

**Medicaid for Working People With Disabilities:  
Impacts of Eligibility Rules and Program Characteristics**

**Report Prepared for the Vermont General Assembly**

**Department of Disabilities, Aging and Independent Living**

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## Executive Summary

In response to a legislative request, this report reviews the impact of current financial eligibility rules and other characteristics of the Medicaid for Working People With Disabilities (WPWD) program on eligibility and enrollments, and assesses the degree to which the program promotes employment opportunities and ensures access to health coverage for Vermonters with disabilities. Methods included a review of regulatory documents, a review of relevant research literature, interviews with key informants, analyses of current administrative data, and reviews of survey and census data. A description and history of the program is provided, including a comparison to similar programs in other states. Enrollment patterns and participant demographics are presented and combined with information from the Social Security Administration and the U.S. Census Bureau to estimate the source and size of the potential eligibility population for the program. Regulatory constraints on enrollments are identified. While Vermont's WPWD Medicaid program has some more restrictive eligibility features than those of Medicaid Buy-In programs in many other states, it ranks relatively high in terms of program penetration, or population coverage, according to statistics provided by Mathematica Policy Research, Inc., an evaluation contractor for the federal Centers for Medicare and Medicaid Services:

- In 2006, Vermont's WPWD Medicaid program had enrolled 292 individuals per 10,000 state residents, aged 16 to 64, who reported an employment-related disability on the 2006 American Community Survey.
- The median rate across the 32 state Medicaid Buy-In programs in 2006 was 70.5 enrollments per 10,000 individuals.
- Vermont placed 7th highest out of the 32 states with Medicaid Buy-In programs in 2006, in terms of population coverage.

Multiple options are presented for increasing access to the program and enhancing its work-incentive function, including an option to pay the Medicare Part B premiums of enrollees who would otherwise drop that healthcare coverage when they have to pay the premiums out of pocket. The latter option has the potential to generate some cost-savings to the State, if certain healthcare expenses for WPWD Medicaid enrollees might otherwise be paid by Medicare Part B.

## **Introduction**

This report is submitted in follow-up to a letter, dated March 21, 2008, from the Commissioner of the Vermont Department of Disabilities, Aging and Independent Living (DAIL) to State Senator Virginia V. Lyons (attached to this report as Appendix A). In accordance with that letter, DAIL has worked with the Office of Vermont Health Access (OVHA) and the Department for Children and Families (DCF) to produce this study and report called for in Senate Bill 279 (S.279; attached to this report as Appendix B), which was introduced to the Vermont Legislature in January of 2008. Senate Bill 279 called on the Agency of Human Services to study the impacts of current financial eligibility rules on population eligibility for the Medicaid for Working People With Disabilities (WPWD) program, in order to promote greater employment opportunities and ensure access to health coverage for Vermonters with disabilities, a goal central to the mission of DAIL. More specifically, the tasks described in S.279 were as follows:

- Review available data on the health insurance status of employed individuals with disabilities to determine whether their ability to access needed health coverage or retain employment has been affected by the state's current asset and income limits.
- Consider the effect of spousal income on these individuals' access to health care.
- Identify any administrative barriers to collecting information.
- Report recommendations for changes to the asset and income limits, if any.
- Suggest viable outreach strategies for increasing awareness of the Medicaid for Working People with Disabilities program and other work incentives.

## **Methods**

Methods for conducting this study included regulatory document review, interviews with expert staff in public benefit issues at the Agency of Human Services, review of published program reports and statistics, new analyses of administrative data, and review of available survey and census data. AHS staff who were interviewed for this report included benefits counselors at DAIL and administrative staff at DCF. Regulatory documents, reports, and administrative data were provided by DCF and OVHA.

## **Program Description and History**

Vermont's Medicaid for Working People With Disabilities (WPWD) program was initiated in January 1, 2000, under the authority of the federal Balanced Budget Act (BBA) of 1997, PL 105-33, Sec. 4733, and Vermont Act 62 of 1999. Known at the federal level as the "Medicaid Buy-In Program", it allows many people with disabilities to work while keeping or obtaining Medicaid coverage for which they might not otherwise qualify due to higher incomes resulting from employment. The program is designed as a work incentive for people with disabilities, to help them achieve community inclusion through employment and achieve greater economic independence. In Vermont, the program was initiated in part as a response to a legislative study

and statewide series of focus groups conducted in 1997 showing that fear of losing health care coverage was a major barrier to employment for people with disabilities.<sup>1</sup>

Under current rules, to qualify for WPWD Medicaid, a person must:

- Live in Vermont.
- Be disabled according to Social Security standards.
- Be employed or self-employed.
- Have countable assets of less than \$5,000 for an individual, or \$6,000 for a couple, excluding savings from earnings generated while on the program.
- Have net countable family income of less than 250% of the federal poverty level (FPL), based on the person's family size.
  - This is referred to as the Step 1 income eligibility test. Net countable income is calculated based on standard income exclusions under federal SSI rules, as is done for SSI-related Medicaid generally.
- Have no more than a limited amount of unearned income.
  - This is referred to as the Step 2 income eligibility test. The income must not exceed the Medicaid Protected Income Level (PIL) for one person, or the supplemental security income (SSI) payment level for two, whichever is higher, after disregarding all earnings of the working individual with disabilities, any Social Security Disability Insurance benefits, and any veteran's disability benefits.

An index of rules and policy sources for the WPWD program is presented in Appendix C. "Disability" under this program is defined as receiving Social Security disability benefits (Social Security Disability Insurance or disability-related Supplemental Security Income) or having been determined disabled or blind by the Vermont Department for Children and Family's Disability Determination Services (DDS) unit according to Social Security Administration rules. Work status is documented by evidence of Federal Insurance Contributions Act tax payments, Self-employment Contributions Act tax payments, or a written business plan approved and supported by a third-party investor or funding source. Things that may qualify as a written business plan include (but are not limited to) a formal business plan reviewed by the Small Business Administration, a Voc Rehab Individual Plan for Employment, a written self-employment plan created in conjunction with a person's caseworker, or a written contract containing work/business specifications and payment provisions. The required third-party funding source may be a bank, a credit union, a party to a written contract, a nonprofit social service organization, or a State agency such as Vocational Rehabilitation. Earnings from work under the WPWD program are not counted as an asset against Medicaid eligibility, so long as the earnings are kept in a separate account. WPWD provides full-benefit Medicaid coverage for the person with a disability, including coverage for doctors, hospitals, and prescription drugs. Family coverage is not available through WPWD.

Since its inception in January of 2000, the program has undergone two sets of policy changes. The first occurred in 2004. From January 2000 until June 2004, enrollees paid healthcare premiums for WPWD coverage, based on their income. That is, consistent with the original federal intent for the

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<sup>1</sup> Johnson-Lamarque, Heather, *The Barriers to Employment Faced By Persons With Disabilities: Problems and Solutions*, (Report prepared for the Governor and the 1997 General Assembly, January 1997).

program, enrollees with certain minimum levels of income would "buy-in" to Medicaid coverage while employed. Premiums were paid by enrollees at two levels of net household income: the first level was greater than 185 percent of FPL but less than or equal to 225 percent of FPL, and the second level was greater than 225 percent of FPL but less than or equal to 250 percent of FPL. Premium amounts charged by the State were similar to or slightly higher than those for children under 18 years of age who were enrolled in the Dr. Dynasaur Medicaid-expansion program. After June 2004, however, premiums were no longer charged for WPWD coverage because the administrative costs of manually calculating and collecting the premiums were found to outweigh the income obtained by the State from premium payments. The second set of changes occurred in 2005, as a result of Act 56. In order to extend the WPWD work incentive to individuals with disabilities who qualified for greater levels of public disability benefits (usually due to more substantial work histories), an unearned-income exclusion for Social Security Disability Insurance (SSDI) and veterans' disability benefits was added to Step 2 of the financial eligibility determination. At the same time, evidence-of-work requirements were more clearly specified, in order to protect the work-incentive function of the program. Fiscal impacts of the two sets of changes in 2005 roughly cancelled each other out, in net budget neutrality.

