

**SENIOR BULLETIN: MEDICAID – INSTITUTIONAL/COPEs**

**New in-home program to begin for people  
not eligible for COPEs due to income**

Some people who want care in their own homes, and who would be eligible for COPEs<sup>1</sup> except that their monthly incomes exceed the current COPEs limit of \$1,652, may soon be able to get the care they want and need. Currently, these individuals – classified as “medically needy” – are eligible for Medicaid-funded nursing home care, and for some other options. But they must leave their homes to get publicly funded help with long-term care. An in-home alternative for people classified as “medically needy” is expected to be available by June 1<sup>st</sup>.

**The current “Medically Needy Residential Waiver” program**

In March of 2003, the Department of Social & Health Services began to offer some options to medically needy clients who need nursing home level of care: it offered services in “community residential” settings (adult family homes, assisted living facilities and enhanced adult residential care facilities), similar to those available under the COPEs program. The new options were provided under terms approved by the federal Centers for Medicare & Medicaid Services (CMS) in what is referred to as a “waiver.”<sup>2</sup> (The COPEs program is also based on a waiver.) The waiver allowed the Department to implement what is called the “Medically Needy Residential Waiver” (or “MNRW”) program.<sup>3</sup>

The MNRW program rules do not provide protection for the income and resources of a non-applicant spouse that are comparable to those provided under the COPEs program. However, significant protection of spousal income and resources can be achieved under current rules, if the MNRW application is not made until the calendar month following the month in which the applicant enters a community residential facility.<sup>4</sup>

Conspicuously, the MNRW program did not offer in-home care. So, medically needy clients in need of long-term care could still get state help only on the condition that they leave home.

## **The planned new in-home care program**

Now the Department is on the verge of offering an in-home alternative to nursing-home care for some medically needy clients. Funding for this previously missing piece in the State's long-term care offerings was contained in the 2004 supplemental budget adopted by the Legislature. At this writing, it is awaiting the Governor's signature. DSHS Aging & Disability Services Administration staff is working toward implementation of services in May.<sup>5</sup>

The conditions under which in-home services are offered to medically needy clients are expected to differ from those applicable to COPES clients in some important respects. One important difference is that the new program will not include the protections for spouses – in particular, it will not include the spousal resource allocation at time of application (currently between \$40,000 and \$92,760) or the income allocation for a community spouse (currently between \$1,515 and \$2,319). Consequently, the new program is not likely to work for married people. The spousal protection provisions are not included in the new program because the federal Centers for Medicare and Medicaid Services would not approve the Department's request to include them. Federal approval is required for the implementation of the new program.

Financial eligibility requirements for the new program are expected to be similar to those for the non-institutional medically needy program (often called the "spenddown" program). An otherwise eligible individual must have no more than \$2,000 of non-exempt resources, and countable income in excess of a monthly personal needs allowance of \$571 will need to be offset by corresponding medical expenses. The expenses may include the following:

- Medicare and other health insurance premiums, deductibles, coinsurance charges, enrollment fees, or copayments
- medical expenses potentially covered by Medicaid, which have been paid by the applying person during the base period, or
- other medical expenses, whether or not potentially covered by Medicaid, incurred within the base period or before, provided that (1) they are not subject to third-party payment, (2) they have not been used to satisfy a previous spend-down liability, (3) they have not been used to reduce excess resources and (4) they remain the liability of the client.

The move to offer in-home services to medically needy individuals otherwise eligible for Medicaid-funded nursing home care had significant public support. A coalition of 27 professional, religious, labor and other

public interest groups issued a joint statement last year calling for such a move.<sup>6</sup> At the same time, in making it, legislative and executive branch leaders responded to the likelihood that failure to offer these services voluntarily would likely have led to a court order requiring them.

### **The Townsend v. Quasim decision**

In May of 2003, in the case of *Townsend v. Quasim*, 328 F.3d 511, the United States Court of Appeals for the Ninth Circuit sent a pointed message. It considered the application of the Americans with Disabilities Act to the long-term care services offered to Washington residents in the medically needy category. Applying what it characterized as “the ADA’s integration mandate,” the court held that so long as nursing home care is offered to such residents, other alternatives must be offered as well, unless the State can show that to offer them would fundamentally alter the nature of the services provided. Significantly, the court rejected the argument that providing services in a different setting – at home instead of in a nursing home, for example – would itself amount to a fundamental alteration.

The appellate court sent the case back to the federal district court in Seattle to give the State an opportunity to establish a fundamental alteration defense. To do so, it would have to show that offering alternative services to medically needy clients would result in an inequitable distribution of funding for long-term care.<sup>7</sup> Since the average net cost per client of providing such care to medically needy clients would be expected to be lower than the average net cost for other clients, it is not obvious how the State could make such a showing.<sup>8</sup>

In January of this year, lawyers for the Department of Social & Health Services and the lawyers for the *Townsend* class (Kay Frank and Andrea Brenneke of MacDonald, Hoague & Bayless in Seattle) jointly asked the district court to stay proceedings in the case until June, with the Department undertaking to seek legislative and CMS approval for an in-home waiver program. If such a program is started by June 1<sup>st</sup>, the case would then be stayed for another two years, unless either party requests a lifting of the stay.<sup>9</sup> Funding for the in-home program was included in the Governor’s proposed supplemental budget, with a reference to the “*Townsend* settlement,” and in the final budget passed by the Legislature and sent to the Governor.

