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Medicaid: Eligibility for the Aged and Disabled

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Medicaid: Eligibility for the Aged and Disabled

Summary

Medicaid is a means-tested federal-state matching program that provides medical assistance for persons who are unable to afford needed medical and health-related services. Since the program's establishment in 1965, it has become the largest single source of financing–both private and public–for long-term care for those elderly and disabled who are low-income or who have depleted their income and assets on medical and long-term care expenses. In order to be eligible for Medicaid, individuals must meet certain eligibility criteria. These criteria are determined by broad federal requirements and state decisions about whom they want to cover under their Medicaid programs. The financial eligibility standards that states do use are shaped in large part by estimates of spending that will occur with these standards. The elderly and disabled are the most expensive groups that are covered under Medicaid, largely because Medicaid covers nursing home and other institutional long-term care and because this care is expensive.

Eligibility for the program's benefits has traditionally been linked to eligibility for cash welfare assistance; that is, a person receiving welfare assistance under certain programs can also become eligible for Medicaid. For the elderly and disabled groups, the cash welfare program linked to Medicaid eligibility is the Supplemental Security Income (SSI) program. It provides federal cash welfare assistance to needy aged, disabled and blind individuals who have little or no income and resources. Medicaid law generally requires that states cover persons receiving SSI.

Medicaid, however, also covers elderly and disabled persons who are not poor and who may have income in excess of SSI welfare standards. It does so through options in Medicaid law that allow states to cover persons who need help with medical expenses. One of these options is a medically needy program by which states may cover persons regardless of income who incur medical expenses that deplete their income to levels that make them needy. Medicaid also allows states to use a higher income standard (up to 300% of basic SSI payment) for those who reside in nursing homes or other medical care institutions or who are eligible for certain long-term care services offered in the community. It is through these two options that Medicaid ends up covering long-term care expenses for many non-poor elderly persons. To make sure that persons with income and assets exceeding the welfare standards apply their resources toward the cost of their care, Medicaid eligibility rules include additional provisions that impose penalties on individuals who give their assets away in order to gain Medicaid eligibility sooner than they otherwise would and require states to recover assets from beneficiary's estates up to amounts paid for long-term care services after their death.

Medicaid eligibility rules also result in a diverse disabled population receiving coverage. Many disabled persons become eligible because they cannot work and are dependent on welfare assistance from SSI. However, Medicaid provides incentives for other disabled persons to work and retain Medicaid coverage. The disabled population also includes children who need a broad range of home and community based care as well as some who need nursing home care.

Contents

List of Tables

Medicaid: Eligibility for the Aged and Disabled

Introduction

Medicaid is a federal-state matching entitlement program that provides medical assistance for certain groups of low-income individuals. The program was established in 1965 under Title XIX of the Social Security Act and has become the largest single source of financing – both private and public – for long-term care[1] for the elderly and disabled who are low-income or who have depleted their income and assets on medical and long-term care expenses.[2] Of the 40.3 million individuals who were enrolled in Medicaid in fiscal year 1998 (FY98), approximately 4 million (10.1%) qualified on the basis of being elderly and 6.9 million (17.2%) qualified on the basis of disability.[3]

Although the elderly and individuals with disabilities comprise only 27.3% of Medicaid enrollees, they command a disproportionate share of program spending. In 1998, they accounted for 71% of the total Medicaid spending. This can be largely attributed to Medicaid's coverage of long-term care benefits that provide a wide-array of institutional and community-based services not generally covered (or in some instances only partly covered) by other public programs (such as Medicare), or private insurance plans. Of the approximately $101 billion spent by Medicaid on elderly and disabled individuals in 1998, more than 60% ($61.8 billion) was for long-term care. Of those dollars, 71% ($44.2 billion) was for institutional care – including nursing facilities, intermediate care facilities for the mentally retarded and mental health facilities, and the remaining spending 29% ($17.6 billion) was paid for home and community-based services – including a range of services such as home health,

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[1] Long-term care offers a wide range of personal, social, and medical support services through institutions and community-based programs.

[2] Medicaid also plays a significant role in the provision of preventive, primary and acute care for millions of low-income children, families and pregnant women.

[3] Data prepared by Congressional Research Service (CRS) based on analysis from Health Care Financing Administration, Form 2082. CRS Report RL30733, *Medicaid Expenditures and Enrollees, 1998*, by Evelyne Baumrucker and Jean Hearne. (Hereafter cited as CRS Report RL30733.)

personal care, adult day care, care coordination, home modifications, transportation and respite for caregivers.[4]

Medicaid is a means-tested program intended to provide assistance to persons who are unable to afford needed medical and health-related services. Within broad federal guidelines, states have flexibility to determine eligibility criteria. In general, the federal government mandates states to meet minimum eligibility standards, but states also have a great deal of flexibility in using standards that are more generous or more restrictive. The financial eligibility standards that states do use are shaped in large part by estimates of spending that will occur with these standards. The elderly and disabled are the most expensive groups that are covered under Medicaid. In 1998, spending averaged $9,058 per disabled Medicaid beneficiary and $10,193 per elderly Medicaid beneficiary, as compared to $1,442 for children under age 21 and $2,292 for non-disabled adults.[5]

Eligibility for the program's benefits has traditionally been linked to eligibility for cash welfare program assistance; that is, a person receiving welfare assistance under certain programs can also become automatically eligible for Medicaid. For the elderly and disabled groups, the cash welfare program linked to Medicaid eligibility is the Supplemental Security Income (SSI). It provides federal cash welfare assistance to needy aged, disabled and blind individuals who have little or no income and resources. Medicaid law generally requires that states cover persons receiving SSI.

In addition to the SSI eligibility pathway into Medicaid, the statute includes other provisions that allow states to extend Medicaid eligibility to other elderly and disabled individuals. These individuals must also meet financial standards to become eligible. Financial standards are defined as the maximum amount of income and resources (such as cars, savings accounts, bonds, stocks and real estate) an individual is allowed to have and still qualify for Medicaid.

Not only do states have flexibility, within broad federal guidelines, to use specific financial standards for different eligibility groups, but they also have flexibility in the rules they use to define income and resources. For example, when counting an individual's income to determine whether an individual is Medicaid eligible, some states may count all pensions, social security payments and annuities, but disregard $20 dollars for miscellaneous costs and $200 dollars for housing expenses. Other states may not have such income disregards.

State flexibility has led to variation in income and resources requirements as well as the means by which income and resources are counted across states. In general, individuals in similar circumstances of need for medical or long-term care

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[4] Tables 9 and 10. Medicaid Medical Vendor Payments by Basis of Eligibility of Beneficiaries: Fiscal Year 1998. *Medicaid Statistics: Program and Financial Statistics Fiscal Year 1998*. Health Care Financing Administration, Pub. No. 10129, August 2000. Based on data from the Health Care Financing Administration (HCFA) Form 64 reports.

[5] Data prepared by CRS based on analysis from Health Care Financing Administration Forms 64 and 2082. CRS Report RL30733.

may be automatically eligible for coverage in one state, but may be required to assume a certain portion of their medical expenses before they can obtain coverage in a second state, and not eligible at all in a third state. Statewide variation concerning income and asset requirements, makes generalizations about eligibility as it applies to a particular individual or the nation difficult.

A brief profile of elderly and disabled beneficiaries as well as the variety of eligibility pathways outlined by federal law and implemented, with significant variation, by states will be described in this report.

Elderly and Disabled Medicaid Beneficiaries

In 1998, there were approximately 10.9 million elderly and disabled Medicaid beneficiaries across all states, comprising 27.3% of all Medicaid beneficiaries. Four million of this number were elderly and 6.9 million were disabled. This section presents some of their characteristics as well the acute and long-term care services they receive through Medicaid.

The elderly are defined as persons 65 years of age and older. Demographic projections show record rates of growth in the elderly population. In the year 2000, the nation's elderly population totaled approximately 34 million persons.[6] This number is expected to more than double over the next half century.[7] This growth will impose significant pressure on federal and state budgets that fund Medicaid. The Congressional Budget Office (CBO) estimates that the federal share of Medicaid spending will grow from 1.2% of gross domestic product (GDP) in 1999 to 3.7% in 2040, in part because of the aging of the population.[8]

The population of disabled Medicaid enrollees is diverse, with individuals experiencing a variety of physical impairments (including conditions related to vision, hearing, communication or mobility), severe mental and emotional conditions, and functional limitations (such as bathing, dressing, eating, getting in or out of a bed or chair, preparing meals, shopping or doing housework).[9] Medicaid covers both disabled adults and children. The blind are grouped within the category of individuals with disabilities under the Medicaid statute.

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[6] Kassner, Enid and Bectel, Robert W. *Midlife and Older Americans with Disabilities: Who Gets Help? A Chartbook*. The Public Policy Institute, Research Group, American Association of Retired Persons. 1998.

[7] The population age 65 to 74 is predicted to nearly double – from 18 million in 2000 to 35 million in 2050; the number of individuals age 75 to 85 will also more than double - from 12 million in 2000 to 26 million in 2050; and the population age 85 and older is expected to more than quadruple – from 4 million in 2000 to 28 million in 2050. Projections include institutionalized individuals (Kassner, et. al., 1998).

[8] Congressional Budget Office, The Long-Term Budget Outlook, Washington, October 2000. From website, December 11, 2000:
[http://www.cbo.gov/showdoc.cfm?index=2517&sequence=0&from=7]

[9] Meyer, Ph.D., Jack A., and Pamela J. Zeller, Ph.D. Profiles of Disability: Employment and Health Coverage. *Medicaid and the Uninsured*. The Kaiser Commission on Medicaid and the Uninsured, September 1999.

People with disabilities are more likely to be poor than individuals without disabilities. As a result, disabled individuals are more likely to rely on Medicaid for their health coverage than on private health insurance.[10] In addition, the prevalence of disability increases with age, with a large number of Medicaid recipients being both disabled and elderly.

Many elderly and disabled Medicaid beneficiaries are also covered under Medicare. Medicare is a nationwide entitlement program that provides health insurance coverage for a defined package of services for elderly and certain disabled individuals. When persons qualify for both Medicaid and Medicare they are considered "dual eligibles." Dual eligibles receive their acute care services through Medicare and prescription drug coverage and long-term care services through Medicaid. Medicaid also pays Medicare premium and co-pay costs for some low-income Medicare beneficiaries.

Long-term Care and Other Services for the Elderly and Disabled

Most aged and disabled Medicaid enrollees live in the community and rely on Medicaid to pay for their preventive and acute care needs. There are, however, a significant number who rely on long-term care services paid for by Medicaid. About 467,451 aged and disabled individuals received long-term care services in the community under home and community-based waiver services (described later) and approximately 1.8 million individuals received long-term care services while living in institutional settings, such as nursing facilities and intermediate care facilities for the mentally retarded.[11]

All states determine eligibility for long-term care services based on a test of an applicant's functional limitations. The design of these tests varies across states, but often includes tests to determine an applicant's limitations in his or her ability to carry out activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs refer to activities necessary to carry out basic human functions, and include the following: bathing, dressing, eating, getting around inside the home, toileting, and transferring from a bed to a chair. IADLs refer to tasks necessary for independent community living, and include the following: shopping, light housework, telephoning, money management, and meal preparation.

A wide variety of acute and long-term care services, targeted to the needs of these special populations, are available under Medicaid. Federal law requires state Medicaid programs to cover hospital, nursing facility and other primary and acute care services. States also have the option of offering additional services, such as

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[10] Schneider, Andy, Victoria Strohmeyer, and Risa Elberger. *Medicaid Eligibility for Individuals with Disabilities*. The Henry J. Kaiser Family Foundation, Washington D.C. July 1999.

[11] U.S. Department of Health and Human Services, Health Care Financing Administration, Center for Medicaid and State Operations. Table 32: Medicaid Long-Term Care Beneficiaries and Days of Care. *Medicaid Statistics: Program and Financial Statistics Fiscal Year 1998.* HCFA Pub. NO. 10129. August 2000.

prescription drugs, long-term care services and dental care. This flexibility under Medicaid law has led to widespread variation in state Medicaid benefit packages offered to elderly, disabled and blind individuals across states.

