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Medicaid Financial Eligibility for Older People: State Variations in Access To Home and Community-Based Waiver and Nursing Home Services

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The Public Policy Institute, formed in 1985, is part of the Research Group of the AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of interest to older Americans. This paper represents part of that effort.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent formal policies of the Association.

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Executive Summary

Background

The original purpose of the Medicaid program was to provide health care and nursing home services to poor persons. Today, more than one-third of all Medicaid spending pays for long-term care, making it the primary source of public financing for long-term care services in the U.S. There is a growing movement to expand Medicaid's provision of home and community-based services (HCBS), which most people with disabilities prefer over institutional alternatives. However, HCBS currently are optional services under Medicaid, while states are required to provide nursing home services.

Purpose and Methodology

This study focuses on one particular aspect of the Medicaid long-term care system: the financial eligibility criteria used by states for older people with disabilities who seek services. The purpose of the study is to: 1) catalogue the financial eligibility criteria used for older beneficiaries of Medicaid nursing home and HCBS waiver services; and 2) analyze the extent to which these criteria contribute to Medicaid's institutional bias. AARP contracted with the National Academy on an Aging Society to conduct a survey of the states regarding their financial eligibility criteria for nursing home and HCBS waiver programs for older people.

Principal Findings

Responses to the AARP survey were received from all 50 states and the District of Columbia. All data pertain to the characteristics of state Medicaid programs in effect in 1998. While many states use the same financial eligibility criteria for nursing home and waiver participants, numerous states use more restrictive criteria for establishing waiver eligibility. The areas of financial eligibility considered in this report include the level of assets and income the beneficiary may retain, the level of assets and income that the spouse of a participant may retain, and the manner in which maintenance needs are addressed, an issue that is particularly critical for those who receive waiver services.

Assets

Most states (36) allow both nursing home and waiver beneficiaries to retain $2,000 in assets. In addition, nearly all states (46) apply the same asset standards to their waiver programs as they use for nursing homes. No states allow waiver beneficiaries to retain more assets than nursing home residents. Only Maryland, New Hampshire, New Jersey, and Pennsylvania allow waiver participants to retain *fewer* assets than nursing home residents.

Income

Thirteen states are more restrictive in the income eligibility criteria applied to waiver participants compared to their treatment of nursing home residents. Alabama and Mississippi

allow nursing home residents to be eligible with incomes up to 300 percent of SSI, whereas the incomes of waiver participants may not exceed 100 percent of SSI. Eleven states apply medically needy or 209(b) spend down rules to nursing home participants, but not to waiver participants: Connecticut, Georgia, Indiana, Louisiana, Michigan, Missouri, New Hampshire, New Jersey, Oklahoma, Pennsylvania, and Washington.

Spousal Protection

A substantial number of states (19) fail to offer the spouses of waiver recipients the full level of income and/or asset protection afforded the spouses of nursing home residents. Thirteen states (Alabama, Arkansas, Colorado, Florida, Indiana, Maine, Maryland, Massachusetts, Mississippi, Montana, New Hampshire, Pennsylvania, and West Virginia) protect neither the incomes nor the assets of spouses of waiver participants. An additional six states (Iowa, Louisiana, Missouri, North Carolina, Rhode Island, and Texas) protect the assets, but not the incomes, of the community spouses of waiver participants.

Maintenance and Personal Needs Allowances

Twenty-one states allow only the minimum allowance for personal needs of $30 per month for nursing home residents. Most states that exceed the minimum do so only modestly: 19 states allow Medicaid nursing home residents to keep between $31 and $40 per month. Only 11 states allow residents to retain greater than $40 per month.

The survey revealed a great degree of variation in the maintenance needs allowances permitted by state Medicaid waiver programs serving older people. At the time of the survey, the states' maintenance needs allowances ranged from $242 per month in North Carolina to $1,482 per month in 14 states (300 percent of SSI in 1998). Twenty-one states allowed waiver participants to retain $600 per month or less in income.

Conclusions and Recommendations

This survey reveals that the financial eligibility criteria that many states impose on their HCBS waiver programs contribute to a continuing institutional bias in the program. Any time that eligibility criteria are more restrictive for the waiver program than they are for nursing home coverage, there will be individuals who find it economically advantageous to choose a nursing home over home care. This result is ironic, since the cost of nursing home care is, in most cases, considerably more expensive for the Medicaid program than would be the cost of waiver services.

- At a minimum, states should allow HCBS waiver beneficiaries and their spouses to retain the same level of assets that nursing home residents may keep.
- States also should conduct careful reviews of their maintenance needs allowances for waiver beneficiaries to ensure a reasonable likelihood that beneficiaries can afford to remain in the community.
- Finally, states should allow the spouses of HCBS waiver beneficiaries to retain the same level of income as they allow the spouses of nursing home residents.

Introduction

Across America, thousands of individuals have faced, are facing, or soon will face a crisis precipitated by a need for long-term care, either for themselves or for a friend or relative. The need for long-term care may arise suddenly as the result of an accident or an acute event, such as a stroke. Or, long-term care needs may develop gradually as an older individual becomes progressively more frail and disabled.

Most long-term care is provided informally by unpaid family members, neighbors, or friends. But as disability becomes more severe, individuals and their families often must seek formal long-term care services, either through private sources or public programs. When families first encounter the formal long-term care system, they often are dismayed by its intricacies and inadequacies.

First, they may quickly discover that long-term care is expensive, with the cost of a nursing home averaging more than $47,000 a year in 1996 (Levit, et al., 1997). Even home care is expensive; the average cost of a visit was estimated to be $75 in 1997 (NAHC, 1999). Next, one may discover that neither Medicare nor private health insurance cover any substantial degree of long-term care services, and few older individuals have purchased private long-term care insurance policies that do pay for these services. Smaller public programs, such as the Older Americans Act or state-funded programs may have long waiting lists or cover only a fraction of the needed services. And finally, Medicaid may have functional or financial eligibility criteria that are too restrictive for many people who need long-term care to receive coverage. Moreover, Medicaid may offer only limited home and community-based services, the type of services most people prefer.

Despite these shortcomings, the Medicaid program remains our nation's primary response to the long-term care needs of its citizens. As such, it represents a critical area for public policy analysis if the United States (U.S.) is to ensure that people who need long-term care have access to a publicly funded safety net of services.

Background

The original purpose of the Medicaid program was to provide health care and nursing home services to the poor. Developed in 1965, before the enormous expansion and increased longevity of our nation's aging population, few could have anticipated just how large a role Medicaid would come to play in providing long-term care. Today, more than one-third of all Medicaid spending pays for long-term care (Kaiser 1997), making it the primary source of public financing for long-term care services in the U.S. It is the largest source of financing for nursing home care, constituting 48 percent of payments (Levit et al., 1997). Medicaid also is a significant, though less dominant, source of funding for home care, paying for 14 percent of such services in 1996 (Levit et al., 1997).

