	\$18,150	41%	124%
OH	\$22,600	33%	99%	\$16,150	46%	139%
OK	\$19,100	39%	117%	\$14,350	52%	156%
OR	\$23,850	31%	94%	\$16,900	44%	133%
PA	\$25,250	30%	89%	\$17,700	42%	127%
RI	\$27,100	28%	83%	\$25,600	29%	88%
SC	\$22,550	33%	99%	\$16,300	46%	138%
SD	\$22,100	34%	101%	\$17,050	44%	132%
TN	\$21,550	35%	104%	\$15,250	49%	147%
TX	\$24,900	30%	90%	\$15,100	50%	149%
UT	\$29,200	26%	77%	\$17,250	43%	130%
VT	\$24,700	30%	91%	\$20,600	36%	109%
VA	\$33,100	23%	68%	\$16,300	46%	138%
WA	\$27,250	27%	82%	\$17,450	43%	129%
WV	\$23,150	32%	97%	\$14,550	51%	154%
WI	\$27,500	27%	81%	\$19,200	39%	117%
WY	\$28,650	26%	78%	\$20,500	36%	109%

Q. What is the process for obtaining eligibility and how long does it usually take?

Financial eligibility is usually determined by the State or county agency that is responsible for processing applications for Temporary Aid to Needy Families (TANF) and food stamps.

Applications are supposed to be processed within 90 days for applicants who apply for Medicaid on the basis of disability and within 45 days for all other applicants. It can take longer if the application is not complete or required documentation is missing.

Q. Are States allowed to “presume” eligibility for applicants with very low income or who are at risk of entering a nursing home?

Federal law recognizes the importance of determining financial eligibility quickly for certain categories of beneficiaries such as pregnant women, children under the age of 19 and beneficiaries with breast or cervical cancer. Regulations allow States to provide Medicaid covered services to these groups of beneficiaries because delays in approving access may affect their health status and outcomes. Federal policy allows States to receive federal reimbursement for services only to the above groups that are provided between the date of “presumed” eligibility and the actual determination of eligibility even when the presumption was determined to be in error.

Federal policy does not provide for presumptive eligibility for elders and individuals with a disability, which means that there is no Federal reimbursement if an applicant is found ineligible for Medicaid.⁵ Although current Federal policy does not allow States to receive reimbursement for services delivered to applicants while their eligibility is being decided, several States do use it. Presumptive eligibility is allowed under a new home and community-based services State plan option, created by the Deficit Reduction Act of 2005, which allows States to cover a limited number of services without a §1915 (c) waiver. However, the option has several provisions that may limit how widely it is used.

States that allow presumptive eligibility can often determine financial eligibility within 3 days or whenever sufficient information is available to allow the eligibility worker to determine an applicant is likely to be eligible.

D. Questions about services covered by Medicaid

When housing staff mention health, Medicaid staff interpret health to mean primary and acute care. Long-term care or long-term supports are primarily non-medical in nature. Many tenants have chronic conditions that limit their ability to care for themselves. Tenants may present a complex set of needs that may require intervention by health care professionals or supportive service agencies.

Long term support agencies and staff want to know about activities of daily living (ADL), income and resources in relation to Medicaid, their Medicaid eligibility status and whether the applicant qualifies for home and community-based services.

⁵ See “Expediting Medicaid Eligibility Determinations.” Available at: http://www.nashp.org/Files/presumptive_eligibility.pdf

Some Medicaid services, such as nursing home care, are an entitlement – meaning anyone who meets the financial and functional requirements can access the service. In contrast, home and community-based services are not a legal entitlement, which means that there may be waiting lists for waiver services and there is no guarantee of receiving the service. In contrast, no HUD housing programs are entitlements and waiting lists are common, such as with the Housing Choice Voucher (Section 8) program.

Q. What services are covered?

Services fall into three groups: mandatory, optional, or waiver. Mandatory and optional services are covered under a State plan that is approved by CMS. The services available can be mandatory for some eligibility groups and optional for others.