Welfare-Related Pathways

Coverage of Persons Receiving Supplemental Security Insurance (SSI)

Traditionally, Medicaid eligibility for aged and disabled individuals has been linked to the federal welfare program, Supplemental Security Income (SSI), under Title XVI of the Social Security Act. The SSI program is administered at the federal level and cash benefits are reserved exclusively for the aged, disabled and blind. SSI is a means-tested income assistance program for aged, blind and disabled individuals who have low incomes and limited resources. In FY 2001, about 6.7 million individuals received SSI benefits.

Generally, states are required to provide Medicaid coverage to recipients of SSI and rely on SSI eligibility rules, established at the national level, as the basis for Medicaid eligibility. In order to qualify for SSI, a person must satisfy the program criteria for age or disability and meet SSI's income and resources requirements. In addition, applicants must meet certain citizen and residency requirements.

Categories of Individuals Who Qualify for SSI

Elderly. The elderly, or aged, are defined as persons 65 years and older. The aged comprised approximately 30% of the SSI recipient population in FY 2001, and totaled approximately 2 million individuals. Because the incidence of disability increases with age, many elderly individuals are also disabled, but in these cases, are classified generally as elderly for Medicaid program data collection purposes.

Adults with Disabilities. Individuals with disabilities are defined under Medicaid and SSI as those unable to engage in any substantial gainful activity (SGA) by reason of a medically determined physical or mental impairment expected to last, for a continuous period of at least 12 months. The test of "substantial gainful activity" is to earn $780 monthly in counted income as of 2002, with impairment-related expenses subtracted from earnings. For disabled individuals who are blind – defined as having 20/200 vision or less with the use of correcting lens in the person's better eye, or those with tunnel vision of 20 degrees or less – a different SGA level applies. SGA for the blind is earnings of $1,300 a month in 2002 and is adjusted annually to reflect growth in average wages.[12] Generally, the individual

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[12] The passage of this provision, under P.L. 95-216 in 1977, gave rise to controversy concerning the blind's preferential treatment under the law. Proponents of liberalizing the SGA amount for the blind maintain that adverse employment experiences for the blind, including high job-related costs and unemployment, are greater than for persons who have other disabilities. Opponents, on the other hand, argue that there are many other (continued...)

must be unable to do any kind of work, that exists in the national economy, taking into account age, education, and work experience. Individuals with disabilities aged 18 to 64 comprised the majority of SSI recipients, totaling about 57%, or approximately 3.8 million individuals in FY 2001.

Children with Disabilities. Children may qualify for SSI if they are under age 18 (or under age 22 if a full-time student), unmarried, and meet the applicable SSI disability or blindness, income, and resources requirements. P.L. 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), established a new disability definition for children under age 18 which requires a child to have "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." Parents' income is considered when determining the eligibility of children. SSI requires that some of the income of ineligible family members (i.e., parents) be *deemed* available to meet the basic needs of children before extending eligibility to those children. Individuals with disabilities under age 18 comprised about 13%, approximately 865,700 individuals, of the SSI recipient population in FY 2001.[13]

Financial and Resources Eligibility Criteria

Income. An individual's income is used to determine eligibility for SSI and to calculate the benefit payment. Two types of income are considered: earned and unearned. Earned income includes wages, net earnings from self-employment and earnings from services performed. All other income (including Social Security benefits, other government and private pensions, veteran's benefits, workers' compensation and in-kind support and maintenance) not derived from current work is considered "unearned." In an individual has income, a dollar-for-dollar reduction is made against the maximum federal SSI benefit, which is $580 in 2002 (in 2000 the benefit level was $512). The federal SSI benefit for a couple with both members qualifying for SSI is $817 in 2002 (in 2000, the benefit level was $769).

Resources. In addition to income criteria, SSI limits the countable resources persons may have in order to qualify for benefits. Countable resources generally refer to liquid assets, such as money in bank accounts, stocks and bonds, mutual fund investments, and certificates of deposit. Eligibility for SSI is restricted to otherwise qualifying individuals whose resources do not exceed $2,000 for an individual and $3,000 for a couple.

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[12] (...continued)
impairments that could easily be viewed as needing special compensatory relief, such as quadriplegia, cancer, etc. For more information see CRS Report RS20479, *Social Security: Substantial Gainful Activity for the Blind*, by Geoffrey Kollmann. A variety of Senate and House bills have been proposed to modify P.L. 95-216, but none have become law.

[13] Brooks, Alfreda M. Social Security Administration. Office of Policy, Office of Research, Evaluation, and Statistics, Division of SSI Statistics and Analysis. *SSI Annual Statistical Report, 1999*. June 2000.

Countable resources do not, however, include all resources that an individual or couple may own. As of May 2000, they exclude, but are not limited to, the following:

- An individual's home, of any value, as long as it is used as the applicant's principal place of residence;
- The first $4,500 in current market value of an auto (100% of the auto's value is excluded if it is equipped for use by a handicapped person, if it is needed to go to work or to perform essential daily activities due to distance, climate or terrain, or if it is used to obtain regular medical treatment);
- Up to $2,000 of household goods and personal effects;
- Life insurance policies with a total face value of $1,500 or less per person;
- Burial funds not in excess of $1,500 each for an individual and spouse (plus accrued interest);
- Property essential to self-support, including property used in a trade or business or on the job if the individual works for someone else; and
- Resources set aside to fulfill a plan to achieve self-support.

As of September 2000, 39 states and the District of Columbia provided Medicaid coverage to persons eligible for SSI.

Disabled Recipients Who Lose SSI Benefits. Disabled recipients who lose federal SSI eligibility because of earnings above the substantial gainful activity level may continue to retain eligibility for SSI and Medicaid under Section 1619 (P.L. 96-265) of the Social Security Act. For more information about these rules, see the discussion, "Rules Applying to Disabled Individual Engaged in Work," on page 32 below.

Coverage of Persons in 209(b) States

While 39 states and the District of Columbia extend automatic Medicaid eligibility to persons receiving SSI, 11 states do not. These states are so-called "209(b) states." When SSI was enacted in 1972, certain states expected that the number of elderly and disabled cash assistance recipients would grow significantly. To protect states from potentially large increases in their Medicaid expenditures for the aged and disabled populations, Section 209(b) of the Social Security Amendments of 1972 (P.L. 92-603) gave states the option to continue using the financial standards and definitions for disability they had in effect in January 1972 to determine Medicaid eligibility for the aged, blind, and disabled residents, rather than making all SSI recipients automatically eligible for Medicaid.

Under the 209(b) provision, states may elect the option to use income and resources standards that are no more restrictive than those in effect on January 1, 1972. These states may require persons to meet a lower income standard than SSI's or may use more restrictive policies for defining countable income. They may also have lower limits for the amounts of resources a person may have. Each of the 209(b) states has at least one eligibility standard (income, resources, or definition of

disability) that is more restrictive than SSI standards. The 11 section 209(b) states are Connecticut, Illinois, Hawaii, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia. Of these, three have income standards below the 2000 SSI level of $512 per month, and five states use a resource threshold lower than SSI's standard of $2000. In other cases, a state's standards may be the same as SSI's or even more liberal. It is important to note again, however, that states count income differently. This means that persons with income levels higher than the states' standards, as listed in **Table 1**, might still be able to qualify for Medicaid. In addition to the income standards, **Table 1** shows resources standards used by the 209(b) states.

States that use more restrictive eligibility rules under section 209(b) must also allow applicants to deduct medical expenses from the individual's countable income when determining eligibility. This process is sometimes referred to as the "209(b) spend-down." An example of 209(b) spend-down is as follows: if an applicant has a monthly income of $700 (not including any SSI or SSP payments – described below) and the states' maximum allowable income standard for spend-down eligibility is $600, the applicant would qualify for Medicaid after incurring $100 in medical expenses in that month. As will be discussed later, the spend-down process is also used in establishing eligibility for the medically needy.

Table 1. Medicaid Income and Resources Limits for Individuals Living in States Using the Section 209(b) Option, November 2000

State	Section 209(b) eligibility standard (monthly income)[a]	Section 209(b) eligibility standard (% of FPL)[b]	Section 209(b) resources limit[c]	More restrictive aspects[d]
Federal SSI Standard	$512	74%	$2,000	–
Connecticut	$564.10[e]	81%	$1,600	I,R
Illinois	$487	70%	$2,000	I,R
Hawaii	$512	74%	$2,000	R
Indiana	$512	74%	$1,500	I,R,D
Minnesota	$482	69%	$3,000	I,R
Missouri	$512	74%	$999.99[f]	I,R
New Hampshire	$526	76%	$1,500	I,R,D
North Dakota	$455	65%	$3,000	R
Ohio	$444	64%	$1,500	I,R
Oklahoma	$512	100%	$2,000	R
Virginia	$512	74%	$2,000	R

Source: Congressional Research Service Survey of Selected Medicaid Eligibility and Post-Eligibility for Aged, Blind, Disabled (ABD) Groups, November 2000. State reported responses via email, telephone and fax.

[a] States using the Section 209(b) option may use different methods of counting income than SSI.
[b] The 2000 federal poverty level (FPL) in the 48 contiguous states and the District of Columbia was $8,350 for one person, or $696 per month. The FPL for Hawaii was $9,590 for one person, or $800 per month. **(Source**: HHS Poverty Guidelines, *Federal Register*, v. 65, no. 31, February 15, 2000. p. 7555-7557).
[c] States using the Section 209(b) option may use different methods of counting resources than SSI.
[d] These are the aspects of eligibility determination that are more restrictive than the SSI program, including: methods for counting income (states have flexibility to determine what type of income they count as applying toward a person's total income, as well as flexibility to determine what type of income they will not count, and thus subtract from a person's total income.) (I), methods for counting assets or resources (R), and/or definitions of disability (D).
[e] This amount varies by living situation.
[f] $2,000 in resources are protected for blind individuals.

Coverage of Persons Receiving State Supplemental Payments (SSP)

Many states, recognizing that the SSI benefit standard may provide too little income to meet an individual's living expenses, supplement SSI with additional cash assistance payments made solely with state funds. States use a variety of different policies for providing these state supplemental payments (SSP) and are granted flexibility in determining whether they will make such payments, to whom, and in what amount.[14] These supplements, paid on a regular monthly basis, are intended to cover such items as food, shelter, clothing, utilities and other daily necessities determined by the individual states. Supplementary payments allow a state to provide an income "floor" that takes into account geographic differences in living costs and individualized special needs in a manner that the nationally uniform federal benefit standard used in SSI cannot do.

Some states provide supplemental payments to all persons who receive SSI. Other states may decide to make payments to elderly persons living independently in the community without special needs, while still others may require that the elderly have special needs, such as requiring in-home personal care assistance or home-delivered meals as the result of impairment or frailty. In all of these cases, states may extend Medicaid coverage to persons receiving SSP on the same basis as they do to persons receiving only SSI. They may also decide to extend Medicaid eligibility to only some groups of SSP recipients or decide to extend it to all. States are not required to index SSP payments to inflation. As of January 2000, 27 states provide some form of optional state supplementation to individuals living independently and one state (North Dakota) allows its municipalities to determine whether and to whom payments are provided.

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[14] Federal law prohibits those states that provide SSP from changing their payment levels for SSP as federal SSI payments are increased to reflect cost of living. This rule was made for the purpose of prohibiting states from lowering their SSP payments when federal SSI payments increase as a result of adjustments based on cost of living.

