

CHAPTER 1: MEDICAID ELIGIBILITY

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Introduction	5
I. Overview	5
Categorical Eligibility	6
Income Eligibility	6
Resource Eligibility	6
Immigration Status	7
Residency	7
Other Considerations	8
II. Low-Income Children, Parents, and Adults	8
Medicaid's Role for Children, Parents, and Adults	9
Medicaid Eligibility Pathways for Children, Parents, and Adults	11
III. Low-Income Individuals with Disabilities	17
Medicaid's Role for Individuals with Disabilities	17
Disability for Purposes of Medicaid Eligibility	19
Medicaid Eligibility Pathways for Individuals with Disabilities: Full Benefits	20
Medicaid Eligibility Pathways for Individuals with Disabilities: Assistance with Medicare Premiums and Cost Sharing	29
IV. Low-Income Elderly	32
Medicaid's Role for the Low-Income Elderly	32
Medicaid Eligibility Pathways for the Low-Income Elderly: Full Benefits ...	33
Medicaid Eligibility for the Elderly: Assistance with Medicare Premiums and Cost Sharing	38
V. Other Groups	40
VI. Conclusion	41

HIGHLIGHTS

MEDICAID ELIGIBILITY

Medicaid covers three main groups of low-income Americans: parents and children, the elderly, and the disabled. In 1998, Medicaid covered more than 40 million Americans. About 4 million (10 percent) were elderly, nearly 7 million (17 percent) were blind or disabled, about 21 million (51 percent) were children, and 8.6 million were adults in families with children (21 percent).

- Parents and children.** In 1998, Medicaid covered roughly 21 million low-income children and 8.6 million low-income adults in families with children, the vast majority of whom were women. Historically, most women and children eligible for Medicaid were also eligible for cash assistance through the Aid to Families with Dependent Children (AFDC) program. The repeal of the AFDC program by the 1996 welfare law broke the 30-year link between receipt of cash assistance and eligibility for Medicaid. Only 37 percent of the children enrolled in Medicaid receive cash assistance.
- Elderly.** More than 4 million adults 65 and over were covered by Medicaid in 1998. About half were eligible because they were receiving cash assistance through the Supplemental Security Income (SSI) program. Others have too much income to qualify for SSI but “spend down” to Medicaid eligibility by incurring high medical or long-term care expenses. In both cases, these elderly beneficiaries are covered for nursing home care and prescription drugs as well as other Medicaid services. In addition, some elderly Medicare beneficiaries are eligible for Medicaid payment of their Medicare premiums (but not their nursing home care or prescription drug expenses).
- Disabled.** Nearly 7 million individuals with disabilities were covered by Medicaid in 1998. Almost 80 percent were eligible because they received cash assistance through the SSI program. The remainder generally qualified for Medicaid by incurring large hospital, prescription drug, nursing home, or other medical or long-term care expenses to meet their “spend down” obligation. In addition, some disabled Medicare beneficiaries receive assistance with their Medicare premiums through the Medicaid program.

For each group there are numerous statutory and regulatory “pathways” for establishing eligibility. Each pathway is defined by specific income and resource requirements that are determined by each state within federal guidelines. Some of these pathways apply in all states; for example, all states must cover pregnant women with family incomes below 133 percent of the federal poverty level. Other eligibility pathways are available only in those states that choose to cover them.

In general, individuals must be American citizens in order to qualify for Medicaid. Illegal aliens who are otherwise eligible for Medicaid cannot qualify except for emergency care. Legal immigrants can qualify under certain circumstances, depending on their date of entry.



INTRODUCTION

BECAUSE FEDERAL MEDICAID LAW allows states broad discretion over Medicaid eligibility policy, Medicaid eligibility varies widely from state to state. Medicaid’s flexibility and open-ended federal matching funds have enabled states to use the program to extend health care coverage to uninsured low-income populations. The incremental expansion of Medicaid eligibility options available to the states is one of the main tools available to federal policymakers for reducing the number of uninsured Americans.

This chapter is organized around the three broad populations that Medicaid covers: families with children; individuals with disabilities; and the elderly. The chapter begins with an overview of federal eligibility policies that apply to each of these populations, such as categorical eligibility rules, financial eligibility rules, immigration status, and residency requirements. It then turns to each of the major population groups and delineates the federal requirements and state options specific to each group. It also discusses coverage groups that are distinguished by a particular disease or condition.

The chapter does not attempt to describe Medicaid eligibility policy for low-income individuals in each state. Instead, the focus is on the federal policies that structure the eligibility choices that states make. This chapter does not cover all federal policies related to Medicaid eligibility; several are addressed in other chapters. Medicaid outreach and enrollment procedures (as distinguished from eligibility criteria) are discussed in the chapter on Medicaid Administration. Medicaid section 1115 demonstration waivers, which have been used by some states to expand Medicaid coverage to groups not normally eligible, are discussed in the chapter on Medicaid Financing.

I. OVERVIEW

Medicaid is a means-tested, federal-state, individual entitlement with historical ties to the former Aid to Families with Dependent Children (AFDC)¹ and the Supplemental Security Income (SSI)² cash assistance programs. Medicaid eligibility policy reflects this program structure. Medicaid is means-tested; therefore, it has extensive rules for determining an individual’s income and resources. Furthermore, 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 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.

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 such as adults with disabilities and the elderly—but not other categories like childless, non-disabled adults under age 65. If federal matching funds are not available for a particular category, 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 electing 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 to them. 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. Nationally, about 44% of all Medicaid spending in 1998 was for optional eligibility groups.³

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 all financial and non-financial requirements. These may vary from state to state.

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. 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. The federal Medicaid statute also establishes some eligibility categories based on a particular disease or condition (e.g., tuberculosis, breast cancer).

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 from the income and resource tests applicable to the elderly in most if not all states.

All Medicaid eligibility categories but one are subject to an income test.⁴ Many of these tests vary from category to category (and from state to state). In some cases—e.g.,

pregnant women, children, working disabled individuals, or low-income Medicare beneficiaries—income eligibility standards are tied directly to specified percentages of the federal poverty level (e.g., 100%, 120%, 133%, 135%, 175%, 185%, and 250%). In other cases, such as individuals residing in nursing facilities, income eligibility standards are tied to the federal cash assistance programs (e.g., 300% 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; for example, \$716 per month (100% of the 2001 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. Then it may disregard certain types or amounts of income—e.g., \$20 in monthly income. The standard is meaningless without the methodology. Indeed, the methodology is what converts the nominal dollar standard into the actual amount that an individual can have and still qualify. For instance, if a \$20 income disregard applies to a \$716 standard, an individual can have \$736 in actual income and still qualify.

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 that total to a value less than a specified amount in order to qualify for Medicaid. Resources include items such as cars and savings accounts.

As in the case of income eligibility requirements, resource requirements include both standards and methodologies. A resource *standard* is a dollar amount—typically \$1,000 in the case of a family with children; \$2,000 for an elderly individual or 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, the first \$1,500 in equity value of a car 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 families with children, the resource methodology used by some states in their former AFDC or current TANF programs is the methodology most commonly used for Medicaid eligibility purposes. In the case of the elderly and individuals with disabilities, the resource methodology used by the SSI program is the methodology most commonly used.

The AFDC resource methodology does not count the first \$1,000 in personal or real property for each family unit, excluding the value of the family's home (if any), \$1,500 in equity value in an automobile, and burial plots and funeral arrangements. 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 when 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.⁵

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* cannot qualify for basic Medicaid benefits, although they are eligible for Medicaid coverage for emergency medical 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, depending on the year in which

they entered the country, they may or may not be eligible for the full range of Medicaid services.⁶

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. (Nearly all states 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 five-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. Immigrants who live in states that grant Medicaid eligibility to SSI recipients are eligible for Medicaid, while those in states that generally use more restrictive eligibility rules for SSI recipients are eligible only if they meet these limitations.⁷ Some states use state-only funds to cover immigrant children and pregnant women who are not eligible for federal Medicaid financing.

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. States are prohibited by federal law from denying Medicaid coverage because an individual has not resided in a state for a specified minimum amount of time.

When an elderly individual or an individual with disabilities enters a nursing facility or other institution that 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 facility is located. Thus, it is the state where the institution is located, that determines the individual's eligibility for

Medicaid under its rules and pays for the services covered under its Medicaid program.

Other Considerations

In addition to the five broad requirements, there are three other important features of Medicaid eligibility. The first has to do with multiple eligibility “pathways,” or ways of qualifying for Medicaid coverage. As discussed in this chapter, for each of the major eligibility categories (e.g., children, pregnant women, etc.) there are numerous pathways, each of which has its own unique income, resource, and other requirements. An individual may qualify under more than one pathway. Once an individual has established eligibility under any particular pathway, it is not necessary for the individual to qualify under any other pathway in order to receive Medicaid coverage. However, if a Medicaid beneficiary loses eligibility under one pathway, the state Medicaid agency must determine that the individual is not eligible under any other available pathway before terminating Medicaid coverage altogether.⁸

A second important feature of Medicaid eligibility has to do with private insurance coverage. With one exception, the fact that an individual has private insurance coverage is irrelevant to whether the individual qualifies for Medicaid. Whether an individual qualifies for Medicaid depends on the individual’s ability to meet the five broad financial and non-financial requirements described above. If the individual qualifies, any private insurance coverage the individual may have is treated as “third party liability” (TPL)—that is, a third party payer is liable for some of the costs of care provided to the beneficiary. (Medicare, like private insurance, is also treated as TPL.) The third party’s payments reduce the costs of coverage for Medicaid. This policy—that private insurance coverage is not disqualifying—contrasts sharply with the policy of the State Children’s Health Insurance Program (SCHIP), under which children with private insurance coverage are ineligible for benefits. The one exception in the Medicaid program is the optional eligibility category for women diagnosed with breast or cervical cancer, which is discussed later in this chapter.

A modified version of this approach extends to Americans for whom the federal government has established a separate health system—e.g., veterans (the Veterans’ Hospitals) and Native Americans (the Indian Health Service (IHS)). For example, if an American Indian or Alaska Native is categorically eligible for Medicaid and meets the financial criteria in the state in which he or she resides, the individual is entitled to Medicaid coverage, even though he or she may also be eligible for services from the Indian Health Service. However, unlike an

individual with private coverage, whose insurer would be the first dollar payer, in the case of a Medicaid beneficiary who is also eligible for coverage through IHS, Medicaid is the first dollar payer.⁹

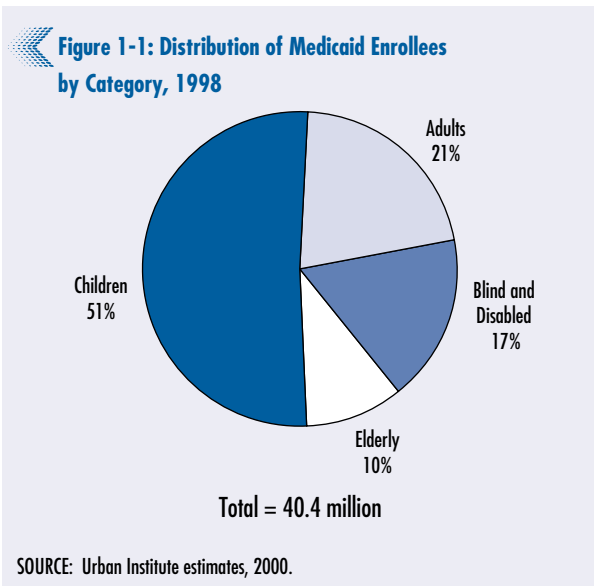
Finally, Medicaid eligibility, once established, is not indefinite. Federal Medicaid regulations require that states redetermine the eligibility of a Medicaid beneficiary at least once every 12 months. This redetermination, like the initial eligibility process, is designed to ensure that a beneficiary 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. In addition, in the case of individuals who qualify on the basis of disability, administrative determinations as to whether an individual remains disabled for purposes of Medicaid eligibility are also subject to periodic review.

The remainder of this chapter describes the federal requirements and state options that are specific to each of three broad populations that Medicaid covers: families with children, individuals with disabilities, and the elderly. The requirements and features described above apply to each of these populations.

This chapter is not exhaustive. It does not discuss every one of the 28 mandatory eligibility groups and 21 optional eligibility groups identified by the Center for Medicaid and State Operations (CMSO) under federal statute.¹⁰ Similarly, this chapter does not address every regulatory issue in Medicaid eligibility policy.¹¹ It does, however, provide a reasonably comprehensive overview of the coverage options available to states as they establish their Medicaid eligibility policies.

II. LOW-INCOME CHILDREN, PARENTS, AND ADULTS

Of the 40 million Americans covered by Medicaid in 1998, more than half were children and about a fifth were adults in low-income families (Figure 1-1). This makes Medicaid the nation’s single largest health insurer of children. Medicaid is also the nation’s largest insurer of maternity care. Historically, Medicaid’s role was to provide coverage primarily to families with dependent children who were receiving cash assistance. That role has evolved over time, and today Medicaid is the health insurer for millions of low-income families and children who have no connection with the welfare system. This section discusses the role that Medicaid plays as an insurer for children and for pregnant women, as well as for adults in families with dependent children and for



childless adults. It also summarizes the pathways by which individuals in these categories establish Medicaid eligibility.

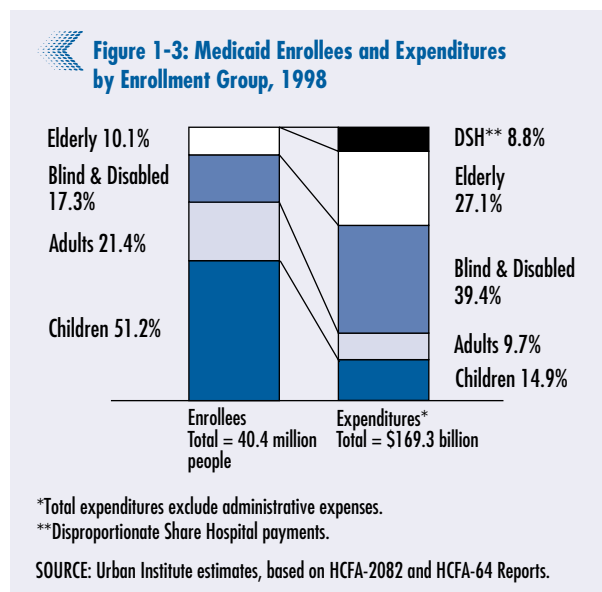
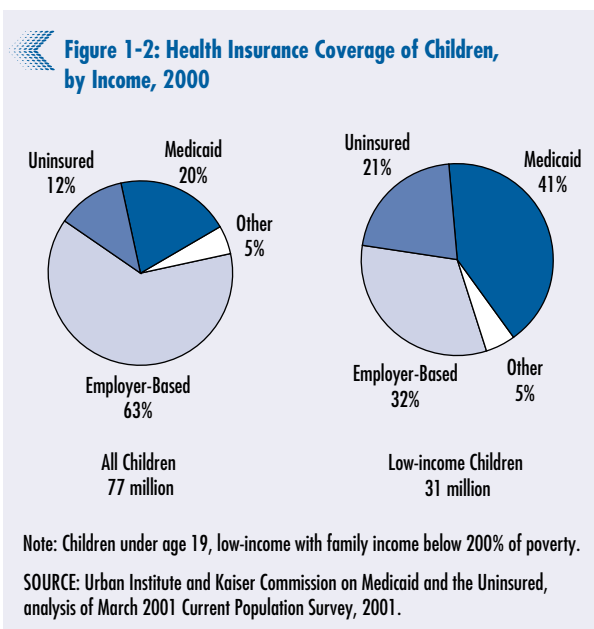
Medicaid's Role for Children, Parents, and Adults

Children. In 1998, Medicaid covered 20.6 million children, or one out of every five children in the United States. As might be expected, the program is particularly

important to low-income children. As shown in Figure 1-2, low-income children are twice as likely to be covered by Medicaid as children generally. Note that these proportions mask significant state-to-state variation. Different income eligibility levels in each state result in variations in Medicaid coverage across the country, ranging from 24 percent of low-income children in Virginia to 60 percent in Vermont for the two-year period between 1999 to 2000.¹²

