

medicaid  
and the uninsured

Updated May 2000

**Medicaid Eligibility for Individuals with Disabilities**

Andy Schneider, Victoria Strohmeier, and Risa Ellberger

One of Medicaid's crucial roles as a safety net program is the financing of health and long-term care services for low-income individuals with disabilities. Medicaid is the single largest source of health care financing — public or private — for this population.<sup>1</sup> The services that Medicaid covers in most states, ranging from personal attendant care to prescription drugs to institutional care, are often critical to the ability of individuals with disabilities to improve their capacity to function and become self-sufficient. Of equal importance, Medicaid's eligibility rules and benefits are generally structured to provide coverage for those with high levels of medical need, such as disabled individuals. Unlike many private health insurers and managed care plans, Medicaid offers what is, in effect, "guarantee issue" coverage to all eligible individuals, regardless of the degree of disability. Unlike Medicare, Medicaid does not impose a 2-year waiting period on individuals who qualify for cash assistance on the basis of disability.

Medicaid is, however, not without its shortcomings as a source of health financing for the disabled. In particular, the rules for determining whether an individual with disabilities is eligible for Medicaid coverage are extraordinarily complicated. As previous Kaiser Commission issue papers have demonstrated, Medicaid eligibility for any population is hardly straightforward.<sup>2</sup> But as this issue paper will confirm, the Medicaid eligibility rules relating to individuals with disabilities are even more complex.

This complexity makes the Medicaid program difficult for low-income individuals with disabilities to understand and for state Medicaid officials to administer. Yet within this complexity are options that enable states, if they so choose, to use their Medicaid programs as a policy tool for reducing institutionalization, promoting independence and self-sufficiency, and reducing cost-sharing burdens for low-income disabled individuals.

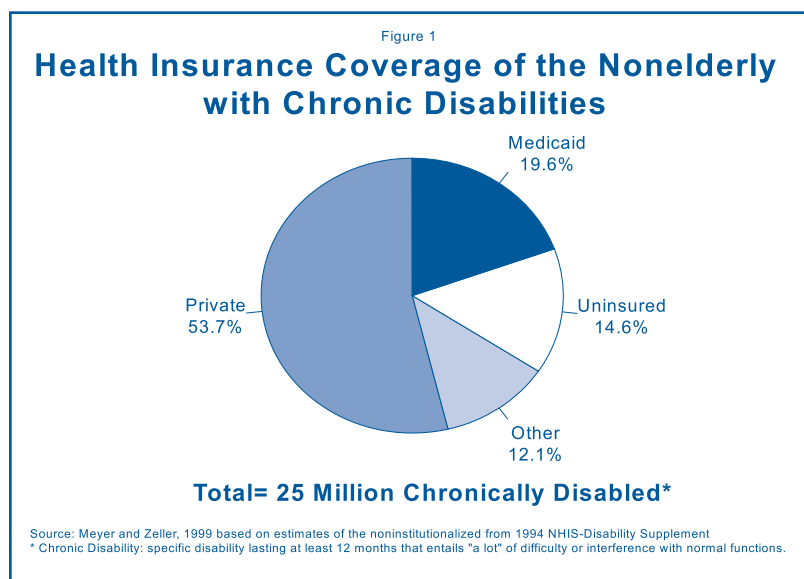
The purpose of this issue paper is to explain Medicaid eligibility policy for low-income disabled individuals. The paper begins with a discussion of the importance of Medicaid for this population. After a general overview of Medicaid eligibility policy, the paper then describes the major statutory and regulatory “pathways” available to low-income disabled individuals to qualify for Medicaid coverage. This discussion focuses on four broad groups of individuals with disabilities: children under 18; adults under 65 who are not living in institutions; adults under 65 who are living in institutions; and adults under 65 who are also eligible for Medicare. Medicaid eligibility policy for adults 65 and older with disabilities is summarized in a separate KCMU issue paper.<sup>3</sup>

As the Congressional Budget Office (CBO) has recognized, states have “a great deal of flexibility in operating the Medicaid program.”<sup>4</sup> For this reason, Medicaid eligibility policy, like Medicaid coverage policy and Medicaid payment policy, varies from state to state.<sup>5</sup> This issue paper does not attempt to describe Medicaid eligibility policy for low-income individuals with disabilities in each state.<sup>6</sup> Instead, the focus is on the federal policies that structure the eligibility choices that states make.

## I. Medicaid and the Disabled

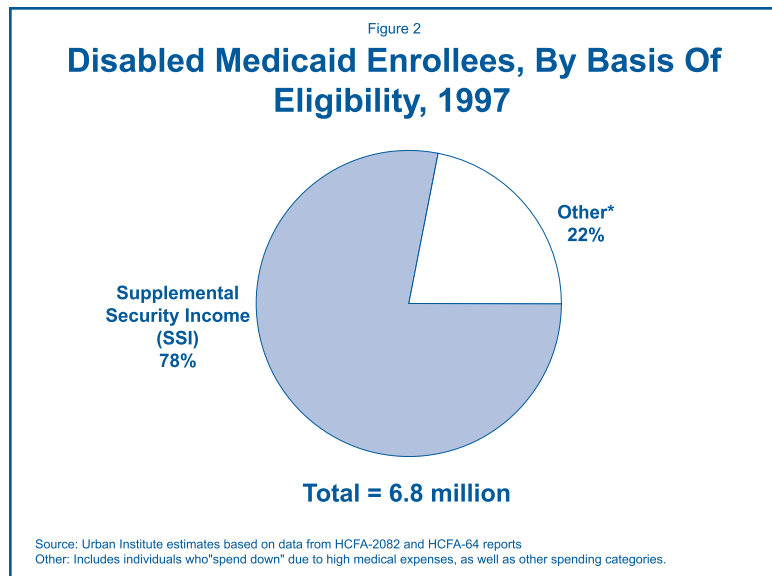
The Medicaid program plays an important role for many Americans with disabilities. People with disabilities are more likely to be enrolled in Medicaid than the general population; they are also less likely to have private insurance. One in five non-elderly persons with a chronic disability who live in the community have health coverage through Medicaid (Figure 1).

Under Medicaid, the disabled have access not only to basic medical and hospital care, but also to long-term care services, both in institutions and, in many states, in the community. (A recent Supreme Court case, *Olmstead v L.C.*, may lead to a greater emphasis on community-based services.)<sup>7</sup>

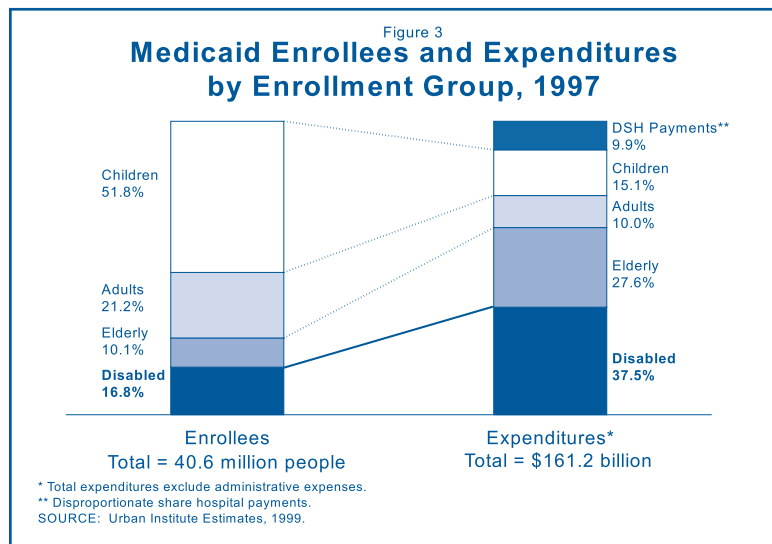


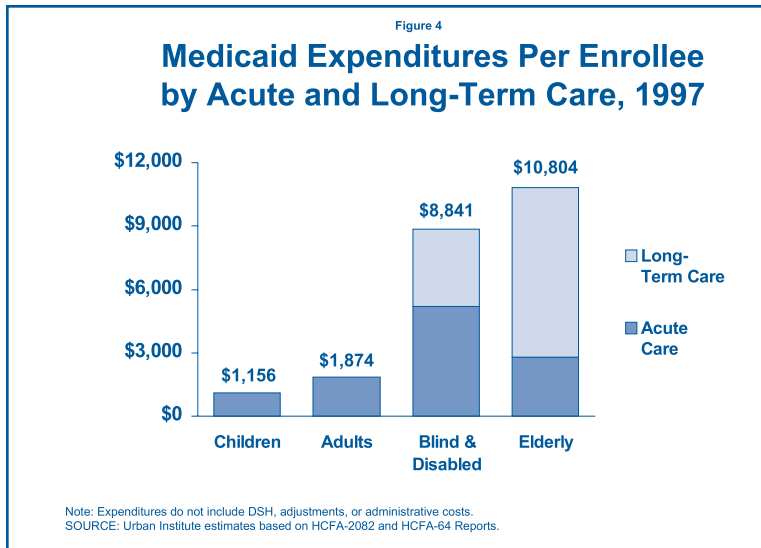
In 1997, Medicaid covered 6.8 million non-elderly individuals who qualified based on disability (Figure 2). Medicaid also covers disabled individuals who may qualify on the basis of limited income or on the basis of age. As will be discussed throughout this paper, persons with disabilities generally qualify for Medicaid through their eligibility for cash assistance through Supplemental

Security Income (SSI) program, or because their high medical expenses enable them to qualify for Medicaid as a “medically needy” individual.



Not surprisingly, Medicaid beneficiaries with disabilities are heavy users of services. Due to their extensive health care needs and use of acute and long-term care services, the Medicaid disabled population is expensive to cover. In 1997, disabled individuals in Medicaid accounted for only 17 percent of all beneficiaries, but 37 percent of total Medicaid expenditures (Figure 3).<sup>8</sup> In the same year, Medicaid spent \$60 billion to provide care to 6.8 million disabled beneficiaries under age 65. Medicaid spends, on average, nearly 8 times more for a disabled beneficiary than for a child who qualifies for Medicaid based on income (Figure 4).