Combined SSI/SSP Benefit. When states that provide automatic Medicaid eligibility to persons receiving SSI provide Medicaid coverage to persons receiving SSP, the combined federal SSI and state SSP benefit payments becomes the effective income eligibility standard for Medicaid. For 209(b) states, however, the effective eligibility standard is the 209(b) categorical eligibility standard plus the SSP payment. **Table 2** provides an example of what the benefit standards were, as of January 2000, for certain persons receiving SSP payments; in this case, aged, disabled and blind individuals living independently. The amounts listed in **Table 2** indicate the maximum state supplement as well as the combined amount of income an individual may maintain and remain eligible for Medicaid through this eligibility pathway.[15]

Table 2. Maximum Income Standard for States that Extend Medicaid to Aged, Disabled and Blind Individuals who Receive State Supplemental Payments and Live Independently (January 2000)

State	Combined SSI/ 209(b) and SSP Income Level[a]	State Supplementation
Alabama	$572	$60
Alaska	874	362
Arizona	582	70
Arkansas	512	0
California[b]	692	180
Colorado[c]	548	36
Connecticut[d]	747	235
Delaware	512	0
District of Columbia	512	0
Florida	512	0
Georgia	512	0
Hawaii	516.9	4.90
Idaho	565	53
Illinois[e]	717.99	351
Indiana	512	0
Iowa[f]	534	22
Kansas	512	0

[15] Because specified amounts of income are disregarded in determining eligibility for SSI and most state SSP programs, a person with income exceeding the maximum benefit may still be eligible for cash assistance and Medicaid.

State	Combined SSI/ 209(b) and SSP Income Level[a]	State Supplementation
Kentucky	512	0
Louisiana	512	0
Maine	522	10
Maryland	512	0
Massachusetts[g]	640.82	128.82
Michigan	526	14
Minnesota[h]	563	81
Mississippi	512	0
Missouri[i]	903 (blind only)	391 (Blind only)
Montana	512	0
Nebraska	519	7
Nevada[j]	548.40 (725.96 for blind)	36.40 ($213.96 for blind)
New Hampshire	553	27
New Jersey	543.25	31.25
New Mexico	512	0
New York	599	87
North Carolina	512	0
North Dakota	455	0 (an option of individual counties)
Ohio	444	0
Oklahoma	565	53
Oregon[k]	513.70 ($537.70 for blind)	1.70 ($25.70 for blind)
Pennsylvania	539.40	27.40
Rhode Island	576.35	64.35
South Carolina	512	0
South Dakota	527	15 (limited to SSI recipients with no other source of income)
Tennessee	512	0
Texas	512	0
Utah	512	0
Vermont[l]	569.66	57.66
Virginia	512	0

State	Combined SSI/ 209(b) and SSP Income Level[a]	State Supplementation
Washington[m]	539	27
West Virginia	512	0
Wisconsin	595.78	83.78
Wyoming	521.90	9.90

Note: Some states have payment levels for the aged that differ from payment levels to the blind and or the disabled.

Source: Social Security Administration, Office of Policy, Office of Research, Evaluation and Statistics, Division of SSI Statistics and Analysis. State Assistance Programs for SSI Recipients, January 2000.

[a] The federal SSI benefit rates in January 2000 are included in the combined federal/state data column. In 2000, the federal SSI benefit for an individual living independently was $512.00.
[b] California's payment amounts pertain only to aged and disabled individuals. Payments offered to blind individuals are higher.
[c] Colorado's payment amounts pertain to aged individuals. Payments offered to blind and disabled individuals are lower.
[d] Connecticut's amounts presented pertain to independent community living and consists of a housing allowance (maximum of $400 for living alone; $200 for living with others), basic needs items, minus countable income. The amounts presented assume eligibility for the highest rental allowance and the maximum budget amount.
[e] Illinois' combined SSI and SSP payment may not exceed $717.99. Illinois also had an income standard for categorically eligible individuals who do not qualify for SSI of $487.
[f] Iowas's payment amounts pertain only to disabled individuals. There are no benefits offered to aged and disabled individuals living independently.
[g] Massachusetts' payment amounts pertain only to aged individuals. Payments offered to blind individuals are higher and payments offered to disabled individuals are lower.
[h] Minnesota allows all persons who receive SSI payments and state supplemental payments to qualify for Medicaid. In 2000, it also allowed persons who did not receive SSI or SSP payments, and whose income did not exceed $482, to qualify for Medicaid.
[i] Missouri provides payments only to the blind.
[j] Nevada's payment amounts pertain only to the aged. Payments offered to blind individuals are higher. There are no payments offered to disabled individuals.
[k] Oregon's payment amounts pertain only to the aged and disabled. Payments offered to blind individuals are higher.
[l] Vermont's payment amounts became effective as of September 1, 2000.
[m] Washington's payment amounts pertain to individuals living in the state-defined Area 1. Payments offered to individuals living in the state-defined Area 2 are lower.

SSP-Only Recipients. States may also extend Medicaid coverage to persons who receive only SSP. These persons must meet all SSI eligibility criteria, other than income, and SSP must be available statewide. Thirty-six states extend optional Medicaid coverage to some SSP-only beneficiaries. **Table 3** shows those groups covered by states (aged, blind and or disabled) that, as of November 2000, offered Medicaid to SSP-only recipients.

Table 3. States Extending Medicaid Coverage to Recipients of Optional State Supplementary Payment-Only (SSP-Only) Groups, as of November 2000

State	States choosing Medicaid coverage for SSP-only groups	SSP-only recipients living independently[a]	SSP-only recipients living in group arrangements[b]
Alabama	no	–	–
Alaska	yes	A,B,D	A,B,D
Arizona	no	–	–
Arkansas	no	–	–
California	yes	A,B,D	A,B,D
Colorado	yes	A	A
Connecticut	yes	A,B,D	A,B,D
Delaware	yes	–	A,B,D
District of Columbia	yes	–	A,B,D[c]
Florida	no	–	–
Georgia	no	–	–
Hawaii	yes	A,B,D	A,B,D
Idaho	yes	A,B,D	A,B,D
Illinois	yes	A,B,D	A,B,D
Indiana	no	–	–
Iowa	yes	A,B,D	A,B,D
Kansas	no	–	–
Kentucky	yes	A,B,D[d]	A,B,D
Louisiana	no	–	–
Maine	yes	A,B,D	A,B,D
Maryland	yes	–	A
Massachusetts	yes	A,B,D	A,B,D
Michigan	yes	A,B,D	–
Minnesota	yes	A,B,D	A,B,D
Mississippi	no	–	–
Missouri	yes	B	A,B,D
Montana	yes	–	D

State	States choosing Medicaid coverage for SSP-only groups	SSP-only recipients living independently[a]	SSP-only recipients living in group arrangements[b]
Nebraska	yes	A,B,D	A,B,D
Nevada	yes	A,B	A,B
New Hampshire	yes	A,B,D	A,B,D
New Jersey	yes	A,B,D	A,B,D
New Mexico	no	–	–
New York	yes	A,B,D	A,B,D
North Carolina	yes	–	A,B,D
North Dakota	no	–	–
Ohio	yes	–	A,B,D
Oklahoma	yes	A,B,D	A,B,D
Oregon	yes	A,B,D	A,B,D
Pennsylvania	yes	A,B,D	A,B,D
Rhode Island	yes	A,B,D	A,B,D
South Carolina	yes	–	A,B,D
South Dakota	yes	A,B,D	A,B,D
Tennessee	no	–	–
Texas	no	–	–
Utah	yes	A,B,D	A,B,D
Vermont	yes	A,B,D	A,B,D
Virginia	yes	–	A,B,D
Washington	yes	A,B,D	A,B,D
West Virginia	no	–	–
Wisconsin	yes	A,B,D	A,B,D
Wyoming	no	–	–

Source: Congressional Research Survey of Selected Medicaid Eligibility and Post-Eligibility for Aged, Blind, Disabled (ABD) Groups, November 2000. State reported responses via email, telephone and fax.

[a] A=aged, B=blind and D=disabled; state supplement available if living independently, such as living alone.

[b] A=aged, B=blind and D=disabled; State supplement available only if living in group environment, such as an adult foster home or group home.

[c] State supplement available only if living in community residential facilities.

[d] State supplement available only if receiving care-taker services.

Medically Needy Coverage

In addition to welfare-related pathways, Medicaid also provides states the option of covering elderly and disabled persons who are not poor by SSI or SSP standards, but who need assistance with medical care expenses. Under the medically needy pathway, individuals who live in a state that exercises the medically needy option can qualify for Medicaid if they have income and resources that exceed the standards established by the states for the medically needy programs, but only if they incur medical expenses that "spend-down" or deplete their income and resources to specified levels.

Spend-down refers to a process by which persons with income above the applicable limit, may reduce their income to the state limit by spending on medical care.[16] This process is similar to the spend-down process used in 209(b) states. For example, if an individual has monthly income of $600 and the state's medically needy income standard is $300, the applicant would be required to incur $300 in medical expenses (i.e., spend-down) before he or she would be eligible for Medicaid. Once Medicaid eligibility is triggered, beneficiaries must still apply their income toward the cost of their medical care.

The state may set its medically needy monthly income limits (MNIL) for a family of a given size at any level up to 133% of the maximum payment for a similar family under the state's AFDC program in place on July 16, 1996.[17] Often these levels are lower than the income standard for SSI benefits. In 11 states, the spend-down limits are less than 50% of the federal poverty level (FPL) for an individual. The spend-down limits range from $92 in Louisiana[18] to $708 in Vermont. This, in effect, is an income threshold for Medicaid eligibility. It also represents, for persons living in the community, the amount of monthly income individuals may retain for their needs after incurring medical expenses that deplete their income to the state standard. Although there is some variation across states, most states use the SSI resources limit of $2,000 for an individual as the medically needy resources standard.

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[16] Medical expenses that are considered when calculating an applicant's spend-down include certain medical and remedial care expenses incurred by an individual, family or financially responsible relative that are not subject to payment by a third party unless the third party is a public program of a state (or territory) or political subdivision of a state (or territory). Some insurance premiums, deductibles or coinsurance charges (including Medicare premiums and cost sharing charges for persons eligible for both programs) can also be deducted from countable income.

[17] In effect as of May 11, 2001, HCFA regulation (42 CFR Part 435) will increase state flexibility in establishing the income disregards used to determine eligibility under Medicaid's medically needy pathway. The new regulation will allow states to apply more liberal income disregards under Section 1902(r)(2) of the Social Security Act, thus increasing the amount of protected income medically needy eligibles can retain to pay for such things as food, clothing or housing. Whereas the income standard for a family of a given size could still not exceed 133% of the maximum payment for a similar family under the state's maximum AFDC payment (described above), states could in effect enable applicants to keep more income to spend on housing, food, transportation, etc.

[18] The MNIL standard varies by geographic region in Louisiana.

State monthly income and resources limits for medically needy programs are shown in **Table 4**. Note that some 209(b) states have medically needy programs.

States that choose to have a medically needy eligibility pathway are required under federal law to cover at a minimum certain children under age 18 and pregnant women who, except for income and resources, would be eligible as categorically needy. They are not, however, required to cover the aged, blind, and disabled nor to cover long-term care services under their medically needy programs, but most do. As of November 2000, 34 states and the District of Columbia had medically needy programs.

The medically needy pathway enables many elderly and disabled persons needing nursing home care to qualify for Medicaid. At an average cost of about $56,000 per year, nursing home costs can quickly deplete the resources of an elderly individual, especially after prolonged stays. States, however, are not required to include nursing facility care among the services covered under their medically needy programs. As a result, not all states with medically needy programs covering the elderly provide coverage to persons in nursing homes. Five among the total 34 states and the District of Columbia that reported having medically needy spend-down programs did not cover nursing facility services. States not covering nursing facility care are Arkansas, Florida, Iowa, Oklahoma, and Oregon.