### **Comparison to Medicaid Buy-In Programs in Other States**

As of January 2007, 35 other states had active Medicaid Buy-In (MBI) programs<sup>2</sup>, primarily under the authority of the Balanced Budget Act (BBA) of 1997 or under the authority of the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999. (BBA Buy-Ins cover ages 18 and older, while TWWIIA Buy-Ins cover the more restricted age range of 16 to 64, but with a state option to cover the Medical Improvement group of SSA disability beneficiaries). The Centers for Medicare and Medicaid Services has contracted with Mathematica Policy Research, Inc. (MPR) to work with the 32 Medicaid Infrastructure Grant (MIG) programs, including Vermont's, in the Medicaid Buy-In states, to gather data and produce descriptive and statistical analyses of the program characteristics and outcomes of the MBI programs nationwide.<sup>3</sup> Appendix D contains MPR's comparative summary of Medicaid Buy-In program characteristics, based on information provided by the MIGs.

Appendix D shows that, of the 35 other state MBI programs, 14 were established under the BBA, 18 were established under TWWIIA, one (CT) had both a BBA and TWWIIA Buy-In, and two (MA and MD) had Medicaid Buy-In programs established under Social Security Act Section 1115 waivers. Of the 18 states that had TWWIIA Buy-Ins, 6 had exercised the option to cover the Medical Improvement group of beneficiaries. Out of the 35 state MBI programs, 7 had Step 1 income limits higher than Vermont (CT, IN, KS, MA, MI, and MN). None of those were BBA-only programs, however. Two of the programs (MA and MN) had no income limits for eligibility whatsoever, and a third (MI) had no earned income limit. Twenty-five states had higher asset limits than Vermont, ranging from \$8,000 per individual in one state (SD) to no limit in four states

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<sup>2</sup> From Mathematica Policy Research, Inc., "The Three E's: Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2006", Table A2, April 2008; with supplemental information for TX and VA provided in an e-mail from Mathematica Policy Research, Inc. to state Medicaid Infrastructure Grants, September 12, 2008.

<sup>3</sup> Copies of all Issue Briefs and Reports produced by Mathematica Policy Research, Inc. on Medicaid Buy-In programs across the country have been posted online at <http://www.mathematica-mpr.com/disability/medicaidbuy-in.asp>.

(AZ, MA, WA, and WY). Fifteen states disregarded spousal income, and 17 states disregarded spousal assets, for eligibility determination. Twenty-three states had some form of grace period, or work-stoppage protection.

An April, 2008 report<sup>4</sup> from Mathematica Policy Research, Inc. (MPR), examined the latest MBI program outcomes available, as of 2006, across the 32 states with a Medicaid Infrastructure Grant, in terms of enrollment patterns, employment, and earnings, and the relationship of those outcomes to program characteristics. Among their major findings relevant to program characteristics were the following:

- In 2006, 97,491 individuals were enrolled in Medicaid Buy-In programs across the country at any point during the year.
- Due to variations in MBI program features across states, including varying evidence-of-work requirements and grace periods (also known as work stoppage protections, which allow an individual to remain on the program during temporary losses of employment), not all MBI enrollees were employed in 2006. About 69% of MBI enrollees nationwide were employed and had earnings in 2006.
- Average annual earnings among employed Medicaid Buy-In enrollees nationwide in 2006 was relatively low, at \$8,237 per year (below the federal Substantial Gainful Activity level of \$10,320), but had increased from \$7,877 in 2005.
- Of all state program features, shorter grace periods (during times of temporary unemployment) had the strongest positive association with employment rate and with average earnings. Enrollees in states with shorter grace periods had a 37% greater likelihood of being employed than those in states with longer grace periods. A shorter grace period of 1 to 6 months was associated with a \$965 increase in earnings compared with a longer grace period of 6 to 12 months.
- Enrollees in states with higher earned income limits were 26% more likely to be employed than enrollees in states with lower earned income limits. A higher earned income limit of 251% FPL to 350% FPL in a state MBI program was associated with a \$386 increase in annual earnings for enrollees, relative to a lower limit of 250% FPL.
- Enrollees in states with a work verification requirement were 27% more likely to be employed, and they had annual earnings \$503 higher, than those in states without such a requirement.

In an analysis of MBI programs using 2005 data<sup>5</sup>, MPR compared 23 states in terms of program characteristics and enrollment patterns. In doing so, MPR created an index of eligibility restrictiveness with a total score that ranged from 0 to 12, based on earned income limits, unearned income limits, and asset limits. Vermont obtained a score of 10 out of 12 (where 12 is the most restrictive), which was above the median score of 5 for the 23 states in the comparison. Despite this, Vermont ranked 7th out of the 23 states in terms of program penetration, or population

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<sup>4</sup> Gimm, Gilbert, et al.. "The Three E's: Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2006." Washington DC: Mathematica Policy Research, Inc., April 11, 2008. Available at <http://www.mathematica-mpr.com/disability/medicaidbuy-in.asp>.

<sup>5</sup> Mathematica Policy Research, Inc., "The Interaction of Policy and Enrollment in the Medicaid Buy-In Program, 2005", May 2007, page 27 and Table III.5. Available at [http://www.mathematica-mpr.com/publications/redirect\\_pubsdb.asp?strSite=pdfs/interaction.pdf](http://www.mathematica-mpr.com/publications/redirect_pubsdb.asp?strSite=pdfs/interaction.pdf).

coverage, due to an annual total Medicaid Buy-In enrollment in Vermont of 114.6 individuals per 10,000 state residents with an employment-related disability, aged 16 to 64, as of December 2005. (The median for the 23 states was 55.1 individuals per 10,000, with a range from 1.0 to 457.2 per 10,000.) Overall, MPR found that the correlation between program penetration and eligibility restrictiveness across the 23 states was -0.48 (meaning that eligibility restrictiveness predicts 23% of the variation in program penetration across the 23 states), yet Vermont was an anomaly which had served to reduce that correlation. Using 2006 data<sup>6</sup>, MPR compared 32 states in terms of program penetration, and found that Vermont had increased its annual total enrollment rate to 292 individuals per 10,000 state residents with an employment-related disability, aged 16-64, as measured by the 2006 American Community Survey. That placed Vermont 7th highest out of the 32 states in 2006. The median rate for 2006 across the 32 states was 70.5 enrollments per 10,000 individuals.

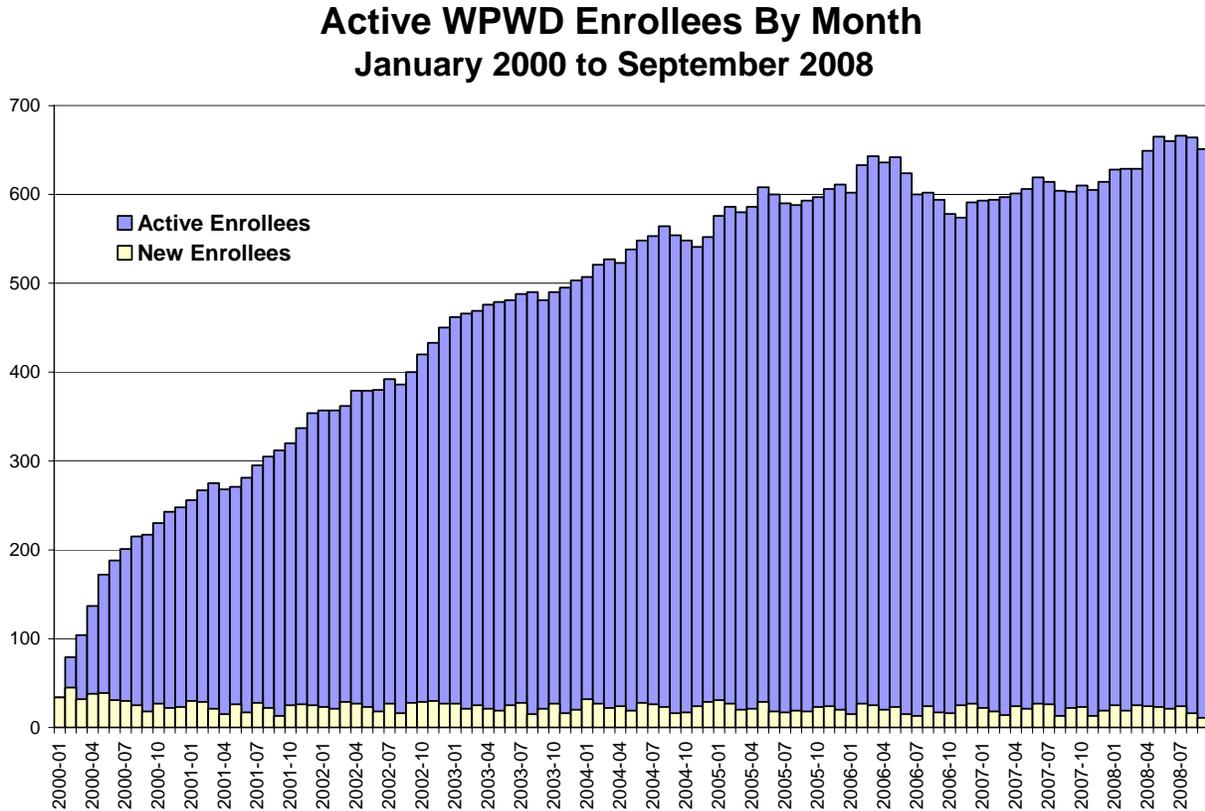
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<sup>6</sup> Gimm, Gilbert, et al.. "The Three E's: Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2006." Washington DC: Mathematica Policy Research, Inc., April 11, 2008, Table C3. Available at <http://www.mathematica-mpr.com/disability/medicaidbuy-in.asp>.

