

SENIOR BULLETIN: MEDICAID – INSTITUTIONAL/COPEs

**New program to begin for individuals
above the COPEs income cap**

The COPEs program provides an alternative for individuals who need the level of care provided in a nursing home. It covers in-home services and services in adult family homes (AFH), assisted living (AL) facilities and enhanced adult residential care (EARC) facilities. Unlike the Medicaid rules governing Medicaid for nursing home care, the COPEs rules deny coverage to any individual with gross income above 300% of the federal Supplemental Security benefit rate (currently \$1,656). In Medicaid jargon, people in need of long-term care with income above this amount are termed “medically needy,” in contrast to those with lower incomes, who are termed “categorically needy.”

Under a rule adopted by the Department of Social and Health Services on February 6, 2003, “residential” services similar to those available under COPEs for care in AFH, AL and EARC settings (but not in-home care) will be available to some individuals who are excluded from COPEs by the income cap.¹ The effective date of the rule is March 17th. The new program is called the Medically Needy Residential Waiver (MNRW) Program.²

The MNRW program differs from COPEs in some important respects. It does not include the protections for spouses – in particular, it does not include the spousal resource allocation at time of application (currently \$90,660) or the income allocation for a community spouse (currently between \$1,493 and \$2,267). Consequently, according to a Home & Community Services Division publication, the new program “is not financially beneficial to most married people.” (The spousal protection provisions are not included in the new program because the federal Centers for Medicare and Medicaid Services [CMS] has refused to approve their inclusion. CMS approval was required for the implementation of the new program.)

Financial eligibility calculations for the MNRW program are 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 \$571 a month must be offset by corresponding medical expenses. The expenses may include the following:

- the “department established cost of care” (i.e., the department rate) in an AFH, AL or EARC facility
- Medicare and other health insurance premiums, deductibles, coinsurance charges, enrollment fees, or copayments
- medical expenses potentially covered by MNRW, which have been paid by the applying person during the base period, or
- other medical expenses, whether or not potentially covered by MNRW, incurred within the base period or before, provided that they are not subject to third-party payment, have not been used to satisfy a previous spend-down liability, have not been used to reduce excess resources and remain the liability of the client.

Except for the spousal allowance provisions, income of individuals eligible under MNRW is allocated in a manner comparable to the allocations used in the COPES program (including, for example, a \$58.84 personal needs allowance).

The legislative authorization for the new program allows for a maximum active caseload of 600, and applications will be accepted on a first-come first-served basis.³ It remains to be seen whether demand will exceed the caseload limit.

The Department expects that the MNW program will produce some savings. This assumes that a significant number of individuals using the program will be relocating from nursing homes (where the care is more expensive).⁴

The 2001 legislation that originally authorized the new program, SHB 1341, also contemplated a parallel program for in-home care. Implementation of that program was blocked by a provision in the 2002 budget bill. Budget writers associated a \$1.5 million dollar savings with the decision to block implementation of an in-home services program for the medically needy. That savings projection appears to have been based on an assumption that most medically needy individuals denied in-home services would decline care for which they would be eligible in a nursing home or in another residential setting. The assumption may well be wrong. If it is wrong, withholding the option of in-home care could result in an increase rather than a saving. Similarly, precluding the option of in-home care may mean that some current nursing home residents on Medicaid who would have opted for in-home services will not opt for, or not be able to arrange, an alternative to continued nursing home care.⁵ At

this point, further action by the Legislature is needed to allow for full implementation of SHB 1341.

Endnotes:

¹ The rule, WAC 388-515-1540 (Medically Needy Residential Waiver [MNRW] Program), was adopted on an emergency basis. The rule making order appears on the Department's web site at the following address:

<http://www.dshs.wa.gov/dockets/10332053196E.html>.

² It is called a "waiver" program because it required approval from the federal Centers for Medicare and Medicaid Services. The approval was in the form of a waiver authorized under 42 U.S.C. § 1396n.

³ The 600 active caseload limit is effective through the end of June 2003. The limit after that depends on the action of the Legislature in the 2003 Session.

⁴ The Department's rule making order of February 6, 2003, contains the following observations in the section justifying immediate adoption of the rule: "This new program will allow individuals who cannot afford community residential care and who do not wish to go into a nursing facility, access to long-term care that they could otherwise not afford. For the past two years, many individuals in Washington State have gone into nursing facilities because they had no other choice for receiving care. Not only did this eliminate client choice, but it cost the state more to care for these individuals."

⁵ For some years, AASA staff have searched for a way to project the numbers of medically needy individuals, not currently receiving long-term care services, who would apply for COPES-like services if those services were offered to them. They had little success. The legislation approved in 2000 (SHB 1341) promised to provide some data with risk limited by the limited numbers of participants permitted under the legislation. Even an in-home program with a very small numerical limit on participants (coupled with the collection of data from individuals placed on a waiting list, if necessary) would give program planners a basis for making more informed judgments, rather than guesses, in the future.