Other Aspects of Spend-Down

States use a specific time period for calculating a person's medical expenses, ranging from 1 month to 6 months (as of November 2000).[19] The calculation becomes the basis for determining the amount of a person's spend-down requirement. Generally a shorter time period is more beneficial to the applicant. For example, if the state has a 1 month spend-down calculation period, the individual would be required to incur $300 in medical expenses in a month, after which services would be covered by Medicaid. On the other hand, if the state had a 6 month calculation period, the individual would have to incur a projected amount of $1,800 ($300 times 6) in medical expenses before Medicaid would begin coverage. The length of the spend-down period does not significantly affect total out-of-pocket expenditures for persons with predictable and recurring medical expenses, such as persons with chronic illnesses or disabling conditions. However, individuals faced with acute nonrecurring problems generally benefit more from a shorter calculation period.

States that do cover nursing facility care under their medically needy programs have the option of using either the Medicaid or private pay (e.g., private insurance or out-of-pocket) nursing facility rates as a standard for determining an applicant's eligibility. This means that states compare a person's monthly income to the cost of nursing home care in that state, either in terms of the total amount that would be paid by Medicaid for a month (Medicaid rate) or the total amount that would be paid out-

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[19] Congressional Research Survey of Selected Medicaid Eligibility and Post-Eligibility for Aged, Blind, Disabled (ABD) Groups, November 2000. State reported responses via email, telephone and fax.

of-pocket (private pay rate). Often the Medicaid monthly rates are lower than the rates paid by private insurance or out-of-pocket. When the Medicaid rate is lower, it is harder for applicants to spend-down to the required level, and thus may result in fewer applicants gaining Medicaid eligibility. (In general, if an applicant's income minus the cost of the Medicaid reimbursement or private pay rate, whichever is used by the state, exceeds the state income limit, then the applicant cannot qualify for Medicaid coverage of institutional care under a medically needy option.) States' policies on using either Medicaid or a private pay rate are shown in **Table 4** as the "spend-down basis" for institutional care.

Table 4. Income Limits for Medically Needy (MNIL) and 209(b) States, and Resources Limits for Aged, Blind, and Disabled Persons, as of November 2000

State	Protected monthly income limit (family of one)	Protected monthly income limit as a percent of FPL	Protected monthly resources limits (family of one)	Spend-down period (months)[a]	Spend-down basis[b]
Alabama	–	–	–	–	–
Alaska	–	–	–	–	–
Arizona	–	–	–	–	–
Arkansas	$108.33	16%	$2,000	3 (non-institutional only)	NF is not a covered benefit under MN
California	$600	86%	$2,000	1	Medicaid
Colorado	–	–	–	–	–
Connecticut[j]	$476[c]	68%	$1,600	6	private
Delaware	–	–	–	–	–
District of Columbia	$377	54%	$2,600	6	private
Florida	$180	26%	$5,000	1 (non-institutional only)	NF is not a covered benefit under MN
Georgia	$317	46%	$3,000	1	private
Hawaii[j]	$418	52%	$2,000	1	Medicaid
Idaho	–	–	–	–	–
Illinois[j]	$283	41%	$2,000	1	private
Indiana[j]	–	–	–	–	–
Iowa	$483	69%	$10,000	2	NF is not a covered benefit under MN
Kansas	$475	68%	$2,000	1/6	Medicaid

State	Protected monthly income limit (family of one)	Protected monthly income limit as a percent of FPL	Protected monthly resources limits (family of one)	Spend-down period (months)[a]	Spend-down basis[b]
Kentucky	$217	31%	$2,000	1/3	private
Louisiana	$100 urban/ $92 rural	14%/ 13%	$2,000	1/3	Medicaid
Maine	$315	45%	$3,000	6	private
Maryland	$350	50%	$2,500	6	private
Massachusetts	$522	75%	$650	1/6	Medicaid
Michigan[i]	$408	–	$2,000	1	private
Minnesota[j]	$482	69%	$3,000	1/1-6[d]	Medicaid[e]
Mississippi	–	–	–	–	–
Missouri[j]	–	–	–	–	–
Montana	$508	73%	$2,000	1	Medicaid
Nebraska	$392	56%	$4,000	1	Medicaid
Nevada	–	–	–	–	–
New Hampshire[j]	$526	76%	$2,500	1-6[d]	Medicaid
New Jersey	$367	53%	$4,000	1 or 6[d] /6	private
New Mexico	–	–	–	–	–
New York	$600	86%	$3,600	6[f]/1	Medicaid
North Carolina	$242	35%	$2,000	6	Medicaid
North Dakota[j]	$455	65%	$3,000	1	Medicaid
Ohio[j]	–	–	–	–	–
Oklahoma[j]	$259	37%	$2,000	3 (non-institutional only)	NF is not a covered benefit under MN
Oregon	$413	59%	$2,000	1 (non-institutional only)	NF is not a covered benefit under MN (nor any other long-term care services)
Pennsylvania	$425	61%	$2,400	6	private
Rhode Island	$600	86%	$4,000	1/6	Medicaid
South Carolina	–	–	–	–	–
South Dakota	–	–	–	–	–

State	Protected monthly income limit (family of one)	Protected monthly income limit as a percent of FPL	Protected monthly resources limits (family of one)	Spend-down period (months)[a]	Spend-down basis[b]
Tennessee	$241	35%	$2,000	1	Medicaid
Texas	–	–	–	–	–
Utah	$382	55%	$2,000	1	private
Vermont	$708	102%	$2,000	1/6	private
Virginia[j]	$250[g]	36%	$2,000	1/6	Medicaid[h]
Washington	$539	77%	$2,000	3 or 6[d]	private
West Virginia	$200	29%	$2,000	1/6	private
Wisconsin	$591.67	85%	$2,000	1/6	private
Wyoming	–	–	–	–	–

Source: Congressional Research Survey of Selected Medicaid Eligibility and Post-Eligibility for Aged, Blind, Disabled (ABD) Groups, November 2000. State reported responses via email, telephone and fax.

Note: The 2000 federal poverty level (FPL) in the 48 contiguous states and the District of Columbia was $695.83 per month, ($8,350 per year) for one person. The FPL for Alaska was $869.16 per month ($10,430 per year) for one person. The FPL for Hawaii was $799.16 per month ($9,590 per year) for one person (**Source**: HHS Poverty Guidelines, *Federal Register*, v. 65, no. 31, February 15, 2000. p. 7555-7557).

[a] This column refers to the number of months used to calculate an individual's pay ability and spend-down. Applicants are divided into two groups, institutional and non-institutional. For those states in which two numbers are presented (x/y), then x = institutional spend-down period and y = non-institutional spend-down period. Where one number is presented, it represents the spend-down period for both groups.

[b] This column describes the basis on which institutional spend-down is calculated in medically needy (MN) programs. States can use either the Medicaid nursing facility (NF) rate or the private pay rate to calculate an individual's monthly spend-down requirement. The private pay rate is higher, therefore resulting in a lower monthly spend-down amount.

[c] $476 refers to geographic regions B and C, comprising the majority of Connecticut residents. Residents living in geographic region A have a protected income amount of $574.

[d] Applicants have the option of selecting the spend-down period.

[e] The private pay rate is equivalent to the Medicaid reimbursement rate for those nursing facilities that care for both types of payers.

[f] Six months for acute inpatient care.

[g] Two regions in Virginia with different protected income levels.

[h] The Medicaid payment rate is used only to determine the time during a month in which the recipient meets his or her spend-down liability. Unlike other states, it is not used to determine a recipient's spend-down amount.

[i] Spend down levels for Michigan vary by region (Shelter Area). $408 is the spend-down region for shelter area VI; $391 is for Shelter Area V; $375 is for Shelter Area IV; $350 is for Shelter Area III; and $341 is for Shelter Area II and I.

[j] Income Standard for 209(b) state having a medically needy program.

Incomes up to 100% of FPL

The enactment of Omnibus Budget Reconciliation Act of 1986 (OBRA 86) offered states another option for covering persons whose income exceeds SSI or 209(b) levels. This option allows states to cover aged and disabled individuals with incomes up to 100% of the federal poverty level (FPL).[20] The American Public Human Services Association reported that 19 states and the District of Columbia (up to 100%) used this option as of October 2001. These states were California (up to 100%), Florida (90%), Georgia (100%), Illinois (85%), Maine (100%), Massachusetts (100%), Michigan (100%), Minnesota (95%), Mississippi (100%), Nebraska (100%), New Jersey (100%), North Carolina (100%), Pennsylvania (100%), Rhode Island (100%), South Carolina (100%), Utah (100%), Vermont (100%), Virginia (80%). CRS survey data found that Oklahoma (100%) and Hawaii (100%) also use this option.

Optional Coverage of Institutionalized Persons Under the 300% Rule

States have another option for covering certain individuals with incomes too high to qualify for SSI, but who are in nursing facilities or other institutions. States can establish a Special Income Rule, known as "the 300% rule," to allow these persons to qualify for Medicaid coverage of their nursing home care. To be eligible, persons must (1) require care provided by a nursing home or other medical institution for no less than 30 consecutive days, (2) meet the resources standard determined by the state, and (3) have income that does not exceed a specified level – no greater than 300% of the maximum SSI payment applicable to a person living at home. For 2000, this limit was $1,536 per month (3 times the monthly SSI payment of $512). In 2002, the limit is $1,635 per month. States may use a level that is lower than the maximum of 300% of SSI, if they wish. As of November 2000, Delaware, Missouri and New Hampshire were the only states using income standards that were less than $1,536.

In November 2000, 34 states used the Special Income Rule to enable persons to qualify for Medicaid coverage of institutional care. Income eligibility levels for nursing homes under the Special Income Rule are shown in **Table 5**.

Fifteen states using the special income rule also have medically needy programs for making persons eligible for institutional care.[21] States that use both pathways are able to make those persons with incomes below the 300% rule automatically eligible for coverage, so as to avoid the spend-down computation necessary under medically

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[20] The poverty guidelines, sometimes referred to as the FPL, are used to determine eligibility for federal programs. In 2000, the Department of Health and Human Services (HHS) reported the FPL to be $8,350 for individuals and $11,250 for two people. For more information see, [http://aspe.hhs.gov/poverty/00poverty.htm]

[21] Two states, Missouri and Ohio, have 209(b) spend-down programs and also use the 300% rule and are included in the total.

needy programs when medical expenses and income must be estimated for a 1 to 6 month time period.[22] In November 2000, 18 states used only the special income rule for making persons eligible for institutional care. These states were Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Florida, Idaho, Iowa, Mississippi, Nevada, New Mexico, Oklahoma, Oregon, South Carolina, South Dakota, Texas and Wyoming. However, with a change in law in 1993, these states are now required to use what can be considered a delayed spend-down process. States must allow individuals to place income, in excess of the special income level used by states, in trusts and still be eligible for Medicaid. These trusts are often referred to as "Miller Trusts".

Miller Trusts

Prior to an amendment included in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), persons living in states using only the 300% rule could not qualify for Medicaid's coverage of their nursing home care if they had income in excess of the limit. This meant that persons with as little as $1 more than the limit could not qualify for Medicaid coverage of their nursing home care, no matter how insufficient their income and assets might be to cover the cost of their care. As a result of the OBRA 93 amendment, Medicaid law now requires those states that use only the special income rule to allow applicants to place income in excess of the special income level in a special trust, or Miller Trust, and receive Medicaid coverage for their care.[23] Following the individual's death, the state becomes the beneficiary of amounts in the trust. This arrangement, which amounts to a delayed spend-down, has reduced the access barriers for those living in non spend-down states. **Table 5** shows those states that use the special income rule and indicates any limits on income that might apply in those states using only the 300% rule.

Table 5. Special Income Rule and Miller Trusts for Institutionalized Individuals, November 2000

State	Special income rule	Monthly income limit as % of SSI[a]	Miller Income Trust monthly limit
Alabama	yes	300%	depends on NF[b]
Alaska	yes	300%	no limit
Arizona	yes	300%	$3,352.91
Arkansas	yes	300%	$2,495
California	no	–	–
Colorado	yes	300%	$3,855

[22] Persons with incomes above the special income level may qualify as medically needy after meeting the spend-down requirements.

[23] OBRA 1993 codified a 1990 ruling from the United States District Court for the District of Colorado which first coined the term "Miller Trust." See *Miller v. Ybarra*, 746 F.Supp. 79 (E. Colo 1990).