- Benefits that are mandatory for most groups include inpatient hospital services, lab and x-ray, physician services, nursing home services for people over 21, and home health services for people who are eligible.
- Optional services include prescription drugs, routine dental care, clinic services, other licensed practitioner services (optometry, podiatry, psychology), inpatient psychiatric care for people under 21 and elders, nursing home services for people under age 21, physical therapy, prosthetic devices, personal care and transportation.
- Services that support a person to live independently in their home or apartment are primarily covered by States under home and community-based waiver service programs. The major exception is services for persons with mental illness who rely heavily on mandatory and optional State Plan services.

State plan services must be offered Statewide in the same amount, duration, and scope. States may place limits on how extensive the service might be, e.g., 15 physician visits.

Home and community-based waiver services may be limited to specific regions of a State and to specific groups of beneficiaries.

Q. What are Medicaid State plan services?

State plan services are health and some long term care services that are covered under the Medicaid program. State plan services may be mandatory or optional. Like eligibility groups, States must cover a core set of services and others are optional. The combination of mandatory and optional eligibility groups and services results in widespread variations among State Medicaid programs. Nursing facility care (for beneficiaries age 21 and older) and home health services are mandatory services.

Nursing home care is a mandatory service for SSI beneficiaries, but is optional for other applicants. Personal care, which helps tenants who need assistance with daily activities, is an

optional service. States that do not cover personal care under the State plan may cover it under a home and community-based services waiver program. States that do cover it under the State plan but with limitations may also cover it under a waiver to supplement the State plan service.

Q. What is PACE?

The Program of All-Inclusive Care for the Elderly (PACE) is a managed care program that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The PACE model was developed to address the needs of long-term care clients, providers, and payers. The comprehensive service package permits individuals to continue living at home while receiving services rather than be institutionalized. Participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing home care by the appropriate State agency. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees. There are currently 37 approved programs in 20 States.⁶

PACE can be an effective service partner for senior housing providers by offering on-site service capacity to allow tenants to live independently.

E. Home and community-based service waivers

CMS has the authority to approve coverage of services that support a person in the community who qualifies to be in an institution. States refer to waivers to describe services or a program of services that are not otherwise covered under Medicaid. While there are several waiver options, the most common home and community-based services waivers are authorized under Section 1915 (c) of the Social Security Act.

Medicaid waiver services are assigned to eligible beneficiaries or consumers rather than to providers. Waiver services are not project based. They may be limited in some states that do not have sufficient funds to serve all eligible applicants. Housing vouchers have similar characteristics. The majority of subsidized housing is paid through vouchers which, like waivers, are limited and assigned to the individual tenant rather than to the building.

Q. What is a home and community-based services waiver?

Home and community-based waiver services help individuals who are eligible for Medicaid who otherwise qualify to be admitted to an institution to live independently in the community. Federal regulations allow States to cover services that are not typically covered under the regular Medicaid program. The Secretary of Health and Human Services may approve additional

⁶ Information about PACE is available from the National PACE Association at <http://www.npaonline.org/website/article.asp?id=12>

services as long as they contribute to the support of individuals in the community. The cost of waiver services cannot exceed what the State would have spent in the absence of the waiver program.

The waiver authority also allows States to limit services to specific counties or regions of a State and to target services to certain groups – strategies that are not normally allowed under the regular Medicaid program. State Medicaid agencies must ensure that waiver programs have provisions to assure the health and welfare of participants. In addition, States must establish in advance how many people they will serve during the course of a year. Thus, unlike the regular Medicaid program, States may limit the number of beneficiaries who will be served and establish waiting lists for waiver programs when the number is reached.

Q. What services can be covered under a home and community based services waiver?

Home and community-based services waivers allow States to cover services that cannot be covered under the regular Medicaid program or optional services that the State has chosen not to cover under the regular Medicaid program. The services listed in statute include: case management services, homemaker/home health aide services, personal care services, adult day health services, habilitation services, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness. The statute also allows States to cover “such other services as the Secretary may approve.” Under this authority, CMS has approved home delivered meals, respite care, personal emergency response systems, environmental accessibility adaptations, and other services that are required to keep a person from being institutionalized.

Q. Who is eligible for waiver services?

In order to receive home and community-based waiver services, a person must meet the financial requirements for Medicaid in a group covered under the State plan. A State can elect to provide waiver services to any eligibility group or combination of groups (e.g., SSI, Medically Needy) in the State’s Medicaid plan. Groups covered under a waiver must use the same income and resource (asset) standards and methodologies as State plan groups.