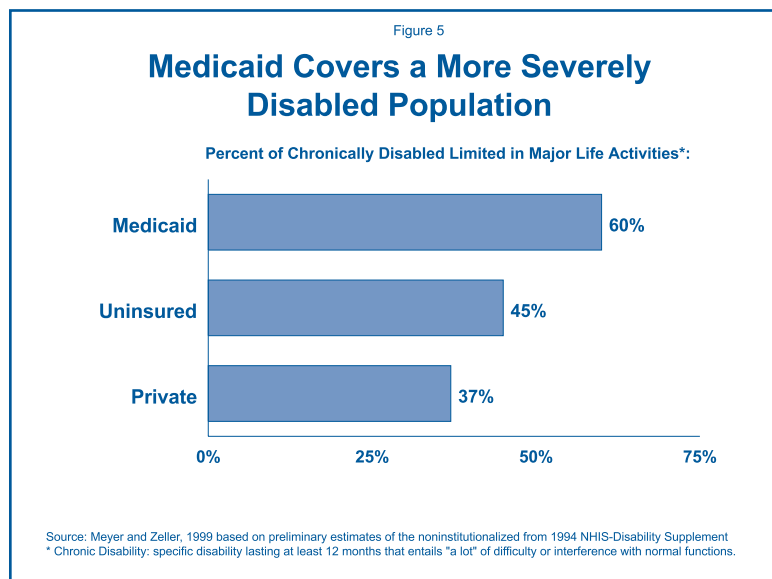




Medicaid disabled beneficiaries are a diverse group ranging in age from very young children to older adults. Disabilities are wide ranging, including physical impairments and limitations like blindness and quadriplegia; severe mental or emotional conditions, including mental illness; and other specific disabling conditions such as cerebral palsy, cystic fibrosis, Downs Syndrome, mental retarda-

tion, muscular dystrophy, autism, spina bifida, and HIV/AIDS.<sup>9</sup> About 50 percent of Medicaid disabled adults have some type of physical impairment or limitation, a quarter have some type of functional limitation on activities of daily living (instrumental or non-instrumental) while almost 40 percent have severe mental symptoms or disorders.<sup>10</sup> (These groupings of disability are not mutually exclusive).

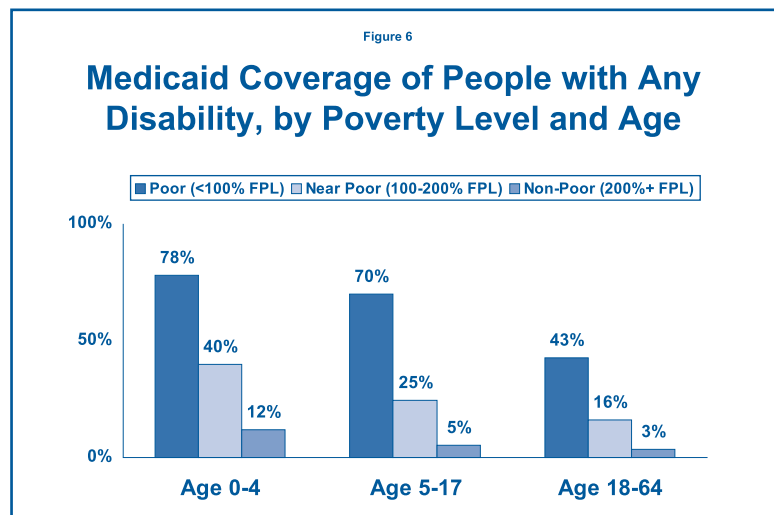
Disabled individuals insured by the Medicaid program are substantially more impaired than other individuals with disabilities. Almost 60 percent of those with a chronic disability, who are covered by Medicaid, are limited in a major life activity (e.g. for children going to school and for adults working) because of the disability, compared to 37 percent of privately insured persons (Figure 5).



About 20 percent of adults with disabilities who are eligible for Medicaid are also employed. An additional 7 percent are unemployed, while the remaining 74 percent are out of the labor force.<sup>11</sup> Some observers believe that if Medicaid eligibility standards were changed, more Medicaid disabled individuals who are out of the labor force would return to work. This is discussed further in Section IV.

Some disabled Medicaid beneficiaries are also enrolled in Medicare. Medicare covers individuals under age 65 who are receiving monthly Social Security Disability Insurance (SSDI) benefits subject to a two-year waiting period. An estimated 1.8 million Medicaid enrollees — about a quarter of all Medicaid disabled enrollees — are also covered by Medicare.<sup>12</sup> For many of these individuals, Medicaid supplements the basic Medicare coverage to provide items and services, such as prescription drugs, that are not covered by Medicare.

Medicaid plays a significant role for the disabled poor, particularly for children and low-income adults. Medicaid covers 78 percent of poor children under five with disabilities and 70 percent of poor children with disabilities ages 5-17. Similarly, Medicaid covers a substantial portion of children with disabilities who are near poor, covering 40 percent of children with disabilities under five and 25 percent of children with disabilities ages 5-17. Medicaid also covers some working age adults with disabilities, predominately those who qualify through SSI, but coverage falls off substantially as income increases (Figure 6).<sup>13</sup>



Over 5.5 million non-elderly individuals with disabilities are uninsured, including 1 million disabled children. The uninsured disabled population is largely a low-income population — over 60 percent have incomes less than 200 percent of the federal poverty level. This lack of health coverage is cause for concern because individuals with disabilities need health services on a regular, ongoing basis, as well as major health care interventions when acute care episodes occur. The lack of health care coverage in this population can lead to avoidable and expensive acute medical problems that could have been prevented by timely care on a regular basis.<sup>14</sup>

## II. Overview of Medicaid Eligibility Policy

Medicaid is a means-tested, federal-state, individual entitlement<sup>15</sup> with historical ties to the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI)<sup>16</sup> cash assistance programs. Medicaid eligibility policy reflects this basic program structure. Because Medicaid is means-tested, it has extensive

rules for determining an individual's income and resources. Because Medicaid is not a uniform federal program like Medicare, there are substantial variations in eligibility policy from state to state. Medicaid's historical links to AFDC and SSI are reflected in its emphasis on certain categories of low-income individuals, such as the disabled. Finally, because Medicaid entitles eligible individuals to coverage for basic health and long-term care services, both the states and the federal government have historically relied on Medicaid eligibility policy as a tool for limiting their financial exposure for the cost of covered benefits, particularly with respect to populations with high average per capita expenditures like the disabled and the elderly.<sup>17</sup> For example, a number of states still use the eligibility criteria applied in 1972 in determining eligibility for the disabled, rather than automatically cover those who receive SSI benefits.

At the federal level, eligibility policy choices are reflected in the way in which the Medicaid statute allows federal matching funds to be used. More specifically, federal Medicaid matching funds are available to states for the costs of covering some categories of low-income individuals — e.g., the blind and disabled — but not other categories — e.g., childless, non-disabled adults under age 65. Similarly, within a category, federal matching funds may be available to states for the costs of covering some individuals — e.g., the disabled in intermediate care facilities for the mentally retarded (ICFs/MR) — even if the state does not cover individuals with disabilities in community-based settings. If federal matching funds are not available, it is less likely that a state will extend Medicaid coverage to that category of individuals, because the state would then bear the costs of care entirely at its own expense.

At the state level, eligibility policy choices are reflected in state decisions as to which optional eligibility categories and which income and resource criteria to adopt. There are certain categories of individuals that all states, which elect to participate in Medicaid, must cover. There are other categories of individuals for which states may receive federal matching funds if they choose to extend Medicaid coverage. However, the availability of federal matching funds for a particular category of individuals does not necessarily mean that a state will cover that category, since the state must still contribute its own matching funds toward the costs of coverage.

The terms on which federal Medicaid matching funds are available to states include five broad requirements relating to eligibility: categorical; income; resource; immigration status; and residency. Two of these broad requirements — income and resources — are financial in nature. The other three — categorical, immigration status, and residency — are non-financial. In order to qualify for Medicaid, an individual must meet both financial and non-financial requirements.

Within each of these five broad requirements there are federal mandates and state options. It is important to understand the context in which these terms

are used. State participation in Medicaid is voluntary, not mandatory. The federal government makes Medicaid matching funds available on an open-ended, entitlement basis to states that elect to take part in the program. In order to participate, states must offer coverage for basic benefits to certain populations — e.g., medically necessary physician and hospital services to certain low-income families and children. States receive federal Medicaid matching funds for at least 50 percent and as much as 80 percent of the costs of this mandatory coverage, depending on the average per capita income of the state. In exchange, states are also able to draw down federal Medicaid matching funds for optional populations and services such as the elderly and disabled at risk of nursing home care and other costly long-term care services. According to the Health Care Financing Administration, over half — about 55 percent — of all Medicaid spending is for optional populations or optional services.<sup>18</sup>

A disabled individual who establishes Medicaid eligibility is not, on the basis of that initial determination, entitled to maintain eligibility indefinitely. Federal Medicaid regulations require that states redetermine the eligibility of a Medicaid beneficiary at least once every 12 months. This redetermination, like the initial eligibility process, is designed to ensure that a beneficiary continues to meet each of the financial and non-financial requirements for eligibility. Those beneficiaries who, due to a change in income or resources, no longer meet the eligibility requirements in their state under any eligibility “pathway” lose their entitlement to Medicaid coverage.<sup>19</sup> In addition, administrative determinations as to whether an individual remains disabled for purposes of Medicaid eligibility are also subject to periodic review.

As discussed above, some disabled Medicaid beneficiaries are also eligible for Medicare. That a disabled individual has Medicare coverage does not disqualify the individual from Medicaid, if he or she is otherwise eligible. From the standpoint of the Medicaid program, Medicare is a type of “third party liability” — a third party payer that is liable for some of the costs of care provided to the beneficiary. The third party’s payments reduce the costs of coverage for Medicaid. When Medicare and Medicaid both cover the same services — e.g., inpatient hospital care — Medicare pays first. Medicaid pays only for the services it covers that Medicare does not — e.g., outpatient prescription drugs.