State	Special income rule	Monthly income limit as % of SSI[a]	Miller Income Trust monthly limit
Connecticut	no	–	–
Delaware	yes	250%	no limit
District of Columbia	no	–	–
Florida	yes	300%	no limit
Georgia	yes	300%	–
Hawaii	no	–	–
Idaho	yes	300%	no limit
Illinois	no	–	–
Indiana	no	–	–
Iowa	yes	300%	$2,758
Kansas	no	–	–
Kentucky	yes	300%	–
Louisiana	yes	300%	–
Maine	no	–	–
Maryland	no	–	–
Massachusetts	no	–	–
Michigan	yes	300%	–
Minnesota	yes	300%	–
Mississippi	yes	300%	no limit
Missouri	yes	175%[c]	–
Montana	no	–	–
Nebraska	no	–	–
Nevada	yes	300%	no limit
New Hampshire	yes	244%	–
New Jersey	yes	300%	–
New Mexico	yes	300%	no limit
New York	no	–	–
North Carolina	no	–	–
North Dakota	no	–	–
Ohio	yes	300%	–
Oklahoma	yes	300%	$2,500

State	Special income rule	Monthly income limit as % of SSI[a]	Miller Income Trust monthly limit
Oregon	yes	300%	no limit
Pennsylvania	yes	300%	–
Rhode Island	yes	300%	–
South Carolina	yes	300%	no limit
South Dakota	yes	300%	no limit
Tennessee	yes	300%	–
Texas	yes	300%	no limit
Utah	no	–	–
Vermont	yes	300%	–
Virginia	yes	300%	–
Washington	yes	300%	–
West Virginia	yes	300%	–
Wisconsin	yes	300%	–
Wyoming	yes	300%	no limit

Source: Congressional Research Survey of Selected Medicaid Eligibility and Post-Eligibility for Aged, Blind, Disabled (ABD) Groups, November 2000. State reported responses via email, telephone and fax.

[a] The special income rule refers to 300% of the federal benefit payment, or 3 times $512 in 2000. States that apply the special income rule at the 300% level, therefore, protect $1,536 of income per month.

[b] If an applicant's income exceeds $3,000 after the liability amount is given to the nursing home, he or she would be deemed ineligible for nursing facility coverage under Medicaid.

[c] Missouri adjusts its monthly income limit by the cost-of-living adjustment (COLA).

Optional Coverage for Persons Needing Home and Community-Based Long-Term Care

States have the option of covering persons needing home and community-based long-term care services, if these persons would otherwise require institutional care that would be paid for by Medicaid. Section 1915(c) of the Medicaid statute allows the Center for Medicare and Medicaid Services (CMS) to waive certain federal requirements in order to allow states to cover a wide range of home and community-based services (HCBS). Services that states may choose to cover include: case management; homemaker; home health aide; personal care; adult day health; habilitation; respite care; day treatment or other partial hospitalization services, psychosocial rehabilitation and clinic services for individuals with chronic mental illness; and other services requested by the state and approved by CMS as cost effective and necessary to avoid institutionalization.

As of 2000, 49 states and the District of Columbia provided at least one or more of these services through 1915(c) waivers. Arizona provides similar services through the Section 1115 demonstration waiver program.

Under the law, states can request authority to waive certain statutory requirements that would otherwise apply to services covered under a state's Medicaid program. Three Medicaid requirements may be waived:

- Waiver of *statewideness.* Medicaid law requires Medicaid covered services to be available on a statewide basis (Section 1902(a)(1)). Section 1915(c) allows states, instead, to cover services in *only a portion* of the state, rather than in all geographic jurisdictions.

- Waiver of *comparability* requirements. Medicaid law requires that Medicaid covered services be available in the same amount, duration, and scope to all individuals eligible under a state's plan (Section 1902(a)(10(B)). Section 1915(c) allows states to cover home and community-based services for specific groups, for example, the elderly, *or* persons with disabilities, rather than for *all* eligible Medicaid beneficiaries. Waiver of this requirement allows states to limit the number of recipients who may be eligible for services and to provide services to some groups, but not others.

- Waiver of *financial eligibility* requirements. Medicaid law requires that states use a single standard to determine income and resources when determining an applicant's eligibility for Medicaid. Section 1915(c) allows states to use more liberal income eligibility requirements for persons needing home and community-based long-term care waiver services, such as the 300% rule.

Eligibility Requirements

In order to be eligible for home and community-based long-term care waiver services, a person must be a member of one of the following target groups who would otherwise be eligible for institutional care: the aged, persons with disabilities, persons with mental retardation or developmental disabilities, and persons with mental illness. States must apply for separate waivers to serve each of these different groups. States may define categories of individuals who may be eligible for certain waivers and the services they should receive. For example, they may cover only the elderly for case management services, or only the disabled for personal attendant services. States may also limit services to individuals who have certain conditions (such as AIDS) or illnesses (such as the chronically mentally ill). Although states may amend the waivers to serve additional recipients, states may also set overall limits on the total number of persons to be served under a waiver. This ability to define and limit eligibility allows states to control costs for the program.

Recipients of 1915(c) waiver services must meet both financial and functional (described below) eligibility requirements set by state and federal law. Under 1915(c) waivers, states may limit coverage to those persons receiving SSI and or SSP (209(b) states may limit coverage to persons meeting more restrictive standards) or

allow persons to qualify under their medically needy standards (described above). States also have the option of setting financial eligibility limits for income as high as 300% of SSI benefits, generally the same level states use for nursing facilities. Those states that use the 300% rule may also allow eligibles to establish Miller trusts if those states do not also have medically needy programs. All states, except Indiana, use higher income levels than the SSI level. Indiana used the SSI income standard but applies more restrictive standards for counting income and resources as well as for defining disability than under federal SSI law.

States also have the option of applying spousal impoverishment protections (discussed below) for couples when only one of the spouses requires Medicaid coverage of long-term care expenses. As of April 2000, 46 states applied the same asset standards to their waiver programs as they used for nursing homes. In **Table 6**, the eligibility pathways selected by states for HCBS waiver programs are shown. The last three columns pertaining to minimum maintenance needs allowance and spousal impoverishment are described later in this report.

Table 6. Pathways and Protected Income and Resources Levels Used to Determine HCBS Waiver Program Eligibility, November 2000

State	Eligibility pathways[a]	Groups covered[b]	MNA (Individual)[c]	MNA as a % of FPL[d]	Spousal impoverish-ment rules apply[e]
Alabama	300% rule	ABD	$1,536	221%	no
Alaska	300% rule, Miller Trusts	AD	$1,536	221%	yes
Arizona	300% rule, Miller Trusts	ABD	$204	29%	yes
Arkansas	300%	ABD	$1,536	221%	no
California	MN	ABD	$600	86%	yes
Colorado	300% rule, Miller Trusts	ABD	$1,536	221%	yes
Connecticut	300% rule	ABD	$1,392	200%	yes
Delaware	300%, Miller Trusts	ABD	$1,280	184%	yes
District of Columbia	300% rule, MN	A (SSI only for D)	$1,536	221%	yes
Florida	300% rule, Miller Trusts	ABD	depends on waiver		no
Georgia	Cap at $1,590	ABD	$530	76%	yes

State	Eligibility pathways[a]	Groups covered[b]	MNA (Individual)[c]	MNA as a % of FPL[d]	Spousal impoverish-ment rules apply[e]
Hawaii	MN, FPL at 100%	AD (B based on MN, SSI only)	equivalent to income ceiling of qualifying eligibility pathway plus $20	54% (MN plus $20) or 103% (FPL at 100% plus $20)	yes
Idaho	300% rule, Miller Trusts	ABD	$796	114%	yes
Illinois	MN, FPL at 70%	ABD	$487	70%	yes
Indiana	209(b) rules	ABD	$512 for children under 18 or students 18-21 only	74%	no
Iowa	300% rule	ABD	$1,536	221%	yes
Kansas	FPL at 100%	ABD	$687	99%	yes
Kentucky	300% rule, MN	ABD	$532	76%	yes
Louisiana	300% rule	ABD	$1,536	221%	yes
Maine	300% rule, MN, FPL at 100%	ABD	$870	125%	no
Maryland	300% rule, MN	BD (MN for A only)	$480	69%	yes
Massachusetts	MN, FPL at 100%	ABD	$522	75%	no
Michigan	300% rule	ABD	$1,536	221%	yes
Minnesota	300% rule, MN	ABD (300% rule used for A only)	$700 for A, $487 for D	101% for A, 70% for D	yes (for elderly only)
Mississippi	300% rule, Miller Trusts	ABD	$1,536	221%	yes
Missouri	300% rule[f]	ABD	$896	129%	yes
Montana	MN	ABD	$508	73%	no
Nebraska	MN	ABD	$392	56%	yes
Nevada	300% rule, Miller Trusts	ABD	$1,024[g]	147%	yes
New Hampshire	MN	ABD	depends on waiver	–	no

State	Eligibility pathways[a]	Groups covered[b]	MNA (Individual)[c]	MNA as a % of FPL[d]	Spousal impoverish-ment rules apply[e]
New Jersey	300% rule, FPL at 100%	ABD	$1,536	221%	yes
New Mexico	300% rule, Miller Trusts	ABD	$1,516	218%	yes
New York	MN	ABD	$600	86%	yes
North Carolina	MN, FPL at 100%	ABD	$696	100%	yes[h]
North Dakota	MN	ABD	$455	65%	yes
Ohio	300% rule	ABD	$1,001	144%	yes
Oklahoma	300% rule, Miller Trusts	ABD	$1,536	221%	yes
Oregon	300% rule, Miller Trusts	ABD	$513.70	74%	yes
Pennsylvania	300% rule	ABD	$1,536	221%	no
Rhode Island	300% rule, MN	AD	$600	86%	no[i]
South Carolina	300% rule, Miller Trusts	ABD	$512	74%	yes
South Dakota	300% rule	ABD	$530	76%	yes
Tennessee	300% rule, MN	ABD	$1,024	147%	no
Texas	300% rule, Miller Trusts	ABD	$1,536	221%	yes
Utah	300% rule, MN, FPL 100%	ABD[j]	$696	100%	yes
Vermont	MN	ABD	$766	110%	yes
Virginia	300% rule, MN	ABD[k]	$512 ($1,536 for AIDS waiver)	74% (221% for AIDS waiver)	yes
Washington	300% rule	ABD	$696l[l]	100%	yes
West Virginia	300% rule	ABD	$1,536	221%	yes
Wisconsin	300% rule, MN	ABD	$616	89%	yes
Wyoming	300% rule, Miller Trusts	ABD	$1,536	221%	yes

Source: Congressional Research Survey of Selected Medicaid Eligibility and Post-Eligibility for Aged, Blind, Disabled (ABD) Groups, November 2000. State reported responses via email, telephone and fax.

[a] This column indicates the highest income eligibility pathways in which a person can become eligible to receive Medicaid HCBS services. The choices provided to state respondents included SSI (income and resources of the Supplemental Security Income program), 300% rule (income standard of 300% of SSI and SSI resources standards) and availability of Miller Trusts, MN (income and resources standards of the states' Medically Needy program), FPL (a specified percentage of the Federal Poverty Level), and 209(b) (income, resources and/or disability standards more restrictive than SSI).

[b] This column describes those groups of individuals for whom waiver services are available. For the purpose of this report, survey choices included aged, blind and/or disabled. Although the information was not requested in this survey, some states provide HCBS waiver services to only a subgroup of the above listed categories, such as only those individuals with mental retardation or developmental disabilities, or only those individuals with AIDS.

[c] This is the amount of money an individual is allowed to keep to use to pay for community living expenses, such as housing, transportation, food, etc., while enrolled in a HCBS waiver program.