**Enrollment Patterns And Demographic Characteristics of WPWD Enrollees in Vermont**

Overall enrollment. Between January 1, 2000 and September 30, 2008, there have been 2,435 cumulative enrollees (as an unduplicated count of individuals) in Vermont's WPWD Medicaid program. As of September 30, 2008, there were 624 active WPWD enrollees, and 1,811 former enrollees. Figure 1 below shows the historical enrollment pattern in Vermont.

Figure 1. Active WPWD Enrollees By Month.

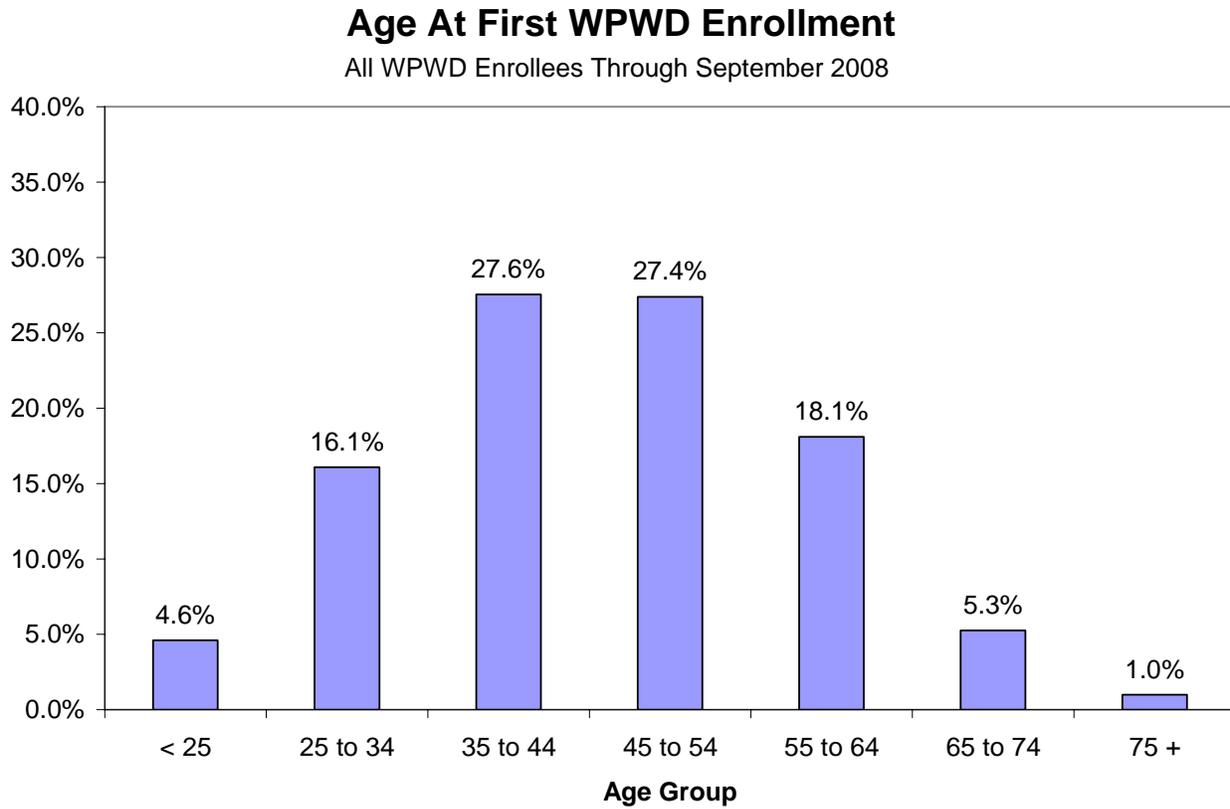


Beginning in 2005, the curve of total enrollment levels began to flatten, and monthly active enrollment totals since that time have hovered around 600, until recently in late 2008.

Basic demographics for the cumulative population of enrollees through September, 2008, are presented below.

Age distribution.

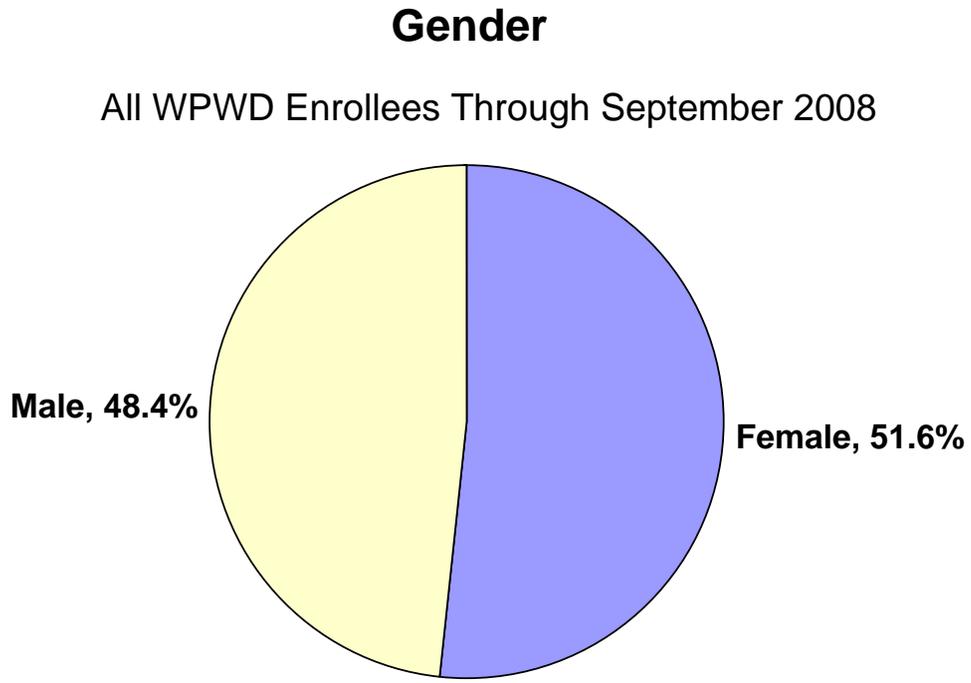
Figure 2. Age at First WPWD Enrollment.



The average at first enrollment into WPWD is 45.8 years, with a standard deviation of 12.4 years. Enrollment has been greatest among middle-aged individuals.