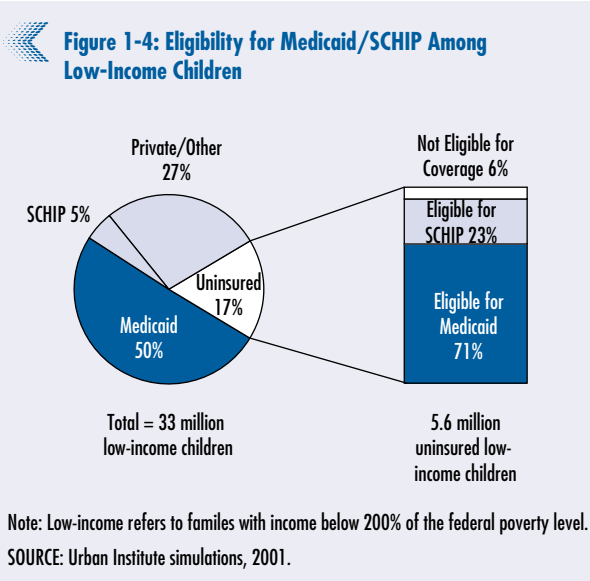
While children represent over half of all Medicaid enrollees, they account for only about 15 percent of program spending (Figure 1-3). Per capita costs for children are the lowest among the groups eligible for Medicaid, at \$1,225, compared to \$9,558 for blind and disabled enrollees and \$11,235 for elderly enrollees in 1998.¹³

Medicaid does not reach all low-income children. Approximately nine million children remained uninsured in 2000. Congress enacted the State Children's Health Insurance Program (SCHIP) in 1997 to allow states to extend health insurance coverage to uninsured children



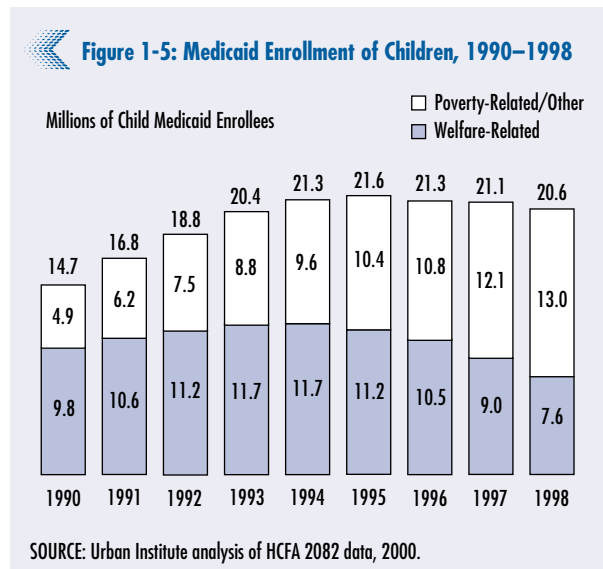
with family incomes below 200 percent of poverty. As of December 2001, 3.5 million children were enrolled in SCHIP.¹⁴ Urban Institute researchers have estimated that taken together, Medicaid and SCHIP have the potential to cover nearly all (96%) low-income uninsured children (Figure 1-4).

There have been two notable trends in Medicaid enrollment of children over the past decade, which are illustrated in Figure 1-5. First, Medicaid enrollment of children declined for three successive years. Some of



this reduction has been attributed to the implementation of the 1996 changes in federal welfare law and federal immigration policy.¹⁵ The second trend is that the number and percentage of children who qualify for Medicaid because they receive cash assistance has been declining. In 1990, two-thirds of children enrolled in Medicaid were also receiving cash assistance; in 1998, the proportion of all Medicaid-enrolled children receiving cash assistance fell to almost one-third. (Data on Medicaid enrollment of children for 1999 were not available as of December 2001.)

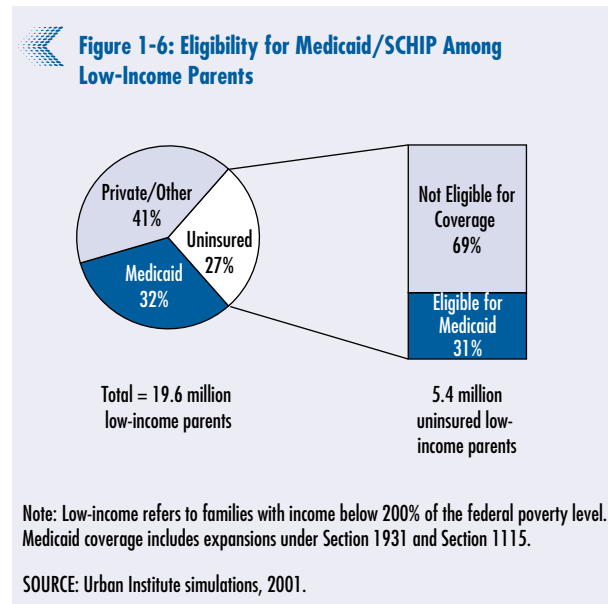
Pregnant Women. In 1998, Medicaid paid for over one million, or over one-third, of the live births nationally,

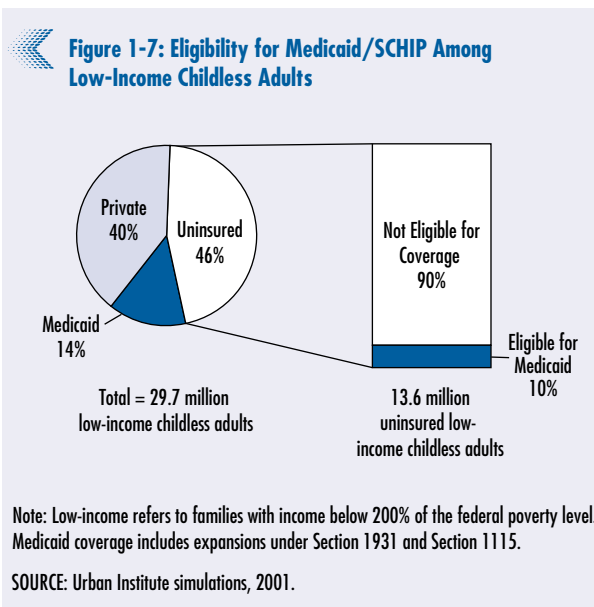


ranging from 20 percent of the live births in New Hampshire to 51 percent in New Mexico.¹⁶ All pregnant women, regardless of age or family circumstances, are eligible for Medicaid if their incomes are at or below 133 percent of the federal poverty level (which equaled \$1,621 per month for a family of three in 2001). States can extend Medicaid coverage to pregnant women at higher income levels and may impose a resource test. Entitlement to coverage extends throughout the pregnancy and for 60 days postpartum and includes prenatal visits, delivery, and other pregnancy-related care. (See Chapter 2, Medicaid Benefits.)

Low-Income Parents. Low-income parents of minor children may qualify for Medicaid, but the income eligibility standards are generally not tied to the federal poverty level. Instead, the Medicaid eligibility standard is usually tied to the standard used in a state's Temporary Assistance to Needy Families (TANF) program, which tends to be considerably lower than the 133 percent of the federal poverty level used for pregnant women (about 41% of the federal poverty level, on average, in 1996).¹⁷ As a result, it has been estimated that over two-thirds of uninsured low-income parents were ineligible for Medicaid, as shown in Figure 1-6. Because the income standard for this population is not tied to the federal poverty level, Medicaid coverage for this group is less secure. For example, between 1994 and 1998 the proportion of low-income single mothers enrolled in Medicaid fell from 54 percent to 39 percent.¹⁸

Childless Adults. There is no Medicaid eligibility category for childless adults. Adults who are not





disabled, pregnant, or elderly and have no minor children generally cannot qualify for Medicaid regardless of their degree of impoverishment. (There are some limited eligibility categories into which some childless adults fit; these are discussed in the section on other groups, below.) The only way in which states can obtain federal Medicaid matching funds for childless adults as a group is through a section 1115 waiver. (See Chapter 3, Medicaid Financing.) Consequently, only about ten percent of uninsured low-income adults without children qualify for Medicaid, as shown in Figure 1-7.

Medicaid Eligibility Pathways for Children, Parents, and Adults

There are many different eligibility pathways that a child or family may use to establish an entitlement to Medicaid coverage. Individuals may potentially qualify for Medicaid under more than one pathway. As discussed earlier in this chapter, there are additional requirements relating to immigration status and residency that apply to all of these pathways. This section reviews the main pathways under federal Medicaid law for children, pregnant women, and non-disabled adults.

Low-Income Children. The main federal statutory pathways through which a low-income child may qualify for Medicaid are summarized in Table 1-1. The pathways are divided into mandatory and optional groupings. For each pathway, the basic income and resource standards are set forth. Table 1-1 is not exhaustive; federal law contains other eligibility categories affecting children.¹⁹

The two primary eligibility pathways for children are (1) membership in a family (one-parent or two-parent) with an income below specified federal poverty level thresholds; and (2) membership in a one-parent (and in some cases two-parent) family with dependent children with income and resources sufficiently low to meet the July 16, 1996 AFDC standards in the state of residence. Unlike the AFDC standards, federal poverty level thresholds are automatically adjusted each year for inflation.²⁰ In 2001, the federal poverty level for a family of three was \$14,630 per year, or \$1,219 per month.

Federal mandatory income thresholds for children vary by age. The minimum income standard for children up to (but not including) age six is 133 percent of the federal poverty level (\$1,621 per month for a family of three in 2001). For children ages six through 18, the minimum income standard is 100 percent of the federal poverty level (\$1,219 per month for a family of three in 2001). This differential has the effect of creating age-based “steps” that divide families into those children eligible for Medicaid and those who are not. For example, in a family with two children age five and age ten with an income at 125 percent of poverty, only the five-year old would qualify for Medicaid coverage under these federal minimum standards.

States have the flexibility to eliminate these “steps” by modifying their income standards for children age six and over. Section 1902(r)(2) of the Social Security Act allows states to use more liberal methodologies than those that apply under the former AFDC program in counting family income.²¹ States can use this flexibility to “even out” age-based income eligibility standards so that all children in a family are eligible for Medicaid. As of 2000, 18 states had used this flexibility to even out eligibility levels, but 33 states still maintained eligibility “steps.”²²

This matrix of mandatory and optional eligibility pathways, combined with different policy decisions made by different states, has resulted in variation from state to state in Medicaid eligibility thresholds for children. Another layer of complexity not reflected in this table comes from the implementation of SCHIP.²³ Thirty-five states are using federal SCHIP matching funds to finance Medicaid eligibility expansions for children.²⁴ Other states have chosen to create separate programs to expand coverage for children. As an example of the complexity that can arise from the various eligibility pathways, plus SCHIP coverage, consider the case of a single-parent family with two children age five and age 17 and an income at 50 percent of the poverty level in 2000. In Colorado, the five-year old would be eligible for Medicaid, the 17-year old would qualify for SCHIP, while



TABLE 1-1: PRINCIPAL MEDICAID ELIGIBILITY PATHWAYS FOR LOW-INCOME CHILDREN, 2001

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
Infants under age 1	≤ 133% FPL*	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ \$1,000 in countable resources per family)
Children age 1 to 5	≤ 133% FPL*	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ \$1,000 in countable resources per family)
Children age 6 to 19^a	≤ 100% FPL*	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ \$1,000 in countable resources per family)
Section 1931 children^b	State AFDC level as of 7/16/96	State AFDC level as of 7/16/96
Children in welfare-to-work families (12-month Transitional Medical Assistance)	Family receives cash assistance in 3 of 6 months prior to ineligibility due to increased earnings up to 185% FPL*	No resource test during coverage period
Title IV-E foster care children	State AFDC level as of 7/16/96	State AFDC level as of 7/16/96
Title IV-E adoption assistance children^c	State AFDC level as of 7/16/96, or SSI level before adoption ^d	State AFDC level as of 7/16/96, or SSI level before adoption ^d
OPTIONAL COVERAGE	Eligibility Criteria	
Primary Pathways		
Infants under age 1	≤ 185% FPL*	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ \$1,000 in countable resources per family)
Children age 1 through 5	> 133% FPL*	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ \$1,000 in countable resources per family)
Children age 6 to 19	> 100% FPL*	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ \$1,000 in countable resources per family)
Targeted low-income children age 18–19 born before 10/1/83	≤ 100% FPL*	Optional; if used, no more restrictive than state AFDC level as of 7/16/96 (≤ \$1,000 in countable resources per family)

* In 2001, 100 percent of the FPL for a family of three was \$14,630/year, or \$1,219/month; 133 percent of the federal poverty level (FPL) for a family of three was \$19,458/year, or \$1,621/month; 185 percent of the FPL for a family of three was \$27,066/year, or \$2,255/month.

^a Social Security Act requires coverage of children to age 19 at or under 100 percent of the FPL born after September 1983. Under this provision, coverage is being phased in one year at a time. By October 2002, all of these children under 19 will be covered. States can choose to accelerate the coverage phase-in.

^b Section 1931(b) allows states to use income and resource methodologies that are “less restrictive” than those used under the state AFDC program as of July 16, 1996. This flexibility does not allow states to liberalize the AFDC family composition rules.

^c Children covered under Title IV-E adoption assistance agreements are defined as “special needs” children, with respect to whom the state determines there is a specific condition or situation (such as disability, age, or membership in a minority group) that prevents placement without special assistance.

^d The 2001 SSI income levels are less than or equal to \$531 per month for an individual and \$796 per month for a couple. The SSI resource level is less than or equal to \$2,000 for an individual and \$3,000 for a couple.



TABLE 1-1: PRINCIPAL MEDICAID ELIGIBILITY PATHWAYS FOR LOW-INCOME CHILDREN, 2001 (continued from previous page)

OPTIONAL COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
Non-Title IV-E foster care children	State AFDC level as of 7/16/96	State AFDC level as of 7/16/96
Non-Title IV-E adoption assistance children	Title IV-E foster care level	Title IV-E foster care level
Medically needy children under age 18	“Spend down” to eligibility by incurring medical expenses	No more restrictive than state AFDC level as of 7/16/96 (≤ \$1,000 in countable resources per family)
Other Pathways		
Ribicoff children^e	State AFDC level as of 7/16/96	State AFDC level as of 7/16/96

Some mandatory and optional pathway thresholds are subject to expansion through use of “less restrictive” methodologies under section 1902(r)(2).^f

* In 2001, 100 percent of the FPL for a family of three was \$14,630/year, or \$1,219/month; 133 percent of the federal poverty level (FPL) for a family of three was \$19,458/year, or \$1,621/month; 185 percent of the FPL for a family of three was \$27,066/year, or \$2,255/month.

^e States also have the option of covering reasonable categories of children under age 21 who are not receiving cash assistance but whose family incomes and resources meet the state’s July 16, 1996 AFDC standards. As a practical matter, the pathways for poverty-related children have largely superseded this “Ribicoff children” pathway.

^f For certain eligibility categories, section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are “less restrictive” than those used under their AFDC programs as of July 16, 1996, enabling them to expand Medicaid eligibility without changing the income and resource standards. This provision applies to all poverty-level infants and children categories (mandatory and optional) as well as to medically needy children. As noted in footnote b, the section 1931(b) eligibility category contains its own “less restrictive” flexibility.

the mother would be ineligible for any coverage. In Ohio, however, all three members of the family would be covered under Medicaid.²⁵

States have the option to move beyond minimum eligibility standards. As of January 2001, 45 states had accelerated phase-in of adolescent coverage, covering all poor children to age 18 under Medicaid. In addition, every state had gone beyond federal requirements and offered coverage to all children, regardless of age, to at least 133 percent of poverty (\$1,621 per month for a family of three in 2001) either through Medicaid or SCHIP.²⁶

Low-Income Pregnant Women. Pregnant women can qualify for Medicaid as either low-income parents or as children, depending upon the woman’s individual circumstances. The primary eligibility pathway, however, is the mandatory “poverty-related pregnant woman” category, defined by the condition of pregnancy combined with a family income at or below 133 percent

of the federal poverty level (\$1,621 per month for a family of three in 2001). States have the option of raising the income standard for pregnant women to 185 percent of the federal poverty level (\$2,255 per month for a family of three in 2001) and, as of October 2000, 33 states had done so. In addition, states have the flexibility to use “less restrictive” income and resource methodologies, and some have raised effective eligibility levels to as high as 300 percent of the federal poverty level.²⁷ In states with “medically needy” programs, pregnant women with incomes above these poverty-level thresholds may “spend down” into Medicaid eligibility if their medical expenses are sufficiently high. Table 1-2 shows the principal eligibility pathways for pregnant women.