When the Medicaid program was developed, there were few, if any, alternatives to institutions for people needing long-term care. Over the past 20 years, however, there has been a growing movement to develop home and community-based services (HCBS). People with disabilities have voiced an overwhelming preference for receiving services outside of an institution, yet public programs, such as Medicaid, have been somewhat slow to respond. It is important to note that Medicaid law *requires* states to offer nursing home services to the eligible population age 21 and older, as a condition of Medicaid participation. The provision of HCBS is optional. Moreover, states that elect to offer HCBS waivers must demonstrate that these services do not increase Medicaid expenditures. While people who meet the functional and financial eligibility criteria are entitled to receive Medicaid nursing home services, waiver services are subject to enrollment caps. As a result, many waiver programs have waiting lists. In 1998, 75 percent of total Medicaid spending on long-term care paid for services received in institutions, while non-institutional care accounted for 25 percent (Burwell 1999). Fifteen percent of Medicaid long-term care expenditures paid for HCBS waivers.[1]

Because Medicaid was, and is, intended to provide services to people who cannot afford to finance their own health and long-term care, individuals must meet strict income and asset rules to become eligible. In most states, aged (defined as age 65+) or disabled adults who are eligible for Supplemental Security Income (SSI) are also eligible for Medicaid. In 1999, the federal SSI limits for individuals were $500 per month in countable income and no more than $2,000 in countable assets (also called resources). However, states may use special, higher, income eligibility rules for people who receive Medicaid long-term care services in a nursing home or through a waiver program that provides HCBS.

Today, the effort to reduce or eliminate Medicaid's institutional bias is a key issue on the policy agenda of many consumers, advocates, and policymakers. A 1996 survey of Medicaid financial eligibility criteria, conducted by the National Academy for State Health Policy, found that just 15 states permitted individuals to "spend down" their incomes to gain Medicaid eligibility for waivers, although 29 states permitted spend down for nursing home eligibility (Horvath 1997). Horvath also reported that only 34 states protected the spouses of HCBS waiver beneficiaries from impoverishment, although Medicaid law requires all states to protect community-residing spouses of nursing home residents from impoverishment.

In 1998, Harrington et al. undertook an extensive review of Medicaid statutes and regulations to identify those that bias the delivery of services toward institutional services and away from home and community-based services. The following issues were considered to be related to institutional bias: whether the program is mandatory, provided on a statewide basis, provided to all financially eligible groups, allows special financial eligibility, has a reasonable scope of benefits, has equitable need criteria, has standard screening and assessment procedures, and allows consumer choice (Harrington et al. 1998).

[1] The remainder of Medicaid long-term care expenditures paid for non-institutional services offered under Medicaid's home health and personal care options. These programs operate under different eligibility rules and are beyond the scope of this paper.

An examination of the HCBS waiver program comprised one aspect of Harrington's study. States can implement HCBS waiver programs to serve specific disability populations, including the "aged and disabled" (generally people age 65 and older and adults with disabilities), people with mental retardation and/or developmental disability (MR/DD), children with disabilities, and people with AIDS. Although Harrington (1998) notes that average *expenditures* for people with MR/DD were seven times greater than those for the aged/disabled, the great majority of the waiver *participants* are older people. According to Harrington, nearly three-fourths (73 percent) of Medicaid HCBS waiver beneficiaries in 1992 (the most recent data available in 1998) were in the "aged and disabled" category, 23 percent received MR/DD waivers, and the remainder of waiver enrollees were children, had AIDS, or had other covered disabilities. Clearly, Medicaid HCBS waiver policies have a significant impact on the older population with disabilities.

Purpose and Methodology

For this study, AARP focused on one particular aspect of the Medicaid long-term care system: the financial eligibility criteria used by states for older people with disabilities who seek services. The purpose of the study is to: 1) catalogue the financial eligibility criteria used for older beneficiaries of Medicaid nursing home and HCBS waiver services; and 2) analyze the extent to which these criteria contribute to Medicaid's institutional bias. AARP contracted with the National Academy on an Aging Society to conduct a survey of the states regarding their financial eligibility criteria for nursing home and HCBS waiver programs for older people. A preliminary survey instrument was pretested in interviews with state officials in Nevada and New Jersey. The instrument then was refined and mailed to every state Medicaid director in November 1998. The Academy made follow-up calls to states when needed to clarify information. Prior to publication, states were given the opportunity to verify the information contained in the tables. The instructions to the Medicaid directors and a copy of the survey instrument are included in Appendix A.

Understanding Medicaid Financial Eligibility

The Medicaid program's complexity is well known. Perhaps no aspect of this intricate program is more difficult to understand than long-term care. To clarify the findings that follow, this section provides a basic overview of Medicaid's financial eligibility rules for long-term care. Other factors that affect Medicaid eligibility – functional eligibility, categorical eligibility, immigration status, and residency – are beyond the scope of this paper. One note on categorical eligibility is relevant, however: individuals must fall into one of Medicaid's designated categories in order to be Medicaid-eligible. One such category is the "elderly," defined by Medicaid as people age 65 and older. Throughout this paper, the phrase "older people" will be used to describe the population age 65 and older.

While older people are categorically eligible for Medicaid, they still must meet financial eligibility criteria in order to qualify. Financial eligibility standards include both income and assets (also called resources).

Income Eligibility

According to Schneider et al. (1999) income eligibility includes both the *income standard* that an individual must meet and the *methodology* that each state uses to determine whether an individual meets the standard. The income standard represents a dollar amount, for example 300 percent of the SSI limit or 100 percent of the federal poverty level. The methodology for determining whether an individual meets this standard includes what sources of income are included or disregarded. For example, states are required to allow nursing home residents who have spouses living in the community to disregard a certain amount of income for the financial support of the community-residing spouse.

States may apply special rules in determining financial eligibility for long-term care services. These special rules reflect an understanding of the devastatingly high cost of long-term care. Individuals whose income is not adequate to cover their health and long-term care costs can usually qualify for long-term care services, even if their income exceeds the SSI limit. There are two primary ways that states can expand financial eligibility. One way is for individuals to contribute nearly all their income to pay for the care they need (called "spend down"), and then rely on Medicaid to pay for their care. This process is accomplished by deducting the cost of one's health and long-term care services from income. Such individuals then qualify for Medicaid under the category called "medically needy."

In a hypothetical example, Mrs. Jackson's monthly income of $2,000 would place her well above the SSI limit ($500 per month in 1999) but would be significantly lower than the average cost of a nursing home (close to $4,000 per month in 1996). States that allow medically needy spend down would permit Mrs. Jackson to contribute her monthly income toward the cost of nursing home care and Medicaid would pay the remainder of the cost.