## **Categorical Eligibility**

Medicaid eligibility is limited to individuals who fall into specified categories. The federal Medicaid statute identifies over 25 different eligibility categories for which federal matching funds are available. These statutory categories can be classified into five broad coverage groups: children; pregnant women; adults in families with dependent children; individuals with disabilities; and the elderly.

This issue paper focuses on individuals with disabilities under age 65. Of course, many of the elderly also have disabilities and could potentially meet the categorical eligibility requirement for Medicaid on the basis of their disabilities. However, in order to avoid the administrative cost and burden associated with disability determinations, state Medicaid programs generally establish categorical eligibility for an elderly individual based on age.

In identifying individuals with disabilities for purposes of categorical eligibility under Medicaid, states are generally required to use the definition of disability that is used under the Supplemental Security Income (SSI) program. States also have the option to use a more restrictive definition of disability. Under this option, known as the “209(b)” option for the section of the 1972 Social Security Act amendments in which it was enacted, a state may use a definition of disability as restrictive as the one it used in January, 1972. As of 1998, 11 states had elected this “209(b)” option: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.<sup>20</sup> Disability must be defined in the state’s Medicaid plan. States may make the actual determinations as to whether an individual is disabled for purposes of categorical eligibility for Medicaid, or they may enter into a “section 1634” agreement with the Social Security Administration under which SSA makes the determination, which is then binding on the state.<sup>21</sup>

Under the SSI definition of disability, an individual must have a severe “medically determinable physical or mental impairment.” The presence of one or more such impairments is not, however, sufficient to establish SSI or Medicaid eligibility. The individual must also, by reason of the impairment, be unable to engage in any “substantial gainful activity.” In regulations, SSA has established a standard for when an individual is engaged in “substantial gainful activity”: the individual earns \$700 per month after impairment-related expenses are deducted from his or her income.<sup>22</sup> The individual’s medical or physical impairment must be sufficiently severe that the individual “is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.”<sup>23</sup> As discussed in Section III, the definition of disability for children under 18 is somewhat different.

SSI does not categorize the blind as “disabled” for purposes of categorical eligibility. Instead, it categorizes them as “blind” and includes individuals whom it defines as having (1) 20/200 vision or less with the use of a correcting lens in the individual’s better eye or (2) tunnel vision of 20 degrees or less. Blindness is also a basis for categorical eligibility under Medicaid.

The determination of disability in an individual case can take a substantial amount of time, whether done by SSA or by a State agency. In recognition of the hardship these delays can cause, federal law permits SSI benefits to be paid to applicants before a formal determination of eligibility is made in cases where there is a high probability that the individual will be eligible. (Of course, in most states, Medicaid coverage accompanies the receipt of SSI benefits). These “presumptive disability” determinations are of particular importance in the case of conditions where immediate medical intervention can forestall further deterioration. One such condition is infection with the human immunodeficiency virus (HIV). Under SSI guidelines, individuals with HIV infection may be found presumptively disabled if they are able to document one or more of a specified listing of opportunistic infections, cancers, or conditions; they need not be diagnosed with AIDS.<sup>24</sup> In most states, presumptive disability for SSI purposes would also enable the individual to establish categorical Medicaid eligibility.

Not all physical or mental impairments can qualify an individual for SSI benefits on the basis of disability, regardless of how severe they may be. Most notably, drug addiction and alcoholism are not qualifying medical impairments under SSI. Individuals with respect to whom drug addiction or alcoholism is the contributing factor to their disability are not eligible for SSI benefits and are not categorically eligible for Medicaid based on disability. In order to qualify for Medicaid coverage, these individuals would have to establish categorical eligibility on some basis other than disability.

## **Income Eligibility**

Fitting into a Medicaid eligibility category is essential to qualifying for Medicaid coverage. It is not, however, sufficient. Because Medicaid assistance is limited to those in financial need, the program also imposes financial eligibility requirements. These requirements take two basic forms: income tests and resource (or assets) tests. These financial requirements vary from category to category. For example, both the income eligibility thresholds and the resource tests (if any) for children differ in most states from the income and resource tests applicable to adults with disabilities or the elderly.

There are some eligibility categories for which states are not required to apply a resource test. However, all Medicaid eligibility categories are subject to an income test. Many of these tests vary from category to category (and from state to state). In some cases — e.g., Medicare beneficiaries receiving Medicaid assistance for Medicare cost-sharing — income eligibility standards are tied directly by federal law to specified percentages of the federal poverty level (e.g., 100 percent, 120 percent, 135 percent, and 175 percent). In other cases — e.g., individuals residing in nursing facilities — income eligibility standards are tied to the federal cash assistance programs (e.g., 300 percent of the Supplemental Security Income payment standard).

There are two components of income eligibility: the standard and the methodology. An income *standard* is a dollar amount — say, \$696 per month (100 percent of the 2000 federal poverty level for an individual). An income *methodology* is the way in which an applicant's income is counted for purposes of applying the income standard. For example, an income methodology typically starts by counting all income received from any source — e.g., Social Security benefits, pensions, wages, interest payments, and dividends. It may then disregard certain types or amounts of income — e.g., the \$20 income monthly disregard or the \$65 monthly earned income disregard (plus one-half of remaining earnings) that are basic to the SSI income methodology. The standard is meaningless without the methodology. Indeed, the methodology is what converts the nominal dollar standard (e.g., \$696) into the actual amount that an individual can have and still qualify (e.g., for an individual with earned income, \$781).

There are some Medicaid eligibility categories for which individuals may qualify by “spending down” — that is, the costs of health care that an individual has incurred are deducted from the income that an individual receives in determining whether he or she qualifies for Medicaid. The most commonly known eligibility category to which the spend-down approach applies is the “medically needy.” These are individuals who fall into one of the required eligibility categories — e.g., pregnant woman, child, adult with dependent children, elderly, or disabled — but whose income is greater than the applicable income threshold for receipt of cash assistance.

## Resource Eligibility

For most eligibility categories in most states, individuals must have resources of less than a specified amount in order to qualify for Medicaid. Resources include items such as cars, savings accounts, and savings bonds.

As in the case of income eligibility requirements, resource requirements include both standards and methodologies. A resource *standard* is a dollar amount — typically \$2,000 in the case of an individual with disabilities and \$3,000 in the case of a couple. In contrast to the Medicaid income standards, some of which are tied to the federal poverty level, Medicaid resource standards are generally not indexed to inflation or otherwise adjusted on a regular basis. As a result, resource standards have become more and more restrictive over time.

A resource *methodology* determines which resources are counted and how they are valued. For example, the home in which an individual lives is generally not a countable resource, regardless of its value. Similarly, a wedding ring or engagement ring is generally not considered a countable resource. Most other resources tend to be countable, although the resource methodology that applies to the eligibility category in question — e.g., children, the disabled, the elderly — may

not count the entire value of the resource. In the case of the disabled, the resource methodology used by the SSI program is the methodology most commonly used for Medicaid eligibility purposes.

The SSI resource methodology does not count the first \$2,000 of household goods or personal effects or the first \$4,500 in current market value of a car. In some cases, such as if the car is used to obtain medical treatment or for employment, its entire value is excluded from the calculation of resources. Similarly, the SSI resource methodology does not count any resources that are necessary for an individual with disabilities to fulfill an approved plan for achieving self-support.<sup>25</sup>

## Immigration Status

The fourth broad Medicaid eligibility requirement is immigration status. Citizens who meet the program's financial and other non-financial eligibility requirements are entitled to Medicaid coverage. Immigrants who have entered the U.S. *illegally* can not qualify for basic Medicaid benefits, although they are eligible for Medicaid coverage for emergency care (if they meet all other financial and non-financial requirements). Most categories of immigrants who are *legally* residing in the U.S. and who meet all other financial and non-financial requirements are eligible for Medicaid coverage for emergency care, but they are not necessarily eligible for the full range of Medicaid services.

The 1996 welfare law created two categories of legal immigrants for Medicaid eligibility purposes: those who were residing in the U.S. prior to August 22, 1996, and those who entered the U.S. on or after that date. Those legal immigrants who were residing in the U.S. before August 22, 1996 are, at state option, eligible for Medicaid if they otherwise meet all the financial and non-financial requirements, whether or not they were receiving Medicaid coverage prior to that date. (All states other than Wyoming have elected to cover this population).

Most immigrants entering the country legally on or after August 22, 1996 are ineligible for non-emergency Medicaid coverage for five years from their date of entry into the U.S. After the 5-year period has expired, states may, at their option, extend Medicaid coverage to these legal immigrants (if they meet the other financial and non-financial requirements) or they may continue to deny them benefits until they become citizens. The 1997 Balanced Budget Act created an exception to this general 5-year bar for immigrants who are receiving SSI benefits on the basis of disability (or age). In states that grant Medicaid eligibility to SSI recipients, these immigrants are eligible for Medicaid; in states that use more restrictive eligibility rules for SSI recipients generally, these immigrants are eligible if they meet the state's more restrictive rules.<sup>26</sup>

## Residency

Being a citizen of the U.S. (or a legal immigrant in the U.S. prior to August 22, 1996) is not sufficient to qualify for Medicaid, even if an individual meets the other categorical, income, and resource requirements. An individual must also be a resident of the state offering the Medicaid coverage for which the individual is applying. In general, an individual is considered a resident of a state if the individual is living there with the intention of remaining indefinitely. Federal law prohibits states from denying Medicaid coverage because an individual has not resided in a state for a specified minimum amount of time.

When an individual with disabilities enters an institution which is in a state other than where the individual's family residence is located, the individual's state of residence for Medicaid purposes is generally the state in which the institution is located. Thus, it is the state where the institution is located, and not the state where the individual's residence is located, that determines the individual's eligibility for Medicaid under its rules and pays for the services covered under its Medicaid program.