States may cover individuals living in the community who would be financially eligible in an institution (hospital, nursing home, or Intermediate Care Facility for the Mentally Retarded) under the “special income level” option. This option allows States to serve individuals whose income is less than 300% of the federal SSI benefit. The federal SSI benefit standard is \$623 a month in 2007 and 300% equals \$1,869 a month.

Individuals must also meet the State’s medical (functional level) criteria for admission to a nursing home or other institution. Waivers are intended to substitute for institutional care and

may only serve beneficiaries who could be admitted to a nursing home if they applied or who live in a nursing home and want to move to the community. Medicaid nursing home admission criteria are set by each State and vary widely. They may be based on the need for medical services, assistance with activities of daily living (such as bathing, dressing, eating, getting to the toilet, mobility and continence) or the need for supervision because of dementia or cognitive impairments. Many States use a combination of these criteria.

Q. What are the differences between waiver and State plan services?

Medicaid State plan services can be viewed as the basic services covered by the State. HCBS waiver services are typically not allowed to be covered by the State plan or, in some instances, a State has chosen not to cover them. HCBS waivers and State plan services differ in several important ways. First, waiver services are available only to beneficiaries who meet the State's nursing home or other institution level of care criteria; that is, they would be eligible for Medicaid payments in a nursing home or other institution if they applied. Nursing home eligibility is not required for beneficiaries using State plan services.

Second, States may set limits on the number of beneficiaries that can be served through waiver programs through a process followed by CMS.

Perhaps the most significant difference between the two options is the ability under HCBS waivers to serve individuals who have more income than beneficiaries in the community as long as the State covers these beneficiaries in an institution. HCBS programs allow States to use the special income level, an optional eligibility category that allows States to set eligibility at up to 300 percent of the Federal Supplemental Security Income (SSI) benefit (\$1,869 in 2007). To cover beneficiaries through this option under the waiver, it must also be available to individuals in a nursing home. The higher eligibility standard in the waiver programs is designed to "level the playing field" between institutional and non-institutional services.

Table 1. Differences Between Medicaid State Plan and Waiver Services		
Issue	State Plan Service	1915(c) Waiver Services
Entitlement	States must provide services to all beneficiaries who qualify for Medicaid	States may limit spending for waiver services
Scope	Must be available in the same amount, scope, and duration to all beneficiaries across the State	May be limited to specific geographic areas or groups of beneficiaries
Duplication between HCBS and the State plan	Provided in accordance with State plan	May not duplicate services available in the plan; may have different limits, definitions, or providers than State plan services
Service Criteria	Must meet requirements of the State plan program to receive the service	Must meet the State's nursing home level-of-care criteria
Income	Must be SSI eligible or meet the State's community eligibility standard for Medicaid	State may set eligibility up to 300 percent (\$1,869) of the monthly federal SSI payment standard (\$623) ⁷
Approval Period	Continuous unless amended by the appropriate State agency	Initial waivers approved for 3 years; 5 years for renewals

Q. What are the criteria for admission to a nursing home?

The criteria are set by each State and therefore they vary considerably. The criteria are based on activities of daily living, medical conditions, and cognitive and behavioral factors.

Q. What are activities of daily living (ADLs)?

ADLs are self-care tasks. While there is some variation in the activities of daily living considered by States, the most common are: bathing, dressing, eating, toileting, transfer, and mobility/locomotion. Some States also consider continence. Instrumental activities of daily living are tasks that support daily living such as housekeeping, meal preparation, shopping, getting around outside the home, using the telephone, and money management.

⁷ As long as the State covers these individuals in an institution.

Q. Can the requirement that individuals must be eligible for admission to an institution be waived?

No, this requirement is specified in statute as a condition for States to provide waiver services as an alternative to institutional care and cannot be waived.

F. Questions about Medicaid and specific housing issues

Q. Can waiver slots be “project based?”

Waiver services are available to eligible individuals and cannot be assigned to providers. CMS requires that waiver participants have a choice of all qualified providers of the services covered under a waiver. Waiver services may be available statewide or in a limited geographic area of a State. Waivers can be limited to a single service such as assisted living. However, beneficiaries must be able to choose from all the assisted living providers that participate in the program. States may specify that a qualified provider means entities that are licensed under the State’s statute governing residential care settings.