In addition to establishing medically needy programs that allow individuals to deduct their long-term care costs from gross income, states may enact a special income rule, also referred to as the "300 percent rule." This rule allows states to establish an income limit higher than SSI, provided it does not exceed 300 percent of the federal SSI benefit (300 percent of SSI was $1,500 per month in 1999). In the above example of Mrs. Jackson, her monthly income of $2,000 would make her ineligible for Medicaid long-term care services in states that use only the "300 percent rule." (Her only avenue to eligibility would be by establishing a "Miller trust," discussed below.) People who establish eligibility under a special income rule also must meet Medicaid's asset eligibility requirements.

Asset Eligibility

As with income eligibility determinations, establishing asset eligibility also depends on both a state's *standard* and its *methodology* for determining whether one meets that standard. In most states, older individuals are required to meet the SSI resource standard ($2,000 for an individual or $3,000 for a couple). In general, the methodology for determining whether one meets this standard excludes the home in which one lives and the first $2,000 of household goods or

personal effects. If one owns a car that is used to obtain medical treatment it generally is excluded from consideration, as are certain burial funds (Schneider 1999). A more detailed discussion of Medicaid's asset rules is beyond the scope of this paper. (An in-depth description of the SSI resource standards and methodologies, also used to determine Medicaid eligibility, can be found on the Social Security Administration's web site: "www.ssa.gov". Many older people who have disabilities come to rely on Medicaid only after depleting their life savings.

209(b) Rules

While most individuals who meet SSI income and asset limits are financially eligible for Medicaid, Congress has allowed certain states to exercise more restrictive financial eligibility criteria. These states are referred to as "209(b)" states, and currently 11 states exercise this option: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. The 209(b) rules can be no more restrictive than those in effect as of January 1, 1972. These 209(b) states are required, however, to allow individuals to spend down to Medicaid eligibility in one of two ways. Either they must offer a medically needy program for the aged, blind, and disabled, or they must establish a similar "209(b) spend down program" that allows individuals to deduct their incurred medical expenses from their monthly incomes in order to determine whether they meet the state's income standard. In other states, the establishment of Medicaid spend down is optional. To illustrate, in Illinois, an SSI beneficiary with a monthly income of $500 would need to qualify for Medicaid long-term care services by spending down, since his or her income would exceed the state's 209(b) limit of $283 per month.

Miller Trusts

Until recently, individuals in states that use a special income rule could be denied nursing home eligibility if their income exceeded the limit by even one dollar (if the state did not also have a medically needy program that allowed individuals to spend down to eligibility). To remedy this situation, Congress enacted legislation permitting what are referred to as "Miller trusts." This provision allows people whose incomes exceed the state's limit to qualify for Medicaid nursing home services. They do so by establishing a special trust used only to pay for specific costs, such as the support of a community spouse. The remainder of the income in the trust must be used to pay Medicaid, either annually or at the death of the beneficiary (Harrington 1998). Some states allow the use of Miller trusts for HCBS waiver beneficiaries, as well.

Understanding Medicaid HCBS Waivers

Medicaid law allows states to offer HCBS under a "waiver" of certain Medicaid rules. These waiver programs may cover people age 65 and older who (1) would be eligible for Medicaid if they resided in a nursing home and (2) would otherwise require the level of care furnished in a nursing facility. Every state has the option of using the same financial eligibility criteria for their HCBS waiver programs as they use for nursing facility services. As noted earlier, these waiver

programs must demonstrate budget neutrality and they need not serve all individuals who meet eligibility criteria.

Individuals who are eligible for Medicaid HCBS waiver programs under special income rules (such as the 300 percent rule or medically needy programs) must have their post-eligibility income treated in a manner that is comparable to others who are similarly situated (Harrington 1998). The term "post-eligibility income" pertains to the treatment of an individual's income once he or she has been found eligible for the program. States must permit deductions from post-eligibility income to protect the maintenance needs of waiver beneficiaries. "Maintenance needs" refer to the expenses that Medicaid allows an individual to deduct from his or her income, in order to remain in the community. Regulations require that the maintenance needs allowance be based on a "reasonable assessment of need." States must set an additional maintenance needs allowance when waiver beneficiaries have a spouse at home. The establishment of a maintenance needs allowance for HCBS waiver beneficiaries is a critical component in determining whether such individuals can afford to remain in the community. It is worth noting that states have considerable leeway in establishing these limits.

Findings

Responses to the AARP survey were received from all 50 states and the District of Columbia. All data pertain to the characteristics of state Medicaid programs in effect in 1998. All 50 states reported having a Medicaid waiver program that serves older people. With the exception of Arizona, all states administer these waivers under the authority of Section 1915(c) of the Social Security Act. The waiver program in Arizona is administered under a Section 1115 waiver. The District of Columbia (D.C.) was the only jurisdiction that did not have a waiver program for the aged and disabled in 1998, but it indicated that one had been approved for 1999. Data for both Arizona and D.C. are included in the findings reported here.

While many states use the same financial eligibility criteria for nursing home and waiver participants, there are numerous states that use more restrictive criteria for gaining waiver eligibility. The areas of financial eligibility considered in this report include the level of assets and income the beneficiary may retain, the level of assets and income that the spouse of a participant may retain, and the manner in which maintenance needs are addressed, an issue that is particularly critical for those who receive waiver services.

Tables I through IV are located in Appendix B.

Table I – Maximum Assets Allowed

In general, the Medicaid program requires states to allow participants to retain at least $2,000 in liquid assets (also called countable resources). States may allow beneficiaries to retain higher levels of assets; however, the 209(b) states are allowed to use more restrictive asset rules.

Most states (36) allow both nursing home and waiver beneficiaries to retain $2,000 in assets. In addition, nearly all states (46) apply the same asset standards to their waiver programs as they

use for nursing homes. No states allow waiver beneficiaries to retain more assets than nursing home residents. Only Maryland, New Hampshire, New Jersey, and Pennsylvania allow waiver participants to retain *fewer* assets than nursing home residents. In Maryland, nursing home residents are allowed $2,500 in assets, whereas waiver participants may keep only $2,000 in assets. In New Hampshire, nursing home residents may retain $2,500, whereas waiver participants are allowed only $1,500 in assets. The New Hampshire respondent noted, however, that the asset level for waiver recipients will be increased in the future. In New Jersey, nursing home residents are allowed to retain $4,000 in assets, whereas waiver participants may keep just $2,000. Pennsylvania rules allow nursing home residents to keep $2,400 in assets; waiver participants may retain only $2,000.

Asset limits may be affected by the methodologies that states use to establish them. The lowest asset limit is in Missouri, which allows beneficiaries to retain no more than $999.99. The highest amount is in Florida, which permits certain beneficiaries to keep up to $5,000. Like Missouri, Connecticut ($1,600), Indiana ($1,500), and Ohio ($1,500) all exercise their 209(b) option of a more restrictive asset level for both nursing home and waiver beneficiaries. In addition to Florida, more generous asset levels are allowed for both nursing home and waiver participants in five states: Minnesota ($3,000), Nebraska ($4,000), New York ($3,500), North Dakota ($3,000), and Rhode Island ($4,000). Four states and D.C. allow more generous asset levels only for nursing home residents: D.C. ($2,600 – D.C. did not operate a waiver program for older people at the time of the survey), New Hampshire ($2,500), Maryland ($2,500), New Jersey ($4,000), and Pennsylvania ($2,400).