[d] This column shows the amount of monthly protected income for an individual receiving HCBS waiver services as a percentage of the federal poverty level (FPL). The 2000 federal poverty level (FPL) in the 48 contiguous states and the District of Columbia was $695.83 per month, ($8,350 per year) for one person. The FPL for Alaska was $869.16 per month ($10,430 per year) for one person. The FPL for Hawaii was $799.16 per month ($9,590 per year) for one person (Source: HHS Poverty Guidelines, *Federal Register*, v. 65, no. 31, February 15, 2000. p. 7555-7557).

[e] When used, these rules typically apply in situations where both members of couples live in the home but only one member is enrolled in the waiver program.

[f] The special income rule is 175% of SSI. Waivers apply only to individuals age 65 and older and to individuals with Mental Retardation and Developmental Disabilities (MRDD) under age 18.

[g] Two hundred percent of the federal benefit rate (FBR) for aged, and 300% of FBR for all other individuals in waiver programs.

[h] Spousal impoverishment rules apply only to resources as states do not perform post-eligibility assessments on spouses of waiver participants.

[i] Spousal impoverishment rules apply only to assisted living waiver programs.

[j] MN and 300% rule apply only to waivers for individuals with physical disabilities.

[k] MN does not apply to waiver services for individuals with mental retardation and developmental disabilities.

[l] Married individuals whose spouses are not receiving HCBS and individuals living in alternative living facilities have $539 protected. This is the medically needy income standard. Individuals participating in the AIDS waiver and living at home may maintain up to $1,536 of protected income.

Level of Care Eligibility Criteria for Institutional and Community-Based Long-Term Care Services

Not only must persons meet Medicaid's financial and categorical eligibility criteria in order to receive institutional and home and community-based long-term care services, but they must also meet certain level of care criteria. Federal statute restricts institutional and HCBS waiver services to persons who would require a level of care provided in a nursing facility, hospital or intermediate care facility for the mentally retarded. The diversity of conditions that creates a need for long term care makes designing measures to adequately and uniformly assess applicants' physical, cognitive and mental conditions difficult.

The measures used by states to determine an applicant's eligibility for long-term care services vary. A survey of 42 states conducted by the American Association of Retired Persons (AARP) in 1996 found the following three types of measures to be those most commonly used: 1) states that score specific factors and require a minimum score for eligibility, 2) states that require a minimum number of specific

impairments or needs for eligibility, and 3) states that use level of care definitions and guidelines to determine eligibility. This study found that those states requiring a minimum score and those states that counted number of impairments considered medical and nursing needs, mental and physical impairments, activities of daily living (ADLs) and instrumental activities of daily living (IADLs) when determining an applicants' eligibility.[24] The survey also found that those states using criteria based on definitions and guidelines to determine eligibility provided the assessor with a greater amount of discretion than those applying the other two assessments. In general, rather than requiring an assessor to determine whether an applicant has three out of five ADL impairments, an assessor in a state using the third approach may be required to determine whether an applicant meets one of a number of general criteria, including a "need for nursing services."[25]

Other Mandatory and Optional Coverage Pathways

Federal law requires states to cover additional groups of elderly and disabled persons. These groups include those discussed below.

Persons Eligible for Medicare Cost-Sharing Assistance

Certain low-income elderly and disabled individuals who are eligible for Medicare may also be eligible to have some of their Medicare cost-sharing expenses paid for by Medicaid.

Qualified Medicare Beneficiary (QMB). Qualified Medicare Beneficiaries are aged or disabled individuals with incomes at or below the federal poverty level. This means that to be eligible for the QMB benefits under Medicaid, a Medicare beneficiary's income must be no greater than 100% of the federal poverty level. Applicants' assets may not exceed $4,000 for an individual and $6,000 for a couple. Under QMB, Medicaid covers the costs of Medicare premiums, deductibles, and coinsurance for Medicare covered benefits.

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[24] ADLs refer to activities necessary to carry out basic human functions, and include the following: bathing, dressing, eating, getting around inside the home, toileting, and transferring from a bed to a chair. IADLs refer to tasks necessary for independent community living, and include the following: shopping, light housework, telephoning, money management, and meal preparation.

[25] For example, Arkansas' 1996 guidelines acknowledged the potential for the functional eligibility test to be applied inconsistently. It states that they "cannot be used in a checklist fashion or as a rigid criteria for approving or denying access to nursing home care." Rather they are "to be used as a general framework for the exercise of professional judgment. Other factors to be considered are the applicant's age, diagnosis, mental status, and overall condition." O'Keeffe, Dr. P.H., R.N., Janet. Determining the Need for Long-Term Care Services: An Analysis of Health and Functional Eligibility Criteria in Medicaid Home and Community Based Waiver Programs. #9617, Public Policy Institute, AARP, Washington, D.C., December 1996.

Specified, Low-income Medicare Beneficiary (SLMB). SLMB benefits are available to Medicare recipients whose income is no greater than 120% of FPL. The asset test is the same as that for QMB. Under this Medicaid pathway, benefits include only the monthly Medicare Part B premium. Medicare Part B provides coverage for physicians' services, laboratory services, durable medical equipment, hospital outpatient department services, and other medical services.

Medicaid coverage for QMBs and SLMBs is limited to Medicare cost-sharing charges. Other Medicaid covered services, such as nursing facility care, prescription drugs and primary and acute care services, are not covered for these individuals unless they qualify through other eligibility pathways into Medicaid (e.g. via SSI, medically needy or special income rule).

Qualifying Individuals (QI-1 and QI-2). If a Medicare recipient's income is between 120 and 135% of poverty, the QI-1 option may pay the monthly Medicare Part B premium for these individuals. If a Medicare recipient's income exceeds the QI-1 criteria but does not exceed 175% of poverty, he or she may qualify for cost-sharing assistance through the QI-2 option. Under QI-2, state Medicaid programs pay that portion of the monthly Part B premium attributable to the gradual transfer of some home health visits from Medicare Part A to Medicare Part B.[26]

Qualified Disabled and Working Individuals (QDWIs). Medicaid is authorized to provide partial protection against Medicare Part A premiums for Qualified Disabled and Working Individuals. QDWIs are persons who were previously entitled to Medicare on the basis of a disability, who lost their entitlement based on earnings from work, but who continue to have a disabling condition. Medicaid is required to pay the Medicare Part A premium for such persons if their incomes are below 200% of the federal poverty line, their resources are below 200% of the SSI limit ($4,000), and they are not otherwise eligible for Medicaid. States are permitted to require individuals whose income is between 150% and 200% of poverty to pay a portion of the premium, based on a sliding scale. QDWIs are further discussed below.

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[26] In general, Medicaid payments are shared between the federal government and the states according to a matching formula. However, expenditures under the QI-1 and QI-2 programs are paid for 100% by the federal government (from the Part B trust fund) up to the state's allocation level. A state is only required to cover the number of persons which would bring its spending on these population groups in a year up to its allocation level. Total allocations are $200 million in FY1998, $250 million for FY1999, $300 million for FY2000, and, $350 million for FY2001, and $450 million for FY2002. Assistance under the QI-1 and QI-2 programs is available for the period January 1, 1998 to December 31, 2002.

Other Pathways

Under the Pickle Amendment (P.L. 94-566, Section 503), a state must cover former SSI recipients who; 1) are receiving Social Security benefits (OASDI), 2) formerly qualified for Medicaid because of simultaneous eligibility for SSI or SSP, and 3) would be eligible for SSI or SSP but for the cost-of-living adjustment (COLA) in Social Security benefits after April 1977.[27] In addition, COLAs paid to the individual's spouse or parent cannot be deemed available to the individual. In 209(b) states, Medicaid must be provided to these persons when their income, after disregard of the COLA and spend-down of incurred medical expenses, falls below the state standard.

Special Rules for Children with Disabilities

Children with disabilities can become eligible for Medicaid through each of the welfare-related and medically needy pathways described above. In addition, there are other eligibility rules that apply only to children with disabilities. These are described below.

For a child under the age of 20 and living at home, the income and resources of the child's parents are automatically considered available for medical care expenses; that is, they are "deemed" to the child. If the same child is institutionalized, however, after the first month away from home, the child is no longer considered to be a member of the parents' household and only the child's own financial resources are considered available for care.

This policy had resulted in some children remaining in institutions even while their medical needs could be met at home. This situation was dramatized in 1982 by the case of Katie Beckett, a child who was dependent on a ventilator and was unable to go home, not because of medical reasons but because she would no longer have been eligible for Medicaid and her family was unable to afford alternative health coverage.

To address this issue, Congress amended Medicaid to include a provision, sometimes referred to as the *Katie Beckett provision*, that allows states to extend Medicaid coverage to certain disabled children under 18 who are living at home and who would be eligible for Medicaid if in a hospital, nursing facility, or intermediate care facility for individuals with mental retardation. The state must determine that: (1) the child requires the level of care provided in an institution; (2) it is appropriate to provide care outside the facility; and (3) the cost of care at home is no more than institutional care. States electing this option are required to cover, on a statewide basis, all disabled children who meet these criteria. As of May 2000, 20 states covered this group of disabled children under Medicaid. These states are Alaska, Arkansas, Delaware, Georgia, Idaho, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, Rhode Island, South Carolina, South Dakota, Virginia, Vermont, West Virginia and Wisconsin.

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[27] Pertains to all cost-of-living increases made after April 1977.

Children with special needs might also qualify for home and community-based long-term care services if the state in which they live has chosen to implement a 1915(c) waiver program for children with disabilities. To qualify, children would need to otherwise require institutional care. Such programs have capped enrollment and are often limited to a defined geographical location (a county). See above for more information on 1915(c) programs.

Disabled children who are not able to become eligible for Medicaid under these special rules could, of course, become eligible through the program's traditional pathways that are not specific to individuals with disabilities. Disabled children can become eligible for Medicaid through poverty-related pathways, AFDC-related pathways, as well as through medically needy programs.[28]

Rules Applying to Disabled Individuals Engaged in Work

Because many disabled workers may not have access to affordable or adequate health insurance through their jobs, the risk of losing Medicaid coverage due to employment earnings can be a disincentive to work.[29] Prior to 1980, a disabled SSI recipient who worked faced substantial risk of losing both SSI cash benefits and Medicaid. In response to this and other work disincentives, Congress created a variety of special rules for the purpose of protecting working individuals with disabilities from losing their SSI and Medicaid benefits.

In order to qualify for SSI and, thus become eligible for Medicaid, applicants must establish disability status under the criteria determined by the Secretary of the Department of Health and Human Services (DHHS). These criteria are linked to an individual's ability to work or earn income from work, commonly referred to as an individual's ability to "engage in substantial gainful activity" (SGA). Current regulations provide that an individual is able to engage in SGA if his or her earnings exceed $780 a month for non-blind disabled and $1,300 for blind in 2002, with impairment-related expenses subtracted from earnings.[30] If persons *applying* for SSI have demonstrated the ability to engage in SGA, they will not be able to establish disability status. (See section entitled *Welfare-Related Pathways* of this report for more information.)

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[28] Furthermore, children have access to Medicaid through the State Children's Health Insurance Program (SCHIP). For more information on eligibility groups, see CRS Report RL30632, *Reaching Uninsured Children: are Medicaid and SCHIP Doing the Job?*, by Trish Riley and Elicia Herz.

[29] Medicaid offers individuals coverage of certain benefits, such as mental health care medications and personal attendant services that are not often available through private health insurance.

[30] Generally, to qualify for SSI, the individual must be unable to do any kind of work that exists in the national economy, taking into account age, education and work experience.

For those who are already covered by SSI, however, a different set of rules applies. Section 1619(a) of SSI law, for example, provides for the continuation of special SSI cash benefits for those persons receiving SSI on the basis of disability even if they are working at the SGA level, as long as there is not a medical improvement in the disabling condition. The amount of their special cash benefits is gradually reduced as their earnings increase under an income disregard formula until their countable earnings reach the SSI benefit standard or what is known as the *breakeven point*. In a state with no state supplemental payment, this earned income eligibility limit is $1,175 per month in 2002 for a person who has no unearned income (e.g., Veterans pension, OASDI payments, etc.). For states that supplement the federal SSI benefit standard, the *breakeven point* increases $2 for every $1 of state supplementation above the federal benefit standard.