Two years ago, individuals who needed long-term care and who were classified as “medically needy” were given only one publicly funded

option – nursing home care. With the introduction of community residential options in 2003, and the promise of an in-home option this year, significant progress has been made.

#### Endnotes:

<sup>1</sup> The COPES program provides alternatives for people who need the level of care provided in a nursing home. It covers in-home services and services in “community residential” settings – adult family homes, assisted living facilities and enhanced adult residential care facilities. Unlike the Medicaid rules governing Medicaid for nursing home care, the COPES rules deny coverage to any individual with gross income above \$1,692 (300% of the 2004 federal Supplemental Security benefit rate).

<sup>2</sup> Waivers are authorized under 42 U.S.C. § 1396n.

<sup>3</sup> The Medically Needy Residential Waiver program was described in a February 2003 CLS Senior Bulletin entitled “New program to begin for individuals above the COPES income cap.” It is posted on the Northwest Justice Project web site at the following address:

[http://www.nwjustice.org/law\\_center/pdf/senior\\_bulletins/2-18-03.pdf](http://www.nwjustice.org/law_center/pdf/senior_bulletins/2-18-03.pdf)

See also WAC 388-515-1540 (Medically Needy Residential Waiver Program):

<http://www.leg.wa.gov/wac/index.cfm?fuseaction=Section&Section=388-515-1540>.

<sup>4</sup> For such an application, only the income and resources of the applicant, plus half of any community resources, would be considered available to the applicant. This point was not obvious when the MNRW program was first announced. The basic rule governing the program is WAC 388-515-1540. It provides, in subsection (2), that “[t]he department determines a client's nonexcluded resources under MNRW as described in WAC 388-513-1350 (1) through (4)(a) and WAC 388-513-1360 . . . .” Proceeding to WAC 388-513-1350(3), we learn that “[t]he department applies the following rules when determining available resources for LTC services: . . . (d) WAC 388-506-0620, SSI-related medical clients.” Finally, WAC 388-506-0620(5) provides as follows: “The department shall consider income and resources separately as of the first day of the month following the month of separation when spouses stop living together because of placement into a congregate care facility (CCF), adult family home (AFH), adult residential rehabilitation center/adult residential treatment facility (ARRC/ARTF), or division of developmental disability-group home (DDD-GH) facility when: (a) Only one spouse enters the facility; (b) Both spouses enter the same facility but have separate rooms; or (c) Both spouses enter separate facilities.”

<sup>5</sup> In 2001, legislation was adopted that authorized the Department to provide both community residential and in-home services for medically needy clients otherwise eligible for Medicaid-funded nursing home care. The legislation (SHB 1341, now codified in RCW 74.39.041) granted this authority subject to budget conditions and federal approval. Budget bills in 2002 and 2003 prevented the Department from

implementing an in-home program. The 2004 supplemental budget adopted by the Legislature limits the in-home program to an active caseload of 200 at any one time. The corresponding caseload limit for the MNRW program is 600. One year into its operation, the caseload has stayed well within that limit.

<sup>6</sup> They included the following organizations:

- AARP Washington
- Advisory Council, Aging & Disability Services, Seattle-King County
- Alzheimer's Association, Western and Central WA State Chapter
- Alzheimer Society of Washington
- Catholic Community Services of Western Washington
- Elder Law Section, Washington State Bar Association
- Home Care Association of Washington
- King County Bar Association
- Lutheran Public Policy Office of Washington State
- National Academy of Elder Law Attorneys, Washington Chapter
- Northwest Health Law Advocates
- Older Women's League, Seattle-King County Chapter
- Project PAS-Port for Change
- Puget Sound Alliance for Retired Americans
- Resident Councils of Washington
- Retired Public Employees Council of Washington
- SEIU Local 775
- Senior Services of Seattle/King County
- Southwest Washington Agency on Aging Advisory Council
- Washington Association of Area Agencies on Aging
- Washington Occupational Therapy Association
- Washington Protection & Advocacy System
- Washington State Association of Home Care Services
- Washington State Catholic Conference
- Washington State Council on Aging
- Washington State Long-Term Care Ombudsman Program
- Washington State Senior Citizens' Lobby

<sup>7</sup> See *Olmstead v. L.C.*, 527 U.S. 581, 119 S.Ct. 2176, 144 L.Ed.2d 540 (1999).

<sup>8</sup> Medically needy clients (that is clients with monthly income of \$1,693 or more) have more income than categorically needy clients (who by definition have \$1,692 or less). Consequently, they would on average be required to contribute more toward the cost of their care, with the State paying correspondingly less.

<sup>9</sup> There are remaining issues that might be addressed in the *Townsend* case. They include the extent to which the ADA requires the State to provide comparable protections for spousal income and resources regardless of whether a medically needy client is provided long-term care in a nursing home or another setting. (Conditioning care in a more integrated setting on acceptance of much less favorable treatment for one's spouse imposes a substantial burden on the federally protected right to choose such care.)