



SMD# 15-001
ACA# 32

May 07, 2015

**Re: Affordable Care Act's Amendments
to the Spousal Impoverishment Statute**

Dear State Medicaid Director:

This letter provides guidance to states on implementation of section 2404 of the Affordable Care Act which amended section 1924 of the Social Security Act (the Act) ("Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment").

Background

Section 1924 of the Act requires the use of special financial eligibility rules, generally referred to as the "spousal impoverishment" rules, for certain married Medicaid applicants and beneficiaries who need or receive long-term services and supports (LTSS). Prior to enactment of section 1924, married individuals requiring Medicaid-covered LTSS were commonly faced with either forgoing services or leaving the spouse still living at home with little income or resources. The spousal provisions were enacted in 1988 to address this issue. In determining the eligibility of married applicants for Medicaid coverage of care in a medical institution, nursing facility or, at state option, home and community-based services provided under section 1915 waivers, states were required to exclude a certain share of the couple's income and resources.¹ Section 2404 of the Affordable Care Act amended section 1924, for the five-year period beginning January 1, 2014, to require states to apply the spousal impoverishment rules to additional individuals receiving LTSS. This guidance describes how states would apply the statute in making Medicaid eligibility determinations.

Definition of an Institutionalized Spouse

The spousal rules apply to married individuals who meet the definition of an "institutionalized spouse" in section 1924(h) (1). Prior to the Affordable Care Act, states were required to include in this definition all married individuals actually in institutions, and had the option to include individuals described in section 1902(a)(10)(A)(ii)(VI) of the Act, referred to as the "217" category,² which is composed of individuals who, in the absence of home and community-based

¹ For the 2015 standards, see <http://medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-ssi-and-spousal-impoverishment-standards.pdf>.

² The reference is based on its regulatory citation, 42 C.F.R. §435.217

services provided through a 1915 waiver, would require care in an institutional setting and who would generally not qualify for Medicaid under other categories.

The Affordable Care Act amended section 1924(h)(1) to *require*, for the five-year period beginning January 1, 2014, that states include in the definition of an “institutionalized spouse” married individuals who are “eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who [are] eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k). . . .”

The new definition eliminates the discrete reference to the 217 category and applies to all married individuals eligible for home and community-based services (HCBS) delivered through 1915(c) waivers, 1915(i) or (k) state plan benefits, or section 1115 waivers who are married to a spouse who is not in a medical institution or nursing facility.³ Also included are those who qualify through a spend down, either as medically needy or categorically needy in a 209(b) state. This expanded definition (hereafter “new definition”) means that states must apply the spousal rules to Medicaid applicants who historically have not had their eligibility determined under these rules.

Individuals eligible for 1915(c), (i) and (k) Services

As a result of the new definition, section 1924(a) (1) requires states to apply the spousal impoverishment rules in determining eligibility for married Medicaid applicants who are eligible for services under 1915(c), (i) or (k), are married to a spouse who is not in a medical institution or nursing facility and are likely to require such services for at least 30 consecutive days. For married individuals who may meet the eligibility requirements for a category to which 1915(i) or (k) benefits are available in the state, or which is included in an approved 1915(c) waiver, we interpret the statute to result in application of the spousal eligibility rules to those who meet the coverage requirements for such services. Thus, the state would determine Medicaid eligibility and also make an assessment that the applicant satisfies other criteria for receipt of services under 1915(c), (i) or (k).

For example, a married Medicaid applicant receives Social Security Disability Insurance (SSDI) benefits (and not Supplemental Security Income). The only non-institutional optional category covered in the state plan that includes people with disabilities is the “aged and disabled” (A/D) poverty level category (authorized under section 1902(a)(10)(A)(ii)(X) of the Act). The state has included the A/D poverty level category in an approved 1915(c) waiver, and the individual requests HCBS at application. The state would evaluate the individual’s eligibility for the A/D category using the spousal eligibility rules if the individual meets the criteria for the waiver. Applying spousal eligibility rules would mean counting only the applicant’s income and

³ The new definition includes HCBS provided under section 1915(d) waivers. As we noted in our final regulation on HCBS waivers and state plan benefits, no state presently operates a section 1915(d) waiver. See 79 Fed. Reg. 2948, 2956. (January 16, 2014). For brevity, references to section 1915(d) are therefore omitted.

comparing that income to a household of one for income eligibility for the category, and removing the community spouse’s resource allowance (CSRA) from the total combined resources of the spouses in the individual’s resource eligibility determination. Similarly, if the same applicant could not receive 1915(c) services because the applicant does not meet the targeting criteria for a 1915(c) waiver operating in the state, but is eligible for an approved 1915(i) benefit available under the state plan, spousal eligibility rules would apply to the applicant’s eligibility determination. In either case, the individual would be enrolled in the A/D poverty level category if eligible using spousal eligibility rules, *provided* that the individual is determined to need the relevant HCBS as part of the underlying eligibility determination. Eligibility for the HCBS described in the new definition is the basis for using spousal eligibility rules. (See below the discussion on “Determining Eligibility for HCBS.”)