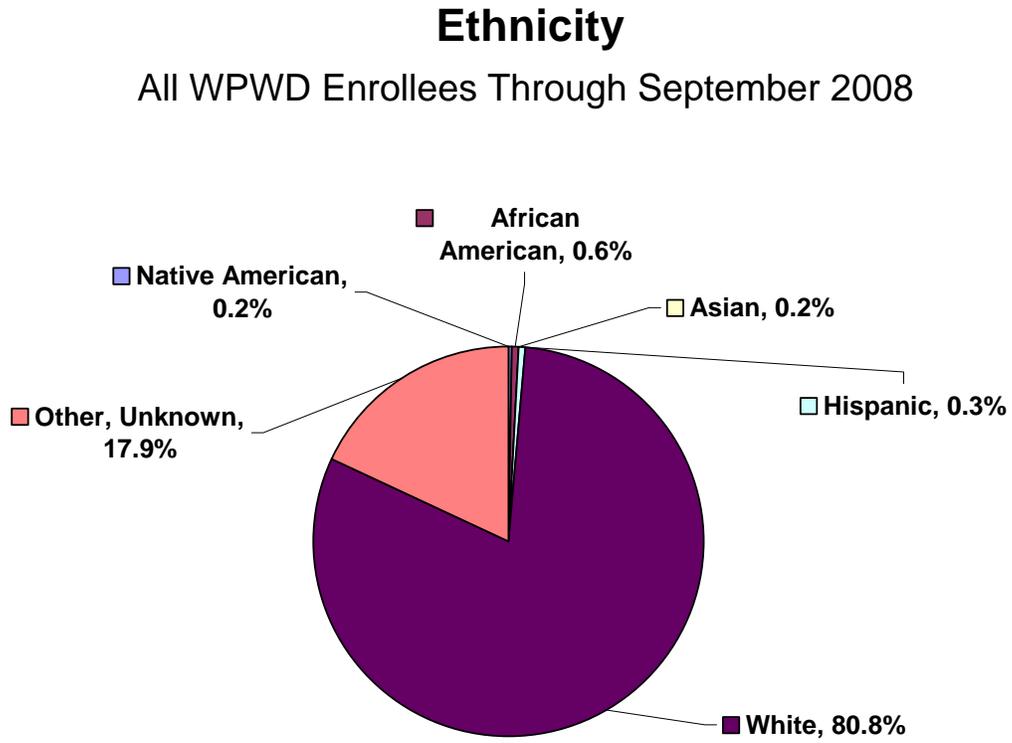
Gender distribution.

Figure 3. Gender distribution among WPWD Medicaid enrollees.



Reported ethnicity.

Figure 4. Reported ethnicity among WPWD enrollees.

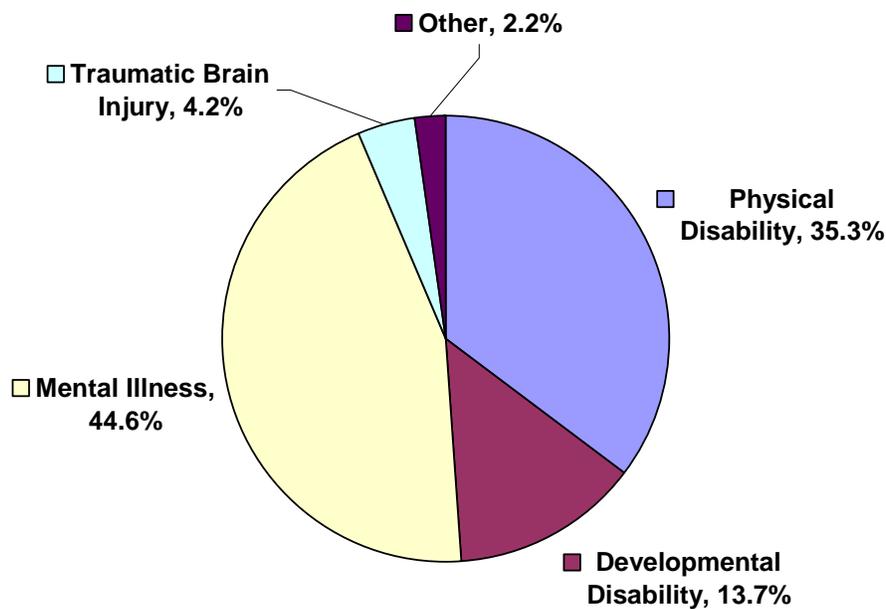


Disability types. Specific disability types are not readily available in the State's electronic healthcare eligibility and claims systems for most applicants, and to the extent that disability info can be derived, it often involves inferences from healthcare utilization patterns, which may be misleading in terms of primary employment-related disabling condition. To obtain information on employment-related disabilities, we examined a sample of WPWD enrollees who also received services from the Division of Vocational Rehabilitation, which records such information.

Figure 5. Disability category among dual WPWD/Voc Rehab consumers.

### **Voc Rehab Primary Disability Category**

All WPWD/Voc Rehab Enrollees Through September 2008



Of the 2,435 cumulative enrollees in WPWD as of 9/30/2008, 1,465 or 60.2% have received services from the Division of Vocational Rehabilitation (DVR). For that subset of WPWD enrollees, we were able to derive the above percentages regarding primary employment-related disability category. Consistent with early goals of the program, the most common disability type among Vermont's WPWD enrollees is mental illness, representing a population that was seen as underserved prior to the introduction of the program. (In statistics presented by Mathematica Policy Research, Inc.,<sup>7</sup> mental illness was the largest category of disability type being served by MBI programs nationally, as well, at 25.1%.)

<sup>7</sup> Gimm, Gilbert, et al. "The Three E's: Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2006." Washington DC: Mathematica Policy Research, Inc., April 11, 2008, page 23, Figure III.4. Available at <http://www.mathematica-mpr.com/disability/medicaidbuy-in.asp>.

Additional information. The above figures provide the latest enrollment and demographic information for program participants since 1/1/2000. Other information gathered in past years about enrollees in the WPWD Medicaid program can be found at the Vermont Work Incentives Initiative website, maintained by the Vermont Medicaid Infrastructure Grant program, at [http://www.dail.state.vt.us/dvr/vocrehab/vwii/s5\\_reports.htm#mbirpts](http://www.dail.state.vt.us/dvr/vocrehab/vwii/s5_reports.htm#mbirpts).

### **Enrollee Earnings Outcomes**

Using records from the Social Security Administration's Master Earnings File, which is verified with information from the Internal Revenue Service, Mathematica Policy Research, Inc. has examined the federally-reported earnings levels of WPWD enrollees in Vermont, and compared them to those of individuals in Medicaid Buy-In programs in other states. (All those analyses were for time periods prior to full implementation of new evidence-of-work requirements in Vermont.) In an analysis of earnings in 2004<sup>8</sup>, MPR found that 88% of Vermont enrollees had earnings, which ranked Vermont the 10th highest out of 27 states. The average earnings rate across the 27 states was 66%. In the same study, MPR found that, among those with earnings, the average earnings level of Vermont enrollees was approximately \$7,000 for the year, which ranked Vermont the 19th highest out of 27 states. The average earnings level across the 27 states was \$7,246 for the year. In another analysis<sup>9</sup>, to see if the earnings of MBI enrollees increased after individuals participated in the program, MPR compared earnings in the year prior to the year of enrollment to those in the year following the year of enrollment. The sample was MBI enrollees from the years 2000 to 2003, across 24 states. In Vermont, the percent of enrollees whose earnings increased after enrollment was 51%, which ranked Vermont the 8th highest out of 24 states. The average percent across the 24 states was 40%. The average amount of increase for the Vermont enrollees whose earnings had increased was \$3,750, which ranked Vermont the 7th highest out of 24 states. The median earnings increase across the 24 states was \$2,582. More recently, in 2006 the rate of Vermont MBI enrollees with federally reported earnings was 86% (versus a national MBI rate of 69%), and the average earnings level of those earners was \$7,385 (versus a national MBI level of \$8,237).<sup>10</sup>

### **Health Insurance Status of Employed Individuals with Disabilities**

Direct, comprehensive information on the health insurance status of employed individuals with disabilities in Vermont was not obtained in the course of this study. In this review, no survey or census data was found that had relevant and representative insurance information specific to employed individuals with disabilities statewide. Available State administrative datasets either did not have all the information needed to directly address the issue or were technically inaccessible for ad hoc querying on the scale needed.