Medicaid waiver services are provided to individuals and stay with the individual when they move. Medicaid funds cannot be assigned to providers.

Q. Can Medicaid pay for rent and meals?

Medicaid cannot pay for rent, utilities, or food. The statute does not allow States to pay for “room and board” under a waiver except in limited circumstances such as meals at an adult day care center or as part of a respite service. Since tenants in subsidized facilities typically pay 30% of the income for rent and utilities, they have income that may be available to pay for a meal program. The cost of the meal program may be reduced if the Medicaid waiver covers meal preparation, serving, and clean up and the tenant’s share pays for the food itself.

Stakeholders sometimes express support for covering room and board in non-institutional settings under Medicaid. However, SSI is more appropriate than Medicaid as the source of support for room and board for beneficiaries whose income is below the SSI payment standard. Further, covering room and board would shift costs from the federal SSI program to Medicaid which requires a State match. Many Medicaid beneficiaries receive social security or income from other sources which is applied to the cost of their care in a nursing home. Those funds are available to the individual to pay for room and board in the community.

Q. If a person enters a nursing home, can they still pay their rent?

Yes, federal regulations allow States to exempt income that is needed to pay for maintaining a home or apartment for not more than six months as long as a physician certifies that the person is expected to return home.

Q. Are services provided by staff to assist individuals locating and maintaining housing reimbursable under Medicaid?

Yes, new regulations defining case management and the scope of activities were published in the Federal Register December 6, 2007. Case management is defined as “services which will assist individuals, eligible under the plan, in gaining access to needed medical, social, educational and other services.” Case management activities – finding affordable, accessible housing, negotiating a lease, mediating conflicts with a landlord, etc. – are also referred to as care management, care coordination, systems navigation or other terms. Case management services are often used to foster the transitioning of a person from institutional care to a more integrated setting or to help maintain a person in the community. Case managers must complete a comprehensive assessment, develop a care plan, refer individuals to needed programs and services, monitor the care plan and follow and make revisions as needed.

Q. Are expenses associated with finding new housing reimbursed by Medicaid?

Yes, Medicaid can pay for transition services such as moving expenses and setting up a household (furnishing, household supplies, etc.). States have the option to cover transition services as an HCBS waiver service for Medicaid beneficiaries who move from an institution to the community. A State Medicaid Directors Letter issued by CMS in 2002⁸ allows States to pay the reasonable costs of community transition services, including some or all of the following components:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential furnishings and moving expenses required to occupy and use a community domicile;
- Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating); and
- Health and safety assurances, such as pest eradication, allergen control, or one-time cleaning prior to occupancy.

The SMD letter states that reasonable costs means “necessary expenses in the judgment of the State for an individual to establish his or her basic living arrangement. For example, essential furnishings in the above context would refer to necessary items for an individual to establish his

⁸ SMD #02-008 May 9, 2002. Available at <http://www.cms.hhs.gov/smdl/downloads/smd050902a.pdf>

or her basic living arrangement, such as a bed, a table, chairs, window blinds, eating utensils, and food preparation items.” In general, CMS does not consider essential furnishings to include diversional or recreational items such as televisions, cable TV access or VCRs. States typically set limits on the amount of funding that will be available to pay for the costs of setting up a household.

Q. Can Medicaid pay for medical equipment or assistive technology?

A July 2003 letter from CMS to State Medicaid Directors⁹ described when waivers can pay for transitioning residents’ medical equipment, and provided additional suggestions for making equipment available to people leaving institutions:

Individuals seeking to move to the community from institutions often require medical equipment for their personal use. In the community, medical equipment is a mandatory component of the home health benefit under the State Plan. Federal regulations do not define medical equipment and, each State decides which equipment will be covered. Those adaptive aids and communication devices that are not covered under a State Plan can often be covered under Medicaid home and community-based services waiver.