### III. Medicaid Eligibility Pathways: Disabled Children

There are a number of eligibility pathways through which low-income children — including children with disabilities — may qualify for Medicaid.<sup>27</sup> Many of these pathways are not specific to children with disabilities. For example, under the “poverty-related” pathways, states must cover all children under 16 in families with incomes below 100 percent of the federal poverty level. If a child with disabilities meets these criteria, the child qualifies for Medicaid, just as a child without disabilities would qualify.<sup>28</sup>

There are, however, cases in which none of the general eligibility pathways for children may be adequate to enable a child with disabilities to qualify for Medicaid. For example, a child with disabilities may be cared for at home by parents who are not poor but who are unable to obtain or afford private health insurance coverage for the child. Medicaid policy addresses these and similar circumstances through additional pathways that are targeted to children with disabilities. This section reviews these pathways, which are summarized in Figure 7. Some of these pathways, including the SSI recipient, foster care, and adoption assistance pathways, are mandatory — that is, states that elect to participate in Medicaid must offer coverage to individuals in these categories. The remaining pathways, including the “medically needy” and “Katie Beckett” categories, are optional.

**Figure 7**  
**Medicaid Eligibility Pathways for Children with Disabilities**

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
<b>SSI recipients</b>	≤ \$512 for individual, ≤ \$769 for couple per month <sup>1</sup>	≤ \$2,000 for individual ≤ \$3,000 for couple
<b>Title IV-E foster care children</b>	State AFDC income level as of 7/16/96	State AFDC resource level as of 7/16/96 (\$1,000)
<b>Title IV-E Adoption Assistance Children</b>	Met AFDC level as of 7/16/96, or SSI standard before adoption	AFDC level as of 7/16/96, or SSI standard
<b>Children in “209 (b)” States<sup>2</sup></b>	States set income standard; children may “spend down” to eligibility by deducting incurred medical expenses from income	State sets resource standard; individuals may not “spend down” or dispose of resources to qualify
Other Pathways		
<b>SSI recipients as of 8/22/96</b>	Same as SSI	Same as SSI
OPTIONAL COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Other Pathways		
<b>Medically needy</b>	State sets income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State sets resource standard; individuals may not “spend down” or dispose of resources to qualify
<b>Katie Beckett children (non-waiver state option)</b>	Would meet Medicaid/SSI eligibility standard if institutionalized and parents’ income not attributed	Would meet Medicaid/SSI eligibility standard if institutionalized and parents’ resources not attributed
<b>Home- or community-based waiver children</b>	Would meet Medicaid eligibility standard if institutionalized and parents’ income not attributed	Would meet Medicaid eligibility standard if institutionalized and parents’ resources not attributed
<b>Independent Foster Care Adolescents</b>	State sets income standard; standard no more restrictive than State AFDC level as of 7/16/96	State sets resource standard; standard no more restrictive than State AFDC level as of 7/16/96
<b>Non-Title IV-E foster care children</b>	State AFDC level as of 7/16/96	State AFDC level as of 7/16/96 (\$1,000)
<b>Non-Title IV-E adoption assistance children</b>	Met Medicaid standard before adoption agreement	Met Medicaid standard before adoption agreement

<sup>1</sup> SSI income standard for 2000. Does not include \$20 per month income disregard. These standards are adjusted annually based on the 12-month change in the Consumer Price Index (CPI).

<sup>2</sup> Section 209(b) states are states that use more restrictive eligibility requirements than those in effect under the SSI program. These states may not impose requirements that are more restrictive than those in effect in the state’s Medicaid plan as of January 1, 1972.

**SSI Recipient Pathway.** In most states, children who receive cash assistance under the Supplemental Security Income (SSI) program on the basis of disability are automatically eligible for Medicaid. However, there are a number of states that apply rules more restrictive than those under SSI in determining Medicaid eligibility for the disabled (and the elderly) under the so-called “209(b)” option. This option, named for the section in the 1972 Social Security Act Amendments in which the SSI program was established, allows states to use their 1972 state assistance eligibility rules in determining Medicaid eligibility for the disabled instead of federal SSI rules. These rules can be more restrictive with respect to non-financial criteria, financial criteria, or both. (For a summary of the current financial eligibility standards used by “209(b)” states see Figure 10, Section IV). Note that if a state uses its more restrictive 1972 standards, it must also allow individuals to “spend down” into Medicaid eligibility by deducting incurred medical care expenses from income.<sup>29</sup>

Children under 18 (or under 22 if a full-time student) may qualify for SSI if they are not married and they meet the SSI requirements for disability (or blindness), income, and resources. A child under 18 is disabled for SSI purposes if he or she has “a medically determinable physical or mental impairment which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”<sup>30</sup> The Social Security Administration has issued a medical “listing of impairments” that serves as the basis for this determination.<sup>31</sup> As discussed above, SSA generally makes the determination of disability, although states have the option of making these determinations themselves.

A child meets the SSI income requirements if his or her parent’s countable income is below the maximum monthly SSI benefit. In the case of an unmarried child who is under 18 and living at home, a portion of the parent’s income is “deemed” to be the child’s income for purposes of determining eligibility.<sup>32</sup> If the child is in an institution for more than 30 days, none of the parent’s income is attributed to the child for purposes of determining eligibility.

A child meets the SSI resource requirements if his or her countable resources do not exceed \$2,000 (for a one-parent family), or \$3,000 (for a two-parent family). If a child under 18 is not married and is living at home, all of the countable resources of the parents are attributed to the child. If the child is in an institution for more than 30 days, none of the parent’s income or resources is deemed available to the child.<sup>33</sup>

Narrowed by the 1996 welfare law, this eligibility pathway established the listing of medical impairments as the sole basis for a determination of SSI disability in the case of a child.<sup>34</sup> As a result of this more restrictive disability standard, an estimated 135,000 children with disabilities were expected to lose SSI benefits.<sup>35</sup> To ensure that these children do not also lose Medicaid benefits, the 1997 Balanced

Budget Act required states to reinstate Medicaid coverage to children receiving SSI benefits as of August 22, 1996.<sup>36</sup>

**Foster Care Pathways.** Under Title IV-E of the Social Security Act, states receive federal matching funds for maintenance payments made on behalf of eligible children in foster care. In order to qualify for Title IV-E payments, a child must have been receiving (or have been eligible to receive) cash assistance payments prior to removal from the home of a relative and placement in foster care. In determining eligibility for cash assistance, states must apply the deprivation criteria and income and resource standards and methodologies in effect under their AFDC programs as of July 16, 1996. States must provide Medicaid coverage to all children receiving Title IV-E foster care payments, including those with disabilities. States also have the option of extending Medicaid coverage to all children in foster care who are supported not with Title IV-E funds but with state funds only.<sup>37</sup>

The Foster Care Independence Act of 1999 (P.L. 106-169) gives states the option of extending Medicaid eligibility to former foster care children between the ages of 18 and 21. States may cover these adolescents if on their 18<sup>th</sup> birthday they were in foster care. A state may impose income and resource requirements, but these may not be more restrictive than the state's AFDC rules as of July 16, 1996.

**Adoption Assistance Pathways.** Title IV-E also makes federal matching payments available to states for monthly adoption assistance payments with respect to eligible children. In order to qualify, a child must be eligible for SSI or meet the eligibility criteria under the state's AFDC program in effect on July 16, 1996. The child must also have special needs. A special needs child is one whom the state determines has a specific condition or situation, including a mental, emotional, or physical handicap, which prevents placement in an adoptive home without special assistance. The state must also enter into an adoption assistance agreement with the adoptive parents. States must provide Medicaid coverage to children with respect to whom Title IV-E adoption assistance payments are being made.

There is also a Medicaid eligibility pathway for children with special needs who are adopted under a state-funded adoption subsidy program but who do not qualify for Title IV-E payments because they are not eligible for SSI or they do not qualify under their state's AFDC rules as of July 16, 1996. States may extend Medicaid coverage to these children up to age 21 so long as there is an adoption assistance agreement in effect, the child was eligible for Medicaid before the agreement was entered into, and the state has determined that the child cannot be placed without Medicaid because of his or her special needs for medical or remedial care.<sup>38</sup> This Medicaid eligibility pathway is optional; as of 1998 all but 6 states had elected to offer such coverage.<sup>39</sup>

**Katie Beckett Pathway.** As discussed above, the SSI eligibility rules do not attribute the income and resources of parents to a disabled child if the child has been in an institution for 30 days. This creates a financial incentive for parents who are not poor, but who cannot afford to meet the financial and medical needs of a child with disabilities, to place the child in an institution in order to be eligible for Medicaid coverage. One way in which states can neutralize this incentive is to offer Medicaid coverage through the “Katie Beckett” eligibility pathway.

Under this pathway, children under age 19 may qualify for Medicaid if the following circumstances apply: the child meets the SSI standard for disability; the child would be eligible for Medicaid if he or she were in an institution; and the child is receiving at home medical care that would be provided in an institution. In each case, the state must determine that it is appropriate to provide care to the child outside an institution and the estimated cost to Medicaid of caring for the child at home is no higher than the estimated cost to Medicaid of placing the child in an institution. This pathway makes it possible for families who are not poor, but cannot afford to keep a child with costly medical needs at home, to be able to do so.

**Home and Community-Based Services Waiver Pathway.** If states elect the “Katie Beckett” option, they must offer Medicaid coverage to all qualified children throughout the state. States that wish to limit the number of eligible children with disabilities to whom they provide Medicaid coverage in the community have another option: the home-and community-based services (HCBS) waiver. Under section 1915(c) of the Social Security Act, the Secretary of HHS is authorized to waive certain provisions of the Medicaid statute in order to enable states to receive federal Medicaid matching funds for the cost of providing home-and community-based services to certain populations. In particular, states can limit the areas in which such services are offered and the number of individuals in those areas who may qualify, subject to the requirements of the Americans with Disabilities Act.<sup>40</sup>

As in the case of the “Katie Beckett” pathway, children receiving Medicaid coverage under an HCBS waiver must be eligible for Medicaid if institutionalized and must, in the absence of home-and community-based services, require the level of care furnished in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded (ICF/MR). The state must also, as a condition of receiving a waiver, document budget neutrality.<sup>41</sup> The state may limit the number of otherwise eligible children who participate in such a waiver program, both by targeting the coverage to children at risk of particular institutional care (e.g., ICF/MR services), or by limiting the number of participants to no more than 200 at a time (e.g., “model” waivers), or both.<sup>42</sup>

**“Medically Needy” Pathway.** States have the option of extending Medicaid coverage to children and adults who are disabled or aged but who do not qualify for SSI benefits because their countable incomes exceed the SSI eligibility level (77 percent of the federal poverty level of \$696 per month, \$8,350 per year for a single

individual in 2000). As of 1996, 36 states and the District of Columbia had elected to offer coverage to the “medically needy.”<sup>43</sup> This eligibility pathway is often used by elderly individuals residing in nursing facilities; however, it can also benefit children and adults with disabilities who live in the community with high prescription drug, medical equipment, or other health care expenses.