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<sup>8</sup> Black, William E., Liu, Su, and Irely, Henry T. "How Much Are Medicaid Buy-In Participants Earning?" Working with Disability, Earnings In Brief #1, Mathematica Policy Research, Inc., May 2006. Available at [http://www.mathematica-mpr.com/publications/redirect\\_PubsDB.asp?strSite=PDFs/howmuchmedicaid.pdf](http://www.mathematica-mpr.com/publications/redirect_PubsDB.asp?strSite=PDFs/howmuchmedicaid.pdf).

<sup>9</sup> Liu, Su, and Weathers, Bob. "Do Participants Increase Their Earnings After Enrolling in the Medicaid Buy-In Program?" Working with Disability, Earnings In Brief #4, Mathematica Policy Research, Inc., May 2007. Available at [http://www.mathematica-mpr.com/publications/redirect\\_pubsdb.asp?strSite=PDFs/WWDparticipants.pdf](http://www.mathematica-mpr.com/publications/redirect_pubsdb.asp?strSite=PDFs/WWDparticipants.pdf).

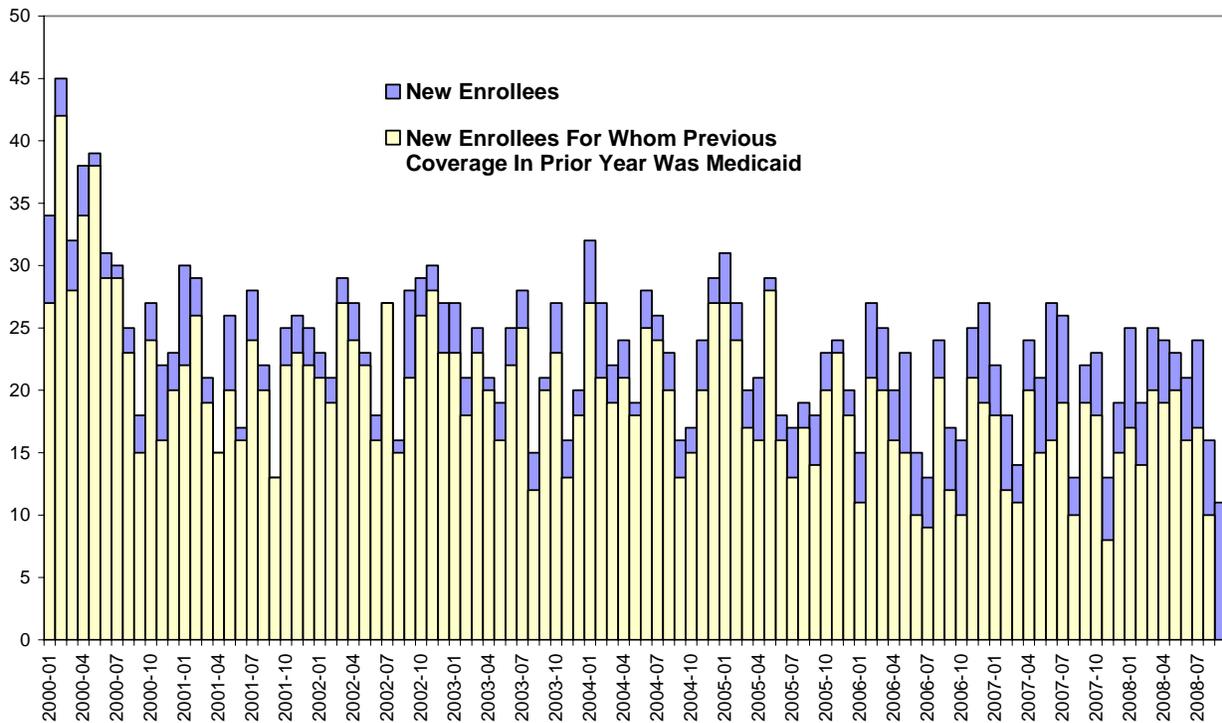
<sup>10</sup> Gimm, Gilbert, et al.. "The Three E's: Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2006." Washington DC: Mathematica Policy Research, Inc., April 11, 2008, Tables D1 and E1. Available at <http://www.mathematica-mpr.com/disability/medicaidbuy-in.asp>.

For an indirect answer to the question, however, we can look to the health coverage histories of individuals with disabilities whom we know met the eligibility criteria of WPWD Medicaid at some point in time. In those histories, we can see the levels and types of health care coverage held by individuals just prior to and just following their enrollment in WPWD Medicaid, as well as concurrent coverage while they were on WPWD Medicaid. The focus of this analysis was on public health insurance coverage.

Figure 6 below expands on the enrollment information provided in Figure 1, by providing additional details on the source of new enrollees to the WPWD program, broken out by month.

Figure 6. New enrollees to WPWD by month.

### New Enrollees To WPWD By Month January 2000 to September 2008



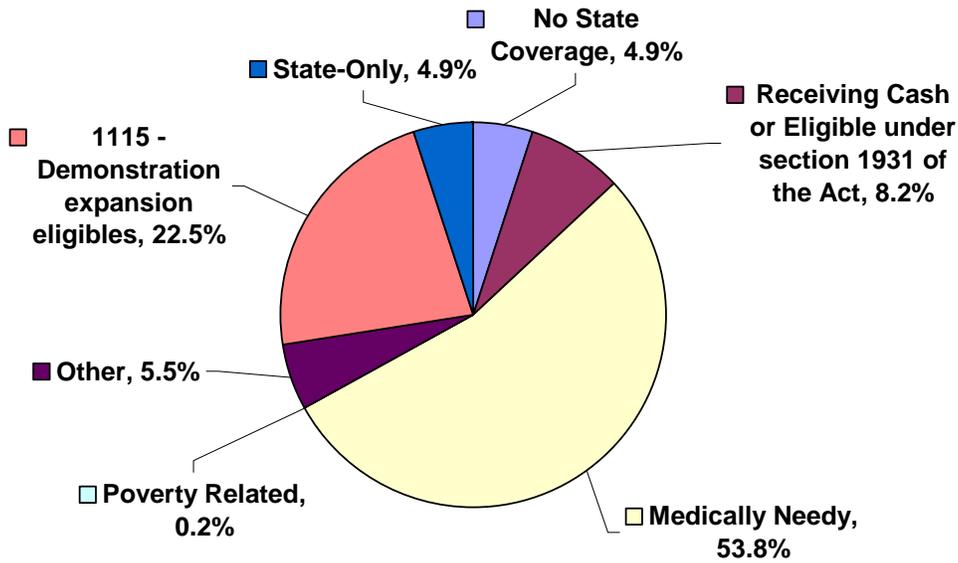
As envisioned in the original design of the federal Medicaid Buy-In program, most enrollees have transferred from other forms of public health coverage, rather than entering the State health coverage system as new beneficiaries. Of the 2,435 cumulative enrollees in Vermont's WPWD Medicaid program, 2,227 individuals or 91.5% had been receiving health care coverage through the State of Vermont in the year prior to first enrollment in WPWD. Of all cumulative enrollees, 2,062 or 84.7% received Medicaid sometime in the year prior to first enrollment in WPWD, and 165 or 6.8% received State-funded-only coverage sometime in the year prior to first enrollment (some of these individuals received both).

More specifically, Figure 7 below shows the Maintenance Assistance Status (MAS) category for the last form of healthcare coverage provided by the State prior to WPWD Medicaid for program enrollees.

Figure 7. Last State coverage prior to first WPWD enrollment.