Low-Income Parents. There are two mandatory eligibility pathways for low-income parents: “Section 1931” and Transitional Medical Assistance (TMA) (Table 1-3). States also have the option of expanding Medicaid coverage for low-income parents beyond these minimum requirements



TABLE 1-2: PRINCIPAL MEDICAID ELIGIBILITY PATHWAYS FOR PREGNANT WOMEN, 2001

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
Pregnant Women	≤ 133% FPL*	Optional; if used, no more restrictive than SSI test (≤ \$2,000 in countable resources for individual)
OPTIONAL COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
Pregnant women	≤ 185% FPL*	Optional; if used, no more restrictive than SSI test (≤ \$2,000 in countable resources for individual)
Other Pathways		
“Medically needy”	Spend down to eligibility by incurring medical expenses	No more restrictive than state AFDC test as of 7/16/96 (≤ \$1,000 in countable resources per family)

Mandatory and optional pathway thresholds are subject to expansion through 1902(r)(2) “less restrictive” methodologies.^a

* In 2001, 133 percent of the federal poverty level (FPL) for a family of three was \$19,458/year, or \$1,621/month; 185 percent of the FPL for a family of three was \$27,066/year, or \$2,255/month.

^a For certain eligibility categories, section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are “less restrictive” than those used under the state AFDC programs as of July 16, 1996, enabling states to expand Medicaid eligibility without changing the income and resource standards. This flexibility applies to each of the eligibility pathways set forth in this table.

by using less restrictive income and resource methodologies in connection with section 1931 eligibility and by covering the medically needy category. States can use these options to align Medicaid eligibility policy for low-income parents with that for low-income children. Because mandatory eligibility criteria for low-income parents are lower than those for low-income children, this alignment will expand Medicaid coverage for low-income parents. At the same time, this alignment has the potential to increase enrollment on the part of eligible low-income children, whose parents are more likely to enroll their children if they are able to enroll themselves.²⁸

Prior to the repeal of AFDC in 1996, adults and children in families receiving AFDC cash assistance were automatically eligible for Medicaid. With the enactment of the Personal Responsibility and Work Opportunity

Reconciliation Act of 1996 (P.L. 104-193), families receiving cash assistance under the Temporary Assistance to Needy Families (TANF) program are no longer automatically eligible for Medicaid by virtue of their receipt of cash assistance. Instead, a new eligibility category, found at section 1931 of the Social Security Act, was created for these adults and children. Under section 1931, a state Medicaid program must cover families that meet the AFDC eligibility criteria that were in effect in a state as of July 16, 1996, whether or not the family receives cash assistance under the state’s TANF program.

The AFDC eligibility criteria include two basic elements: categorical and financial. The categorical requirement is that the family be either a single-parent family or a two-parent family in which the principal earner is

unemployed (i.e., does not work more than 100 hours each month). The financial requirement is the AFDC income and resource standards in effect in the state as of July 16, 1996. Note that these financial requirements are generally much lower than those that apply to children under Medicaid. The Center on Budget and Policy Priorities calculated that in 2000 the median state income standard that represents the threshold under the section 1931 eligibility category is 56 percent of the federal poverty level, or \$688 per month for a family of three.²⁹ This compares with 200 percent of poverty, or \$2,438 per month for a family of three, in the case of children.

The other mandatory eligibility group concerns working low-income parents who become ineligible for Medicaid due to an increase in earnings. States are required to provide Transitional Medical Assistance (TMA) to both the parents and children in these families. Under TMA, working families are entitled to Medicaid for at least six months and as many as 12 months if their income does not exceed 185 percent of the federal poverty level, net of child care expenses.³⁰ A number of states have chosen to extend TMA to working families beyond the required 12-month period.³¹ In order to qualify, families must have been on Medicaid for three of the six preceding months, requiring that families apply soon after losing their earlier Medicaid coverage due to increased earnings.

While TMA offers an important support for families transitioning from welfare to work, administrative difficulties in identifying and educating families who qualify have contributed to the underutilization of this eligibility pathway.³² In 1997, one year after leaving cash assistance, 22 percent of women retained Medicaid coverage while nearly half (49%) of women were

uninsured (Figure 1-8). The TMA provision sunsets on September 30, 2002; if not extended, the 12-month period of coverage will be reduced to four months.

States have the option to expand coverage for low-income parents beyond the mandatory groups described above. There are two approaches states may take: expanding categorical eligibility and expanding financial eligibility. Section 1931's mandatory categorical criteria limit Medicaid coverage to non-disabled adults in single-parent households with a minor child or to non-disabled adults in two-parent households where the principal earner is unemployed.³³ This is a vestige of the pre-1996 welfare law "deprivation" requirements, under which "a child in a family must be deprived of parental support and care by reason of the death, absence, incapacity, or unemployment of a parent."

Under section 1931, states have the option of covering all two-parent families, not just those in which the principal earner is unemployed. Under a federal regulation issued in 1998, states have the option of defining unemployment, although they cannot be more restrictive than the pre-1996 welfare law standard, which generally prohibited the principal earner from working more than 100 hours per month. This new flexibility, in effect, eliminates the "100-hour rule," allowing states to treat two-parent families as they treat single parent families, by simply applying an income test in determining Medicaid eligibility and ignoring the number of hours worked.³⁴

With respect to financial eligibility, section 1931 also gives states the option to use "less restrictive methodologies" than those used in their former AFDC programs to calculate family income and resources when determining Medicaid eligibility. As with income eligibility standards for children, states can modify their income standards for the parents of these families by adjusting the methodologies used for counting income and resources, enabling states to make more people eligible for Medicaid.³⁵ As of 2000, most states were using at least one of the options available under section 1931 to simplify or expand Medicaid coverage for parents; however, only seven states had taken advantage of this categorical and financial flexibility to cover low-income parents up to the poverty level.³⁶

States interested in expanding Medicaid coverage of low-income parents have another policy option, not found in the Medicaid statute but rather in section 1115 of the Social Security Act. "Demonstration" waivers approved by the Secretary of HHS under this authority enable states to receive federal Medicaid matching funds for the cost of covering populations, for which federal funds would otherwise not be available. As of 2000, four states

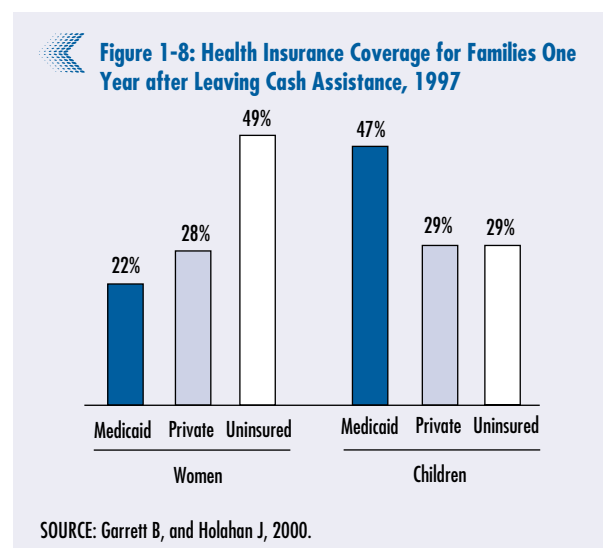




TABLE 1-3: PRIMARY MEDICAID ELIGIBILITY PATHWAYS FOR LOW-INCOME PARENTS, 2001

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
Section 1931: Parents in low-income families with dependent children	State AFDC level as of 7/16/96	State AFDC level as of 7/16/96 (≤ \$1,000 in countable resources)
Parents in welfare-to-work families (12-month Transitional Medical Assistance)	Family receives cash assistance in 3 of 6 months prior to ineligibility due to increased earnings; earnings during TMA coverage period (less child care costs) cannot exceed 185% FPL*	No resource test during coverage period
OPTIONAL COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
Section 1931: Parents in low-income families with dependent children^a	State discretion under section 1931(b) to use higher income level than state AFDC level as of 7/16/96	State discretion under section 1931(b) to use higher resource level than state AFDC level as of 7/16/96
Other Pathways		
“Medically needy”^b	“Spend down” to eligibility by incurring medical expenses	No more restrictive than state AFDC test as of 7/16/96 (≤ \$1,000 in countable resources per family)

* In 2001, 185 percent of the FPL for a family of three was \$27,066/year, or \$2,255/month.

^a Covered adults include single parents and adults in two-parent households where the principal wage earner is unemployed. Section 1931(b) of the Social Security Act allows states to use income and resource methodologies that are “less restrictive” than those used under the state AFDC program as of July 16, 1996, effectively expanding Medicaid eligibility. This flexibility does not allow states to liberalize the AFDC family composition rules although a regulation enables states to amend these rules.

^b For certain eligibility categories, section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are “less restrictive” than those used under their AFDC program as of July 16, 1996, enabling states to effectively expand Medicaid eligibility without changing the income and resource standards. This flexibility applies to the “medically needy” eligibility pathway.

(Minnesota, Missouri, Rhode Island, and Wisconsin) used section 1115 waivers to extend Medicaid coverage to low-income parents.³⁷

The Secretary of HHS has granted waivers allowing a number of states to expand Medicaid eligibility beyond the allowable statutory categories. As of 2001, Delaware, Hawaii, Massachusetts, New York, Oregon, Tennessee, and Vermont all operate statewide section 1115 demonstration programs to cover adults—including parents—in Medicaid. Unlike the four states (Minnesota, Missouri, Rhode Island, Wisconsin) that use section 1115 specifically for family coverage, all these states have also

extended Medicaid eligibility to childless adults who would otherwise be excluded for family composition reasons.³⁸ In some cases, states had previously covered some or all of these adults under their General Relief or General Assistance programs entirely at state or local expense; the section 1115 waiver enables these states to draw down federal Medicaid matching funds for part of the cost of this coverage. (See Chapter 3, Medicaid Financing.)

Childless, Nondisabled Adults Under 65. Since its inception, the Medicaid program’s eligibility categories have excluded low-income adults without dependent

children who are not disabled and not elderly. As a general rule, states cannot receive federal matching funds for extending Medicaid to adults in this category, regardless of the extent of their poverty or medical need. Historically, the policy rationale for this exclusion was that these individuals, unlike women with dependent children, individuals with disabilities, or the elderly, were not “deserving” poor. The financing implication of this policy is that states and localities bear the cost of whatever uncompensated health care services the public sector providers furnish to these individuals; similarly, private hospitals and physicians that furnish emergency or urgent care services to these adults cannot look to Medicaid for payment.

One federal policy that in part addresses this categorical exclusion is the Medicaid “disproportionate share hospital” (DSH) program, discussed in Chapter 3, Medicaid Financing. Under this program, qualifying hospitals receive Medicaid payments for the costs of treating uninsured patients, including low-income childless, nondisabled adults. As discussed on page 16, the other federal policy that addresses this exclusion is the section 1115 waiver authority, also discussed in the Financing chapter, which has been used to allow states to extend Medicaid coverage with federal financial participation to childless, nondisabled adults.

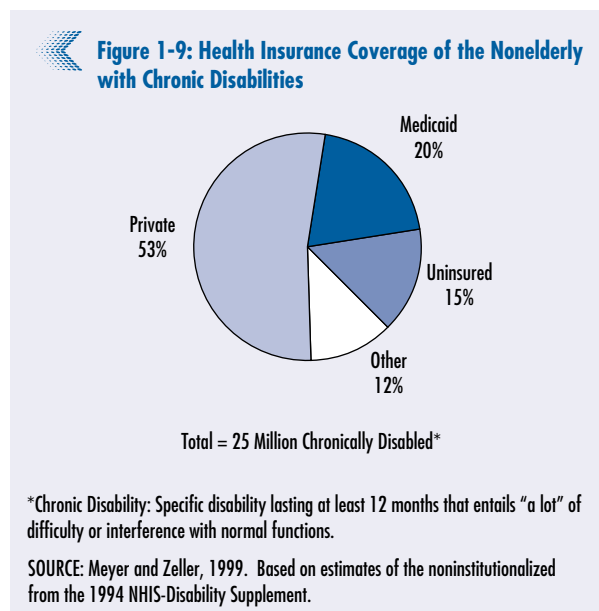
III. LOW-INCOME INDIVIDUALS WITH DISABILITIES

Of the 40 million Americans covered by Medicaid in 1998, about one sixth—6.9 million—were nonelderly adults who qualified on the basis of a disability. In the case of some types of disabilities, Medicaid is the nation’s single largest insurer. For example, Medicaid covers over 50 percent of all persons living with AIDS and is the largest single payer of direct medical services for these individuals.⁴⁰ This section discusses the role that Medicaid plays as an insurer for low-income children and non-elderly adults with disabilities and discusses the specialized meaning of disability for purposes of establishing Medicaid eligibility. The section summarizes the various pathways in federal Medicaid law through which individuals with disabilities may establish Medicaid eligibility. It examines the following groups: 1) children, 2) non-elderly adults who are not in institutions, 3) those who are at risk of institutionalization, and 4) those who are institutionalized. This section also reviews the eligibility pathways to assistance with Medicare cost-sharing. Medicaid’s role for low-income elderly individuals with disabilities is discussed in the next section.

Medicaid’s Role for Individuals with Disabilities

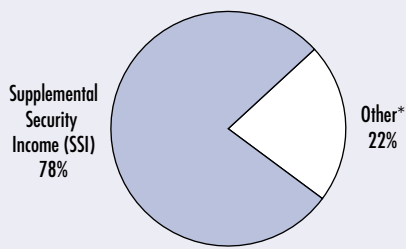
The Medicaid program plays an important role for many Americans with disabilities. People with disabilities are more likely to be enrolled in Medicaid than the general population; they are also less likely to have private health insurance. One in five non-elderly persons with a chronic disability who live in the community has health coverage through Medicaid (Figure 1-9). 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.⁴¹

In 1998, Medicaid covered 6.9 million low-income, non-elderly individuals who qualified on the basis of a disability (Figure 1-10). Nearly four-fifths of low-income persons with disabilities who qualify for Medicaid do so because they receive cash assistance under the Supplemental Security Income (SSI) program (Figure 1-10). However, there are numerous other eligibility pathways for individuals with disabilities who do not receive SSI payments.



Medicaid plays a significant role for the disabled poor, particularly for children and low-income adults. Medicaid covers 78 percent of poor children under age five with disabilities and 70 percent of poor children ages 5 through 17 with disabilities. Similarly, Medicaid covers a substantial portion of children with disabilities who are near poor, covering 40 percent of children up to age four with disabilities and 25 percent of children ages five through 17 with disabilities. Medicaid also covers some

Figure 1-10: Disabled Medicaid Enrollees, by Basis of Eligibility, 1998



Total = 6.9 Million

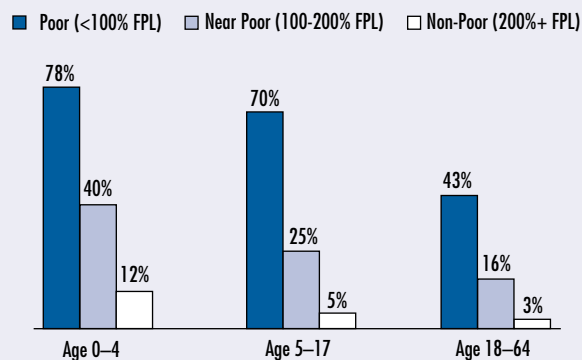
SOURCE: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports
*Other eligibility pathways include the "spend down" category.

working age adults with disabilities, predominantly those who qualify through SSI, but coverage falls off substantially as income increases (Figure 1-11).⁴²

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 1998, disabled individuals in Medicaid accounted for only 17 percent of all beneficiaries, but 39 percent of total Medicaid expenditures (Figure 1-3, page 9).⁴³ Medicaid spends, on average, nearly eight times more for a disabled beneficiary than for a child who qualifies for Medicaid based on income (Figure 1-12).