Table I illustrates the level of assets allowed for nursing home residents and waiver beneficiaries in each state.

Table II – Income Criteria Used to Determine Medicaid Eligibility

The general rule for older people who seek Medicaid eligibility, is that they must either be eligible for Supplemental Security Income (SSI), or have a level of income and assets that would not exceed SSI limits. However, Medicaid allows states to use special income rules to determine eligibility for nursing home care. States may apply these special income rules to home and community-based waiver programs, as well. The "300 percent rule" permits states to allow nursing home or waiver participants to have incomes up to, but no higher than, 300 percent of the federal SSI limit. Three hundred percent of SSI was $1,482 in 1998, the year in which this survey was conducted. While most states that exercise this special income option allow long-term care recipients to have incomes up to the federally allowable maximum of 300 percent of SSI, some states are more restrictive. For example, Delaware allows nursing home and waiver recipients to have income up to 250 percent of SSI.

In addition to this special income rule, states may allow individuals to participate in Medicaid using "medically needy" rules. Such rules allow participants whose income exceeds the established limit to contribute their "excess" income to pay for the cost of their care. For nursing home residents with no spouse in the community, all their income (except for a small personal needs allowance and other small deductions) is contributed to the nursing home; Medicaid pays

the remainder of the nursing home cost. Waiver participants are treated somewhat differently, since they must be able to maintain themselves in their own homes or communities. In making eligibility determinations, states that use medically needy rules in their waiver programs allow participants to deduct incurred medical and long-term care expenses from their income. Each state establishes a "medically needy income level (MNIL)" – the amount of income that cannot be exceeded, after allowable deductions are taken from gross income. By federal law, this amount may not exceed 133 percent of the state's welfare standard – a level that generally is substantially lower than the federal SSI benefit. In 1998, MNILs ranged from $100 per month in Louisiana (15 percent of the federal poverty level or FPL) to $741 per month in Vermont (110 percent of the FPL) (Bruen et al. 1999).

An additional requirement pertains to the 209(b) states that have more restrictive Medicaid eligibility standards. If these states do not offer medically needy coverage to the aged, blind, or disabled, they must allow individuals with incomes greater than the 209(b) level to spend down their income to become eligible for nursing home coverage. Indiana, Missouri, Ohio, and Oklahoma are 209(b) states that do not have medically needy programs, but do allow nursing home residents to spend down their incomes, in accordance with 209(b) requirements. Ohio also allows *waiver* participants to spend down under the 209(b) provisions.

Table II illustrates the income eligibility rules used in state Medicaid programs that provide nursing home and HCBS waiver services to older people. The table indicates whether each state uses a special income level and/or medically needy rules. To facilitate comparisons among states, the special income levels are represented as a percentage of the federal SSI limit.

Nearly all states allow both nursing home and waiver participants to use either the 300 percent rule or medically needy rules. Only Indiana and Missouri use neither, but both states allow nursing home residents to spend down as a result of 209(b) rules. Sixteen states use both eligibility options for nursing home residents; eleven states use both options for waiver beneficiaries. Some states use both provisions so that individuals who can qualify under the special income rule need not undergo the often complex calculations involved in making spend down determinations. However, four state waiver programs (Alabama, Indiana, Mississippi, and Missouri) use neither option, restricting waiver eligibility to people who meet the basic Medicaid financial eligibility criteria (100 percent of SSI in Alabama and Mississippi; 209(b) rules in Indiana and Missouri).

Thirteen states are more restrictive in the income eligibility criteria applied to waiver participants compared to their treatment of nursing home residents. Alabama and Mississippi allow nursing home residents to be eligible with incomes up to 300 percent of SSI, whereas the incomes of waiver participants may not exceed 100 percent of SSI. Eleven states apply medically needy or 209(b) spend down rules to nursing home participants, but not to waiver participants: Connecticut, Georgia, Indiana, Louisiana, Michigan, Missouri, New Hampshire, New Jersey, Oklahoma, Pennsylvania, and Washington.

While three states (Kansas, Maryland, and Utah) apply a special income rule to waiver participants, but not to nursing home residents, this difference would not adversely affect nursing

home beneficiaries because each state allows spend down for both the nursing home and the waiver program. Because of the high cost of nursing home care, it is unlikely that anyone would qualify under the special income rule who would not qualify under a medically needy program.

Table III – Spousal Protection Rules

Medicaid law requires states to protect the income and assets of the spouses of Medicaid nursing home residents. According to Neuschler (1991), the spousal provisions operate as follows. When one member of a couple enters a nursing home, the total value of all resources belonging to either spouse is computed. Half the total is attributed to each spouse; however, the community spouse must be allowed to keep at least $16,392 in assets (in 1999), even if this is more than half the couple's combined assets. The community spouse may not keep more than $81,960. The state may set its minimum level of protection higher than $16,392.

Income is treated differently: it belongs to the spouse in whose name it is received. However, income received in both names is considered to be divided equally between the spouses. If the income in the name of the community spouse is less than the state's spousal allowance, income from the nursing home resident is transferred to the community spouse for his or her support. Each state is required to provide a spousal maintenance needs allowance for nursing home residents. This allowance must be at least 150 percent of the federal poverty level (FPL) for a couple (150 percent of the FPL for a couple was $1,383 as of July 1, 1999). Additional income can be protected for community spouses with high shelter costs and/or additional dependents. States are allowed to establish a higher spousal allowance, which generally may not exceed $2,049 in 1999. Exceptions can be made by court order or under exceptional circumstances.

The spousal protection laws have been heralded as a critical tool for avoiding the impoverishment of the community spouses of nursing home residents – an issue that had been a significant problem prior to the enactment of these provisions. While the above levels of spousal protection are required for all state Medicaid nursing home programs, they are optional for the waiver programs. Waiver programs must allow the protection of income for the maintenance needs of a spouse, but it need not reach the minimum level required for spouses of nursing home residents.

According to this survey, a substantial number of states (19) fail to offer the spouses of waiver recipients the full level of income and/or asset protection afforded the spouses of nursing home residents. Thirteen states (Alabama, Arkansas, Colorado, Florida, Indiana, Maine, Maryland, Massachusetts, Mississippi, Montana, New Hampshire, Pennsylvania, and West Virginia) protect neither the incomes nor the assets of spouses of waiver participants. An additional six states (Iowa, Louisiana, Missouri, North Carolina, Rhode Island, and Texas) protect the assets, but not the incomes, of the community spouses of waiver participants.

Table III illustrates states' spousal impoverishment rules for nursing home residents and waiver participants. In 1998, the income standard ranged from $1,357 to $2,019 per month; the resource standard ranged from $16,152 to $80,760.