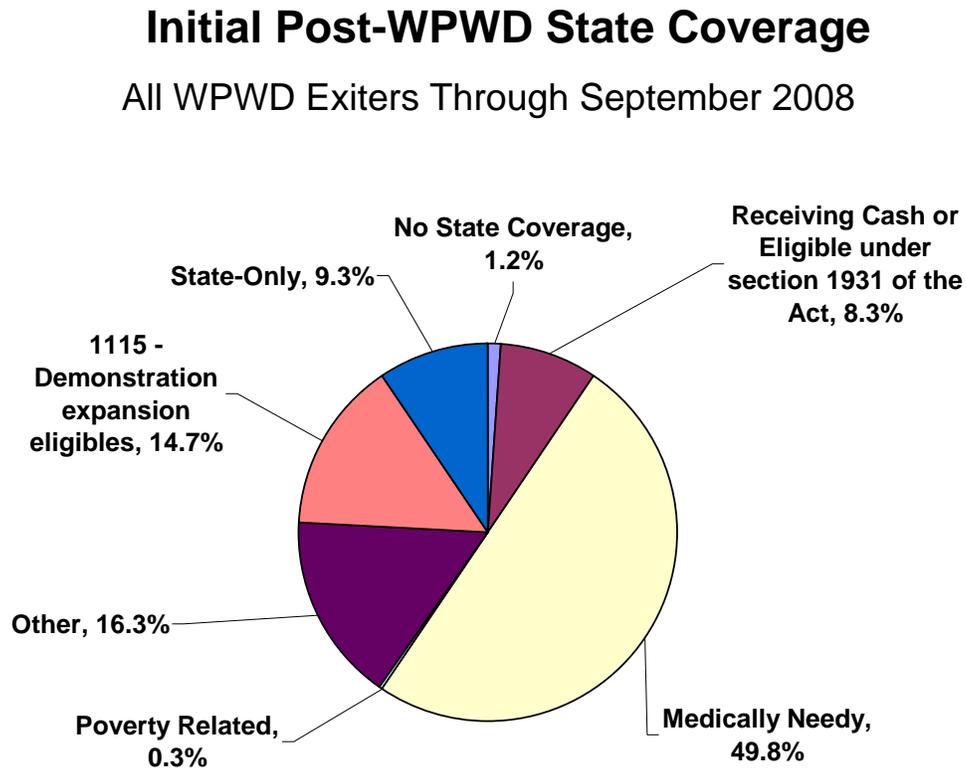
### Last State Coverage Prior To First WPWD Enroll

All WPWD Enrollees Through September 2008



After enrollees exit from WPWD Medicaid, where do they go? As of 9/30/2008, there were 624 active WPWD enrollees and 1,811 former WPWD enrollees. For the former enrollees, Figure 8 shows where they went to next, in terms of public health care coverage, by MAS category.

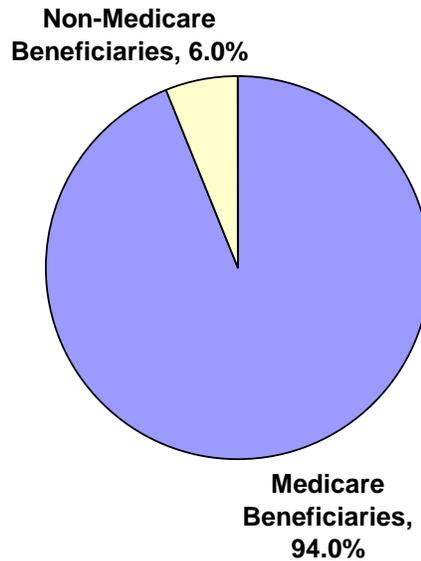
Figure 8. Initial post-WPWD State coverage.



Medicare status. Most WPWD enrollees are SSDI-only beneficiaries, and as a result also have Medicare. Of the 2,435 cumulative WPWD enrollees, 2,290 or 94% were Medicare beneficiaries. Of the remaining 6%, many are likely within their 2-year waiting period for Medicare.

Figure 9. Medicare coverage among WPWD enrollees.

### **Medicare Status** All WPWD Enrollees Through September 2008



The above information showed what types of coverage WPWD-eligibles generally have when they are not on the WPWD program. The next section estimates the size of the potential WPWD-eligible population.

#### **Estimated Size of the Population Potentially Eligible for WPWD Medicaid**

According to the latest available U.S. Census Bureau information,<sup>11</sup> among Vermont's population of 424,097 non-institutionalized individuals aged 16 to 64 years, 14.0% reported that they had a disability, and 7.5% (31,858 individuals) reported that they had a disability which impacted employment. Of those who reported an employment disability, 19.7% were employed, versus 79.9% for those who did not report an employment disability. The eligibility population for WPWD Medicaid, as defined in federal law however, is somewhat narrower, being restricted to those individuals with the most severe employment-related disabilities, according to Social

<sup>11</sup> U.S. Census Bureau, 2006 American Community Survey, Tables B18020 and B18026, Disability Status By Sex By Age, and Sex By Age by Employment Status, For the Civilian Non-Institutionalized Population 16 to 64 - Universe: Civilian Non-Institutionalized Population 16 to 64 Years.

Security Administration standards. With few exceptions, this means individuals who qualify for federal SSDI and/or SSI disability benefits. If individuals qualify for both SSDI and SSI, however, they do not need the WPWD Medicaid program, as they are already categorically eligible for Medicaid coverage in Vermont, and former SSI recipients are able to make use of the Medicaid protections of the SSI 1619b program. Consequently, for general purposes, the eligibility population for WPWD consists of SSDI-only beneficiaries.

Table 1 below presents statistics and calculations used to estimate the size of the eligibility population in Vermont for WPWD Medicaid.

Table 1. Estimated Eligibility Population for WPWD Medicaid.

Row	Value	Calculation	Description
a	17,160		VT SSDI beneficiaries aged 18-64 as of Dec. 2007. - SSA: Annual Statistical Report on the Social Security Disability Insurance Program, 2007, Table 66.
b	3,017		VT SSDI/SSI dual beneficiaries aged 18-64 (already eligible for Medicaid) as of Dec. 2007. - SSA: Annual Statistical Report on the Social Security Disability Insurance Program, 2007, Table 66.
c	14,143	a-b	VT adult SSDI-only beneficiaries.
d	9.7%		Rate of VT SSI Blind and Disabled beneficiaries who work. - SSA: SSI Annual Statistical Report, 2007, Table 40. (VT SSDI who work at a level triggering withholding or termination of their benefits is less than 1.2% - SSA: Annual Statistical Report on the Social Security Disability Insurance Program, 2007, Table 56.)
e	1,372	c*d	Estimated VT SSDI-only workers. (Greater work histories among SSDI beneficiaries would be offset by the greater proportion of beneficiaries close to retirement age.)
f	30.3%		SSDI workers with family income greater than or equal to 300% FPL. - SSA: Annual Statistical Report on the Social Security Disability Insurance Program, 2004, Table 67.
g	20.2%		SSDI workers with family income 200% to 299% FPL. - SSA: Annual Statistical Report on the Social Security Disability Insurance Program, 2004, Table 67.
h	40.4%	f+(0.5*g)	Estimated SSDI workers with gross family income 250% FPL or greater.
i	50.1%		Percent of family income from earnings for married SSDI beneficiaries (lower for unmarried beneficiaries). - SSA: Annual Statistical Report on the Social Security Disability Insurance Program, 2004, Table 66.
j	50.0%		Approximate maximum amount of family earned income that could be disregarded under SSI countable income rules, due to earned income disregard.
k	25.1%	i*j	Approximate maximum amount of gross family income that could be disregarded under SSI countable income rules, due to earned income disregard.
l	30.3%	h*(1-k)	Estimated SSDI workers with net SSI-countable income 250% FPL or greater.
m	956	e*(1-l)	Estimated maximum number of VT SSDI-only workers who might qualify for WPWD.
n	651		Current monthly WPWD Medicaid Buy-In enrollment (Combined DCF and OVHA data for September, 2008).
o	68.1%	n/m	Percent of estimated potential WPWD eligibles currently enrolled.

p	305	m-n	Estimated non-enrolled WPWD eligibles (qualifying, non-enrolled, VT SSDI-only workers).
q	50.0%		Estimated percent of remaining non-enrolled WPWD eligibles who might seek health coverage beyond Medicare for such things as mental health services, personal assistance services, or high pharmaceutical costs (despite having a Medicare drug benefit). Considerations include individual level of service need, competing opportunities for private health coverage, and the degree of self-selection that has already taken place in WPWD enrollments to date.
r	153	p*q	Estimated potential unmet demand for WPWD enrollment, as a count of individuals.

With the current employment pattern among individuals with SSA-defined disabilities, the potential eligibility pool for WPWD Medicaid in Vermont, under current rules, is estimated to be about 956 individuals. Given a current actual monthly enrollment level of about 651 individuals, the potential unmet demand for WPWD at this time would appear to be between 153 and 305 individuals. An unknown portion of those individuals may currently be on other forms of Medicaid in Vermont, however, possibly due to low earnings. The potential eligibility pool for WPWD could increase if a significantly greater proportion of SSDI beneficiaries in Vermont were to engage in employment than would be predicted by historical experience. The next question is what constraints there may be on WPWD eligibility and utilization, keeping enrollments below the potential maximum.