States electing the “medically needy” option must, at a minimum, cover children under 18 who, but for income or resources, would be eligible under a mandatory pathway such as the “poverty-related” pathway. States may modify their Medicaid benefits package for the “medically needy,” but they must, at a minimum, provide ambulatory services for all “medically needy” children under 18.

Under the “medically needy” option, a state establishes an income standard, as well as a resource standard. In counting income or resources for children, a state must apply methodologies no more restrictive than those under the AFDC program as in effect on July 16, 1996. In determining income — but not resource — eligibility, the state deducts the medical expenses an individual has incurred over a budget period (not more than 6 months) from the individual’s countable income. If the child’s family income, minus incurred medical expenses, is less than the state’s medically needy income standard, and if the countable resources of the child’s family are less than the state’s medically needy resource standard (an individual cannot “spend down” resources), then the child is eligible for Medicaid coverage for the remainder of the budget period. At the end of the budget period, the individual’s “medically needy” eligibility must be redetermined for a new budget period.

#### **IV. Medicaid Eligibility Pathways: Non-Institutionalized Adults with Disabilities**

This section reviews Medicaid eligibility pathways appropriate to non-elderly adults with disabilities who are not residing in hospitals, nursing homes, or ICFs/MR. The focus is on two general groups of individuals with disabilities: those who are working, and those who are at risk of institutional care but want to remain at home or in the community.

##### **Pathways for the Working Disabled<sup>44</sup>**

As discussed in section II, categorical eligibility for Medicaid on the basis of disability turns on the definition used by the SSI program (or, in the “209(b)” states, a more restrictive definition). In determining income eligibility, the SSI program disregards the first \$65 of monthly earned income (or, if the individual has no unearned income, the first \$85), plus one half of the remaining earnings. The program also disregards impairment-related work expenses. However, even if these earnings-related disregards have the effect of bringing an individual’s income below the SSI benefits standard (\$512 per month per individual in 2000), the individual may nonetheless be ineligible for SSI because of earnings. The reason for this is that under the SSI definition of disability it is insufficient that an individual has a

severe “medically determinable physical or mental impairment.” An individual must also be unable to engage in “substantial gainful activity”, which SSA has defined in regulations as earnings on an average of \$700 per month.<sup>45</sup>

While this definition may be prudent from the standpoint of cash assistance policy, it is problematic from the standpoint of health care policy. Individuals with severe medical or physical impairments face high monthly medical costs. As a result, they are going to have a great deal of difficulty finding affordable private health insurance coverage. Their employers may not offer coverage at all; the individuals may not be able to afford whatever coverage their employer does offer; or the individual may be denied coverage in the individual market on the basis of health screens. Yet if these individuals engage in “substantial gainful activity” by earning more than \$700 per month (on average), they are no longer considered “disabled” for purposes of SSI or Medicaid, even though they continue to have physical or mental impairments.

For many individuals with disabilities, their Medicaid coverage is often the only way they are able to secure the personal attendant care, prescription drugs, or other medical services they need in order to remain independent. Thus, given the choice between working fewer hours and keeping their Medicaid coverage and earning more money but losing their Medicaid coverage, many individuals may rationally decide to work less. To counteract this work disincentive, four Medicaid eligibility pathways have evolved. These are summarized in Figure 8. There is also an eligibility pathway for working individuals with disabilities that qualifies them for assistance with Medicare Part A premiums; this is discussed in Section VI.

**Qualified Severely Impaired Individuals.** Section 1905(q) of the Social Security Act requires states to continue to provide Medicaid coverage to “qualified severely impaired individuals.” (The parallel policy also appears in the SSI title of the Social Security Act at section 1619.) These are individuals under 65 who are eligible for both SSI payments and Medicaid coverage, who continue to have the disabling physical or mental impairment on the basis of which they were found to be disabled, who need continued Medicaid coverage in order to continue working, and who would lose categorical eligibility for Medicaid because their earnings push them over the “substantial gainful activity” limit of \$700 per month. These individuals are entitled to continue to receive Medicaid coverage, even after they have lost their SSI benefits due to earnings, until their earned income is sufficient to enable them to purchase a “reasonable equivalent” of SSI, Medicaid, and publicly-funded attendant care services. The Social Security Administration has published state-specific thresholds for annual gross income to be used as the basis for this “reasonable equivalent” determination. These thresholds range from \$13,792 in Arizona to \$34,125 in Alaska.<sup>46</sup> In 1996, about 35,000 working individuals with disabilities continued to receive Medicaid coverage under this provision despite the loss of SSI

benefits; nearly 39 percent of these were diagnosed with mental retardation, and another 32 percent were diagnosed with mental disorders.<sup>47</sup>

**Working Disabled Under 250 Percent of Poverty.** Unlike section 1905(q), this pathway is optional for the states. Added by the 1997 Balanced Budget Act, this pathway is targeted at individuals who meet the SSI definition of disability except that their earnings exceed the maximum amount allowed under section 1905(q), and who are otherwise eligible for SSI because their unearned income and their countable resources are below the SSI standards.<sup>48</sup> The family income of these individuals may not exceed 250 percent of the federal poverty level (\$2,948 per month for a family of 3 in 2000).<sup>49</sup> States have the flexibility, through use of “less restrictive” methodologies, to raise the effective income and resource thresholds to whatever level they choose. For example, Oregon disregards all unearned income, up to \$10,000 in countable resources, and approved retirement or pension payments. In contrast to the section 1905(q) pathway, this pathway affords states the option of imposing a monthly premium or other cost-sharing charges set on a sliding scale according to income. As of April 2000, four states (Alaska, Minnesota, South Carolina, and Wisconsin), in addition to Oregon, had received approval for Medicaid plan amendments covering the working disabled through the use of “less restrictive” income or resource methodologies. Four states, (Nebraska, Maine, California, and Mississippi) have submitted plan amendments and are awaiting approval.

**Working Disabled.** The Ticket to Work and Work Incentives Improvement Act of 1999 creates two new eligibility pathways for working disabled individuals.<sup>50</sup> Both are optional for the states, and both will become effective October 1, 2000. The first of these pathways somewhat overlaps the current pathway for the working disabled under 250 percent of poverty and its “less restrictive methodologies” flexibility. Under the new working disabled pathway, states will be able to extend Medicaid coverage to disabled individuals who would be eligible for SSI but for earnings that exceed the maximum amount allowed under section 1905(q). States will have the flexibility to impose a ceiling on allowable income or resources at whatever level they choose, and to use whatever methodologies for determining income or resources that they wish. States may also elect not to impose any income or resource test at all.

The flexibility with respect to income and resource policies under this new option does not differ in substance from that available to states under the BBA option combined with the use of “less restrictive methodologies.” The same is true of the broad discretion that states will have under this new option to impose premiums or other cost-sharing charges on a sliding scale based on income. Some of the differences between the two eligibility pathways are found in the details with respect to premiums and cost-sharing. In particular, in the case of individuals with incomes below 450 percent of the poverty level, states, under the new option, may not

**Figure 8**  
**Medicaid Eligibility Pathways for Non-Institutionalized Adults with Disabilities**

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
<b>SSI recipients</b>	≤ \$512 for individual or ≤ \$769 for couple per month <sup>1</sup> ; earnings may not exceed \$700 per month	≤ \$2,000 for individual ≤ \$3,000 for couple
<b>Individuals in “209(b)” states<sup>2</sup></b>	State sets income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State sets resource standard; individuals may not “spend down” or dispose of resources to qualify
<b>Qualified severely impaired individuals<sup>3</sup></b>	But for earnings, income under SSI level; earnings may not exceed specified amount	≤ \$2,000 for individual ≤ \$3,000 for couple
OPTIONAL COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
<b>Medically needy</b>	States set income standard; individuals may “spend down” to qualify by deducting incurred medical expenses	State sets resource standard; individuals may not “spend down” or dispose of resources to qualify
<b>Working disabled under 250 percent of poverty<sup>4</sup></b>	But for earnings, would be eligible for Medicaid as qualified severely impaired individuals; income < 250% FPL <sup>5</sup>	Same as SSI <sup>6</sup>
<b>New Optional Pathways Effective October 1, 2000</b>		
<b>Working disabled<sup>4</sup></b>	But for earnings, income under SSI level; earnings ≤ state established level	State sets resource standards and methodologies
<b>Working individuals with medically improved disability<sup>4, 7</sup></b>	State sets income standards and methodologies	State sets resource standards and methodologies

<sup>1</sup> The SSI income level is adjusted annually based on the 12-month change in the Consumer Price Index (CPI).

<sup>2</sup> Section 209(b) states use more restrictive eligibility requirements than those in effect under the SSI program. These states may not impose requirements that are more restrictive than those in effect in the state’s Medicaid plan as of 1/172.

<sup>3</sup> Individual must have been receiving SSI and must continue to have the physical or mental impairment as the basis on which the individual was found to be disabled.

<sup>4</sup> States have the option of imposing sliding scale premiums and other cost sharing charges on this group.

<sup>5</sup> In 2000, 250 percent of the federal poverty level (FPL) for an individual was \$20,875 per year, or \$1,740 per month.

<sup>6</sup> Under section 1902(r) (2) of the Social Security Act, states may use income and resource methodologies that are “less restrictive” than those which would otherwise apply.