Medicaid beneficiaries with disabilities are a diverse group ranging in age from very young children to older adults. Types of disabilities include physical impairments

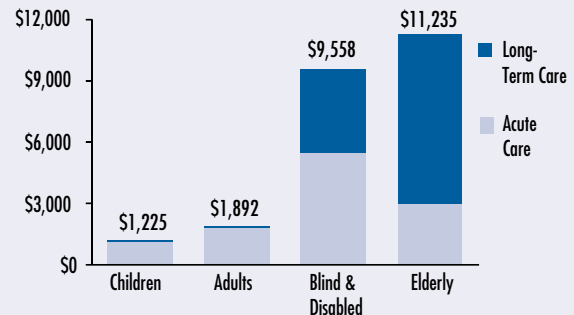
Figure 1-11: Medicaid Coverage of People with Any Disability, by Poverty Level and Age



SOURCE: Economic and Social Research Institute, Based on data from the 1994 National Health Interview Survey, Disability Supplement, Phase 1, April 1999.

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, Down's syndrome, mental retardation, muscular dystrophy, autism, spina bifida and HIV/AIDS.⁴⁴ About 50 percent of Medicaid disabled

Figure 1-12: Medicaid Expenditures Per Enrollee by Acute and Long-Term Care, 1998



Note: Expenditures do not include DSH, adjustments, or administrative costs.

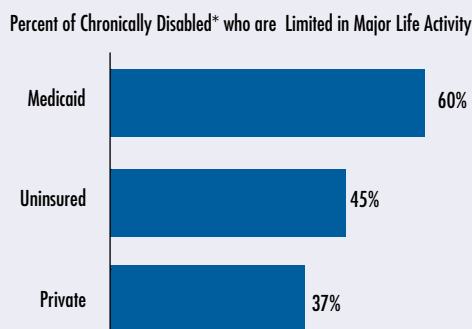
SOURCE: Urban Institute estimates based on HCFA-2082 and HCFA-64 Reports.

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), and almost 40 percent have severe mental symptoms or disorders.⁴⁵ (These groupings of disability are not mutually exclusive.)

Disabled individuals insured by the Medicaid program are substantially more impaired than are other individuals with disabilities. Almost 60 percent of those with a chronic disability who were covered by Medicaid were 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 1-13).

About 20 percent of adults with disabilities who were eligible for Medicaid are also employed. An additional 7 percent were unemployed (and are actively looking for employment), while the remaining 74 percent were out of the labor force.⁴⁶ Medicaid coverage is one potential policy tool for assisting people with disabilities who would like to enter and remain in the labor market. As Meyer and Zeller have noted, "[f]or millions of people with disabilities, Medicaid provides critical health coverage, coverage that is almost always better than that available in the private market."⁴⁷

Figure 1-13: Proportion of Chronically Disabled* Who Are Limited in Major Life Activity, By Health Insurance Coverage



*Chronic Disability: specific disability lasting at least 12 months that entails "a lot" of difficulty or interference with normal functions

SOURCE: Meyer and Zeller, 1999.

Some disabled Medicaid beneficiaries are also enrolled in Medicare. People who are under age 65 can become eligible for Medicare if they have received monthly Social Security Disability Insurance (SSDI) benefits for two years. In 1997, an estimated 1.8 million Medicaid enrollees—about a quarter of all Medicaid disabled enrollees—fell into this category.⁴⁸ For many of these individuals, Medicaid supplements the basic Medicare coverage to provide benefits and services, such as long-term care and prescription drugs, that are not covered by Medicare.

Over 5.5 million non-elderly individuals with disabilities, including one million children with disabilities, are not eligible for or enrolled in Medicaid and do not have other public or private insurance coverage. 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. Uninsurance among this population can lead to avoidable and expensive acute medical problems that could have been prevented by timely care on a regular basis.

Disability for Purposes of Medicaid Eligibility

As discussed above, in order to qualify for Medicaid, an individual must not only meet financial eligibility criteria but must also fall into a covered category. For ease of exposition, this chapter speaks of "individuals with disabilities" as a covered category. Technically, however,

federal Medicaid law has two eligibility categories that most people would view as individuals with disabilities: "disabled" and "blind." These two statutory categories reflect Medicaid's historical ties to the Supplemental Security Income (SSI) program, which provides cash assistance to aged, blind, or disabled individuals who meet certain income and resource requirements.⁴⁹ This section will outline these two technical categories, but the remainder of the discussion in this chapter will treat both categories as individuals with disabilities.

In general, states are required to use the definition of disability that is used for SSI purposes. 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 2001, 11 states had elected this "209(b)" option: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.⁵⁰

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, the Social Security Administration (SSA) has established a standard for when an individual is engaged in "substantial gainful activity": the individual earns \$740 per month after impairment-related expenses, which are deducted from his or her income (as of 2001).⁵¹ 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."⁵² As discussed below, the definition of disability for children under age 18 is somewhat different.

Blindness is a separate basis for receipt of cash assistance under SSI and for categorical eligibility under Medicaid. The SSI definition of "blind" includes individuals who have (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.⁵³

The determination of disability in an individual case can take a substantial amount of time. 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. In most states, presumptive disability for SSI purposes would also enable the individual to establish categorical Medicaid eligibility. 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.⁵⁴

Not all physical or mental impairments can qualify an individual for SSI or Medicaid 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 material 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.

The process of determining whether an individual is disabled for purposes of categorical Medicaid eligibility is a complex one. States have the option of making this determination themselves, or of entering into a “section 1634” agreement with the Social Security Administration under which SSA makes the determination, which is then binding on the state. As of January 2000, 32 states had entered into such “section 1634” agreements 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.⁵⁵ For a further discussion of Medicaid eligibility processes, see Chapter 4, Medicaid Administration.

Medicaid Eligibility Pathways for Individuals with Disabilities: Full Benefits

Medicaid offers two types of assistance to eligible individuals with disabilities. The more visible of the two is the full Medicaid benefits package—e.g., hospital,

physician, prescription drug, and other services. Less well known is that Medicaid also covers the monthly premiums and cost-sharing of eligible individuals with disabilities who are enrolled in Medicare. This section reviews the pathways available under federal Medicaid law for eligibility for the full Medicaid benefits package. The next section discusses the pathways to qualify for assistance with Medicare premiums and cost-sharing.

Pathways for Disabled Children

As discussed in the previous section, federal Medicaid law creates a number of eligibility pathways through which low-income children—including children with disabilities—may qualify for Medicaid. Many of these pathways are not specific to children with disabilities. For example, under the “poverty-related” pathways, states must cover all children through age 18 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.

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, of which the principal ones are summarized in Table 1-4. 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 (described below), including the “medically needy” and “Katie Beckett” categories, are optional.

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. As noted in the previous section, there are a number of states that apply rules more restrictive than those under SSI in determining Medicaid eligibility for the disabled (and 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



TABLE 1-4: PRINCIPAL MEDICAID ELIGIBILITY PATHWAYS FOR CHILDREN WITH DISABILITIES, 2001

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
SSI recipients	< \$531 for individual, < \$796 for couple per month ^a	≤ \$2,000 for individual, ≤ \$3,000 for couple
Title IV-E foster care children	State AFDC level as of 7/16/96	State AFDC level as of 7/16/96
Title IV-E adoption assistance children	State AFDC level as of 7/16/96, or SSI level before adoption	State AFDC level as of 7/16/96, or SSI level before adoption
Children in “209(b)” states ^b	State-set income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State-set resource standard
Other Pathways		
SSI recipients as of 8/22/96	Same as SSI	Same as SSI
OPTIONAL COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
“Medically needy”	State-set income standard; children may “spend down” to eligibility by deducting incurred medical expenses from income	State-set resource standard no more restrictive than AFDC level as of 7/16/96; individuals may not “spend down” to eligibility by deducting incurred medical expenses from resources
Katie Beckett children (non-waiver state option)	Would meet SSI/Medicaid eligibility standard if institutionalized and parents’ income not attributed	Would meet SSI/Medicaid eligibility standard if institutionalized and parents’ resources not attributed
Home and community-based services (HCBS) waiver children	Would meet SSI/Medicaid eligibility standard if institutionalized and parents’ income not attributed	Would meet SSI/Medicaid eligibility standard if institutionalized and parents’ resources not attributed
Independent foster care adolescents	State-set income standard that is no more restrictive than state AFDC level as of 7/16/96	State-set resource standard that is no more restrictive than state AFDC level as of 7/16/96
Non-Title IV-E foster care children	State AFDC level as of 7/16/96	State AFDC level as of 7/16/96
Non-Title IV-E adoption assistance children	Title IV-E foster care level	Title IV-E foster care level

Some mandatory and optional pathway thresholds are subject to expansion through the use of “less restrictive” methodologies under section 1902(r)(2).^c

^a SSI income standard for 2001. 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).

^b 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.

^c For certain eligibility categories, section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are “less restrictive” than those used under their AFDC program as of July 16, 1996, enabling states to effectively expand Medicaid eligibility without changing the income and resource standards. This flexibility applies to the eligibility pathways for children in “209(b)” states, the “medically needy,” independent foster care adolescents, HCBS waiver children, and non-Title IV-E adoption assistance children.

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 Table 1-7.) 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.⁵⁶

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, 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.”⁵⁷ The Social Security Administration (SSA) has issued a medical “listing of impairments” that serves as the basis for this determination.⁵⁸ The 1996 welfare law narrowed this list.⁵⁹ As discussed above, the 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.⁶⁰ 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.⁶¹

As a result of the more restrictive disability standard enacted in 1996, an estimated 102,000 children with disabilities were found ineligible for SSI benefits.⁶² 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 before the 1996 welfare bill was enacted.⁶³

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 the 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 have the option of extending Medicaid coverage to children in foster care who are supported not with Title IV-E funds but with state funds only.⁶⁴

The Foster Care Independence Act of 1999 gives states the option of extending Medicaid eligibility to former foster care children between the ages of 18 and 21. States may cover these individuals if they were in foster care on their 18th birthday. 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, 1996.⁶⁵

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 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 1) an adoption assistance agreement in effect, 2) the child was eligible for Medicaid before the agreement was entered into, and 3) the state has determined that the child cannot be placed without Medicaid because of his or her special needs for medical or remedial care.⁶⁶ This Medicaid eligibility pathway is optional; as of 2000, all but 4 states (Connecticut, Illinois, New Mexico, and Michigan) had elected to offer such coverage.⁶⁷

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 rule 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 qualify for Medicaid coverage. One way in which states can neutralize this incentive is to offer Medicaid coverage through the “Katie Beckett” eligibility pathway (sometimes referred to as the “TEFRA” option after the 1982 legislation in which it was enacted).⁶⁸

Under this pathway, children under age 19 may qualify for Medicaid if the following circumstances apply: 1) the child meets the SSI standard for disability; 2) the child would be eligible for Medicaid if he or she were in an institution; and 3) 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 geographic 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.⁶⁹

As in the case of the “Katie Beckett” pathway, children receiving Medicaid coverage under a 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.⁷⁰ 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.⁷¹ As of 1999, 15 states

were operating 16 HCBS waivers for children with special needs.⁷²

“Medically Needy” Pathway. States have the option of extending Medicaid coverage to disabled children and to adults who are disabled or aged but who do not qualify for SSI benefits because their countable incomes exceed the SSI eligibility level (74% of the federal poverty level of \$716 per month, \$8,590 per year for a single individual in 2001). As of 2001, 35 states including the District of Columbia had elected to offer coverage to the “medically needy.”⁷³ Elderly individuals residing in nursing facilities often use this eligibility pathway; 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 through that pathway 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 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 six 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.

Pathways for Non-Institutionalized Adults with Disabilities

This section reviews Medicaid eligibility pathways for 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, (or seeking to work), and those who are

at risk of institutional care but want to remain at home or in the community.

*Pathways for the Working Disabled*⁷⁴

As discussed earlier, 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 (\$531 per month per individual in 2001), 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 average of \$740 per month in 2001.⁷⁵

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. The individuals may not be able to afford whatever coverage their employer offers; their employers may not offer any coverage at all; 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 \$740 per month, 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, or earning more money but losing their Medicaid coverage, many individuals with disabilities may rationally decide to work less. To counter this work disincentive, four optional Medicaid eligibility pathways have evolved (summarized in Table 1-5). There is also an eligibility pathway for working individuals with disabilities that

qualifies them for assistance with Medicare Part A premiums, discussed in the next section.

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 \$740 per month. These individuals are entitled to continue to receive Medicaid coverage, even after they have lost their SSI benefits due to earnings, until they have earned income sufficient to enable them to purchase a “reasonable equivalent” of SSI, Medicaid, and publicly-funded attendant care services. The SSA has published state-specific thresholds for annual gross income to be used as the basis for this “reasonable equivalent” determination. In 1999, these thresholds ranged from \$13,939 in Arizona to \$34,036 in Alaska.⁷⁶ As of December 2000, about 84,000 working individuals with disabilities continued to receive Medicaid coverage under this provision despite the loss of SSI benefits.⁷⁷

Working Disabled Under 250 Percent of Poverty. Unlike section 1905(q), this pathway is optional for 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.⁷⁸ The family income of these individuals may not exceed the income standard of 250 percent of the federal poverty level (\$3,048 per month for a family of three in 2001). However, states have the flexibility, through use of “less restrictive” methodologies, to raise the income and resource thresholds to whatever level they choose.⁷⁹ As of 2001, Minnesota had the most generous income and asset standards—all income is disregarded as well as up to \$20,000 in countable resources and certain retirement and medical savings accounts. In contrast to the section 1905(q) pathway, this pathway provides states with the option of imposing a monthly premium or other cost-sharing charges set on sliding scale according to income. As of December 2001, 10 states (Alaska, California, Iowa, Maine, Mississippi, Nebraska, New Mexico, Oregon, Vermont,



TABLE 1-5: PRIMARY MEDICAID ELIGIBILITY PATHWAYS FOR NON-INSTITUTIONALIZED ADULTS WITH DISABILITIES, 2001

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
SSI recipients	< \$531 for individual, < \$796 for couple per month; ^a earnings may not exceed \$740 per month	≤ \$2,000 for individual, ≤ \$3,000 for couple
Individuals in “209 (b)” states ^b	State-set income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State-set resource standard
Qualified severely impaired individuals ^c	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
Primary Pathways		
“Medically needy”	State-set income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State-set resource standard no more restrictive than SSI test (≤ \$2,000 in countable resources); individuals may not “spend down” to eligibility by deducting incurred medical expenses from resources
Working disabled under 250 percent of poverty ^d	But for earnings, would be eligible for Medicaid as a qualified severely impaired individual; income < 250% FPL*	Same as SSI
Working disabled ^d	But for earnings, income under SSI level; earnings ≤ state established level	State sets resource standards and methodologies
Working individuals with medically improved disability ^{d,e}	State sets resource standards and methodologies	State sets resource standards and methodologies

Some mandatory and optional pathway thresholds are subject to expansion through the use of “less restrictive” methodologies under section 1902(r)(2).^f

* In 2001, 250 percent of the federal poverty level for an individual was \$21,475 per year, or \$1,790 per month.

^a SSI income standard for 2001. 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).

^b 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.

^c Individual must have been receiving SSI and must continue to have the physical or mental impairment on the basis of which the individual was found to be disabled.

^d States have the option of imposing sliding scale premiums and other cost-sharing charges on this group.

^e A state may cover this group only if the state also covers the working disabled group.