**Identifying Constraints on WPWD Eligibility and Utilization: Data Limitations**

There are significant data limitations involved in identifying potential constraints on WPWD eligibility and utilization. Records of who has been screened for WPWD Medicaid eligibility, and how, are not systematically kept, particularly not in electronic form, unless the person is found eligible. The eligibility determination system was not designed for that purpose, as the priority was to record what an individual is eligible for. It is very difficult, therefore, to quantify the number of people who have been assessed or found ineligible for WPWD, or the exact reasons for findings of ineligibility (or a lack of eligibility findings). Federal rules require that individuals be screened for WPWD only after they are determined ineligible for most other forms of Medicaid, so the total number of individuals who might qualify for and benefit from the work incentive provisions of WPWD is unknowable from eligibility determination records. SSDI-only beneficiary status combined with earnings is a clue, but much more information about household composition, family income, assets, and evidence of work is required to determine WPWD eligibility with any reasonable degree of accuracy. Independent employment records, such as Unemployment Insurance (UI) wage records are of limited utility in estimating eligibility on a batch scale, because UI records are in quarterly increments while the eligibility criteria are based on monthly or point-in-time assessments. Finally, the automated eligibility system, DCF ACCESS, is not open to ad hoc batch querying without extensive expert programming. Existing administrative data systems are simply not very helpful for determining the extent or nature of ineligibility findings for WPWD Medicaid, or for identifying the most common constraints on eligibility or utilization. For those purposes, this study relied on regulatory reviews and structured interviews with AHS staff who

regularly deal with significant numbers of WPWD eligibility determination cases, and are experts in WPWD issues, as well as public benefit issues generally: DVR benefits counselors.

### **Constraints on Eligibility from Income and Asset Limits**

Income limits. As described above, the WPWD Medicaid program has a two-step income test for eligibility. Step 1 is that net household income (using SSI rules) must be below 250% of FPL. Step 2 is that the income must not exceed the Medicaid Protected Income Level (PIL) for one person, or the supplemental security income (SSI) payment level for two, whichever is higher, after disregarding all earnings of the working individual with disabilities, any Social Security Disability Insurance benefits, and any veteran's disability benefits. The latter disregards for SSDI and veteran's benefits were added by Act 56 of 2005, but were accompanied by a new specification of evidence-of-work requirements, resulting in budget neutrality. Step 1 of Vermont's WPWD income test is currently at the default maximum specified by the Balanced Budget Act of 1997, and Step 2 exceeds the default maximum. As explained in a 2004 technical assistance memo to the State from the National Consortium for Health Systems Development (Appendix E), and in a 2001 Question & Answer document<sup>12</sup> (Appendix F) from the Centers for Medicare and Medicaid Services, and, however, Vermont has the option to increase or effectively eliminate either of these limits, through the provisions of Section 1902(r)(2) of the Social Security Act. If Vermont were to do so, Rows f through l of Table 1 above show that such a change could increase the potential eligibility pool for WPWD by up to 44% (from 956 to 1,372 individuals, at current rates of employment among SSA disability beneficiaries). The primary constraint for the State in making such changes would be budgetary. To date, no other state with a Medicaid Buy-In implemented under the authority of the Balanced Budget Act of 1997 has a Step 1 income limit higher than Vermont's, at 250% FPL, though 7 states with non-BBA Buy-In programs have higher income limits.

Asset limits. The current resource, or countable asset, limit for WPWD eligibility is \$5,000 for an individual, and \$6,000 for a couple. Earnings from work under the WPWD program are not counted as an asset against Medicaid eligibility, however, so long as those earnings are kept in a separate account. This means that the asset limit can be met by a one-time spend-down to the \$5,000 or \$6,000 level to establish initial eligibility for WPWD, after which there is no limit on the amount of assets that can be accumulated from WPWD earnings. Savings from WPWD earnings remain disregarded for any Medicaid eligibility determination (not just WPWD eligibility determinations for the individual) as long as they are kept in a separate account. For savings from earnings, then, the asset limit is generally a one-time constraint, at initial enrollment only. It has been argued, however, that it is more difficult for people with disabilities to accumulate new assets, and asset retention is an issue of economic independence. One area where the asset limits cause particular problems for individuals is in the area of retirement accounts, such as IRA's or 401K's. With retirement accounts, an individual often cannot spend the assets down quickly without serious long-term financial impacts and without incurring significant financial penalties. Another situation that causes eligibility problems is when an individual gets a one-time disability-related settlement

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<sup>12</sup> Centers for Medicare and Medicaid Services. Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers. May 11, 2001. Available at <http://www.cms.hhs.gov/MedicaidEligibility/downloads/DefinitionElig1902r2.pdf>.

payment. To address those situations, individuals can establish special needs trusts, or new disregards might be created, or the asset limits might be increased. In looking for possible models, long-term Medicaid under the Choices for Care waiver has an asset limit of \$10,000, and there is no resource test for QMB/SLMB coverage. (Virtually all WPWD enrollees are eligible for Medicare Part B, for which QMB/SLMB programs pay individuals' premiums.) Because health coverage is a high priority for most people with disabilities, and because the asset limits can be met through one-time spend-downs, it seems unlikely that the current asset limits have significantly constrained enrollment in WPWD for individuals without substantial retirement accounts. More likely, however, the asset limits reduce the short-term and long-term financial independence of working people with disabilities. Finally, new federal rules effective July 1, 2004<sup>13</sup> appear to work at counter-purposes regarding whether interest and dividends from WPWD-earned savings should be disregarded in financial eligibility determinations, and, depending on how they are interpreted, could provide a disincentive for significant savings or investments of earnings for people with disabilities.

Spousal income. According to the Social Security Administration, 48.5% of SSDI beneficiaries nationally are married<sup>14</sup>. While the consideration of spousal income in financial eligibility determination is a common constraint on eligibility across Medicaid programs, it creates a particular work disincentive for couples where the non-WPWD Medicaid spouse of a potential WPWD enrollee is likely to lose their Medicaid coverage due to earnings of the WPWD person. This particular form of a "marriage penalty" doesn't limit the number of people who become eligible for Medicaid, but instead only serves to keep two individuals on standard Medicaid when one might have the opportunity to become more economically independent. Benefits counselors report that they have been seeing more of these types of cases in the past year. In such cases, the treatment of spousal income completely undermines the work incentive aim of the WPWD program. An alternative model would be to disregard WPWD earnings for all Medicaid eligibility determinations, and not just those of the WPWD enrollees. Two Vermont precedents for disregards of spousal income, generally, can be found in long-term care Medicaid and in Medicaid for ANFC households with children under 18. As stated above, as of January, 2007, 15 of 35 other state MBI programs disregarded spousal income, and 17 of them disregarded spousal assets, for MBI eligibility determination. If Vermont were to disregard spousal income and assets completely for WPWD eligibility, Rows f through l of Table 1 above suggest that such a change could increase the potential eligibility pool for WPWD by up to 44% (from 956 to 1,372 individuals, at current rates of employment among SSA disability beneficiaries). (An increase in the eligibility pool by a full 44% is unlikely, however, because that would only occur if all VT SSDI workers screened out by WPWD financial eligibility rules fail the tests due to spousal income or spousal assets.)

### **Constraints on Eligibility and Utilization from Other Regulations**

No grace period. Vermont has no grace period for WPWD eligibility during times of temporary unemployment. As soon as an individual becomes unemployed, they become ineligible for WPWD health coverage. While a recent analysis of Medicaid Buy-In programs nationally found

<sup>13</sup> DCF Interpretive Memo dated 7/1/04 for Rule M242.2, versus Rule M232.88.