The new definition of an institutionalized spouse also specifically includes married individuals eligible for HCBS by reason of section 1902(a)(10)(C) (medically needy), or through a spend down in a 209(b) state.⁴ Thus, such married individuals with income above the threshold for any optional state plan categories in a state that covers the medically needy, or above the categorically needy standard in a 209(b) state, should be permitted the option to spend down to qualify, and the community spouse’s income and community spouse’s resource allowance (CSRA) would not be deemed available to the individual for the purpose of spend down.

For example, if the married applicant is determined, based on the separation of income mandated by the spousal eligibility rules, to have income above the poverty level and the state covers the medically needy, the statute requires that the individual be permitted to spend down to the state’s medically needy income level (MNIL), based on the difference between the individual’s income and the MNIL for a one-person household. In addition, no part of the CSRA would be deemed available to the individual in the resource eligibility determination. If the individual qualifies on this basis, the individual would be eligible for coverage of all services provided under the state plan to his or her medically needy group.

Determining Eligibility for HCBS

As described above, an individual must be eligible for HCBS provided under specified sections of the statute for the spousal eligibility rules to apply. We interpret this to mean that an individual who would meet the nonfinancial eligibility requirements for any new HCBS referenced in the new definition that is covered in the state would be “eligible for medical assistance for home and community-based services . . .” within the meaning of the statute. This means that a state would determine a married applicant’s need for the relevant HCBS within the underlying Medicaid eligibility process in order to determine if spousal eligibility rules apply.

The determination of need for HCBS would be triggered when a married applicant requests HCBS coverage offered under the state plan. States should permit applicants a method of requesting such HCBS coverage. This could be done through a supplemental form that asks applicants if they need HCBS, or a process whereby written or verbal requests for HCBS are

⁴ Under section 1902(f) of the Act, and 42 C.F.R. §435.121, 209(b) states must permit individuals applying for Medicaid on the basis of being aged, blind or disabled to reduce their available income by incurred medical expenses, even if the state does not provide medically needy coverage to these groups.

acknowledged and used to determine whether spousal impoverishment rules should apply. The single streamlined application contains a question regarding whether an applicant has any health conditions that cause limitations in activities, and many states have questions in their non-modified adjusted gross income (MAGI) applications that solicit information from applicants on whether they need assistance with activities of daily living. Affirmative answers to these questions by married applicants would be the most practical basis for proceeding to evaluate whether the applicants meet the criteria for the relevant HCBS.

States would perform the evaluation of the need for HCBS with respect to the services for which an applicant may be eligible under the state plan or the state's approved waivers. For example, where a state covers 1915(i) services and operates a 1915(c) waiver, and a married applicant who indicates a need for HCBS does not meet the targeting criteria for the state's 1915(i) benefit, the state would limit its HCBS assessment to whether the individual meets the waiver's clinical standard (assuming the individual meets the targeting criteria for the waiver).

Importantly, for those eligible through use of the spousal eligibility rules based on their need for HCBS, the statute does not require that they actually receive the HCBS for which they are eligible. While the discrete HCBS-related eligibility categories—the 217 category and the 1915(i)-related category described in section 1902(a)(10)(A)(ii)(XXII)—generally impose actual receipt of 1915(c) or (i) services as an eligibility condition, the new definition explicitly applies to individuals “eligible for” the relevant HCBS.

For example, where an applicant meets the financial eligibility requirements for the A/D poverty level category by application of spousal eligibility rules based on meeting a 1915(c) clinical standard (as in one of the examples described above), the individual would be enrolled in the A/D poverty level category even if the individual will not receive 1915(c) services upon enrollment because there is a waiting list for the waiver. If, however, an individual who is eligible under spousal eligibility rules based on a need for HCBS is later determined not to meet the coverage requirements for 1915(c), (i) or (k) services, the individual's financial eligibility would be re-determined using the standard methodology that applies to the category in which the individual is enrolled.

Alternatively, however, because states are generally required in the application process to collect information on the income and, where applicable, resources of a Medicaid applicant's spouse, regardless of whether spousal eligibility rules are applied, the state may enroll the individual without screening the applicant's need for HCBS if it can determine that a married applicant potentially in need of HCBS is eligible for Medicaid even if the spouse's income and resources are deemed available.