^f For certain eligibility categories, section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are “less restrictive” than those used under the SSI program, enabling states to effectively expand Medicaid eligibility without changing the income and resource standards. This flexibility applies to each of the four optional coverage pathways in this table, as well as to individuals in “209(b)” states.

and Wisconsin) had enacted buy-in programs; in addition, Massachusetts used a section 1115 waiver to create a buy-in program for the working disabled.⁸⁰

Working Disabled. The Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170) creates two new eligibility pathways for working disabled individuals. Both are optional for the states, and both went into effect October 1, 2000. The first of these pathways somewhat overlaps with the BBA 1997 pathway for the working disabled under 250 percent of poverty and its “less restrictive” methodologies flexibility. Under the Ticket to Work pathway, states are able to extend Medicaid coverage to disabled individuals between age 16 and 64 who would be eligible for SSI but for earnings that exceed the maximum amount allowed under section 1905(q) (described under the qualified severely impaired individuals section above). Under the Ticket to Work Act, states have the flexibility to impose a ceiling on allowable income or resources at whatever level they choose and to set the methodologies for determining income or resources.

State flexibility with respect to income and resource policies under this Ticket to Work option does not differ in substance from that available to states under the BBA 1997 option combined with the use of “less restrictive” methodologies. The same is true of the broad discretion that states have under both options to impose premiums or other cost-sharing charges on a sliding scale based on income. Some of the differences between the two pathways are found in the details with respect to premiums and cost-sharing.⁸¹ In particular, in the case of individuals with incomes below 450 percent of the poverty level, states, under the Ticket to Work option, may not 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 \$75,000.⁸² As of December 2001, 15 states (Arkansas, Arizona, Colorado, Connecticut, Florida, Indiana, Kansas, Missouri, Montana, New Hampshire, New Jersey, Oklahoma, Pennsylvania, Texas, and Washington) had enacted buy-in programs under the Ticket to Work option.⁸³

Working Individuals with Medically Improved Disability. The other optional eligibility pathway created by the Ticket to Work legislation concerns working disabled individuals whose medical conditions improve. 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 be receiving Medicaid coverage under the new eligibility pathway for working disabled individuals in order to qualify for this new coverage.⁸⁴ It would not be sufficient for these individuals to have been receiving Medicaid coverage under the BBA 1997 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 for the working disabled group described above.

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. Table 1-6 summarizes the principal Medicaid eligibility pathways for these individuals.

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 (\$531 per month for an individual in 2001) plus the amount of the State Supplemental 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 \$550 per month (in 2001), or 77 percent of the federal poverty level of that year.

There were about 5.2 million disabled SSI recipients in 1999.⁸⁵ However, not all of these SSI beneficiaries automatically qualified for Medicaid. Eleven states have adopted the “209(b)” option, which allows them 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. Table 1-7 shows the 2000 financial eligibility standards and resource limits for the “209(b)” states.



TABLE 1-6: PRIMARY MEDICAID ELIGIBILITY PATHWAYS FOR INDIVIDUALS WITH DISABILITIES AT RISK OF INSTITUTIONAL CARE, 2001

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
SSI Recipients	< \$531 for individual, < \$796 for couple per month ^a	≤ \$2,000 for individual, ≤ \$3,000 for couple
Individuals in “209 (b)” states^b	State-set income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State-set resource standard
OPTIONAL COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
SSP-only recipients^c	State determined level	Same as SSI
“Medically needy”	State-set income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State-set resource standard no more restrictive than SSI test (≤ \$2,000 in countable resources); individuals may not “spend down” to eligibility by deducting incurred medical expenses from resources
Individuals receiving home and community-based services	Would be eligible if institutionalized	Would be eligible if institutionalized

Some mandatory and optional pathway thresholds are subject to expansion through the use of “less restrictive” methodologies under section 1902(r)(2).^d

^a SSI income standard for 2001. 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).

^b 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.

^c States have the option of extending Medicaid coverage to disabled individuals who are receiving State Supplementation Payments (SSP) but not SSI payments.

^d For certain eligibility categories, section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are “less restrictive” than those used under the SSI program, enabling states to effectively expand Medicaid eligibility without changing the income and resource standards. This flexibility applies to each of the optional coverage groups listed in this figure as well as to individuals in “209(b)” states.

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 cash payment to supplement the basic federal SSI payments to individuals who earn too much to qualify for SSI. As of April 2001, 25 states reported making Medicaid coverage

available to disabled individuals living independently and receiving state supplementation payments but not SSI benefits.⁸⁶

“Medically Needy” Pathway. States have the option of extending Medicaid coverage to disabled individuals who



TABLE 1-7: MEDICAID INCOME AND RESOURCE LIMITS FOR INDIVIDUALS WITH DISABILITIES IN STATES USING THE SECTION 209(b) OPTION, 2000

	Eligibility Standard (Monthly Income) ^a		Resource Limits ^a	
	Individual	Couple	Individual	Couple
Federal SSI Standards ^b	\$531	\$796	\$2,000	\$3,000
209(b) State				
Connecticut	\$476	\$633	\$1,600	\$2,400
Hawaii ^c	N/A	N/A	N/A	N/A
Illinois	\$283	\$375	\$2,000	\$3,000
Indiana	\$528	\$785	\$1,500	\$2,250
Minnesota	\$482	\$601	\$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 SSI standard for 2001. This figure does not include the \$20 per month income disregard. The SSI standard for 2000 was \$512.

^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.

are ineligible for SSI payments because of excess income or resources. In the case of individuals at risk of institutional care, this excess income 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 one to six 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. (States can offer these

HCBS services on a statewide basis or only in certain areas of the state.) 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 section 1915(c) waiver, may be targeted just to individuals with disabilities, such as individuals with mental retardation. 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 level (as discussed 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” rules to individuals needing home and community-based services as well as those in ICFs/MR. As of 1999, every state had at least one section 1915(c) waiver targeted at individuals with disabilities.⁸⁷

Pathways for 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 level” pathway. These are summarized in Table 1-8.

SSI-Related Pathway. As discussed throughout this chapter, states must, subject to the “209(b)” exception, make Medicaid coverage available to children or adults with disabilities who qualify for SSI benefits. In either case, if a disabled individual receiving SSI benefits is also eligible for Medicaid, and if that individual enters a hospital, a 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.⁸⁸ 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 5.2 million disabled SSI beneficiaries in 1999, only 2.2 percent, or 114,000, were residing in institutions at Medicaid’s expense.⁸⁹

“Medically Needy” Pathway. The “medically needy” pathway is also available to disabled, non-elderly adults in hospitals, nursing facilities, and ICFs/MR. As in the case of 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, 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 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. (This allowance for the community spouse is discussed in the next section on eligibility pathways for the elderly.)

Special Income Level. 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 in ICFs/MR but want to set an upper limit on the beneficiary’s income have another option: the so-called “special income level” for individuals in nursing facilities and other institutions.

Under the “special income level” option, a state may set an income standard at up to 300 percent of the SSI benefit (\$1,590 per month in 2001) 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 the 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. As of September 1996, 33 states had elected to cover this group; 14 of these states did not cover the “medically needy.”⁹⁰

Medicaid Eligibility Pathways for Individuals with Disabilities: Assistance with Medicare Premiums and Cost-Sharing

The eligibility pathways discussed in the previous sections lead to coverage for the full Medicaid benefits package. This package includes not just coverage for hospital care, physician services, and prescription drugs, but also assistance with Medicare cost-sharing requirements.⁹¹ For low-income disabled Medicare beneficiaries, Medicaid’s assistance with Medicare’s cost-sharing obligations can make a substantial difference in the amount of financial burden imposed by Medicare and in the accessibility of covered services.

TABLE 1-8: PRIMARY MEDICAID ELIGIBILITY PATHWAYS FOR INSTITUTIONALIZED ADULTS WITH DISABILITIES, 2001

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
SSI Recipients	< \$531 for individual, < \$796 for couple per month ^a	≤ \$2,000 for individual, ≤ \$3,000 for couple
Individuals in “209(b)” states ^b	State-set income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State-set resource standard
OPTIONAL COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
“Medically needy”	State-set income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State-set resource standard no more restrictive than SSI test (≤ \$2,000 in countable resources); individuals may not “spend down” to eligibility by deducting incurred medical expenses from resources
Institutionalized individuals under “special income level”	Income standard no higher than 300% of the SSI standard (\$1,593 monthly)	Same as SSI

Some mandatory and optional pathway thresholds are subject to expansion through the use of “less restrictive” methodologies under section 1902(r)(2).^c

^a SSI income standard for 2001. 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).

^b 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.

^c For certain eligibility categories, section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are “less restrictive” than those used under the SSI program, enabling states to effectively expand Medicaid eligibility without changing the income and resource standards. This flexibility applies to both of the optional groups listed in this table as well as to individuals in “209(b)” states.

Federal Medicaid law recognizes that there are substantial numbers of disabled Medicare beneficiaries whose income is too high to qualify for full Medicaid benefits but who need assistance with Medicare premiums and 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 to certain categories of low-income Medicare beneficiaries. (These individuals are

not entitled to the full Medicaid benefits package.) 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 77%, depending on the state). These pathways are summarized in Table 1-9. The Centers for Medicare and Medicare Services refers to this type of Medicaid assistance as the “Medicare Savings Program.”⁹²

TABLE 1-9: MEDICAID ELIGIBILITY PATHWAYS FOR INDIVIDUALS WITH DISABILITIES: MEDICAID ASSISTANCE WITH MEDICARE COST-SHARING, 2001

	Family Income*	Resource Test	Medicaid Pays	Entitlement
Qualified Medicare Beneficiaries (QMBs)	≤ 100% FPL* ^a	≤ 200% of SSI limit (\$4,000 for individuals, \$6,000 for couples) ^a	All Medicare premiums and cost-sharing charges ^b	Yes
Specified Low-Income Medicare Beneficiaries (SLMBs)	Between 100% and 120% FPL* ^a	≤ 200% of SSI limit (\$4,000 for individuals, \$6,000 for couples) ^a	Medicare Part B monthly premium	Yes
Qualifying Individuals 1 (QI1s)	Between 120% FPL and 135% FPL*	≤ 200% of SSI limit (\$4,000 for individuals, \$6,000 for couples)	Medicare Part B monthly premium; benefit is subject to annual federal funding cap	No
Qualifying Individuals 2 (QI2s)	Between 135% FPL and 175% FPL*	≤ 200% of SSI limit (\$4,000 for individuals, \$6,000 for couples)	Portion of Medicare Part B monthly premium (\$3.09 per month in 2001); benefit is subject to annual federal funding cap	No
Qualified Disabled Working Individuals	Eligible for Medicare Part A and income ≤ 200% FPL*	≤ 200% of SSI limit (\$4,000 for individuals, \$6,000 for couples)	Medicare Part A premium only	Optional

* In 2001, 100 percent of the federal poverty level (FPL) was \$716 for individuals, \$968 for couple per month; 120 percent FPL was \$859 for individuals and \$1,161 for couples per month; 135 percent FPL \$967 for individuals and \$1,307 for couples per month; 175% FPL was \$1,253 for individuals and \$1,694 for couples per month; 200 percent FPL was \$1,432 for individuals and \$1,936 for couples per month.

^a Under Section 1902(r)(2) of the Social Security Act, states may use income and resource methodologies that are “less restrictive” than those that would otherwise apply, enabling states to expand eligibility without changing the standards.

^b 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.

Most of these pathways—qualified Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs), and qualifying individuals (QIs)—cover both elderly and disabled Medicare beneficiaries. These pathways are discussed in the next section of this chapter on Medicaid eligibility and the elderly. There is one pathway that is specific to Medicare beneficiaries with

disabilities: qualified disabled working individuals (QDWIs).

Under the QDWI pathway, eligible individuals are entitled to payment of their Part A Medicare premiums (\$300 per month in 2001). (These individuals are required to pay Part A Medicare premiums because they

have not worked enough quarters to qualify for Medicare without paying a premium.) QDWIs are not entitled to assistance with Medicare 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 the QDWI 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 (\$3,048 per month for a family of three in 2001); and (3) their resources do not exceed twice the SSI standard (\$4000 for an individual, \$6000 for a couple). Both income and resources must be determined using SSI methodologies.⁹³

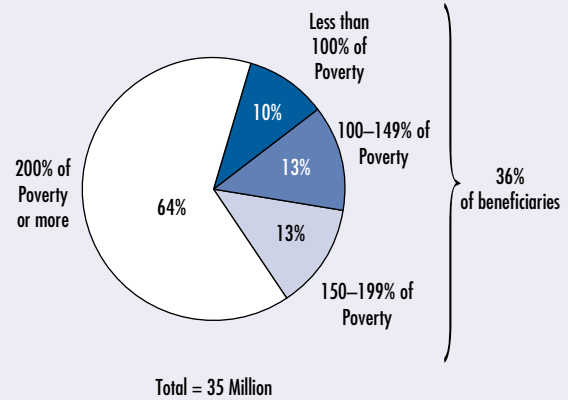
IV. LOW-INCOME ELDERLY

Of the 40 million Americans covered by Medicaid in 1998, about four million, or ten percent, were age 65 or older (Figure 1-1, page 9). Although almost all of these elderly Medicaid beneficiaries are also eligible for Medicare, Medicaid is essential to making Medicare coverage effective for this low-income population. This section discusses the role that Medicaid plays for the low-income elderly, and it summarizes the pathways by which individuals in these categories establish eligibility for full Medicaid coverage as well as for Medicaid assistance with Medicare premiums and cost-sharing.

Medicaid's Role for the Low-Income Elderly

In 1998, one in three elderly individuals (36%)—almost 13 million people—were low-income, living on incomes below 200 percent of the federal poverty level (Figure 1-14). Ten percent of the elderly had an income below the federal poverty level (\$8,590 per year in 2001 for an individual, \$11,610 for a couple). Another 26 percent lived on incomes between 100 and 200 percent of the poverty level. Social Security income is the main source of support for the majority of the elderly, particularly those in the lowest income segments of the population: for elderly Medicare beneficiaries with the lowest incomes, Social Security accounted for over of 80 percent of income in 1998.⁹⁴ With an average annual Social Security benefit (in 2000) of \$11,136 for men and \$8,352 for women, it is not surprising that many of the elderly live on incomes at or near the poverty level.⁹⁵ Poverty rates increase with age, are higher for women than men,

Figure 1-14: Medicare's Elderly Population by Poverty Level, 1999



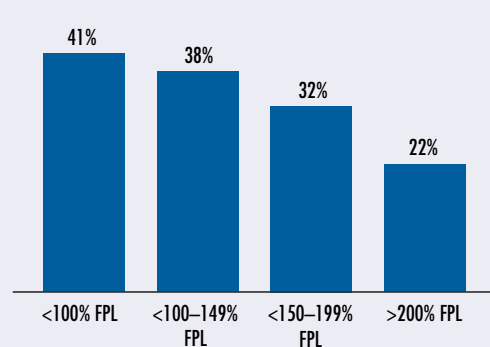
Note: Based on income of noninstitutionalized population. Reflects income from all household family members. 1999 federal poverty level was \$8,240 for individuals; \$11,060 for couples.

Source: Urban Institute estimates based on 2000 Current Population Survey.

and are higher for elderly minority populations than whites.⁹⁶

Medicare is especially important to low-income elderly people because they are in poorer health than higher income elderly people (Figure 1-15). In a 1999 survey, forty-one percent of poor elderly individuals perceived their health to be fair or poor compared to 22 percent of elderly people with incomes above 200 percent of the poverty level. Poor and near-poor elderly individuals were also more likely to suffer from chronic conditions, including arthritis, hypertension, and diabetes that require on-going medical treatment.⁹⁷

Figure 1-15: Percent of Medicare Beneficiaries Reporting Fair or Poor Health, 1998



Note: Includes self-reported health status of community residents only. The 1998 federal poverty level for people over age 65 was \$8,050 for individuals and \$10,850 for couples.

Source: Urban Institute analysis of 1998 Medicare Current Beneficiary Survey.