<sup>7</sup> A state can cover this group only if the state also covers the working disabled group.

impose premiums that exceed 7.5 percent of an individual's income. In addition, while states are generally not required to impose premiums on this group, they are required to impose premiums equal to 100 percent of the cost of Medicaid coverage upon individuals whose adjusted gross income exceeds \$75,000.<sup>51</sup>

**Working Individuals with Medically Improved Disability.** The other optional eligibility pathway created by the Ticket to Work and Work Incentives Improvement Act concerns working disabled individuals who experience medical improvement. These individuals continue to have a severe medically determinable impairment, but they lose their eligibility for SSI or SSDI (Social Security Disability Insurance) benefits because of a determination, made at a regularly scheduled continuing disability review, that there has been medical improvement. At the time of this determination, these individuals would have to have been receiving Medicaid coverage under the new eligibility pathway for working disabled individuals in order to qualify for this new coverage. It would not be sufficient for these individuals to have been receiving Medicaid coverage under the BBA pathway at the time of a determination of medical improvement. The state options with respect to premiums and cost-sharing charges for individuals with medically improved disabilities are the same as those described above with respect to the new working disabled group.

## Pathways for Individuals with Disabilities at Risk of Institutional Care

There are individuals with disabilities who are not able to work, have impairments that are sufficiently severe to warrant institutional placement, but who want to remain in the community. Figure 9 summarizes the Medicaid eligibility pathways appropriate to these individuals.

**Figure 9**  
**Medicaid Eligibility Pathways for Individuals with Disabilities at Risk of Institutional Care**

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
<b>SSI recipients</b>	≤ \$512 for individual or ≤ \$769 for couple per month <sup>1</sup> ;	≤ \$2,000 for individual ≤ \$3,000 for couple
<b>Individuals in “209(b)” states<sup>2</sup></b>	State sets income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State sets resource standard; individuals may not “spend down” or dispose of resources to qualify
OPTIONAL COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
<b>SSP-Only Recipients<sup>3</sup></b>	State determined level	Same as SSI
<b>Medically needy</b>	States set income standard; individuals may “spend down” to qualify by deducting incurred medical expenses from income	State sets resource standard; individuals may not “spend down” or dispose of resources to qualify
<b>Individuals receiving home- and community- based services</b>	Would be eligible if institutionalized	Would be eligible if institutionalized

<sup>1</sup> SSI Income standard for 2000. Does not include \$20 per month income disregard. These standards are adjusted annually based on the 12-month change in the Consumer Price Index (CPI).

<sup>2</sup> Section 209(b) states use more restrictive eligibility requirements than those in effect under the SSI program.

<sup>3</sup> States have the option of extending Medicaid coverage to disabled individuals who are receiving State Supplementation Payments (SSP) but not SSI payments.

**SSI-Related Pathways.** To qualify for SSI — and, in most states, Medicaid — an individual with disabilities must have countable income and resources below the SSI standards. In the case of income, this standard is the total of the basic SSI income standard (\$512 per month for an individual in 2000) plus the amount of the State Supplementation Payment (SSP), if any, that the state in which the individual resides pays. The SSI program has specific methodologies for counting income and resources in determining eligibility; for example, SSI disregards the first \$20 in monthly income. Thus, in a state that does not make state supplementation payments, an individual with disabilities who has no earned income may not have an income of more than \$532 per month (in 2000), or 76 percent of the federal poverty level of that year.

There were about 4.5 million disabled SSI recipients in 1998. Not all of these SSI recipients automatically qualified for Medicaid, however, because of the “209(b)” option. This option allows states to use their 1972 financial and non-financial standards in determining eligibility for the disabled instead of the federal SSI standards. If a state uses its more restrictive 1972 financial eligibility standards, it must also allow disabled individuals to “spend down” into Medicaid eligibility by deducting incurred medical expenses from income. Figure 10 shows the 2000 financial eligibility standards and resource limits for the “209(b)” states.

**Figure 10**  
**Medicaid Income and Resource Limits in States**  
**Using the Section 209(b) Option, 2000**

	Eligibility Standard (Monthly Income) <sup>a</sup>		Resource Limits <sup>a</sup>	
	Individual	Couple	Individual	Couple
Federal SSI Standards <sup>b</sup>	\$512	\$769	\$2,000	\$3,000
<b>209(b) State</b>				
Connecticut	\$476	\$633	\$1,600	\$2,400
Hawaii <sup>c</sup>	N/A	N/A	N/A	N/A
Illinois	\$283	\$375	\$2,000	\$3,000
Indiana	\$528	\$785	\$1,500	\$2,250
Minnesota <sup>d</sup>	\$467	\$583	\$3,000	\$6,000
Missouri	\$512	\$769	\$ 999.99	\$2,000
New Hampshire	\$526	\$770	\$1,500	\$1,500
North Dakota	\$455	\$475	\$3,000	\$6,000
Ohio	\$444	\$769	\$1,500	\$2,250
Oklahoma	\$512	\$769	\$2,000	\$3,000
Virginia	\$512	\$769	\$2,000	\$3,000

a) States using the Section 209(b) option may use different methods of counting income and resources than SSI.

b) This figure does not include the \$20 per month income disregard.

c) Hawaii maintains its Section 209(b) status, but all aged, blind, and disabled people are eligible under other coverage options with higher income standards and/or resource standards than SSI.

d) Minnesota is increasing the eligibility standard to \$482 for an individual and \$601 for a couple, effective July 1, 2000.

States have the option of extending Medicaid coverage to disabled individuals who are receiving State Supplementation Payments (SSP) but not SSI payments. Under SSI law, states have the option of providing a cash payment to supplement the basic federal SSI payment. Under the SSP-only eligibility option, states may make Medicaid available to individuals with disabilities receiving these SSP payments, even though they do not qualify for SSI. As of September 1996, 28 states reported making Medicaid coverage available to disabled individuals living independently and receiving state supplementation payments but not SSI benefits.<sup>52</sup>

**Medically Needy Pathway.** States have the option of extending Medicaid coverage to disabled individuals who are ineligible for SSI payments because of excess income or resources. In the case of individuals at risk of institutional care, this excess income or resources would in all likelihood be attributable not to earnings, but to Social Security or private pension income. Under the “medically needy” pathway, the individual’s incurred medical costs are deducted from income over an accounting period of 1 to 6 months. If the net result is below the state-established medically needy income level, the individual will qualify for Medicaid coverage for the remainder of the accounting period. This eligibility pathway can provide access to Medicaid coverage for individuals with recurring drug and medical expenses that are high in relation to their monthly income.

**Home and Community-Based Services Pathway.** Under the “section 1915(c)” waiver authority, states have the option of receiving federal Medicaid matching funds for covering home-and community-based services to individuals with disabilities at risk of placement in an ICF/MR or other institutional care. Accompanying this flexibility in benefits design is an eligibility pathway that gives states the option of making Medicaid eligibility standards and methodologies for home-and community-based services comparable to those for institutional services. In the absence of such an eligibility pathway, individuals with disabilities (or their relatives) might face strong financial incentives for institutional placement.

The federal Medicaid statute and regulations establish an optional eligibility pathway for individuals with disabilities who (1) would be eligible for Medicaid if they were in an institution, and (2) but for the provision of home-and community-based waiver services would require the level of care provided in an institution. This eligibility pathway, which is tied to the 1915(c) waiver, may be targeted just on individuals with disabilities. In effect, it allows states to apply the same income and resource standards and methodologies to individuals in need of home-and community-based services as they would apply to individuals in hospitals, nursing facilities, or ICFs/MR. For example, a state that has elected the option of covering institutionalized individuals under the special income rule (described in the next section) may apply this same special income rule to individuals in the community. Similarly, states with “medically needy” coverage could apply their “spend down”

to individuals needing home-and community-based services as well as those in ICFs/MR.

## V. Medicaid Eligibility Pathways: Institutionalized Disabled Adults

Not all non-elderly adults with disabilities are able to remain in the community. For various reasons, some require institutional care. Medicaid eligibility policy contains three basic pathways for financing these services: the SSI-related eligibility pathway; the “medically needy” pathway; and the “special income rule” pathway. These are summarized in Figure 11.

**SSI-Related Pathway.** As discussed in section IV, states must, subject to the “209(b)” exception, make Medicaid coverage available to children or adults with disabilities who qualify for Supplemental Security Income (SSI) benefits. In either case, if a disabled individual receiving SSI benefits is also eligible for Medicaid, and if that individual enters a hospital or nursing facility or ICF/MR, that individual remains eligible for Medicaid. However, the SSI program reduces the individual’s monthly benefit to \$30, beginning with the first full calendar month of residence.<sup>53</sup> This reduced benefit, known as the personal needs allowance, is intended to offset small personal expenses that the Medicaid payment to the institution does not cover. Of the 5.1 million disabled SSI recipients in 1996, only 2.3 percent, or 117,000, were residing in institutions.<sup>54</sup>

**“Medically Needy” Pathway.** The “medically needy” pathway discussed in Sections III and IV with respect to children and non-institutionalized adults is also available to disabled, non-elderly adults in hospitals, nursing facilities, and ICFs/MR. As in the case of the non-institutionalized adults, these individuals meet the SSI standard for disability but do not qualify for SSI benefits (even the reduced personal needs allowance) because their countable incomes exceed the SSI eligibility level. In those states that have elected the “medically needy” option, these individuals may qualify for Medicaid by deducting the costs of their institutional care from their income to bring their net income below the state’s medically needy income level. Once the individual has established eligibility for Medicaid, most of the income that the individual receives is applied to the cost of the institutional care, reducing the amount that the Medicaid program pays. Beneficiaries are allowed to retain a small (at least \$30 per month) personal needs allowance, and, in the case of a beneficiary with a family or spouse remaining at home, a family or spousal maintenance allowance.