Table IV – Maintenance and Personal Needs Allowances

Individuals who receive help from Medicaid in paying their nursing home bills must first surrender virtually all their income to pay for the cost of their care. Medicaid pays the remainder of the cost. Aside from income they may protect for a community-dwelling spouse, Medicaid nursing home residents may keep only a small personal needs allowance (PNA). This PNA must be used to pay for all items and services that are not covered by Medicaid. Depending on the state, Medicaid residents may need to pay for clothing, reading materials, telephone, television or radio for personal use, special foods, or toiletries that are in excess of those provided by the facility. By federal law, the PNA must be at least $30 per month, but may not exceed $90 per month.

The survey found that 21 states allow only the minimum PNA of $30. Most states that exceed the minimum do so only modestly: 19 states allow Medicaid nursing home residents to keep between $31 and $40 per month. Only 11 states allow residents to retain greater than $40 per month. Just two states (Arkansas and Mississippi) use the maximum PNA of $90, but only in limited circumstances: for veterans who receive this amount as a reduced pension.

The situation is different for HCBS waiver beneficiaries. Individuals who receive SSI (or have incomes that do not exceed SSI) are considered "categorically eligible" for Medicaid and are not required to help pay for the cost of services they may receive under an HCBS waiver. In most states, however, the higher income eligibility guidelines that pertain to nursing home eligibility also are applied to waiver beneficiaries. States must define a level of income that waiver recipients may retain for their "maintenance needs." Individuals who have income in excess of this maintenance needs allowance are subject to cost-sharing: they must help pay for the cost of the care they receive.

The maintenance needs allowances established by the states play a critical role in determining whether beneficiaries can afford to stay in their homes. If the maintenance needs allowance is inadequate, waiver beneficiaries will be unable to afford food, utilities, taxes, home repairs, and any rent or mortgage payments they incur. Inadequate maintenance needs allowances may be a critical factor leading to an institutional bias in the Medicaid program.

The survey revealed a great degree of variation in the maintenance needs allowances permitted by state Medicaid waiver programs serving older people. At the time of the survey, the states' maintenance needs allowances ranged from $242 per month in North Carolina to $1,482 per month in 14 states (300 percent of SSI in 1998). (Note: After this survey was completed, North Carolina raised its maintenance needs allowance to 100 percent of the FPL for 1999.) Twenty-one states allowed waiver participants to retain $600 per month or less in income – in most cases allowing only SSI or 209(b)-level income to be protected. Five states (Hawaii, Kansas, Massachusetts, Utah, and Washington) allowed waiver participants to protect their incomes up to 100 percent of the federal poverty level ($671 per month in 1998, $772 in Hawaii). The remaining 10 states allowed income protection somewhere between the federal poverty level and 300 percent of SSI.

Table IV illustrates each state's PNA for nursing home residents and its maintenance needs allowance for waiver participants. It also describes the methodology used by the state to calculate the maintenance needs allowance for waiver participants.

A comparison of the states' maintenance needs allowances reflects the degree of inter-state variation. These levels should be interpreted cautiously, however, for the methodologies used to arrive at the maintenance needs allowances also vary from state to state. For example, while most states allow individuals to deduct their uncovered medical bills from income, a limited number of states allow individuals to deduct such expenses as housing costs (9 states), utilities (6 states), insurance premiums (21 states), income taxes (1 state), guardianship fees (2 states), or allowances for dependents (4 states). To illustrate:

- Idaho's maintenance needs allowance is $534, but waiver participants may deduct $409 per month in housing costs, $171 per month in utility costs, and the cost of insurance premiums from their countable income.

- Nebraska's maintenance needs allowance of $392 per month is somewhat offset by its allowance of deductions of $205 per month in housing costs, unlimited deductions for insurance payments, and deduction of any guardianship fees.

- Waiver participants in Tennessee may deduct up to $1,356 per month in housing costs, some utility expenses, and insurance premiums in arriving at their maintenance needs allowance of $988 per month.

- Utah's maintenance needs allowance is $671 per month, but waiver participants can deduct insurance premiums and housing and utility costs that exceed $408 per month from their countable income.

Conclusions and Recommendations

Medicaid waiver programs that provide HCBS are a desirable alternative to nursing home care. They allow older people with disabilities to receive a broad range of services in their own homes or, in some cases, in community settings such as assisted living. The growth of these waiver programs is notable. In 1991 only 40 states operated waiver programs serving just 135,000 people in the aged and disabled category. By 1996, close to 291,000 "aged and disabled" people were served, and currently every state operates one or more Medicaid HCBS waiver program(s).

By contrast, more than one million individuals received Medicaid assistance in paying for nursing home care in 1996. Although each state's Medicaid HCBS waivers require beneficiaries to have the same level of disability as nursing home residents, nursing homes remain the predominant long-term care service funded by Medicaid. As Harrington et al. (1998) point out, the limited size of the Medicaid HCBS waiver program stems from federally imposed cost controls and state-imposed funding decisions. When the waiver program was established,

Congress wanted to ensure its cost-effectiveness, and required that home care services not result in increased expenditures over what would have been spent on nursing home care.

Yet this survey reveals that the financial eligibility criteria that many states impose on their HCBS waiver programs contribute to a continuing institutional bias in the program. Any time that eligibility criteria are more restrictive for the waiver program than they are for nursing home coverage, there will be individuals who find it economically advantageous to choose a nursing home over home care. This result is ironic, since the cost of nursing home care is, in most cases, considerably more expensive for the Medicaid program than would be the cost of waiver services. For example, Harrington (1998) noted that the average expenditure for aged/disabled waiver beneficiaries was $3,533 in 1994, whereas the average nursing facility expenditure for the aged/disabled was $17,424 per person in 1995.

States are understandably concerned about the potential size of their HCBS waiver programs, given the public preference for home care, the growth of the older population, the high cost of long-term care, and the dearth of available long-term care options, especially for people with limited resources. However, as currently structured, HCBS waiver programs protect states' liabilities through cost-neutrality requirements and enrollment caps. State policies that bias service delivery in favor of nursing homes over home care are counter-productive. Not only do such policies fail to provide the services that most older people with disabilities prefer, they also are likely to drain the state's resources available to provide long-term care.

A review of the financial eligibility criteria examined in this study leads to the following recommendations:

- At a minimum, states should allow HCBS waiver beneficiaries and their spouses to retain the same level of assets that nursing home residents may keep. If anything, state Medicaid programs should allow community-residing individuals to preserve a *higher* level of assets than they allow for nursing home residents, since community residents must continue to pay for food, utilities, and either rent or the costs associated with home ownership: maintenance and repair, property taxes, insurance, etc. A recent study of older people who were functionally eligible for HCBS waivers but not receiving them, found that financial criteria were the major impediment (O'Keeffe et al. 1999). Medicaid's asset limits were especially problematic.