Although Medicare provides basic health coverage for hospital and physician visits, the costs of uncovered services, coupled with substantial cost-sharing requirements and the Part B premium, impose a serious financial burden upon many elderly people. In addition to a monthly Medicare Part B premium (\$50 in 2001), Medicare beneficiaries must pay a Medicare Part B annual deductible (\$100 in 2001), Medicare hospital deductible (\$792 in 2001), Part A coinsurance, Part B reinsurance and coinsurance and deductibles charged by health maintenance organizations. These costs can have a substantial impact on low-income Medicare beneficiaries, who spend a significant share of their incomes on health-related costs.

While many of those with higher incomes have private supplemental insurance to cover Medicare's gaps, the low-income elderly are less likely to have private supplemental coverage.⁹⁸ Many low-income elderly rely on Medicaid to fill this role; the program covers 56 percent of poor (< 100% of poverty) and 18 percent of low-income (between 100–199% poverty) elderly Medicare beneficiaries.⁹⁹ The low-income elderly who are covered both by Medicare and Medicaid are in poorer health and are more likely to be over age 85, female, and living without a spouse than other Medicare beneficiaries.¹⁰⁰ Medicaid plays an important role for these beneficiaries. In 1997, poor Medicare beneficiaries who did not have Medicaid coverage to supplement Medicare spent one-third (35%) of their incomes on out-of-pocket health costs, while poor Medicare beneficiaries with full-year Medicaid coverage spent 8 percent of their incomes on out-of-pocket costs.¹⁰¹ Medicaid also improves access to care: despite their greater health care needs, low-income Medicare beneficiaries with Medicaid coverage are much more likely than those with Medicare only to have a regular source of care and to obtain care in a timely manner.¹⁰²

Medicaid Eligibility Pathways for the Low-Income Elderly: Full Benefits

As noted above, Medicaid offers two types of coverage for the low-income elderly: (1) coverage for the full Medicaid benefits package (e.g., physician, hospital, nursing facility, prescription drug, and other services), plus assistance with Medicare premiums and cost-sharing; and (2) assistance with the costs of Medicare premiums, and cost-sharing only. Some Medicare beneficiaries qualify for the full Medicaid benefits package plus assistance with cost-

sharing, while others qualify only for coverage for Medicare premiums and cost sharing. The income standards for assistance with Medicare premiums and cost sharing are higher than those an elderly person must meet in order to qualify for the full Medicaid benefits package. Full Medicaid coverage is generally not available to elderly individuals with incomes above 100 percent of poverty (\$8,590 in 2001), unless they qualify as “medically needy” by incurring large medical expenses.

This section reviews the pathways to eligibility for full Medicaid benefits available to the low-income elderly under federal Medicaid law, summarized in Table 1-10. The eligibility pathways for assistance with Medicare premiums and cost-sharing only are discussed in the next section.

SSI-Related Pathways. Subject to one important exception, states are required to cover elderly individuals receiving cash assistance under the Supplemental Security Income (SSI) program.¹⁰³ In 2001, to qualify for SSI, an elderly individual must have had an income of less than \$531 per month (\$796 per month for a couple) and countable resources of less than \$2,000 (\$3,000 for a couple). These figures do not include the \$20 monthly income disregard. There were 1.3 million elderly SSI beneficiaries in 2000.¹⁰⁴

Not all of these SSI recipients automatically qualify for Medicaid, however. The so-called “209(b)” option, named for the section of the 1972 Social Security Act Amendments in which the SSI program was enacted, allows states to use their 1972 state assistance eligibility rules in determining eligibility for the elderly instead of the federal SSI rules, which adjust income standards for inflation each year. However, if a state uses its more restrictive 1972 standards, it must also allow individuals to “spend down” into Medicaid eligibility by deducting incurred medical expenses from income. (Elderly individuals generally cannot deduct their medical expenses in calculating their income in order to qualify for SSI). As of 2001, the 11 states that had elected the “209(b)” option, applying income standards, resource standards, and/or resource methodologies more restrictive than those applicable under SSI: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.¹⁰⁵

Another option available to states is to extend Medicaid coverage to individuals who receive state supplementation payments (SSP), but not SSI payments. Under SSI law, states have the option of providing a cash payment (SSP) to supplement the basic federal SSI payment. States also have the option of making an SSP payment to elderly individuals whose income exceeds the SSI income standards. In 1999, all but six states provided



TABLE 1-10: PRIMARY MEDICAID ELIGIBILITY PATHWAYS FOR ELDERLY INDIVIDUALS RECEIVING FULL MEDICAID BENEFITS PACKAGE, 2001

MANDATORY COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
SSI recipients	< \$531 for individual, < \$796 for couple per month ^a	< \$2,000 for individual, < \$3,000 for couple
Other Pathways		
Individuals in “209 (b)” states ^b	State-set income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State-set resource standard
Individuals who lose SSI (“Pickle Amendment”)	Would meet SSI standard but for Social Security cost-of-living increase	Same as SSI
Disabled widows and widowers ineligible for SSI due to increase in benefits	Would meet SSI standard but for Social Security disability benefit increase	Same as SSI
OPTIONAL COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
Primary Pathways		
“Medically needy”	State-set income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State-set resource standard no more restrictive than SSI test (≤ \$2,000 in countable resources); individuals may not “spend down” to eligibility by deducting incurred medical expenses from resources
Institutionalized individuals under “special income level”	Income standard no higher than 300% of the SSI standard (\$1,593 monthly)	Same as SSI
Individuals receiving state supplementation payments (SSPs)	SSI-eligible but for increased income	Same as SSI
Individuals receiving home and community-based services	Would be eligible if institutionalized	Would be eligible if institutionalized
Poverty-level individuals age 65 or older	≤ 100% FPL* ^c	Same as SSI ^c

Some mandatory and optional pathway thresholds are subject to expansion through the use of “less restrictive” methodologies under section 1902(r)(2).^d

* In 2001, 100% of the federal poverty level (FPL) was \$716 per month for an individual.

^a SSI income standard for 2001. 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).

^b 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.

^c Under Section 1902(r)(2) of the Social Security Act, states may use income and resource methodologies that are “less restrictive” than those that would otherwise apply. This enables states to effectively expand eligibility without altering the income or resource standard.

^d For certain eligibility categories, section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are “less restrictive” than those used under their AFDC program as of July 16, 1996, enabling states to effectively expand Medicaid eligibility without changing the income and resource standards. This flexibility applies to all five of the optional coverage categories listed in this table, as well as to individuals in “209(b)” states.

some amount of supplementary payment, ranging from \$2 per month in Oregon to \$247 per month in Connecticut; the median SSP payment that year was \$31 per month.¹⁰⁶ Under the SSP-only eligibility option, states may make Medicaid available to elderly individuals receiving these payments. In 2001, 25 states reported making Medicaid coverage available to elderly individuals living independently and receiving state supplementation payments but not SSI benefits.¹⁰⁷

Many elderly individuals receiving SSI also receive Social Security benefits. In some cases, cost-of-living increases in the Social Security benefit may cause an individual to lose his or her SSI (or SSP) benefits. Although these individuals may lose their SSI or SSP payments, they remain eligible for Medicaid in those states that cover elderly individuals receiving SSI or SSP benefits. That is because under the so-called “Pickle Amendment,” these states are required to disregard the Social Security cost-of-living increases received by the individual for Medicaid purposes.¹⁰⁸

“Medically Needy” Pathway. Many low-income elderly individuals and couples with Medicare coverage have incomes that exceed the SSI eligibility level (\$531 per month for an individual, \$796 for a couple in 2001) and medical expenses that Medicare does not cover. States that want to offer Medicaid coverage to assist these individuals or couples with their medical expenses have the option of covering them with federal matching funds through the “medically needy” pathway. In 2001, 35 states, including the District of Columbia, had elected to offer coverage to the “medically needy.”¹⁰⁹ This eligibility pathway is often used by elderly individuals residing in nursing facilities or by individuals living in the community with high prescription drug or medical equipment expenses.

Under the “medically needy” option, a state establishes an income standard, as well as a resource standard. In counting income or resources for the elderly, a state must apply methodologies no more restrictive than those under the SSI program. In determining income—but not resource—eligibility, the state deducts the medical expenses an individual has incurred over a budget period (not more than six months) from the individual’s countable income. If the individual’s income, minus incurred medical expenses, is less than the state’s “medically needy” income standard, and if the individual’s countable resources are less than the state’s “medically needy” resource standard, then the individual is eligible for Medicaid coverage for the remainder of the budget period.¹¹⁰ At the end of the budget period, the individual’s “medically needy” eligibility must be redetermined for a new budget period.¹¹¹

Hypothetical Medically Needy Eligibility Determination

Assume a hypothetical state with an income standard for individual SSI recipients of \$580 per month in 2001 (\$531 federal SSI payment, \$29 state supplementation payment, and \$20 income disregard). Assume further that this state offers a medically needy program and sets its medically needy income standard at \$470 per month, its medically needy resource standard at \$2,000, and uses a one-month accounting period. Finally, assume that an elderly individual living alone in this state receives a monthly Social Security check of \$775, making her ineligible for Medicaid through the SSI pathway because her monthly income is \$195 higher than the \$580 per month income standard.

If this individual has high medical expenses, she may be able to qualify for Medicaid if her countable resources do not exceed \$2,000. Assume she has prescription drug expenses of \$475 per month. After incurring expenses of \$305, she will have met her “spend-down” obligation of \$305 (\$775 less \$470) for the month. Medicaid would pay for her remaining prescription drug expenses of \$170, plus any other medical costs that Medicaid covers, incurred during the remainder of the month. This process would then be repeated the following month.

If the state were to use a six-month accounting period, then she would have to meet a “spend-down” obligation of \$1,830 (six times \$305). In this case, it would take about four months for her to incur \$1,830 in prescription drug costs. After incurring these expenses, however, she would receive a Medicaid card that would pay her prescription drug and other covered medical expenses for the remainder of the six-month period.

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. In states with “medically needy” coverage, many individuals in nursing homes qualify this way. However, states that wish to provide Medicaid coverage for the elderly in nursing facilities 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.

Under the “special income level” option, a state may set an income standard at up to 300 percent of the SSI benefit (\$1,590 per month in 2001) 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. Individuals who qualify through this pathway must apply all of their income, except for a small personal needs allowance, towards the cost of nursing home care. As of September 1996, 33 states had elected to cover this group; 14 of these states did not cover the “medically needy.”¹¹²

The high cost of nursing facility services—on average, \$56,000 per year according to a 2001 report,¹¹³—makes Medicaid an important benefit for the elderly at risk of nursing facility care. It also makes nursing facility residents a high-cost population for state Medicaid programs. The tension between beneficiary need for financial protection and state concerns about costs has led to the development of Medicaid eligibility policies specific to the coverage of nursing facility services for the elderly (and disabled).¹¹⁴

Transfer of Resources. Federal Medicaid law attempts to discourage individuals from transferring savings and other countable resources to adult children, siblings, or others in order to satisfy the Medicaid resource test and qualify for nursing facility coverage. It does so by imposing, for a specified period of time, an exclusion of nursing facility coverage upon those individuals who engage in such transfers. Although an individual’s home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual’s spouse, minor or disabled child, or, in some circumstances, sibling or adult child.

More specifically, if an elderly individual who is living at home (or the individual’s spouse) disposes of resources for less than fair market value within 36 months of applying for Medicaid, then the individual is subject to a period of exclusion from coverage for nursing facility services (or home and community-based care). The 36-month “look-back” period is extended to 60 months in the case of transfers into a trust.

The period of exclusion from Medicaid coverage is related to the amount of resources transferred, the average monthly cost of nursing facility care in the state,

and the date on which the transfer was made. For example, assume that 12 months before applying for Medicaid, an elderly individual transferred \$25,000 in savings to her granddaughter and that on average, the monthly cost to a private (i.e., non-Medicaid) resident in a nursing facility is under \$5,000 per month. Under the statutory formula, the amount transferred is divided by the average monthly cost to yield a number that represents the number of months of exclusion from coverage. In this case, she would be excluded for five months (\$25,000 divided by \$5,000). However, because the exclusion begins to run from the date of the transfer, and because in this case the transfer occurred 12 months before application, there would be no exclusion from coverage in this case. If she had transferred \$100,000 to her granddaughter 12 months prior to application, she would be excluded from coverage for eight months (\$100,000 divided by \$5,000 equals 20 months minus the original 12 months).

Spousal Impoverishment Methodologies. Federal Medicaid law requires states to apply a special set of income and resource methodologies in determining eligibility when one spouse is in a nursing facility and the other remains in the community. (States may, but are not required to use them when one member of a couple receives home and community-based services under Medicaid). The purpose of these methodologies is to enable the institutionalized spouse to receive Medicaid coverage for nursing facility care while leaving the community spouse with sufficient resources and monthly income to avoid hardship. These methodologies apply to any eligibility pathway that a state uses under its Medicaid program in determining Medicaid eligibility for nursing facility residents, including the “medically needy” and “special income level” options. Once Medicaid eligibility has been established, these methodologies also govern the calculation of the amount of the couple’s monthly income that must be applied toward the cost of nursing facility care for the institutionalized spouse.

The spousal impoverishment methodologies are triggered when one spouse enters a nursing facility (or hospital) and is likely to be there for at least 30 days, whether the spouse applies for Medicaid at the time of institutionalization or after. At that point, the value of all of the couple’s countable resources is calculated, and the community spouse is allowed to keep one-half of the resources, subject to a minimum and maximum amount. As shown in Table 1-11, the minimum amount that a state must allow the community spouse to retain is \$17,856 in 2001, the maximum, \$89,280 (these figures are adjusted each year for inflation). Once the community spouse’s protected resource amount has been determined, the



TABLE 1-11: SPOUSAL IMPOVERISHMENT 2002 FEDERAL INCOME AND RESOURCE STANDARDS

Income Standards (indexed to the federal poverty level)	Income Standards (indexed to the federal poverty level)	Resource Standards
Minimum	\$1,406 per month	\$17,400
Maximum	\$2,175 per month	\$87,000

Source: Centers for Medicare and Medicaid Services.

institutionalized spouse must reduce the remaining resources to \$2,000 before qualifying for Medicaid in most states.

With respect to income, the spousal impoverishment methodologies require states to allow the community spouse to retain a certain amount of monthly income. Again, there is a minimum amount that states must allow the community spouse to keep (\$1,406 per month in 2001) and a maximum (\$2,175 in 2001) (these figures are adjusted each year for inflation). If the Social Security or pension income in the community spouse's name is not sufficient to reach the state-specified level, income in the institutionalized spouse's name is reserved for the community spouse in an amount necessary to make up the shortfall. Any remaining income of the institutionalized spouse (other than a small personal needs allowance) is applied toward the cost of the institutionalized spouse's care. In the case of both the income and resource protections, the law allows for exceptions to the general formulas in individual cases through both administrative and judicial procedures.¹¹⁵

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 elderly individuals at risk of nursing facility care. (States can cover HCBS waiver services on a statewide basis or only in certain areas). One purpose of this benefit's flexibility is to enable states to eliminate the institutional bias inherent in a benefits package that covers only nursing facility care. Benefits design is only part of the solution to institutional bias, however. If eligibility criteria for nursing facility residents are more generous than those for individuals who live at home, many of the low-income elderly in need of long-term care may be precluded from Medicaid eligibility, and therefore home and community-based services, so long as they remain at home.