Blind and disabled individuals can continue to be eligible for Medicaid even if their earnings take them past the SSI income disregard *breakeven point*. Special eligibility status granted by Section 1619(b)(1), under which the individual is considered an SSI recipient for purposes of Medicaid eligibility (although he or she is not actually receiving SSI) applies as long as the individual: (1) continues to be blind or have a disabling impairment; (2) continues to meet all the other requirements, except for earnings, for SSI eligibility; (3) would be seriously inhibited from continuing to work by the termination of eligibility for Medicaid services; and (4) has earnings that are not sufficient to provide a reasonable equivalent to the benefits that would have been available if he or she did not have those earnings from SSI, state supplementary payments, Medicaid and publicly funded personal care.[31]

To further reduce work disincentives and improve opportunities for individuals with disabilities who rely on Medicaid for their health care needs to participate in the labor force, Congress enacted legislation in 1997 and 1999. This legislation expanded state flexibility in creating Medicaid "buy in" opportunities for individuals with disabilities. The first piece of legislation was added by the Balanced Budget Act of 1997 (BBA97). BBA97 allows states to elect to provide Medicaid coverage to disabled working individuals whose family income does not exceed 250% of the FPL. The second piece of legislation was added by Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170, TWWIIA). TWWIIA allows states to further expand Medicaid coverage to the working disabled, between the ages of 16 and 64, with incomes above 250% of the FPL. In addition, assets may not exceed standard SSI limits. Under both of these provisions, disabled persons who are working may have to purchase or "buy into" Medicaid coverage through the payment of premiums and/or co-payments. These options were designed to expand the number of disabled individuals who could continue working while maintaining their Medicaid coverage.

As of April 1, 2002, 27 states had enacted legislation for a Medicaid buy-in program. Of these, 19 states had implemented buy-in program (16 states have over 1 year of implementation experience). The remaining eight states were in the policy

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[31] A similar provision to 1619(b) exists under Medicaid law in Section 1905(q). The provision refers to this group of individuals as Qualified Severely Impaired Blind or Disabled Individuals under age 65.

refinement and pre-implementation phase. Several other states have introduced Medicaid buy-in bills to their respective state legislatures.[32]

Rules Applying to Individuals who are Homeless

Elderly and disabled individuals who are homeless may also be eligible for Medicaid. In order to qualify, an individual must still meet the program's financial and categorical eligibility criteria. However, a state may not exclude from coverage any eligible person who resides in the state, regardless of whether the residence is maintained at a fixed address. States are required to provide a method of making eligibility cards available to eligible individuals who do not reside in a permanent dwelling or do not have a permanent home or mailing address.

Rules Applying to the Transfer of Assets

Some years prior to the passage of Omnibus Budget Reconciliation Act of 1993 (OBRA 93), Congress began to be concerned with a practice commonly referred to as Medicaid estate planning. Medicaid estate planning is a means by which elderly people shelter their income and assets in order to qualify for Medicaid's coverage of long-term care services sooner than they would if they had spent their income on the cost of care. Such practices included (1) converting "countable assets into "exempt assets," (2) sheltering assets in trusts, annuities, and other financial instruments that are deemed "not available" to the Medicaid applicant to pay for nursing home care, or (3) transferring assets through joint bank accounts. The goal of this practice was to protect resources for the individual and/or heirs, while appearing to be "poor enough" to qualify for Medicaid.

To try to ensure that Medicaid applicants apply their assets to the cost of their care and do not give them away in order to gain Medicaid eligibility sooner than they otherwise would, OBRA 93 established penalties under Medicaid for the transfer of assets for less than fair market value. Specifically, Medicaid has required that states delay Medicaid eligibility for institutionalized individuals and for certain services (including home and community-based services provided under waivers) provided to non-institutionalized persons who dispose of assets for less than fair market value on or after a "look-back date." This date is 36 months prior to application for Medicaid or 60 months if the transfer is made through an irrevocable trust. In other words, transfers are prohibited during the 3-year or 5-year period prior to application for Medicaid. The law also prohibits spouses of these persons from transferring assets during this same period. If the state has determined that a transfer occurred, then applicants may be subject to delay in eligibility. Certain transfers are permitted to spouses, to minor or disabled children, or to trusts solely for the benefit of disabled persons under 65.

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[32] See CRS Report RL31157, *Ticket to Work and Work Incentives Improvement Act of 1999: Implementation Status*, by Jennifer Hess.

The length of the period of ineligibility for institutionalized and non-institutionalized individuals is determined by dividing the total cumulative uncompensated value of all assets transferred on or after the look-back date by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. For example, a transferred asset worth $60,000, divided by a $5,000 average monthly private-pay rate, results in a 12-month penalty period. There is no limit to the length of the penalty period. This period of ineligibility begins with the first month during which the assets were transferred.

Medicaid Estate Recovery

Congress also included other provisions in OBRA 93 to address concerns with estate planning. Since OBRA 93, Medicaid statute has mandated all 50 states and the District of Columbia to recover from the individual's estate amounts paid for nursing facility services, home and community-based services and related hospital and prescription drug services. In addition, states are given the option of recovering funds spent on additional items or services covered under the state's Medicaid plan. Adjustment or recovery may only be made after the death of the individual and his or her surviving spouse, if any, and only at a time when there is no surviving child under age 21 or a child who is blind or permanently and totally disabled.[33]

For purposes of these recovery provisions, estates are defined to include all real and personal property and other assets included within an individual's estate, as defined under state laws governing the treatment of inheritance. At the option of the state, recoverable assets also include any other real and personal property and other assets in which the individual had any legal title or interest at the time of death, including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. These provisions apply for persons who received such medical assistance at 55 years of age or older.[34] Medicaid law and regulations also require states to establish procedures for waiving the application of these rules in cases of undue hardship.

Special provisions apply to persons who become eligible for Medicaid under a more liberal asset standard used in certain states for those who purchase long-term care insurance. The statute prohibits states from recovering from the estates of individuals who received medical assistance under a state plan amendment, approved by May 14, 1993, which provided for disregarding any assets or resources related to payments made under a long-term care insurance policy or because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

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[33] In addition, states can not recover against a beneficiary's home on which the state has placed a lien, unless additional protections for siblings and adult children are satisfied.

[34] There is no document that records or explains why the age floor was changed from 65 years old (in pre-OBRA 93 statute) to 55 years old (by OBRA 93).

States with such amendments are California, Connecticut, Indiana, Iowa (few individuals have participated in the Iowa program as of April 2002) and New York.[35]

Finally, among the Medicaid Estate Recovery provisions in OBRA 1993 is a provision requiring the state agency to establish procedures for waiving the application of adjustment or recovery if it would cause an undue hardship (as determined on the basis of criteria established by the Secretary).

Rules Applying to Institutionalized Persons with Spouses Living at Home

Medicaid law includes provisions to prevent *spousal impoverishment* – a situation that leaves the spouse who lives at home in the community with little or no income or resources when the other spouse requires institutional or home and community-based long-term care.[36] These provisions were added to Medicaid law by the Medicare Catastrophic Coverage Act (MCCA) of 1988. Before MMCA, states could consider all of the assets of the community spouse, as well as the institutionalized spouse, available to pay for the cost of medical care for an institutionalized spouse under Medicaid. These rules created hardships for the spouse living in the community who was forced to spend-down virtually all of the couple's assets to Medicaid eligibility levels so that the institutionalized spouse could qualify for Medicaid. MCCA established new rules for the treatment of income and resources of married couples to determine how much income or resources a community spouse must contribute toward the cost of care for the spouse requiring the care, and how much of the institutionalized spouse's income and resources is actually protected for use by the community spouse.

For example, today the income of many elderly couples comes largely from the Social Security and pension benefits that the husband receives because of his work history in the labor force. The wife, who may have had limited or no attachment to the work force, may receive only a small Social Security benefit in her own name. If the husband requires nursing home care and seeks Medicaid coverage for his care under a state's medically needy program, for instance, most states, prior to spousal impoverishment protections, considered the husband's income his for purposes of determining eligibility. They also considered resources held in the husband's name,

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[35] Other states that did not file a state plan amendment prior to May 14, 1993, such as Illinois and Washington, also allow persons who purchased long-term care insurance policies to protect a certain amount of assets. The OBRA 93 provision allowed California, Connecticut, Indiana, Iowa and New York to waive recovery of a person's resources related to payments under a private long-term care insurance policy. Although Illinois and Washington are required to recover any assets or resources initially disregarded because of the payments made by a qualified long-term care insurance policy, they allow individuals to transfer these assets up until the time of their death even while they are receiving Medicaid covered services.

[36] Report of the Special Committee on Aging United States. *Developments in Aging: 1997 and 1998 Volume 1*. Pursuant to S. Res. 54, Sec. 19(c), February 13, 1997, 106th Congress, 2nd Session. Senate Report 106-229, February 7, 2000.

as well as jointly held resources, to be fully available to him and would require that these resources be spent down to the states resource standard before considering him Medicaid eligible. In most states, this could mean that the community spouse would have been left with only $2,000 in assets held, for example, in a savings account.

Following eligibility, Medicaid's post-eligibility rules considered the husband's income to be available for the cost of his care, and allowed a deduction to be made for his wife's living expenses only to the extent that her own income did not exceed the standard specified by the state. In most states, this standard was the basic SSI benefit level, or less. This meant that a wife with little or no income of her own would have available for her living expenses an amount less than the federal poverty level.

Protected Resources. Spousal impoverishment resource eligibility rules provide for a method of counting a couple's resources in initial eligibility determinations. Under the rules, states must assess a couple's combined countable resources, when requested by either a spouse, at the beginning of a continuous period of institutionalization (defined as at least 30 consecutive days of care). The Centers for Medicare and Medicaid Services' (CMS) guidance on implementing spousal impoverishment law requires that nursing homes advise people entering nursing homes and their families that resource assessments are available upon request. The couple's home, household goods, and personal effects are excluded from countable resources. In addition, 209(b) states may not use more restrictive policies for defining these resources under spousal impoverishment law.

MCCA allows states to protect resources equivalent to the amount of a community spouse resources allowance (CSRA).[37] Federal restrictions limit the maximum amount states can allow community spouses' to retain. This is the greater of an amount equal to one-half of the couple's resources at the time the institutionalized spouse entered the nursing home, up to a maximum of $84,120 as of 2000 ($89,280 in 2002), or the state standard. Federal law stipulates that state standards may be no lower than $16,824 in 2000 ($17,856 in 2002). Maximum and minimum CSRA amounts are adjusted annually at the federal level by the same percentage as the consumer price index (CPI).[38] When the community spouse's half of the couple's combined resources is less than the state standard, the institutionalized spouse may transfer resources to the community spouse to bring that spouse up to the state standard. If, on the other hand, the community spouse's resources exceed the CSRA, he or she may be required to apply the excess resources to the nursing home spouse's cost of care. Section 209(b) states may not use more

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[37] These resource eligibility determinations are performed at the request of either spouse and can be associated with a fee when not conducted in conjunction with an application for Medicaid eligibility. HCFA guidance on implementing spousal impoverishment law requires that nursing homes advise people entering nursing homes and their families that resources assessments are available upon request.

[38] Ahmad, Omar N. Medicaid Eligibility Rules for the Elderly Long-Term Care Applicant. History and Developments, 1965-1998. *The Journal of Legal Medicine*, Taylor and Francis. June 1999.

restrictive policies for defining these resources under spousal impoverishment law. **Table 7** shows state spousal resources standards as of November 2000.