- States should conduct careful reviews of their maintenance needs allowances for waiver beneficiaries to ensure a reasonable likelihood that beneficiaries can afford to remain in the community. This survey reveals that 21 states allow waiver participants to retain $600 per month or less in income. Even accounting for variations in methodology, such restrictive income levels make it difficult or impossible for older people with disabilities to accept the help they need, and for which they are eligible under Medicaid. Because most people are willing to go to great lengths to avoid moving to a nursing home, many endure great hardships to remain in their own homes. These hardships include heavy reliance on family members and other informal caregivers, high out-of-pocket payments for services, or going without necessary long-term care services. For example, O'Keeffe et al. (1999) reported a

heavy reliance on informal caregivers and, in some cases, extremely labored efforts to perform self-care tasks. Ultimately, overly restrictive maintenance needs allowances may force older people with disabilities to enter nursing homes paid for by Medicaid, with the resulting higher cost to both federal and state governments.

- States should allow the spouses of HCBS waiver beneficiaries to retain the same level of income as they allow the spouses of nursing home residents. While Congress recognized the need to prevent the impoverishment of community spouses of nursing home residents, it failed to ensure that the spouses of HCBS waiver beneficiaries receive the same protection. A substantial number of states (19) have not elected to provide the full level of spousal income protection for HCBS waiver beneficiaries as they provide the spouses of nursing home residents. This short-sighted policy is sure to have a chilling effect on the use of waiver services, and may contribute to institutional bias.

Home and community-based long-term care services are preferred by nearly all individuals with disabilities. State Medicaid programs should encourage this cost-effective form of delivery and craft systems that encourage people to remain at home for as long as possible. By analyzing the ways in which their financial eligibility criteria bias long-term care delivery in favor of nursing homes, and by taking steps to reverse such bias, states can take an important first step in improving their long-term care systems.

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Appendix A

Financial Eligibility Criteria Used By State Medicaid Programs:

Nursing Home Care and Home and Community-Based Services Waiver Programs

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State:_____

Respondent's Name:_____ Respondent's Title:_____

Agency:_____

Address:_____

Phone:_____ Fax:_____ Email:_____

Note: For the purposes of this survey:

1. nursing home care facilities do not include intermediate care facilities (ICF's/MR's) for the mentally retarded or mental health facilities;
2. Home and Community-Based Services (HCBS) waiver programs refer only to those created under Section 1915 (c) of the Social Security Act that serve the **aged/disabled** population.

I. Asset Eligibility

1. Does your state have a Home and Community-Based Services (HCBS) waiver program that serves the **aged/disabled** population? ❑ Yes ❑ No

2. If applicable, please indicate the amount of liquid assets that an individual may have to meet Medicaid eligibility rules for:

   Nursing Home Care $_____ HCBS Waiver $_____

3. Please indicate the maximum amount of assets that the community-dwelling spouse of a **nursing home resident** may retain: $_____

4. If applicable, please indicate the maximum amount of assets that the community-dwelling spouse of **a HCBS waiver recipient** may retain: $_____

5. Please indicate the monthly cost of a nursing home stay used by your state (for the purpose of determining asset spend down in nursing homes): $_____

II. Income Eligibility

6. Please check the income criteria used to determine Medicaid eligibility for nursing home care and home and community-based services under a waiver that serve the aged/disabled population: (Please check all that apply.)

	Nursing Home	HCBS Waiver
a.	❑ SSI rules	❑ SSI rules
b.	❑ 209(b) rules	❑ 209(b) rules
c.	❑ _____% of SSI level	❑ _____% of SSI level
d.	❑ Miller Trusts	
e.	❑ Medically Needy rules	❑ Medically Needy rules

1. If your state has a Medically Needy program, please indicate the Medical Needy Income Level (MNIL) for a **HCBS waiver recipient**: $_____

2. If your state uses 209(b) rules, please specify the income level for a **HCBS waiver recipient**: $_____

III. Post-Eligibility Income Rules

3. Please indicate the maximum amount of deductions from income allowed for the maintenance needs of a **nursing home resident** per month:

Category	Maximum Amount
a. ❑ Personal Needs	$_____
b. ❑ Spousal Allowance	$_____

4. Please indicate the maximum amount of deductions from income allowed for the maintenance needs of a **HCBS waiver recipient** per month:

Category	**Maximum Amount**
a. ❑ Personal Needs	$_____
b. ❑ Medicare	$_____
c. ❑ Medical Bills	$_____
d. ❑ Spousal Allowance	$_____
e. ❑ Housing Costs	$_____
f. ❑ Utilities	$_____
g. ❑ Insurance	$_____
h. ❑ Other (Please specify.)	$_____
	$_____
	$_____

IV. Miller Trusts

11. Does your state allow **HCBS waiver recipients** to use Miller Trusts as a means to gain eligibility to Medicaid? ❑ Yes ❑ No

12. Please describe how your state informs individuals about using Miller Trusts to become eligible for Medicaid.

Appendix B

Table I. Maximum Assets Allowed

	Nursing Home	HCBS Waiver
Alabama	$2,000	$2,000
Alaska	$2,000	$2,000
Arizona	$2,000	$2,000
Arkansas	$2,000	$2,000
California	$2,000	$2,000
Colorado	$2,000	$2,000
Connecticut	$1,600	$1,600
Delaware	$2,000	$2,000
District of Columbia	$2,600	--[DC-1]
Florida	$5,000[FL-1]	$5,000[FL-1]
Georgia	$2,000	$2,000
Hawaii	$2,000	$2,000
Idaho	$2,000	$2,000
Illinois	$2,000	$2,000
Indiana	$1,500	$1,500
Iowa	$2,000	$2,000
Kansas	$2,000	$2,000
Kentucky	$2,000	$2,000
Louisiana	$2,000	$2,000
Maine	$2,000	$2,000
Maryland	$2,500	$2,000
Massachusetts	$2,000	$2,000
Michigan	$2,000	$2,000
Minnesota	$3,000	$3,000
Mississippi	$2,000	$2,000
Missouri	$999.99	$999.99
Montana	$2,000	$2,000
Nebraska	$4,000	$4,000
Nevada	$2,000	$2,000
New Hampshire	$2,500	$1,500[NH-1]
New Jersey	$4,000	$2,000
New Mexico	$2,000	$2,000
New York	$3,500	$3,500
North Carolina	$2,000	$2,000
North Dakota	$3,000	$3,000
Ohio	$1,500	$1,500
Oklahoma	$2,000	$2,000
Oregon	$2,000	$2,000
Pennsylvania	$2,400	$2,000
Rhode Island	$4,000	$4,000
South Carolina	$2,000	$2,000
South Dakota	$2,000	$2,000

	Nursing Home	HCBS Waiver
Tennessee	$2,000	$2,000
Texas	$2,000	$2,000
Utah	$2,000	$2,000
Vermont	$2,000	$2,000
Virginia	$2,000	$2,000
Washington	$2,000	$2,000
West Virginia	$2,000	$2,000
Wisconsin	$2,000	$2,000
Wyoming	$2,000	$2,000

Note: 209(b) states are italicized.