Application of Spousal Rules to Section 1115 Waivers

As mentioned above, the new statutory definition of an institutionalized spouse includes individuals eligible to receive HCBS under a section 1115 waiver. The provision does not specifically define the type of HCBS for which a married section 1115 applicant must be eligible. In each of the other HCBS examples identified in the new definition—1915(c), (i) and (k)—an eligible individual who meets the nonfinancial requirements for coverage is potentially

eligible for a multiple-service HCBS package. In the context of section 1915(c) waivers and the 1915(k) benefit, an individual is only eligible for the coverage if he or she would otherwise be institutionalized in the absence of the HCBS.

We interpret the statute's reference to HCBS provided under a section 1115 waiver to apply to HCBS in which: a) an individual who meets a clinical eligibility standard is potentially eligible for a multi-service benefit package of the type authorized under 1915(c), (i), or (k); or b) an individual is eligible for coverage of a service or services of the type provided under 1915(c), (i) or (k) where the individual demonstrates that, in the absence of such service(s), the individual would otherwise require the level of care provided in an institution. In either case, where a married individual is seeking coverage for such HCBS under a section 1115 waiver and is subject to an income and asset test, the spousal eligibility rules would apply. The applicant's need for HCBS would be determined in the eligibility process in the same manner described above.

Section 1924 and the Post-eligibility Treatment of Income

Section 1924 imposes both eligibility and post-eligibility rules. The post-eligibility rules, or post-eligibility treatment-of-income (PETI) rules, require that a state Medicaid agency's payment for institutional and HCBS waiver services be reduced by the amount of available income a beneficiary has after certain deductions are made. Required deductions include a personal needs allowance, an amount for the maintenance needs of the individual's spouse and family, and certain other deductions.⁵ Under these regulations, when spousal rules apply to individuals subject to PETI, the amount deducted from the beneficiary's income for the community spouse and family must be determined based in accordance with the formula mandated by section 1924(d).

These regulations apply only to HCBS waiver enrollees eligible under the 217 category.⁶ By virtue of the new statutory definition, for married individuals who are enrolled in the 217 category, states are required to deduct in the PETI determination, for the maintenance needs of a community spouse and family members, the amounts required under section 1924(d). Additionally, for all section 1115 waiver participants who are subject to PETI rules, all married individuals must have the deductions for the community spouse and family members calculated under section 1924(d).

For all other individuals whose eligibility is determined using the spousal rules of section 1924 on the basis of the new definition of an institutionalized spouse, section 1924's PETI rules will not be applied because these individuals are not subject to PETI rules.

The New Definition of an "Institutionalized Spouse" and MAGI

Because 217 category enrollees are the only HCBS beneficiaries subject to PETI rules under current regulations, and as the 217 category is exempt from MAGI per 42 C.F.R. §435.603(j)(4), section 1924's PETI rules are not relevant for individuals whose eligibility is based on MAGI

⁵ See 42 C.F.R. §435.700 et seq., and 42 C.F.R. §435.832.

⁶ We have also authorized application of PETI rules to section 1115 waiver participants receiving HCBS whose financial eligibility determinations are effectively identical to 217 financial eligibility determinations.

even if receiving HCBS. Likewise, because MAGI individuals may not be subject to a resource test, the CSRA is also not relevant for MAGI individuals. For a married Medicaid applicant potentially eligible for HCBS and being screened for a MAGI category, only section 1924's mandatory separation of income between spouses could be implicated. However, we have concluded that section 1924's income deeming rules do not effectuate a change in the definition of a MAGI household described in our regulations at §435.603(f), under which a married individual's household includes his or her spouse if the spouses file their tax returns jointly or are living together.

Therefore, states should screen a married applicant subject to MAGI rules under the MAGI household rules of §435.603(f) and enroll the applicant if he or she is eligible. If the individual is not eligible and requests HCBS coverage, the instructions provided above, under "Determining Eligibility for HCBS," will apply.

Implementation Considerations

The change to section 1924's definition of an institutionalized spouse became effective January 1, 2014. This change affects initial eligibility determinations and in some circumstances redeterminations of eligibility. States that have not already done so should begin work on conforming their eligibility practices for married individuals potentially in need of HCBS as soon as possible. We are available to provide technical assistance to states to facilitate implementation of eligibility policies consistent with the statute in light of this guidance.

If you have questions about this guidance, please contact Gene Coffey at 410-786-2234, or gene.coffey@cms.hhs.gov, or contact your SOTA team lead.

Sincerely,

/s/

Vikki Wachino
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State and Territorial Health Officials

Council of State Governments