Purchases of medical equipment are typically made after the individual has moved into the community. However, the delay in receiving and adapting to such equipment often causes hardships for the individual and/or caregiver(s). The delay may also introduce unnecessary hazards into the transition and the first few weeks of community dwelling. In addition, the equipment is most effectively employed if it is obtained prior to institutional discharge and tested with the individual to ensure proper fit, use, adaptability to individual requirements, and appropriateness for the particular community environment to which the person will move. We further appreciate that it may take time, prior to discharge, to make unique accommodations to the equipment or to afford the individual reasonable opportunity to learn to use the equipment and become as independent and proficient in its use as possible.

The SMD letter allows States to use a waiver to pay for equipment that is purchased within 60 days of a scheduled transition. For billing purposes, the date of service is the date the person moves and enrolls in the waiver. A state cannot use a waiver to pay for the equipment if the person does not move to the community or enroll in the waiver. Under these circumstances, the medical equipment can be billed as a Medicaid administrative expenditure.

Medicaid equipment for individuals who plan to move may be covered as part of the payment to the institution. Arrangements can be made with providers to make the equipment available for a trial period. Including items in institutional reimbursement, as Pennsylvania does with its Exceptional Durable Medical Equipment payment, may give facilities an incentive to purchase items that benefit only a few residents, or that a resident would want to keep if he or she leaves

⁹ SMD Letter #03-006, July 14, 2003. Available at <http://www.cms.hhs.gov/smdl/downloads/smd071403.pdf>

the facility. Some facilities transfer the title for equipment to a transitioning resident when he or she moves.¹⁰

Q. What are environmental modifications?

A report by Abt Associates for the Office of the Assistant Secretary for Planning and Evaluation describes home modifications as:

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.¹¹

A letter to State Medicaid Directors from CMS, issued July 2000 describes how States may address home modifications through home and community-based services waiver programs.

Environmental modifications may be necessary to make environmental modifications to an individual's home before an individual moves from an institution to the community. For example, a wheelchair ramp may need to be built and doors may need to be widened to permit the individual to access his/her home.

Q. What are the requirements for these services?

These services are covered by most home and community-based services waiver programs serving elders, adults with physical disabilities, and individuals with mental retardation or developmental disabilities. Some waiver programs for individuals with traumatic brain injuries and HIV/AIDS also cover them.

Requirements for approving assistive technology and home modifications vary widely. States may require that the service is approved by a case manager, a physician, or another health professional. Most States require that the service must meet the definition of medical necessity. Most States also require prior authorization before the service is delivered. The Abt report found that about half the States require bids for the equipment or service.

¹⁰ CMS. State Medicaid Directors letter #03-006. Available at:
<https://www.cms.hhs.gov/smdl/downloads/smd071403.pdf>

¹¹ Terry Moore and Beth O'Connell. Compendium of Home Modification and Assistive Technology Policy and Practice Across States. Abt Associates Inc., October 27, 2006. Available at:
<http://aspe.hhs.gov/daltcp/reports/2006/HM-AT.pdf>

The amount of Medicaid waiver funds that may be spent on assistive technology or home modifications may be set as a lifetime limit (for example, Arkansas, Georgia, Iowa, Kansas), an annual limit (Alabama, Iowa, New Mexico, Virginia), a limit that may extend over multiple years (Alaska, Florida, Illinois, Oklahoma), or an annual limit for all waiver participants (Montana, Tennessee).

Q. Are these costs reimbursable if done before an eligible person moves in to the unit?

Yes, the individual does not have to be a current leaseholder; however, home modifications begun while the person is institutionalized are not considered complete until the date the individual leaves the institution and is enrolled in the waiver. A State may claim reimbursement for home modifications (including actual construction costs) furnished as a waiver service for up to 180 days prior to discharge when

- The modifications have been initiated before the individual leaves the institution and enrolls in HCBS waiver,
- Home modifications are included in the approved HCBS waiver. The claim for federal reimbursement must indicate the date the individual leaves the institution and enrolls in the waiver as the date of service for allowable expenses incurred during the previous 180 days.

CMS allows States to claim reimbursement for assessments and modifications as an administrative expense if the individual died before their transition to the community or their enrollment in a home and community-based services waiver program if the person has:

- Applied for waiver services,
- Was found eligible for the waiver by the State when the transition was planned to occur, but
- Died before the actual delivery of the waiver services.