DC-1 At the time of the survey DC did not have a HCBS waiver for the aged/disabled population. However, a waiver was implemented on January 4, 1999.

FL-1 Individuals eligible for nursing home care or waiver services under the Medicaid Expansion (MEDS-AD) program, which serves the aged and disabled populations with incomes up to 90% of the federal poverty level (FPL), are able to retain up to $5,000 in resources. All other individuals who are eligible for nursing home care or waiver services are able to keep up to $2,000 in resources.

NH-1 The HCBS waiver resource limit will be increased to $2,500 in the near future under a Medically Needy program.

Table II. Income Criteria Used to Determine Medicaid Eligibility

	Percent of SSI Payment		Medically Needy Rules	
	Nursing Home	*HCBS Waiver*	*Nursing Home*	*HCBS Waiver*
Alabama	300%	100%	No	No
Alaska	300%	300%	No	No
Arizona	300%	300%	No	No
Arkansas	300%	300%	No	No
California	--	--	Yes	Yes
Colorado	300%	300%	No	No
Connecticut	300%	300%	Yes	No
Delaware	250%	250%	No	No
DC	--	--[DC-1]	Yes	--[DC-1]
Florida	300%	300%	No[FL-1]	No[FL-1]
Georgia	300%	300%	Yes	No
Hawaii	--[HI-1]	--[HI-1]	Yes	Yes
Idaho	300%	300%	No	No
Illinois	--	--	Yes	Yes
Indiana	--	--	No[IN-1]	No
Iowa	300%	300%	No	No
Kansas	--	300%	Yes	Yes
Kentucky	300%	300%	Yes	Yes
Louisiana	300%	300%	Yes	No
Maine	300%	300%	Yes	Yes
Maryland	--	200%	Yes	Yes
Massachusetts	--	--[MA-1]	Yes	Yes
Michigan	300%	300%	Yes	No
Minnesota	--	--	Yes	Yes
Mississippi	300%	100%	No	No
Missouri	--	--	No[MO-1]	No
Montana	--	--	Yes	Yes
Nebraska	--	--	Yes	Yes
Nevada	300%	300%	No	No
New Hampshire	253%	253%	Yes	No[NH-1]
New Jersey	300%	300%	Yes	No
New Mexico	257%	257%	No	No
New York	--	--	Yes	Yes
North Carolina	--	--	Yes	Yes
North Dakota	--	--	Yes	Yes
Ohio	300%	300%	No[OH-1]	No[OH-1]
Oklahoma	300%	300%	No[OK-1]	No
Oregon	300%	300%	No	No
Pennsylvania	300%	300%	Yes	No
Rhode Island	300%	300%	Yes	Yes
South Carolina	300%	300%	No	No
South Dakota	300%	300%	No	No

	Percent of SSI Payment		Medically Needy Rules	
	Nursing Home	*HCBS Waiver*	*Nursing Home*	*HCBS Waiver*
Tennessee	300%	300%	No	No
Texas	300%	300%	No	No
Utah	--	300%[UT-1]	Yes	Yes
Vermont	--	--	Yes	Yes
Virginia	300%	300%	Yes	***Yes***
Washington	300%	300%	Yes	No
West Virginia	300%	300%	Yes	Yes
Wisconsin	300%	300%	Yes	Yes
Wyoming	300%	300%	No	No

Note: 209(b) states are italicized.
Note: -- signifies that the state does not use the Special Income Rule (up to 300% of SSI).

[DC-1] At the time of the survey DC did not have a HCBS waiver for the aged/disabled population. However, a waiver was implemented on January 4, 1999.

[FL-1] Although Florida does not have a Medically Needy program, aged and disabled individuals with incomes up to 90% of the federal poverty level (FPL) are eligible for nursing home care or a HCBS waiver under the Medicaid Expansion program.

[HI-1] Hawaii allows individuals with incomes at or below 100% of the FPL to qualify for nursing home care or a HCBS waiver. The FPL in HI in 1998 was $772.

[IN-1] Although Indiana does not have a Medically Needy program, individuals with incomes above the 209(b) standard must be allowed to "spend-down" to qualify for nursing home care.

[MA-1] Massachusetts allows individuals with incomes at or below 100% of the FPL ($671 in 1998) to qualify for a HCBS waiver.

[MO-1] Although Missouri does not have a Medically Needy program, individuals with incomes above the 209(b) standard must be allowed to "spend-down" to qualify for nursing home care.

[NH-1] A Medically Needy program will be implemented in the near future.

[OH-1] Although Ohio does not have a Medically Needy program, individuals with incomes above 300% of the SSI payment can "spend-down" for nursing home care and a HCBS waiver.

[OK-1] Although Oklahoma does not have a Medically Needy program, individuals with incomes above 300% of the SSI payment must be allowed to "spend-down" for nursing home care.

[UT-1] The special income rule is only applied to the older population. The disabled population is eligible at or below 100% of the FPL.

Table III. Spousal Protection Rules

	Income		Resources	
	Nursing Home	*HCBS Waiver*	*Nursing Home*	*HCBS Waiver*
Alabama	$1,357	--	$80,760	--
Alaska	$2,019	$2,019	$80,760	$80,760
Arizona	$2,019	$2,019	$80,760	$80,760
Arkansas	$2,019	--	$80,760	--
California	$2,019	$2,019[CA-1]	$80,760	$80,760[CA-1]
Colorado	$1,357	--[C0-1]	$80,760	--[C0-1]
Connecticut	$2,019	$2,019	$80,760	$80,760
Delaware	$2,019	$2,019	$80,760	$80,760
DC	$2,019	--[DC-1]	$80,760	--[DC-1]
Florida	$2,019	--	$80,760	--
Georgia	$2,019	$2,019	$80,760	$80,760
Hawaii	$2,019	$2,019	$80,760	$80,760
Idaho	$2,019	$2,019	$80,760	$80,760
Illinois	$2,019	$2,019	$80,760	$80,760
Indiana	$2,019	--	$80,760	--
Iowa	$2,019	--[†]	$80,760	$80,760
Kansas	$2,019	$2,019	$80,760	$80,760
Kentucky	$2,019	$2,019	$80,760	$80,760
Louisiana	$2,019	--[†]	$80,760	$80,760
Maine	$2,019	--	$80,760	--
Maryland	$2,019	--	$80,760	--
Massachusetts	$2,019	--	$80,760	--
Michigan	$2,019	$2,019	$80,760	$80,760
Minnesota	$2,019	$2,019[MN-1]	$80,760	$80,760[MN-1]
Mississippi	$2,019	--	$80,760	--
Missouri	$2,019	--[†]	$80,760	$80,760
Montana	$2,019	--	$80,760	--
Nebraska	$1,357	$1,357	$80,760	$80,760
Nevada	$2,019	$2,019	$80,760	$80,760
New Hampshire	$2,019	--	$80,760	--
New Jersey	$2,019	$2,019	$80,760	$80,760
New Mexico	$2,019	$2,019	$80,760	$80,760
New York	$2,019	$2,019	$80,760	$80,760
North Carolina	$2,019	--[†]	$80,760	$80,760
North Dakota	$2,019	$2,019	$80,760	$80,760
Ohio	$2,019	$2,019	$80,760	$80,760
Oklahoma	$2,019	$2,019	$80,760	$80,760
Oregon	$1,357	$1,357	$80,760	$80,760
Pennsylvania	$2,019	--[PA-1]	$80,760	--
Rhode Island	$2,019	--[RI-1]	$80,760	$80,760
South Carolina	$1,662	$1,662	$66,480	$66,480
South Dakota	$2,019	$2,019	$80,760	$80,760
Tennessee	$2,019	$2,019	$80,760	$80,760