To enable states to avoid this anomalous result, the federal Medicaid statute allows them to apply the same

eligibility rules to individuals in need of home and community-based services as they would apply to individuals in nursing facilities. For example, a state that has elected the option of covering institutionalized individuals under the special income level may apply this same income rule (up to 300% of the SSI benefit level) 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 nursing facilities. As of 1999, every state had at least one section 1915(c) waiver targeted at the elderly.¹¹⁶ As of September 1996, 34 of the 50 states offering home and community-based waiver services to the elderly reported using a special income rule of 300 percent of SSI, 15 reported using "medically needy" spend-down rules, and 34 applied spousal impoverishment rules.¹¹⁷

Poverty-Level Pathway. In 2001, SSI benefits without state supplementation were about 74 percent of the federal poverty level for an individual and 82 percent of poverty for a couple (not counting the \$20 disregard).¹¹⁸ States have the option of extending full Medicaid coverage to elderly individuals at higher poverty thresholds. Specifically, states may cover elderly individuals whose income does not exceed 100 percent of the federal poverty level and whose countable resources do not exceed the SSI threshold of \$2,000 for an individual or \$3,000 for a couple. In counting income or resources, states may use the SSI methodology or they may use any methodology that is "less restrictive" than the SSI methodology. This flexibility enables states to effectively raise the poverty-level income standards or resource standards for this population beyond 100 percent of poverty or \$2,000 if they choose.¹¹⁹ Under this option, elderly individuals are not permitted to "spend down" into Medicaid eligibility by incurring large medical expenses, as they are able to do through the "medically needy" pathway. As of April 2001, 19 states had expanded income eligibility standards for the elderly to at least 100 percent of poverty.¹²⁰



TABLE 1-12: MEDICARE PREMIUMS AND COST SHARING OBLIGATIONS, 2001

Service	Cost
Part A Hospital	Deductible: \$792 per benefit period Coinsurance: (days 61–90): \$198/day (reserve days): \$396/day
Part B Premium	\$50/month
Physician and other ambulatory services	\$100 deductible and 20% coinsurance

Medicaid Eligibility Pathways for the Low-Income Elderly: Assistance with Medicare Premiums and Cost-Sharing

The eligibility pathways discussed in the previous section lead to coverage for the full Medicaid benefits package. This package includes not just nursing home care and prescription drugs, but also assistance with Medicare premiums and cost-sharing requirements. For low-income Medicare beneficiaries, Medicaid's assistance with Medicare premium and cost-sharing obligations can make a substantial difference in the amount of financial burden imposed by Medicare and in the accessibility of covered services (Table 1-12).

Federal Medicaid law recognizes that there are substantial numbers of elderly Medicare beneficiaries who are not sufficiently poor to qualify for full Medicaid benefits but who need assistance with Medicare premium and cost-sharing requirements. Thus, states participating in Medicaid are required to offer assistance for Medicare premiums and cost-sharing—but not any other Medicaid benefits—to certain categories of low-income Medicare beneficiaries. The Center for Medicaid and State Operations (CSMO) terms this assistance the “Medicare Savings Program.”¹²¹ 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 76% depending on the state). This section reviews each of these pathways to eligibility for Medicare premium and cost-sharing assistance, which varies with respect to income levels, scope of assistance, and entitlement status. These pathways are summarized in Table 1-13.

It is important to note that even though all states are required to cover certain categories of low-income

elderly, Medicaid assistance for Medicare cost-sharing for these groups varies from state to state. This is because under the Balanced Budget Act of 1997, states have the flexibility to avoid paying Medicare deductibles and coinsurance if their Medicaid payment rates for the service in question are sufficiently lower than those under Medicare. For example, if Medicare will allow \$100 for a physician visit, the coinsurance requirement is 20 percent of this amount, or \$20 and Medicare pays only \$80. However, if the state Medicaid program only allows \$60 for the physician visit, the state does not have to pay any of the \$20 coinsurance requirement. Even prior to the Balanced Budget Act, at least 12 states did not pay the full amount of Medicare cost-sharing for eligible Medicaid beneficiaries.¹²²

The Balanced Budget Act prohibits physicians and other Medicare providers from charging the beneficiary for the amount of the cost-sharing that the state Medicaid program does not pay. To continue the previous example, the physician may not charge the beneficiary the \$20 coinsurance amount that the state Medicaid program does not pay. This protects the beneficiary from an out-of-pocket burden but reduces the provider's payment to \$80, creating a disincentive for the provider to treat the beneficiary. The more low-income beneficiaries a provider treats, the greater the financial impact.

Qualified Medicare Beneficiaries (QMBs). States are required to provide assistance for Medicare premiums and cost-sharing to Medicare beneficiaries with incomes at or below 100 percent of the federal poverty level and countable resources at or below twice the allowable resource level under SSI.¹²³ In 2001, the federal poverty level was \$716 per month for an individual and \$968 per month for a couple; twice the SSI resource level was

TABLE 1-13: MEDICAID ELIGIBILITY PATHWAYS FOR ELDERLY INDIVIDUALS: MEDICAID ASSISTANCE WITH MEDICARE COST-SHARING, 2001

	Family Income*	Resource Test	Medicaid Pays	Entitlement
Qualified Medicare Beneficiaries (QMBs)	≤ 100% FPL* ^a	≤ 200% of SSI limit (\$4,000 for individuals, \$6,000 for couples) ^a	All Medicare premiums and cost-sharing charges ^b	Yes
Specified Low-Income Medicare Beneficiaries (SLMBs)	Between 100% and 120% FPL* ^a	≤ 200% of SSI limit (\$4,000 for individuals, \$6,000 for couples) ^a	Medicare Part B monthly premium	Yes
Qualifying Individuals 1 (QI1s)	Between 120% and 135% FPL*	≤ 200% of SSI limit (\$4,000 for individuals, \$6,000 for couples)	Medicare Part B monthly premium; benefit is subject to annual federal funding cap	No ^c
Qualifying Individuals 2 (QI2s)	Between 135% and 175% FPL*	≤ 200% of SSI limit (\$4,000 for individuals, \$6,000 for couples)	Portion of Medicare Part B monthly premium (\$3.09 per month in 2001); benefit is subject to annual federal funding cap	No

* In 2001, 100 percent of the federal poverty level (FPL) was \$716 for individuals, \$968 for couple per month; 120 percent FPL was \$859 for individuals and \$1,161 for couples per month; 135 percent FPL \$967 for individuals and \$1,307 for couples per month; 175 percent FPL was \$1,253 for individuals and \$1,694 for couples per month; 200 percent FPL was \$1,432 for individuals and \$1,936 for couples per month.

^a Under Section 1902(r) (2) of the Social Security Act, states may use income and resource methodologies that are “less restrictive” than those that would otherwise apply.

^b 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.

^c Persons selected to receive assistance in a calendar year are entitled to receive assistance for the remainder of the year, but not beyond, as long as they continue to qualify.

\$4,000 for an individual and \$6,000 for a couple. In counting income and resources for these individuals, known as Qualified Medicare Beneficiaries, or QMBs, states must use methodologies that are no more restrictive than those under SSI. At a minimum, states must disregard the first \$20 per month in income, raising the effective standard to \$736 per month for an individual and \$988 per month for a couple in 2001. States also have the flexibility to disregard any amount of income or resources they choose.

Specified Low-Income Medicare Beneficiaries (SLMBs). States are also required to provide assistance with

Medicare premiums to Medicare beneficiaries with incomes between 100 and 120 percent of the federal poverty level (\$716–\$860 per month in 2001 for an individual) and resources that do not exceed twice the SSI resource level (\$4,000 for an individual, \$6,000 for a couple).¹²⁴ In determining income and resources for these individuals, known as Specified Low-Income Medicare Beneficiaries (SLMBs), states must, at a minimum, use the SSI methodologies, including the \$20 income disregard. As in the case of QMBs, states have the flexibility to use “less restrictive” methodologies with respect to SLMBs.

In contrast to QMBs, SLMBs are not entitled to Medicaid assistance for all forms of Medicare cost-sharing. Instead, their protection is limited to the monthly Part B premium. For elderly individuals, this is still a significant benefit: \$50 per month (or \$600 per year in 2001) that would otherwise be deducted from the beneficiary's Social Security check.

Qualifying Individuals. The Balanced Budget Act of 1997 established two new categories of Medicare beneficiaries who may receive Medicaid assistance with all or a portion of their monthly Part B premiums.¹²⁵ Unlike QMBs or SLMBs, these Medicare beneficiaries, referred to as Qualifying Individuals (QIs), do not have an individual entitlement to this assistance. In addition, the federal funding for this assistance is capped each year and expires in FY 2002. Within this annual cap, each state is allocated a fixed amount of federal funds each year; no state match is required. States are required to limit the number of beneficiaries receiving such assistance so that the federal cost does not exceed the state's allocation (there is no state share). States must select among eligible Medicare beneficiaries on a first-come, first-served basis.

As shown in Table 1-13, the QI category is divided into two subcategories. The first subcategory (QI1) is composed of Medicare beneficiaries with incomes between 120 percent of the federal poverty level and less than 135 percent of the federal poverty level (\$967 per month in 2001 for an individual, \$1,307 for a couple) and resources of no greater than twice the SSI resource level (\$4,000 for an individual, \$6,000 for a couple). In counting income and resources, states must use SSI methodologies, including the \$20 income disregard. If a QI1 individual is selected by the state on a first-come, first-served basis in a given year, he or she receives assistance from Medicaid with the cost of the full Medicare Part B premium.

In contrast, Medicare beneficiaries who fall into the other subcategory of Qualifying Individuals (QI2s) do not receive assistance with the full amount of the Part B premium. Instead, they receive assistance with only the portion of the premium attributable to the increases related to home health benefits enacted in the Medicare savings provisions of the Balanced Budget Act of 1997. For 2001, this amount is \$3.09 per month (the monthly premium in 2001 was \$50). States must make this benefit available to Medicare beneficiaries with incomes between 135 percent of the federal poverty level and less than 175 percent of the poverty level. (In 2001, 175% of the federal poverty level was \$1,253 per month for an individual and \$1,694 per month for a couple). A state must impose the same resource test that applies to Medicare beneficiaries with incomes of under 100

percent of the federal poverty level: \$4,000 for an individual and \$6,000 for a couple. However, the state may not use "less restrictive" methodologies in determining either income or resources.

V. OTHER GROUPS

As noted at the beginning of this chapter, there are, by the Center for Medicaid and State Operations (CMSO) count, 28 mandatory and 21 optional Medicaid eligibility groups. The previous sections have reviewed the most common of these groups. This section discusses three federal eligibility categories that, while less well known, give states options to extend limited Medicaid coverage to three populations of uninsured or potentially uninsured low-income individuals, including childless individuals under 65 who are not disabled: 1) newly unemployed workers and others entitled to COBRA continuation coverage; 2) individuals infected with tuberculosis; and 3) women diagnosed with breast or cervical cancer (Table 1-14).

COBRA Continuation Beneficiaries. Under the Consolidated Budget Reconciliation Act of 1985 (COBRA), employers with 20 or more employees that offer health insurance to their workforce are required to allow employees who lose their jobs to continue their coverage through the employer's group health plan for 18 months by paying 102 percent of the monthly premium. The federal Medicaid statute allows states to pay these premiums on behalf of low-income unemployed workers and to receive federal Medicaid matching funds for these costs.¹²⁶ In order to qualify for a premium subsidy, the individual must have an income that does not exceed 100 percent of the federal poverty level (\$8,590 per year for an individual in 2001) and resources that do not exceed twice the allowable amount for SSI benefits (\$4,000 in 2001). Eligible individuals are entitled only to a premium subsidy, not to the full Medicaid benefits package.

Individuals Infected with Tuberculosis. Among the populations at significant risk for tuberculosis are individuals who are homeless, including childless adults who are generally categorically ineligible for Medicaid coverage regardless of the extent of their poverty. Federal Medicaid law gives states the option of extending limited Medicaid coverage to low-income individuals who are infected with tuberculosis, regardless of whether they would otherwise qualify for Medicaid.¹²⁷ In order to qualify, an individual must be infected with TB and have an income and resources no greater than the amounts allowed an individual with disabilities to qualify for Medicaid in the state. Eligible individuals are not entitled

TABLE 1-14: MEDICAID ELIGIBILITY PATHWAYS FOR OTHER GROUPS, 2001

OPTIONAL COVERAGE	Eligibility Criteria	
	Income Test	Resource Test
COBRA continuation beneficiaries	≤ 100% FPL*	≤ \$4,000 per individual, ≤ \$6,000 per family
Individuals infected with tuberculosis	≤ maximum amount for individuals with disabilities ^a	≤ maximum amount for individuals with disabilities ^a
Women under 65 with breast or cervical cancer	None (must be screened by CDC program)	None (must be screened by CDC program)

* In 2001, 100 percent of the federal poverty level for a family of three was \$14,630/year, or \$1,219/month.

^a Under Section 1902(r)(2) of the Social Security Act, states may use income and resource methodologies that are “less restrictive” than those that would otherwise apply. This enables states to effectively expand eligibility without altering the income or resource standard.

to the full Medicaid benefits package: they are covered only for physician and clinic services, diagnostic tests, prescription drugs, case management, and directly observed therapy relating to treatment of the TB.

Women with Breast or Cervical Cancer. In the Breast and Cervical Cancer Prevention and Treatment Act of 2000, P.L. 106-354, a new optional eligibility category was established for women under 65 in need of treatment for breast and cervical cancer. Like other optional eligibility groups, women who qualify are entitled to coverage for the basic Medicaid benefits package. Unlike other optional eligibility groups, however, eligibility is not determined using an income or resource test. Instead, women qualify if they (1) are not already covered as a mandatorily-eligible Medicaid beneficiary; (2) are under age 65; (3) have been screened at the early detection program funded by the Centers for Disease Control and Prevention (CDC) and need treatment for breast or cervical cancer; and (4) do not have private health insurance or other health care coverage.¹²⁸ Also unlike other optional eligibility groups, the costs of coverage are matched by the federal government at an enhanced rate (between 65 and 85 percent, depending on state per capita income). As of December 2001, 34 states had elected to implement this option.¹²⁹

VI. CONCLUSION

Medicaid serves as the nation’s primary source of health insurance coverage for the poor. During the past decade,

federal and state eligibility policy changes to promote Medicaid coverage of low-income pregnant women and children, the disabled, and elderly have resulted in greater coverage of these groups within the low-income population. However, many low-income childless adults fall outside the program’s eligibility categories and are precluded from coverage no matter how poor they are. Nonetheless, states have numerous options available to them under federal Medicaid law for broadening eligibility criteria to reach a greater proportion of their uninsured low-income residents, whether children, pregnant women, parents, individuals with disabilities, or elderly.