**Figure 11**  
**Medicaid Eligibility Pathways**  
**for Institutionalized Adults with Disabilities**

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
<b>SSI recipients</b>	≤ \$512 for individual, ≤ \$769 for couple per month <sup>1</sup>	≤ \$2,000 for individual ≤ \$3,000 for couple
<b>Individuals in “209(b)” states<sup>2</sup></b>	State sets income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State sets resource standard; individuals may not “spend down” or dispose of resources to qualify
OPTIONAL COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
<b>Medically needy</b>	States set income standard; individuals may “spend down” to qualify by deducting incurred medical expenses from income	State sets resource standard; individuals may not “spend down” or dispose of resources to qualify
<b>Institutionalized individuals eligible under special income level</b>	Income standard no higher than 300% of SSI standard (\$1,545 per month)	Same as SSI

<sup>1</sup> SSI income standard for 2000. Does not include \$20 per month income disregard. These standards are adjusted annually based on the 12-month change in the Consumer Price Index.

<sup>2</sup> Section 209(b) states are states that use more restrictive eligibility requirements than those in effect under the SSI program. These states may not impose requirements that are more restrictive than those in effect in the state’s Medicaid plan as of January 1, 1972.

**Nursing Facility Pathway.** Under the “medically needy” pathway, there is no upper limit on the amount of monthly income an individual can receive and still qualify for Medicaid coverage. So long as the individual’s incurred medical expenses are sufficiently high to reduce the individual’s income to the state medically needy income standard during the budget period, the individual will qualify for Medicaid. States that wish to provide Medicaid coverage for individuals with disabilities and ICFs/MR but want to set an upper limit on the beneficiary’s income have another option: the so-called “special income rule” for individuals in nursing facilities and other institutions. As of September 1996, 33 states had elected to cover this group; 14 of these states did not cover the “medically needy.”<sup>55</sup>

Under the “special income rule” option, a state may set an income standard at up to 300 percent of the SSI benefit (\$1,545 per month in 2000) for individuals in nursing facilities and other institutions. Institutionalized individuals with Social Security, pension, and other income of more than this amount may not qualify for Medicaid, even if their monthly costs of care in the nursing facility exceed their income. If their countable income is under the state-established limit, these individuals must also meet the SSI resource test in order to qualify for Medicaid.

## **VI. Eligibility Pathways for the Disabled: Assistance with Medicare Cost-Sharing**

The eligibility pathways discussed in the previous sections lead to coverage for the full Medicaid benefits package. This package includes not just personal attendant care and prescription drugs, but also assistance with Medicare cost-sharing requirements.<sup>56</sup> For low-income disabled Medicare beneficiaries, Medicaid’s assistance with Medicare cost-sharing obligations can make a substantial difference in the amount of financial burden imposed by Medicare and in the accessibility of covered services.<sup>57</sup>

Federal Medicaid law recognizes that there are substantial numbers of disabled Medicare beneficiaries who are not sufficiently poor to qualify for full Medicaid benefits but need assistance with Medicare cost-sharing requirements if Medicare coverage is to be affordable for them. Thus, states participating in Medicaid are required to offer assistance for Medicare cost-sharing — but not for any other Medicaid benefits — to certain categories of low-income Medicare beneficiaries. The federal government matches the costs of this assistance at the same rate that it matches the costs of the full benefits package (between 50 and 80 percent depending on the state). These pathways are summarized in Figure 12.

Most of these pathways—qualified Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs), and qualified individuals (QIs)—cover both elderly and disabled Medicare beneficiaries. These pathways are discussed in the Kaiser Commission issue paper, “Medicaid Eligibility for the Elderly”.<sup>58</sup> There is one pathway that is specific to Medicare beneficiaries with disabilities: qualified disabled and working individuals (QDWIs).

Under the QDWI pathway, eligible individuals are entitled to payment of their Part A Medicare premiums (\$301 per month in 2000). They are not entitled to assistance with Part A or Part B deductibles or Part B premiums. In addition, for QDWIs with an income level between 150 and 200 percent of the federal poverty level, states may impose a sliding scale premium (as a percentage of the Medicare premium). Those eligible for this pathway are individuals with disabilities who are not otherwise eligible for Medicaid but who meet the following criteria: (1) they are eligible for Medicare Part A (hospital) benefits on the basis of disability; (2) their

income is less than 200 percent of the federal poverty level (\$2,358 per month for a family of 3 in 2000); and (3) their resources do not exceed twice the SSI standard (\$4000 for an individual, \$6,000 for a couple). Both income and resources must be determined using SSI methodologies. Recent survey findings concluded that the QDWI may be a very underutilized program.<sup>59</sup>

**Figure 12**  
**Medicaid Eligibility Pathways for Individuals with Disabilities:**  
**Medicaid Assistance with Medicare Cost-Sharing**

Category	Family Income (all income figures include \$20 income disregard)	Resource Test	Medicaid Pays:	Entitlement
<b>Qualified Medicare Beneficiaries (QMBs)</b>	≤ 100% of FPL (per month, \$696 for individual, \$937 for couple) <sup>1</sup>	≤ 200% of SSI limit (\$4,000 for individual, \$6,000 for couple) <sup>1</sup>	All Medicare premiums and cost-sharing charges <sup>2</sup>	Yes
<b>Specified Low-Income Medicare Beneficiaries (SLMBs)</b>	Between 100% and 120% of FPL (per month, less than \$835 for individual and \$1,125 for couple) <sup>1</sup>	≤ 200% of SSI limit (\$4,000 for individual, \$6,000 for couple) <sup>1</sup>	Medicare Part B monthly premium	Yes
<b>Qualifying Individuals 1 (QI1s)</b>	At least 120% FPL and, at state option, up to 135% of FPL (per month, less than \$939 for individual and \$1,265 for couple)	≤ 200% of SSI limit (\$4,000 for individual, \$6,000 for couple)	Medicare Part B monthly premium. This benefit is subject to annual federal funding cap.	No
<b>Qualifying Individuals 2 (QI2s)</b>	At least 135% FPL and, at state option, up to 175% of FPL (per month, less than \$1,217 for individual and \$1,640 for couple)	≤ 200% of SSI limit (\$4,000 for individual, \$6,000 for couple)	Portion of Medicare Part B monthly Premium (2.5%, or \$1.04 per month in 2000). This benefit is subject to annual federal funding cap.	No
<b>Qualified Disabled Working Individuals</b>	Eligible for Medicare Part A, and income ≤ 200% of FPL	Resources do not exceed twice the SSI standard (≤ \$4,000 for individual, ≤ \$6,000 for couple)	Medicaid pays Medicare Part A Premium Only	Optional

<sup>1</sup> Under section 1902 (r)(2) of the Social Security Act, states may use income and resource methodologies that are “less restrictive” than those which would otherwise apply.

<sup>2</sup> States are not required to pay for Medicare cost-sharing if the Medicaid payment rates for a given service are sufficiently lower than the Medicare payment rates.

## VII. Conclusion

Medicaid serves as the nation's primary source of health insurance coverage for the poor. Medicaid eligibility policy is complex and confusing for beneficiaries, program administrators, and potential enrollees. Options are available for states that choose to simplify and broaden eligibility criteria to reach a greater number of low-income disabled individuals and to remove disincentives for this population to return to work.

Prepared by Andy Schneider, Medicaid Policy, LLC, Victoria Strohmeier, Federal Legislation Clinic, Georgetown University Law Center, and Risa Ellberger, Kaiser Commission on Medicaid and the Uninsured. This issue paper draws from a chapter on Medicaid eligibility in the Medicaid Resource Book being prepared for the Kaiser Commission on Medicaid and the Uninsured.

## Endnotes

<sup>1</sup> The Congressional Budget Office estimates that this FY 1999 Medicaid will spend a total of \$67.7 billion (\$38 billion federal and \$29.1 state) in purchasing acute and long-term care benefits for the blind and disabled CBO, *The Economic and Budget Outlook: Fiscal Years 1999-2008*, January 1999, Table G-2.

<sup>2</sup> Andy Schneider, Kristen Fennel, and Peter Long, Kaiser Commission on Medicaid and the Uninsured, *Medicaid Eligibility for Families and Children*, September 1998; Andy Schneider, Kristen Fennel, and Patricia Keenan, Kaiser Commission on Medicaid and the Uninsured, *Medicaid Eligibility and the Elderly*, January, 1999. [www.kff.org](http://www.kff.org).

<sup>3</sup> Andy Schneider, Kristen Fennel, and Patricia Keenan, Kaiser Commission on Medicaid and the Uninsured, *Medicaid Eligibility and the Elderly*, January 1999. [www.kff.org](http://www.kff.org).

<sup>4</sup> Congressional Budget Office, *Behind the Numbers: An Explanation of CBO's January 1997 Medicaid Baseline*, April 1997, p. 7.

<sup>5</sup> For detailed state-by-state data on the number and type of beneficiaries covered, see David Liska, Brian Bruen, Alina Salganicoff, Peter Long, and Bethany Kessler, Urban Institute and Kaiser Commission on the Future of Medicaid, *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends, 1990-1995*, Third Edition, November 1997.

<sup>6</sup> See Jane Horvath, National Academy for State Health Policy, *Medicaid Financial Eligibility for Aged, Blind and Disabled: Survey of State Use of Selected Options*, May 1997.

<sup>7</sup> In a recent letter to State Medicaid Directors, HCFA and the Office of Civil Rights wrote, "the Court's decision clearly challenges us to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services." Letter to State Medicaid Directors, January 14, 2000, [www.hcfa.gov/Medicaid](http://www.hcfa.gov/Medicaid).

<sup>8</sup> The figures do not include individuals with disabilities who qualify for Medicaid through other eligibility "pathways"—e.g. as elderly, or as poverty-level children.

<sup>9</sup> Drawn from the typology presented by Meyer and Zeller in *Profiles of Disability: Medicaid and the Uninsured Populations*, prepared for the Kaiser Commission on Medicaid and the Uninsured, July 1999.

<sup>10</sup> Jack Meyer and Pamela Zeller. *Profiles of Disability: Employment and Health Coverage*, prepared for the Kaiser Commission on Medicaid and the Uninsured, September 1999.

<sup>11</sup> Ibid.

<sup>12</sup> See Faces of Medicare, *Medicare and the Under-65 Disabled*. Kaiser Family Foundation, July 1999. <http://www.kff.org>.