Protected Income. The spousal impoverishment protections do not permit income of community spouses to be used in determining the nursing home spouse's eligibility unless the income is actually made available to the institutionalized spouse. Thus, all of the community spouse's income is protected for use by the community spouse and need not be applied to the cost of institutional care. MCCA also required states to establish an income level that the community spouse can retain without affecting the institutionalized spouse's eligibility for Medicaid. The rules require that states recognize a minimum maintenance needs allowance (MMNA) for the living expenses of the community spouse. This minimum according to federal law can be no lower than 150% of the federal poverty level. As of 2000, the minimum was $1,406.25 per month. States can set the maintenance needs allowance as high as $2,103 per month in 2000. States can increase this amount, depending on the amount of the community spouse's actual shelter costs and whether the minor or dependent adult children or certain other persons are living with the community spouse. Both of these minimum and maximum amounts are adjusted at the federal level to reflect increases in the CPI.

To the extent that income of the community spouse falls below the state's maintenance need standard and the institutionalized spouse wishes to make part of his or her income available to the community spouse, the nursing home spouse may supplement the income of the community spouse to bring the spouse up to the state standard. **Table 7** shows state spousal income standards for November 2000.

Table 7. Spousal Impoverishment: State Protected Income and Resources Amounts, November 2000

State	Community spouse's minimum maintenance needs allowance (monthly protected income)[a]		Community spouse's protected resources amounts[b]
	Income	% of poverty	
Alabama	$1,407	202%	$84,120
Alaska	$2,103	302%	$84,120
Arizona	$2,103	302%	$84,12
Arkansas	$1,406.25	202%	$16,824
California	$2,1030	302%	$84,120
Colorado	$1,407	202%	$84,120
Connecticut	$1,406-$2,103	202%-302%	$16,824-$84,120
Delaware	$1,407-$2,103	202%-302%	$25,000-$84,120
District of Columbia	$2,103	302%	$16,824
Florida	$2,103	302%	$84,120

State	Community spouse's minimum maintenance needs allowance (monthly protected income)[a]		Community spouse's protected resources amounts[b]
	Income	% of poverty	
Georgia	$2,103	302%	$84,120
Hawaii	$2,103	302%	$84,120
Idaho	$1,407	202%	$16,900-$84,120
Illinois	$2,103	302%	$84,120
Indiana	$1,407-$2,103	202%-302%	$16,824-$84,120
Iowa	$2,103	302%	$24,000-$84,120
Kansas	$1,407-$2,103	202%-302%	$16,824-$84,120
Kentucky	$2,103	302%	$84,120 (non-excludable)
Louisiana	$2,103	302%	$84,120
Maine	$2,175	313%	$84,120
Maryland	$2,049	294%	$81,960
Massachusetts	$1,407	202%	$84,120
Michigan	$2,103	302%	$84,120
Minnesota	$1,407	202%	$23,774-$84,120
Mississippi	$2,103	302%	$84,120
Missouri	$1,407	202%	$84,120
Montana	$2,103	302%	$16,900-$84,120
Nebraska	$1,407	202%	$84,120
Nevada	$2,103	302%	$84,120
New Hampshire	$2,103	302%	$16,824-$84,120
New Jersey	$1,408	202%	$84,120
New Mexico	$1,407	202%	$31,290-$84,120
New York	$2,103	302%	$74,820
North Carolina	$2,103	302%	$84,120
North Dakota	$2,103	302%	$84,120
Ohio	$1,407	202%	$84,120
Oklahoma	$2,103	302%	$84,120
Oregon	$1,407	202%	$16,824

State	Community spouse's minimum maintenance needs allowance (monthly protected income)[a]		Community spouse's protected resources amounts[b]
	Income	% of poverty	
Pennsylvania	$1,407-$2,103	202%-302%	$16,824- $84,120
Rhode Island	$1,407-$2,103	202%-302%	$16,824-$84,120
South Carolina	$1,662	239%	$66,480
South Dakota	$1,407	202%	$84,120
Tennessee	$1,407	202%	$16,824- $84,120
Texas	$2,103	302%	$16,824-$84,120
Utah	$1,407	202$	$16,824-$84,120
Vermont	$1,407	202%	$84,120
Virginia	$1,406.25-$2,103	202%-302%	$16,824-$84,120
Washington	$1,407-$2,103	202%-302%	$84,120
West Virginia	$1,407-$2,103	202%-302%	$84,120
Wisconsin	$1,875	269%	$84,120
Wyoming	$2,103	302%	$84,120

Source: Congressional Research Survey of Selected Medicaid Eligibility and Post-Eligibility for Aged, Blind, Disabled (ABD) Groups, November 2000. State reported responses via email, telephone and fax.

[a] Federal law establishes both a floor and a ceiling for the amount of monthly income states must protect. In 2000, states were required to protect at least $1,406.25 per month (150% of the federal poverty level) and had the option to protect up to $2,103 per month. States have flexibility to set the protected income amounts in between this range.

[b] Federal law requires states to protect the assets of a couple up to $16,824. States have the option to protect half of the resources for the community spouse up to $84,120. States can choose a protected level in between these two amounts. Further, states can elect to have both a floor and a ceiling, or can collapse the floor and the ceiling into one amount. Where two numbers are shown, the first is the minimum and the second is the maximum amount. Where one number is shown, this is the floor and the ceiling.

Post-Eligibility Treatment of Income

Medicaid has another set of rules for treatment of income *after* a person has become eligible for coverage and is living in a nursing home, other institution or is receiving HCBS waiver services while living in the community. These rules apply to eligible beneficiaries who qualify under a medically needy program or the 300% rule, and determine how much of the beneficiary's income must be applied to the cost of care before Medicaid makes its payment. These rules are commonly referred to as the *post-eligibility* rules, or more accurately, the post-eligibility treatment of income rules.

Personal Needs Allowance (PNA)

For persons in nursing homes and other institutions, Medicaid requires that states reserve a personal needs allowance (PNA) from a beneficiary's income. This is an amount that is considered reasonable to cover various personal care items not included in the institution's basic charge, such as clothing, individual preferences on personal care items (toothpaste and shampoo), social support (telephone, stationary, etc.), and occasional outings. If a nursing resident enters a hospital, a daily fee must be paid to the nursing facility to reserve a bed for her return. PNA funds are often used for this payment. Medicaid law requires that states set aside $30 for an individual and $60 for a couple for monthly spending on an individuals' personal needs, including clothing, etc.[39]

SSI recipients for whom more than half of their medical bills in an institution are paid for by Medicaid are also subject to PNA restrictions. These individuals automatically have their monthly SSI benefit reduced to $30, beginning with the first full calendar month of residence.[40]

States have the option of supplementing the federal minimum PNA with state funds. The PNA amount, therefore, varies by state, with 16 states having no supplement. Personal Needs Allowances are not adjusted to reflect changes in the annual cost of living, although two states, Connecticut and Minnesota, increase their PNA levels annually. **Table 8** shows PNA levels by state.

Table 8. Personal Needs Allowance, November 2000

State	Personal Needs Allowance
Alabama	$30
Alaska	$75
Arizona	$76.80
Arkansas	$40
California	$35
Colorado	$50
Connecticut	$52
District of Columbia	$42
Delaware	$70

[39] The federal PNA benefit was increased from $25 to $30 a month on July 1, 1988 by the Omnibus Budget Reconciliation Act of 1987 (OBRA 87). OBRA 87 increased the PNA for both Medicaid and SSI programs and was the first increase since the SSI Program began in 1974.

[40] However, the 1987 Budget Reconciliation Act stipulates that if a physician certifies that the recipient's stay in such a medical institution is not likely to exceed 3 months and they need to continue to maintain a home to which they may return, SSI benefits will not be reduced and recipients will continue to receive full SSI benefits for up to the first 3 months of institutionalization.

State	Personal Needs Allowance
Florida	$35
Georgia	$30
Hawaii	$30
Idaho	$30
Illinois	$30
Indiana	$50
Iowa	$30
Kansas	$30
Kentucky	$40
Louisiana	$38
Maine	$40
Maryland	$40
Massachusetts	$60
Michigan	$60
Minnesota	$67
Mississippi	$44
Missouri	$30
Montana	$40
Nebraska	$50
Nevada	$35
New Hampshire	$50
New Jersey	$35
New Mexico	$45
New York	$50
North Carolina	$30
North Dakota	$40
Ohio	$40
Oklahoma	$50
Oregon	$30
Pennsylvania	$30
Rhode Island	$50
South Carolina	$30
South Dakota	$30
Tennessee	$30
Texas	$45
Utah	$45

State	Personal Needs Allowance
Vermont	$47.66
Virginia	$30
Washington	$41.62
West Virginia	$50
Wisconsin	$45
Wyoming	$30

Source: Congressional Research Survey of Selected Medicaid Eligibility and Post-Eligibility for Aged, Blind, Disabled (ABD) Groups, November 2000. State reported responses via email, telephone and fax.

Maintenance Needs Allowance for Persons Receiving Home and Community-Based Care Services

As noted above, states may apply more liberal income eligibility standards, e.g. the 300% rule, to persons qualifying for community-based waiver services. When that is the case, beneficiaries may become responsible for paying some portion of the costs of their care, after deductions (or income disregards) are made for their living expenses in the community. **Table 9** shows amounts of income and resources that states protected, as of November 2000, for persons receiving waiver services. Any income above these amounts must be applied toward the cost of their care. Six states protected less income than the 2000 SSI benefit standard of $512 (Arizona, Illinois, Maryland, Montana, Nebraska and North Dakota) and three states protected the SSI benefit level (Indiana, South Carolina and Virginia).

States also have the option of applying spousal impoverishment protections to the ineligible spouse of a beneficiary receiving services. As of November 2000, 38 states used spousal impoverishment rules for couples living in the community when one spouse receives waiver services.

Table 9. Maintenance Needs Allowance and Spousal Impoverishment Rules for HCBS, November 2000

State	Maintenance Needs Allowance (maximum protected monthly income)	Spousal Impoverishment Rules Apply
Alabama	$1,536	no
Alaska	$1,536	yes
Arizona	$204	yes
Arkansas	$1,536	no
California	$600	yes
Colorado	$1,536	yes
Connecticut	$1,392	yes
District of Columbia	$1,280	yes
Delaware	$1,536	no
Florida	depends on waiver	no
Georgia	$530	yes
Hawaii	Equivalent to income ceiling of qualifying eligibility pathway plus $20	yes
Idaho	$796	yes
Illinois	$487	yes
Indiana	$512 for children under 18 or students 18-21 only	no
Iowa	$1,536	yes
Kansas	$687	yes
Kentucky	$532	yes
Louisiana	$1,536	yes
Maine	125% of FPL	no
Maryland	$480	yes
Massachusetts	$522	no
Michigan	$1,536	yes
Minnesota	$700 elderly/$487 disabled	yes (for elderly only)
Mississippi	$1,536	yes
Missouri	$896	yes
Montana	$508	no
Nebraska	$392	yes

State	Maintenance Needs Allowance (maximum protected monthly income)	Spousal Impoverishment Rules Apply
Nevada	$1,024 (200% of SSI for aged only/ 300% of SSI for all other waiver cases)	yes
New Hampshire	depends on waiver	no
New Jersey	$1,536	yes
New Mexico	$1,516	yes
New York	$600	yes
North Carolina	100% of FPL	yes (resources only, do not assess post-eligibility for HCBS)
North Dakota	$455	yes
Ohio	$1,001	yes
Oklahoma	$1,536	yes
Oregon	$513.70	yes
Pennsylvania	$1,536 (individuals do not contribute toward waiver services)	no
Rhode Island	$600	no (spousal impoverishment rules apply only to assisted living waiver)
South Carolina	$512	yes
South Dakota	$530	yes
Tennessee	$1,024	no
Texas	$1,563	yes
Utah	$696	yes
Vermont	$766	yes
Virginia	$512 ($1,536 for AIDS waiver)	yes
Washington	$696 (depends on waiver)	yes
West Virginia	$1,536	yes
Wisconsin	$616	yes
Wyoming	$1,536	yes

Source: Congressional Research Survey of Selected Medicaid Eligibility and Post-Eligibility for Aged, Blind, Disabled (ABD) Groups, November 2000. State reported responses via email, telephone and fax.