- 1 Aid to Families with Dependent Children (AFDC) was a joint federal-state cash assistance program targeted primarily at low-income single parent families with dependent children. Enacted in 1935, the program was repealed in 1996 and replaced by the Temporary Assistance to Needy Families (TANF) program. See *2000 Green Book*, Committee on Ways and Means, pp. 352–54 www.access.gpo.gov/congress/wm001.html.
- 2 Enacted in 1972, the Supplemental Security Income (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, *2000 Green Book*, Committee on Ways and Means, pp. 211–78.
- 3 Holahan, J. and Bruen, B., Urban Institute, *Medicaid “Mandatory” and “Optional” Eligibility and Benefits*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, July 2001, Accessed on www.kff.org/content/2001/4002/4002.pdf on April 5, 2002.
- 4 The optional coverage group of women in need of treatment for breast or cervical cancer is not subject to an income or resource test. Section 1902(aa) of the Social Security Act, 42 U.S.C. 1396a(aa).
- 5 20 CFR 416.1201-416.1266.
- 6 For a full discussion of immigration and Medicaid eligibility, see Rosenbaum, S., *Medicaid Eligibility and Citizenship Status: Policy Implications for Immigrant Populations*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, August 2000. Accessed on www.kff.org on April 5, 2002.
- 7 Section 5305(b) of P.L. 105-33. The Balanced Budget Act of 1997 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.
- 8 Under 42 C.F.R. 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. CMS has also issued guidance in letters to State Medicaid Directors clarifying Medicaid/welfare delinking policies, April 7, 2000. Accessed www.hcfa.gov/medicaid/letters/smdltrs.htm on April 5, 2002.
- 9 See Schneider, A., and Martinez, J., *Native Americans and Medicaid: Coverage and Financing Issues*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, December 1997. Accessed on www.kff.org on April 5, 2002.
- 10 *Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers*, Center for Medicaid and State Operations, May 11, 2001. Accessed on www.hcfa.gov/medicaid/elig0501.pdf on April 5, 2002.
- 11 For a more technical discussion of Medicaid eligibility policy, including regulatory and judicial annotations, see Perkins, J. and Somers, S., *An Advocate’s Guide to the Medicaid Program*, National Health Law Program, Chapter III, June 2001. Accessed on www.healthlaw.org April 5, 2002.
- 12 Hoffman, C., and Pohl, M., *Health Insurance Coverage in America: 2000 Data Update*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, February 2002, Table 16, p. 36.
- 13 Urban Institute estimates, based on CMS-2082 and CMS-64 reports.
- 14 Smith, V., Rousseau, D., and Guyer, J., *CHIP Program Enrollment: December 2001*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, 2002.
- 15 For more information on the impact of Medicaid/welfare delinking and immigration policies on Medicaid enrollment, see Kronebusch, K., “Medicaid for Children: Federal Mandates, Welfare Reform, and Policy Backsliding,” *Health Affairs*, January/February 2001, p. 97–111; Ellwood, M., *The*

- Medicaid Eligibility Maze: Coverage Expands, but Enrollment Problems Persist, Findings from a Five State Study*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation and the Urban Institute's Assessing the New Federalism Project, September 1999, www.kff.org/content/1999/2164/; Maloy, K., Pavetti, L., Darnell, J., and Shin, P., *A Description and Assessment of State Approaches to Diversion Programs and Activities Under Welfare Reform*, George Washington University Center for Health Policy Research, August 1998; and Feld, P. and Power, B., *Immigrants' Access to Health Care after Welfare Reform: Findings from Focus Groups in Four Cities*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, November 2000. Accessed on www.kff.org/content/2000/1608/ on April 5, 2002.
- 16 *Maternal and Child Health (MCH) Update: States Have Expanded Eligibility and Increased Access to Health Care for Pregnant Women and Children*, National Governors' Association, February 2001, www.nga.org/center/divisions/1,1188,C_ISSUE_BRIEF^D_1468,00.html.
- 17 Mann, C., Hudman, J., Salganicoff, A., and Folsom, A. "Five Years Later: Poor Women's Health Coverage After Welfare Reform." *Journal of American Medical Women's Association*, Winter 2002.
- 18 Moreover, low-income single mothers experienced the largest increase in the number of uninsured between 1994 and 1998. See Wyn, R., Solis, B., Ojeda, V., and Pourat, N., *Falling Through the Cracks: Health Insurance Coverage of Low-Income Women*, The Henry J. Kaiser Family Foundation, February 2001, Exhibit 9.
- 19 See *Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers*, Center for Medicaid and State Operations, May 11, 2001. Accessed on www.hcfa.gov/medicaid/elig0501.pdf on April 5, 2002.
- 20 Federal poverty level guidelines are updated each year in the Federal Register by the Department of Health and Human Services. Accessed on www.aspe.hhs.gov/poverty/01poverty.htm on April 5, 2002.
- 21 See *Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers*, Center for Medicaid and State Operations, May 11, 2001. Accessed on www.hcfa.gov/medicaid/elig0501.pdf on April 5, 2002.
- 22 Ross, D.C., and Cox, L., *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures, Findings from a 50-State Survey*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, October 2000.
- 23 For a discussion of state-by-state SCHIP enrollment, see Smith, V., Rousseau, D. and Guyer, J. *CHIP Program Enrollment: December 2000*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, September 2001. Accessed on www.kff.org/content/2001/4005/4005.pdf on April 5, 2002. Note that a state that reduces its Medicaid eligibility levels for children below those in effect as of June 1, 1997 is ineligible for federal SCHIP matching payments, section 2105(d)(i) of the Social Security Act.
- 24 Health Care Financing Administration, January 2001. Accessed on www.hcfa.gov/init/chip-map.htm on April 5, 2002.
- 25 Ross, D.C., and Cox, L., *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures, Findings from a 50-State Survey*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, October 2000, Table 1.
- 26 Center on Budget and Policy Priorities. *State Income Eligibility Guidelines for Children's Medicaid and Separate Child Health Insurance Programs*. Updated January 2001. Accessed on www.cbpp.org/shsh/elig.htm on April 5, 2002.
- 27 See *Maternal and Child Health (MCH) Update: States Have Expanded Eligibility and Increased Access to Health Care for Pregnant Women and Children*, National Governors' Association, February 2001, Table 3.
- 28 Dubay, L., and Kenney, G., *The Urban Institute, Covering Parents Through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, October 2001.
- 29 Broaddus, M., et al. *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000*. Center on Budget and

- Policy Priorities, February 13, 2002. Accessed on www.cbpp.org/1-2-02health.htm on April 5, 2002.
- 30 Section 1925(b)(3) of the Social Security Act.
- 31 Broaddus, M., et al. *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000*. Center on Budget and Policy Priorities, February 13, 2002. Accessed on www.cbpp.org/1-2-02health.htm on April 5, 2002.
- 32 See Garrett, B. and Holahan, J. "Health Insurance Coverage After Welfare," *Health Affairs*, January/February 2000, pp. 175–84; *Go Directly to Work, Do Not Collect Health Insurance: Low-Income Parents Lose Medicaid*, Families USA, June 2000; Guyer, J., *Health Care After Welfare: An Update of Findings from State-Level Leaver Studies*. Center on Budget and Policy Priorities, August 2000; and Kaplan, J., *Transitional Medicaid Assistance*, Welfare Information Network, December 1997.
- 33 For a discussion of eligibility rules relating to two-parent families, see Guyer, J., and Mann, C., *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Care Coverage to Low-Income Working Parents*, Center on Budget and Policy Priorities, August 1998.
- 34 63 Fed. Reg. 42270 (August 7, 1998).
- 35 For example, Pennsylvania disregards 50 percent of a parent's earned income in determining Medicaid eligibility, and Louisiana disregards the equity value of one vehicle up to \$10,000. See Broaddus, M., et al. *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000*. Center on Budget and Policy Priorities, February 13, 2002. Accessed on www.cbpp.org/1-2-02health.htm on April 5, 2002.
- 36 Broaddus, M., et al. *Expanding Family Coverage: States' Medicaid Eligibility Policies for Working Families in the Year 2000*. Center on Budget and Policy Priorities, February 13, 2002. Accessed on www.cbpp.org/1-2-02health.htm on April 5, 2002.
- 37 Mann, C. *The New Medicaid and CHIP Waiver Initiatives*. The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, February 2002. Accessed on www.kff.org/content/2002/4028/ on April 5, 2002.
- 38 Under section 1931 of the Social Security Act, states have the option of liberalizing their financial eligibility standards for adults in one-parent and certain two-parent families by adopting "less restrictive" income or resource methodologies. Recent regulations allow states to amend family composition rules for single- and two-parent families with dependent children. However, in order to receive federal Medicaid matching funds for the coverage of childless non-disabled adults, states must obtain a waiver from the Secretary of HHS under section 1115.
- 39 Mann, C. *The New Medicaid and CHIP Waiver Initiatives*, February 2002.
- 40 CMS estimates that 116,000 persons living with HIV disease will be served by the Medicaid program nationwide in Federal fiscal year 2001. Combined Federal and State Medicaid expenditures for serving this population are estimated to be \$4.3 billion in FY 2001. Center for Medicaid and State Operations Fact Sheet, February 2001. Accessed on www.hcfa.gov/medicaid/obs11.htm on April 5, 2002.
- 41 See Rosenbaum, S., *The Olmstead Decision: Implications for Medicaid*, The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, March 2000.
- 42 Meyer, J., and Zeller, P., *Profiles of Disability: Employment and Health Coverage*, prepared for The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, September 1999.
- 43 The figures do not include individuals with disabilities who qualify for Medicaid through other eligibility "pathways", such as elderly, or as poverty-level children.
- 44 Drawn from the typology presented by Meyer and Zeller in *Profiles of Disability: Employment and Health Coverage*, prepared for The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, September 1999.
- 45 Meyer, J., and Zeller P., *Profiles of Disability: Employment and Health Coverage*, prepared for The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, September 1999.
- 46 Estimated using 1994 data by Meyer, J., and Zeller P., *Profiles of Disability: Employment and Health Coverage*, prepared for The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, September 1999.

- 47 Meyer, J., and Zeller P., *Profiles of Disability: Employment and Health Coverage*, prepared for The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, September 1999.
- 48 Medicare Current Beneficiary Survey, 1997 and Urban Institute Estimates based on CMS 2082 and CMS-64 Reports, 1999.
- 49 For an overview of the SSI program, see *2000 Green Book*, Committee on Ways and Means, (WCMP: 106-14), Section 3.
- 50 Families USA. *Could Your State Do More to Expand Medicaid for Seniors and Adults with Disabilities?* November 2001.
www.familiesusa.org/media/pdf/ExpandingMedicaid.pdf
- 51 20 C.F.R. 416.974 (b), published at 65 Fed. Reg. 82905 (December 29, 2000).
- 52 Section 1614(a)(3) of the Social Security Act.
- 53 Section 1614(a)(2) of the Social Security Act.
- 54 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.
- 55 House Committee on Ways and Means, 2000 Green Book, page 225.
- 56 Note also that “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 do not receive SSI. 42 C.F.R. 435.121(d).
- 57 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.”
- 58 20 C.F.R. 404, Subpart P, App. 1 (listing of impairments).
- 59 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.
- 60 20 C.F.R. 416.1165.
- 61 20 C.F.R. 416.1165(g)(4).
- 62 House Committee on Ways and Means, 2000 Green Book, p.252.
- 63 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. Accessed on www.hcfa.gov/medicaid/letters/smdltrs.htm on April 5, 2002.
- 64 42 CFR Section 435.222 (b)(1).
- 65 For additional information, see Letter to State Medicaid Directors, December 1, 2000, www.CMS.gov/medicaid/smd12100.htm.
- 66 Section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act, 42 C.F.R. 435.227(a).
- 67 *2000 Green Book*, House Committee on Ways and Means, p. 673.
- 68 Section 1902(e)(3) of the Social Security Act, 42 U.S.C. 1396a(e)(3).
- 69 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, S., *The Olmstead Decision: Implications for Medicaid*, prepared for The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, March 2000.
- 70 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).

- 71 42 C.F.R. 441.305(b).
- 72 Harrington et al. *State Variation in the Growth of Medicaid Home and Community-Based Services*. The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation. Forthcoming 2002.
- 73 Families USA. *Could Your State Do More to Expand Medicaid for Seniors and Adults with Disabilities?* November 2001.
- 74 See generally, McCormack, T., "Returning to Work and Keeping Medicare and Medicaid," February 2001. Title II Community AIDS National Network. See also the Resource Center for Developing and Implementing Medicaid Buy-in Programs and Related Employment Initiative for Persons with Disabilities. Accessed on www.uiowa.edu/~lhpd/work/index.html on April 11, 2002.
- 75 20 C.F.R. 416.974(b) published at 65 Fed. Reg. 82905 (December 29, 2000).
- 76 SSA Program Operations Manual System.
- 77 *Annual Statistical Supplement, 2001 to the Social Security Bulletin*. Social Security Administration, Office of Policy, Table 7-F3, page 294.
- 78 Section 1902(a)(10)(A)(ii)(xiii) of the Social Security Act.
- 79 *Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers*, Center for Medicaid and State Operations, May 11, 2001. Accessed on www.hcfa.gov/medicaid/elig0501.pdf on April 5, 2002.
- 80 National Association of State Medicaid Directors, <http://disabilities.aphsa.org/Resource%2#Directory/MedicaidBuyIn.htm>.
- 81 The other main difference between this eligibility pathway and the BBA pathway has to do with state spending. Under this new option, in order to receive federal Medicaid matching funds for the cost 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 the state fiscal year 1999. Section 1903(1)(20) of the Social Security Act.
- 82 Section 1916(g)(2) of the Social Security Act.
- 83 National Association of State Medicaid Directors, disabilities.aphsa.org/Resource%2#Directory/MedicaidBuyIn.htm.
- 84 Section 1902(a)(10)(A)(ii)(xvi) of the Social Security Act.
- 85 House Committee on Ways and Means, 2000 Green Book, page 230, Table 3–4.
- 86 Families USA. *Could Your State Do More to Expand Medicaid for Seniors and Adults with Disabilities?* November 2001.
- 87 Harrington et al. *State Variation in the Growth of Medicaid Home and Community-Based Services*. The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation. Forthcoming, 2002.
- 88 This reduction in the SSI benefit payment does not occur for the first three months of institutionalization if a physician certifies that the individual is not likely to stay for more than three months and if the individual maintains a home to which he or she may return.
- 89 House Committee on Ways and Means, 2000 Green Book, page 230, Table 3–4.
- 90 Horvath, J., *Medicaid Financial Eligibility For Aged, Blind and Disabled*, National Academy of State Health Policy, May 1997, Chart #1.
- 91 Medicare cost-sharing requirements are: Part A hospital deductible (\$792 in 2001); Part A coinsurance; Part B monthly premium (\$50 in 2001); Part B annual deductible (\$100); and Part B coinsurance.
- 92 *Medicare Savings Program: You Could Save Up to \$600 Per Year in Medicare Expenses*, CMS. Accessed on www.medicare.gov/publications/pubs/pdf/qmb99.pdf on April 5, 2002.
- 93 Section 1902(a)(10)(E)(ii) of the Social Security Act.

- 94 Gluck, M. and Hanson, K. *Medicare Chart Book*, The Henry J. Kaiser Family Foundation, Fall 2001.
- 95 *Fast Facts and Figures about Social Security*, Social Security Administration, June 2001.
- 96 Gluck, M. and Hanson, K. *Medicare Chart Book*, The Henry J. Kaiser Family Foundation, Fall 2001.
- 97 Barents Group of KPMG Consulting analysis of the 1999 Medicare Current Beneficiary Survey, prepared for The Henry J. Kaiser Family Foundation.
- 98 Urban Institute analysis of the 1998 Medicare Current Beneficiary Survey, prepared for The Henry J. Kaiser Family Foundation.
- 99 Urban Institute analysis of the 1998 Medicare Current Beneficiary Survey, prepared for The Henry J. Kaiser Family Foundation.
- 100 Health Care Financing Administration. The Characteristics and Perceptions of the Medicare Population: Data from the 1998 Medicare Current Beneficiary Survey. Accessed on www.hcfa.gov/surveys/mcbs/PubCNP98.htm on April 5, 2002.
- 101 AARP Public Policy Institute and The Lewin Group, *Out of Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections*, December 1997.
- 102 Barents Group of KPMG Consulting analysis of the 1999 Medicare Current Beneficiary Survey, prepared for The Henry J. Kaiser Family Foundation.
- 103 For an overview of the SSI program, see *2000 Green Book*, Committee on Ways and Means.
- 104 House Committee on Ways and Means, *2000 Green Book*, page 214, Table 3-1 <http://cms.hhs.gov/medicaid/eligibility/ssi0101.asp>.
- 105 Families USA. *Could Your State Do More to Expand Medicaid for Seniors and Adults with Disabilities?* November 2001.
- 106 The six states that did not provide SSP in 1999 are: Arkansas, Georgia, Kansas, Mississippi, Tennessee, and West Virginia. House Committee on Ways and Means, *2000 Green Book*, page 223.
- 107 Families USA. *Could Your State Do More to Expand Medicaid for Seniors and Adults with Disabilities?* November 2001.
- 108 Section 503 of P.L. 94-566; 42 C.F.R. Section 435.135.
- 109 Families USA. *Could Your State Do More to Expand Medicaid for Seniors and Adults with Disabilities?* November 2001.
- 110 The term “spend-down” is often applied to resources as well as income, most commonly when an individual is said to have “spent down” his or her countable resources to \$2,000 in order to qualify for Medicaid coverage of nursing home care. Note, however, that this use of the term “spend down” is not technically correct. An individual cannot “spend-down” resources to qualify for medically needy eligibility in the same way as an individual can “spend-down” monthly income—that is, by applying countable resources above the \$2,000 or other eligibility threshold toward the cost of care with Medicaid paying the remainder of the cost. An individual with excess countable resources is simply ineligible for Medicaid “medically needy” coverage regardless of the cost of nursing home care.
- 111 States have the option of allowing medically needy individuals to pay their “spend down” liability to the state in advance each month, in a manner comparable to an income-related premium. Conversation with Letty Carpenter, Health Care Financing Administration, October 5, 1998.
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