	Income		Resources	
	Nursing Home	*HCBS Waiver*	*Nursing Home*	*HCBS Waiver*
Texas	$2,019	--[†]	$80,760	$16,152
Utah	$2,019	$2,019	$80,760	$80,760
Vermont	$2,019	$2,019	$80,760	$80,760
Virginia	$2,019	$2,019	$80,760	$80,760
Washington	$2,019	$2,019	$80,760	$80,760
West Virginia	$2,019	--	$16,152	--
Wisconsin	$2,019.50	$2,019.50	$80,760	$80,760
Wyoming	$2,019	$2,019	$80,760	$80,760

Note: 209(b) states are italicized.
Note: -- signifies that the state does not offer spousal protection

[†] These states protect the resources, but not the income of community spouses.

CA-1 Two of the state's five waivers apply spousal impoverishment rules.

C0-1 As of July 1, 1999, the spousal impoverishment rules that are applied to nursing home residents will also be applied to waiver recipients.

DC-1 At the time of the survey DC did not have a HCBS waiver for the aged/disabled population. However, a waiver was implemented on January 4, 1999.

MN-1 Applies only to the older population.

PA-1 The HCBS waiver program does not apply spousal impoverishment rules. However, the spouse of a waiver recipient is allowed to keep up to $521.40 (the SSI payment plus the state SSI supplement).

RI-1 Although Rhode Island protects the resources of a community spouse up to the federal maximum ($80,760), it only protects income up to the MNIL of $558.33.

Table IV. Maintenance and Personal Needs Allowances

	Nursing Home	HCBS Waiver	
	Personal Needs Allowance	*Maintenance Needs Allowance*	*Methodology used to Calculate Maintenance Needs Allowance*
Alabama	$30	$514	SSI + $20 income disregard
Alaska	$75	$1,482	300% of SSI
Arizona	$74.10	$1,482	300% of SSI
Arkansas	$40[AR-1]	$1,482	300% of SSI
California	$35	$600	Medical rules
Colorado	$34	$1,482	300% of SSI
Connecticut	$50	$1,342	200% of FPL
Delaware	$42	$1,235	250% of SSI
DC	$70	--[DC-1]	--
Florida	$35	$1,482	300% of SSI
Georgia	$30	$494	100% of SSI
Hawaii	$30	$772[HI-1]	100% of FPL
Idaho	$30	$534[ID-1]	Annually adjusted for cost of living
Illinois	$30	$283	209(b) rules
Indiana	$35	$494	100% of SSI
Iowa	$30	$1,482	300% of SSI
Kansas	$30	$671	100% of FPL
Kentucky	$40	$514	SSI + $20 income disregard
Louisiana	$38	$1,482	300% of SSI
Maine	$40	$839	125% of FPL
Maryland	$40	$350	MNIL
Massachusetts	$60	$671	100% of FPL
Michigan	$30	$1,482	300% of SSI
Minnesota	$64	$467	209(b) rules
Mississippi	$44[MS-1]	$494	100% of SSI
Missouri	$30	$863	209(b) rules
Montana	$40	$491	MNIL
Nebraska	$40	$392	MNIL
Nevada	$35	$988/$1,482[NV-1]	200% of SSI/300% of SSI
New Hampshire	$40	$508	209(b) rules
New Jersey	$35	$1,482	300% of SSI
New Mexico	$30	$1,268	257% of SSI
New York	$50	$584	MNIL
North Carolina	$30	$242[NC-1]	MNIL
North Dakota	$40	$405	MNIL
Ohio	$40	$964	209(b) rules
Oklahoma	$30	$1,482	300% of SSI
Oregon	$30	$495.70	SSI + state SSI supplement
Pennsylvania	$30	$521.40	SSI + state SSI supplement
Rhode Island	$40	$558.33	MNIL

	Nursing Home	HCBS Waiver	
	Personal Needs Allowance	*Maintenance Needs Allowance*	*Methodology used to Calculate Maintenance Needs Allowance*
South Carolina	$30	$1,482	300% of SSI
South Dakota	$30	$514	SSI + $20 income disregard
Tennessee	$30	$988	200% of SSI
Texas	$30[TX-1]	$1,482	300% of SSI
Utah	$45	$671	100% of FPL
Vermont	$40	$741	MNIL
Virginia	$30	$494	100% of SSI
Washington	$41.62	$671	100% of FPL
West Virginia	$30	$1,482	300% of SSI
Wisconsin	$40	$674 - $1,028	SSI expense rate plus housing costs, utilities, and a portion of earned income
Wyoming	$30	$1,482	300% of SSI

Note: 209(b) states are italicized.

[AR-1] Individuals whose VA pension is reduced are allowed a PNA of $90. Up to $100 of earned income may also be deducted.

[DC-1] At the time of the survey DC did not have a HCBS waiver for the aged/disabled population. However, a waiver was implemented on January 4, 1999.

[HI-1] Single individuals whose countable income does not exceed 100% of the FPL ($772) are allowed to keep up to $772. Individuals whose income does exceed 100% of the FPL are allowed to keep up to $418 (MNIL). Married individuals with a community spouse, who is allowed to keep the maximum spousal allowance of $2,019 in income and $80,760 in resources, are allowed to keep $30.

[ID-1] On March 1, 1999 Idaho's maintenance needs allowance was increased to $750 for those who have a legal obligation for rent or mortgage payments. For all others the maintenance needs allowance was decreased to $500.

[MS-1] Individuals whose VA pension is reduced are allowed a PNA of $90. Individuals who are *not* involved in a work therapy program are allowed $44, and individuals who are involved in a work therapy program are allowed $88.

[NC-1] On January 1, 1999 North Carolina increased its income eligibility criteria to 100% of the FPL. Now individuals who qualify for waiver services are allowed to retain 100% of the FPL ($671 in 1998).

[NV-1] Older recipients are allowed $988, and disabled recipients are allowed $1,482.

[TX-1] In addition, Texas has a Protected Earned Income Allowance. If an individual earns $30 or less, he/she may keep it all. An individual who earns between $30 and $120 may keep the first $30, and one-half of the remainder up to $45 (for a total of $75). An individual who earns more than $120 may keep $75 of the first $120 and 30% of the amount in excess of $120.