<sup>13</sup> Jack Meyer and Pamela Zeller. *Profiles of Disability: Employment and Health Coverage*, prepared for the Kaiser Commission on Medicaid and the Uninsured, September 1999.

<sup>14</sup> Ibid.

<sup>15</sup> For an overview of Medicaid as “mandatory” federal spending, see Michael Hash and John Ferman, Health Policy Alternatives, *Primer on the Federal Budget*, Henry J. Kaiser Family Foundation, July 1997, [www.kff.org](http://www.kff.org).

<sup>16</sup> The SSI program is a federally-administered, means-tested cash assistance program that provides monthly payments to eligible aged, blind, and disabled individuals who need assistance, generally because they are minimally covered under the Social Security program. See Committee on Ways and Means, *1998 Green Book*, May 19, 1998, pp. 261-326.

<sup>17</sup> In 1997, Medicaid expenditures per disabled beneficiary were \$8,841, in contrast to an expenditure of \$3,581 per non-elderly, non-disabled adult. Based on estimates from the Urban Institute.

<sup>18</sup> Only 45 percent of Medicaid expenditures are for services that are required to be provided or to beneficiary groups that states participating in Medicaid are required to cover. Statement of Bruce C. Vladeck, Administrator, Health Care Financing Administration, on the 1998 Budget for Medicaid and Medicare Part B, presented to the House Commerce Committee, Subcommittee on Health and Environment, February 12, 1997.

<sup>19</sup> Under 42 CFR. 435.930(b), a state Medicaid agency may not terminate Medicaid coverage for an individual who loses eligibility on one basis unless the agency determines that the individual is not eligible on some other basis under the State’s eligibility rules.

<sup>20</sup> Bruen et al., *State Medicaid Coverage Options for Low-Income Aged, Blind, and Disabled People*. The Urban Institute, September 1999.

<sup>21</sup> In covering SSI recipients under Medicaid, states may elect, under section 1634 of the Social Security Act, to rely on the Social Security Administration (SSA), which processes applications for SSI cash assistance, to make the Medicaid eligibility determination for the individual on behalf of the state. As of January 1, 1996, 32 states had entered into such “section 1634 agreement” with SSA. Seven of the states that cover SSI recipients (Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, and Utah) do not have a “section 1634 agreement” with SSI; instead, they require SSI recipients to file a separate application with their Medicaid agencies, which in turn make the final eligibility determinations.

<sup>22</sup> 64 FR 18566-02. January 1, 1999. This is the first time the threshold has been increased since 1990.

<sup>23</sup> Section 1614(a)(3) of the Social Security Act.

<sup>24</sup> Note that under the SSI definition, individuals with asymptomatic HIV infection are not presumptively eligible for Medicaid. See Tim Westmoreland et al., Federal Legislation Clinic, Georgetown University Law Center, *Medicaid & HIV/AIDS Policy* (1999), Table 2-2.

<sup>25</sup> 20 CFR 416.1218

<sup>26</sup> Section 5305(b) of P.L. 105-33. The Balanced Budget Act also provided that a legal immigrant with disabilities who was in the U.S. on August 22, 1996, may (if otherwise qualified) receive SSI benefits, even if the individual did not become disabled until after that date.

<sup>27</sup> Andy Schneider, Kristen Fennel, and Peter Long, Kaiser Commission on Medicaid and the Uninsured, *Medicaid Eligibility for Families and Children*, September 1998. [www.kff.org](http://www.kff.org).

<sup>28</sup> Note that if a child loses eligibility for Medicaid through this pathway because the family's income increases, but the child qualifies under another pathway, the child remains eligible for Medicaid. State Medicaid agencies may not terminate eligibility for a child until they have determined that there is no basis on which the child may qualify for Medicaid, 42 C.F.R. 435.930(b). See Liz Schott and Cindy Mann, Center on Budget and Policy Priorities, *Assuring that Families Receive Medicaid Benefits for Which They Qualify When TANF Assistance is Denied or Terminated*, October 8, 1998, [www.cbpp.org](http://www.cbpp.org).

<sup>29</sup> "209(b)" states are allowed to limit Medicaid eligibility for the disabled to individuals age 18 or older. If they do so, they must provide Medicaid to children under 18 who receive SSI benefits and who would be eligible to receive cash assistance under the state's AFDC plan in effect on July 16, 1996, if they did not receive SSI. 42 C.F.R. 435.121(d).

<sup>30</sup> Section 1614(a)(3)(C)(I) of the Social Security Act, 20 C.F.R. 416.906. A child who has such an impairment is not considered disabled if he or she engages in "substantial gainful activity."

<sup>31</sup> 20 C.F.R. 404, Subpart P, App. 1 (listing of impairments).

<sup>32</sup> 20 C.F.R. 416.1165.

<sup>33</sup> 20 C.F.R. 416.1165(g)(4).

<sup>34</sup> The current SSI definition of disability for children was established by the 1996 welfare law, section 211 of P.L. 104-193, in reaction to a more expansive definition under a 1990 Supreme Court ruling, *Sullivan v. Zebley*, 493 U.S. 521, 110 S.Ct. 885 (1990). The 1996 welfare law provisions discontinued the use of individualized functional assessments for children to determine whether an unlisted impairment seriously limited a child's ability to perform normal activities. The welfare law provisions also eliminated from the listings certain medical criteria relating to maladaptive behavior. The result of these provisions is the loss of SSI benefits by children who qualified as a result of an individualized functional assessment.

<sup>35</sup> 1998 Green Book, p. 302.

<sup>36</sup> Section 4913 of the Balanced Budget Act of 1997, P.L. 105-33. To ensure that states know who these children are, the Social Security Administration has made available an electronic listing. Letter to State Medicaid Directors, October 2, 1998, [www.hcfa.gov/Medicaid/bba10298.htm](http://www.hcfa.gov/Medicaid/bba10298.htm).

<sup>37</sup> See Andy Schneider and Kristen Fennel, *Medicaid Eligibility Policy for Children in Foster Care*. 1999. National Academy for State Health Policy.

<sup>38</sup> 42 C.F.R. 435.227(a).

<sup>39</sup> 1998 Green Book, p. 751.

<sup>40</sup> In *Olmstead v. L.C.* U.S. No. 98-536 June 22, 1999, the Supreme Court held that the Americans With Disabilities Act (ADA) requires states to provide services to persons with mental disabilities in "the most integrated setting appropriate to the needs of qualified individuals with disabilities."

Rosenbaum, Sara. *The Olmstead Decision: Implications for Medicaid*, prepared for the Kaiser Commission on Medicaid and the Uninsured, March 2000.

<sup>41</sup> The state's Medicaid expenditures for services provided to beneficiaries under the waiver may not exceed the amount the state would spend for these beneficiaries absent the waiver in a hospital, nursing facility, or ICF/MR. 42 C.F.R.441.302(f).

<sup>42</sup> 42 C.F.R. 441.305(b).

<sup>43</sup> Urban Institute, 1999.

<sup>44</sup> See generally, McCormick, Thomas P., "Returning to Work and Keeping Medicare and Medicaid." (January 2000).Title II Community AIDS National Network. [www.t2cann.org](http://www.t2cann.org).

<sup>45</sup> 64 FR 18566-02 January 1, 1999. This is the first time the threshold has been increased since 1990.

<sup>46</sup> SSA Program Operations Manual System, SI 02302.200FF, June 1999.

<sup>47</sup> 1998 Green Book, Table 3-13.

<sup>48</sup> McCormack, Thomas P., *Medicaid Expansion is Here Right Now: Section 4733 of the 1997 Balanced Budget Act lets states give Medicaid to many more working clients* (December 1998). Title II Community AIDS National Network. [www.t2cann.org](http://www.t2cann.org)

<sup>49</sup> [64 FR 13428-13430](http://www.federalregister.gov/doc/13428/13430). February 15, 2000. <http://aspe.hhs.gov/poverty>.

<sup>50</sup> The other main difference between this new eligibility pathway and the current BBA pathway has to do with state spending. Under this new option, in order to receive federal Medicaid matching funds for the costs of services to this working disabled population, states must demonstrate to the Secretary a maintenance of effort in state spending. More specifically, the level of State funds expended (other than for Medicaid coverage during the fiscal year for "programs to enable working individuals with disabilities to work" must be at least as great as the level spent by the state for such programs during state fiscal year 1999. States will be able to cover many if not all of the working disabled individuals they could cover under this new option through the BBA option without meeting such a maintenance of effort requirement.

<sup>51</sup> Section 1902(a)(10)(A)(ii)(VI), of the Social Security Act, 42 C.F.R. 435.217.

<sup>52</sup> Jane Horvath, May 1997, Chart #5.

<sup>53</sup> This reduction in the SSI benefit payment does not occur for the first 3 months of institutionalization if a physician certifies that the individual is not likely to stay for more than 3 months and if the individual maintains a home to which he or she may return.

<sup>54</sup> 1998 Green Book, Table 3-4, p. 279.

<sup>55</sup> Jane Horvath, May 1997, Chart#1.

<sup>56</sup> Medicare cost-sharing requirements are: Part A hospital deductible (\$776 per benefit period in 2000); Part A coinsurance; Part B monthly premium (\$45.50 in 2000); Part B annual deductible (\$100); and Part B coinsurance.

<sup>57</sup> Diane Rowland and Barbara Lyons, Henry J. Kaiser Family Foundation, “Medicare, Medicaid, and the Elderly Poor”, *Health Care Financing Review*, Winter 1996, pp. 61-69.

<sup>58</sup> Andy Schneider, Kristen Fennel, and Patricia Keenan, *Medicaid Eligibility and the Elderly*, section IIIB.

<sup>59</sup> Patricia B. Nemore, National Senior Citizens Law Center, *Variations in State Medicaid Buy-in Practices for Low-Income Medicare Beneficiaries* (November 1997), Kaiser Family Foundation, p.7.

1450 G STREET NW, SUITE 250, WASHINGTON, DC 20005  
PHONE: 202-347-5270, FAX: 202-347-5274,  
WEB SITE: WWW.KFF.ORG

*Additional free copies of this publication (#2150) are available on our website or  
by calling our publications request line at 800 656-4533.*