Instructions for completing the waiver application state that:

- Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
- When the State authorizes home accessibility modifications up to 180 consecutive days of admission in advance of the community transition of an institutionalized person, the definition should reflect that provision has been made for such modifications. In such cases, the home modification begun while the person was institutionalized is not considered complete, and may not be billed, until the date the individual leaves the institution and enters the waiver.

Q. Can Medicaid cover the costs for determining whether an apartment is accessible?

Yes, environmental modifications are important to help individuals live in the most integrated setting. A State may assess the accessibility and need for modification in a person's home or vehicle at any time. Federal reimbursement for the cost of the assessed may be obtained in three ways:

- **Administrative Expense:** Reimbursement may be claimed at the administrative rate for assessments to determine whether the person's home or vehicle may require modifications to ensure the health and welfare of the HCBS waiver participant;
- **Included in Environmental Modifications:** The cost of environmental assessment may be included in the cost of environmental modification under an HCBS waiver; or
- **Included as part of another service:** The assessment may be performed by another service provider, such as a home health agency or an occupational therapist.

Q. Are other funds available to assist with these costs? If so, what are the sources?

Funds for assistive technology and home modifications may be available through State Vocational Rehabilitation Agencies. A report by the Long Care Term National Resource Center identified 300 nonprofit programs that make home modifications and repairs.¹² The programs tend to be small and serve, on average, about 240 clients per year with an annual budget of \$268,000. Budgets range from zero for programs using donated labor and materials to several million dollars for programs involved in major rehabilitation or weatherization. On the average, about half of all program budgets are spent on repairs, with the remaining money split fairly evenly among modifications, safety/security, and upkeep/weatherization services. Most of these programs are part of larger organizations, such as community action and weatherization agencies, and city and county governments. In addition to Medicaid, programs that pay for home or environmental modifications include the Community Development and Social Service Block Grants, the Farmer's Home Administration, and the Older Americans Act, providing funds for ramps, security (e.g., new locks), and a variety of general repairs. These programs operate on a loan, sliding fee, or grant basis. Some programs provide free labor if the client pays for materials.

A report by the Minnesota Housing Finance Agency described a range of national and State sources of support for home modifications.¹³ Nebraska created an assistive technology partnership to help individuals with disabilities adapt their environment.¹⁴

¹² Jon Pynoos. <http://www.homemods.org/library/pages/strategies.html>.

¹³ Available at: http://www.mhfa.State.mn.us/homes/Access_Financing_Grid.pdf.

¹⁴ Available at: http://www.hcbs.org/files/105/5245/Nebraska_Case_Study_Final.pdf

Q. Are these costs reimbursable while the person is living in the unit if it is owned by a public housing authority?

CMS policy does not allow modifications to be covered in buildings owned by providers. CMS also does not currently allow modifications under HCBS waivers in housing that is considered “public housing.” CMS policy concerning the units that would be covered is under review.

Q. What about if the unit is owned by another entity that received public development subsidies?

This issue is being reviewed by CMS.

Q. What about if the unit is owned/leased by a private landlord that is receiving rental assistance through a government agency?

This issue is being reviewed by CMS.

Q. If repairs/modifications are made to a unit, who is responsible for finding a contractor and managing the work?

If the modifications are covered under a home and community-based services waiver, the individual Medicaid beneficiary, his/her representative, or housing manager would contact the Medicaid HCBS waiver case manager to arrange an assessment and to review the contractors that are available to perform the work. The case manager will know what is covered and the maximum amount that may be approved for the work. With support from the case manager, the individual selects the contractor.

Q. If the individual is responsible for finding a contractor, is technical assistance available to help with this process?

Individuals can receive information and assistance from a Medicaid HCBS waiver care coordinator about the contractors available to provide home modifications. Medicaid beneficiaries who direct their own care may access a “support broker” to receive help.

Q. How long does it generally take for a contractor to get paid for repairs/modifications using Medicaid dollars?

Payment cycles may vary depending on who is responsible for managing the service. Bills submitted directly to Medicaid or a State agency may take longer than bills that can be paid by an organization that contracts with a State agency to authorize, manage, and pay for waiver services. Most contracted organizations would have sufficient cash flow to pay the home modification contractor before receiving payment from the State.