<sup>14</sup> Social Security Administration: Annual Statistical Report on the Social Security Disability Insurance Program, 2004, Table 63.

that programs with longer grace periods are associated with lower average earnings among Buy-In enrollees<sup>15</sup>, there are a few specific situations where a grace period would provide important protections for working people with disabilities, and a level of security necessary to support an ongoing work incentive. The first would be an unemployment grace period for times of hospitalization. The value of any form of health coverage is diminished if the person loses it just at the times they may need it most, such as the start of a hospital stay. The problem is compounded by the fact that transitions to other forms of Medicaid coverage are not always smooth or immediate for people with disabilities who have been working and generating significant income and assets. A second, possibly counter-intuitive, use for a grace period would be for WPWD enrollees while they are receiving unemployment compensation. By definition, unemployment compensation is temporary and the individual must demonstrate that they are available for and seeking employment. Such a grace period might be limited to individuals who were on WPWD Medicaid immediately prior to the period of unemployment, because those individuals would otherwise be returning to the regular Medicaid rolls anyway, and the grace period would simply reduce disruptions in coverage and the administrative costs of "churning" across programs. The unemployment compensation grace period would make sense in part because Medicaid requires individuals to pursue other forms of income for which they are eligible, including unemployment compensation.

DS Waiver Interaction. Program interactions are problematic between WPWD Medicaid and Global Commitment (formerly Home and Community Based) Waiver Personal Assistance Services for People with Developmental Disabilities, also known as the Developmental Services (DS) Waiver. For individuals who are both potential consumers of long-term-care DS Waiver services and potential enrollees in WPWD Medicaid, eligibility criteria are sometimes interpreted more restrictively than is required by federal regulations. Though the Centers for Medicaid and Medicare Services has encouraged states since 2000 to allow Medicaid Buy-In eligibility to establish financial eligibility for personal assistance services for people with disabilities<sup>16</sup>, there is no clear written policy in Vermont to allow this under the DS Waiver. The lower resource or asset limits in the DS Waiver program are frequently a problem for DS Waiver enrollees who are working, and patient share contributions are not required under WPWD Medicaid as they are for DS-Waiver-only enrollees. To resolve this problem, an explicit statement might be added to the State Plan under Global Commitment that WPWD Medicaid enrollment establishes financial eligibility for the DS Waiver program.

QMB/SLMB Interaction. The interaction of rules for the State's Medicare Part B premium subsidy programs (QMB/SLMB) with the WPWD Medicaid program also cause problems for enrollees. WPWD income disregards don't apply to QMB/SLMB eligibility, so WPWD Medicaid enrollees with significant levels of earnings may lose their QMB/SLMB eligibility in which the State would pay their Medicare Part B premium. The Social Security Administration has made it clear<sup>17</sup> that the State has the option and authority to fix this problem by paying Medicare Part B premiums out

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<sup>15</sup> Gimm, Gilbert, et al.. "The Three E's: Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2006." Washington DC: Mathematica Policy Research, Inc., April 11, 2008. Available at <http://www.mathematica-mpr.com/disability/medicaidbuy-in.asp>.

<sup>16</sup> Medicaid Infrastructure Grant solicitations, requirements for personal assistance services, 2000 to present; pages 15 and 33 of the 2009 Medicaid Infrastructure Grant solicitation, HHS-2009-CMS-MIG-0001.

<sup>17</sup> Social Security Administration, POMS Section HI 01001.205.

of Medicaid for beneficiaries at higher levels of income. Many people with disabilities are very fearful of losing healthcare benefits of any kind, even when new earnings might outweigh the cost of the monthly premium (which is currently \$96.40 for WPWD eligibles). WPWD enrollees whose earnings might put them over QMB/SLMB income limits have 3 options: Pay Medicare Part B premiums out-of-pocket, drop the Medicare Part B coverage, or limit their earnings to stay under the QMB/SLMB eligibility limits. Limiting earnings obviously undercuts the work incentive function of the WPWD program, and DVR benefits counselors report seeing a substantial number of cases where WPWD enrollees drop their Medicare Part B coverage, under the rationale that their Medicaid will pay those healthcare costs. When people drop their Part B coverage, however, costs to State increase, and the person will pay a financial penalty when they resume Part B at some future date. In an August 2006 analysis,<sup>18</sup> among a sample of 1,204 individuals who enrolled in WPWD between 1/1/2000 and 12/31/2003, Medicaid expenditures were found to average \$1,280 per month in inflation-adjusted year-2008 dollars<sup>19</sup> over a two-year time period following initial enrollment. Claims for outpatient services (including mental health services) in the first three years of WPWD averaged 58% of WPWD expenditures, while pharmaceuticals averaged approximately 30% of WPWD expenditures<sup>20</sup>. As the pharmaceutical expenses of most WPWD enrollees are now paid predominantly by Medicare Part D, outpatient services now likely constitute about 80% of expenditures. Even if many mental health outpatient services are not covered by Medicare Part B, the potential savings to the State by paying Part B premiums for all WPWD enrollees could be substantial. As of 9/30/08, there were 684 current enrollees in the program. Just one or two doctor visits a month for any beneficiary would repay the cost of the Part B premium to the State. Future analysis would be needed, however, to determine the exact number of WPWD individuals who have dropped their Medicare Part D coverage and the exact amount of potential savings for the State if it were to pay those Medicare Part D premiums.

## Summary and Recommendations

### Summary.

- Compared to 35 other state Medicaid Buy-In programs across the country, Vermont's Working People With Disabilities (WPWD) Medicaid program has more restrictive eligibility criteria than many of those programs. While only 7 other states have higher overall or earned income limits, 25 states have higher asset limits, 15 disregard spousal income, 17 disregard spousal assets, and 23 have some form of grace period or work-stoppage protection.
- Despite having more restrictive eligibility criteria than the Medicaid Buy-In programs of many other states, Vermont's WPWD Medicaid program ranks relatively high in terms of program penetration, or population coverage. In the latest available statistics, in 2006 Vermont's WPWD Medicaid program had enrolled 292 individuals per 10,000 state

<sup>18</sup> Vermont Division of Vocational Rehabilitation, Preliminary Cost-Benefit Analysis of Vermont's Medicaid Buy-In, August, 2006. Available at [http://www.dail.state.vt.us/dvr/vocrehab/vwii/assets/docs/VT\\_MBI\\_Prelim\\_CostBen.pdf](http://www.dail.state.vt.us/dvr/vocrehab/vwii/assets/docs/VT_MBI_Prelim_CostBen.pdf).

<sup>19</sup> \$1,024 dollars per month in year-2000 dollars, adjusted to year-2008 dollars using the Consumer Price Index - Urban (CPI-U), by a factor of 1.25.

<sup>20</sup> Vermont Division of Vocational Rehabilitation, Medicaid for Working People With Disabilities: Chartbook on Vermont's Medicaid Buy-In Program, October, 2003.

residents, aged 16 to 64, who reported an employment-related disability on the 2006 American Community Survey. That placed Vermont 7th highest out of the 32 states with Medicaid Buy-In programs in 2006. The median rate across the 32 state Medicaid Buy-In programs in 2006 was 70.5 enrollments per 10,000 individuals.

- In Vermont, spousal income and assets are likely a barrier to WPWD Medicaid eligibility for a substantial portion of individuals who would otherwise be eligible for the program, as roughly half of the eligibility pool is married, judging by current Social Security Administration statistics. In addition, in a much smaller number of cases, an acute work disincentive is created by current Medicaid rules in Vermont for WPWD-eligible individuals who may cause their spouses on non-WPWD Medicaid to lose coverage if they were to earn at substantial levels.
- A direct accounting of the number of employed individuals with disabilities in Vermont who are not on the WPWD Medicaid program, the reasons why, and the types of health coverage they have, is not available. Current eligibility determination records do not record, in an accessible way, all the programs for which an individual may have been assessed, or all possible reasons for ineligibility. Estimates, therefore, have been made more indirectly, on the basis of population statistics and the coverage histories of known eligibles.
- National analyses of the relationship between program characteristics and employment outcomes have found that higher employment rates and earnings levels are associated with shorter grace periods, higher earned income limits, and work verification requirements.
- Roughly half of employed individuals with disabilities in Vermont who are not on WPWD Medicaid appear to obtain healthcare coverage in Medically-Needy categories of Medicaid. Another 40% are on other forms of Medicaid, and the remaining 10% are on State-only programs or have no coverage at all provided through the State. All those alternative public programs involve spend-downs and income and asset limits that can serve as a disincentive to work.
- 94% of WPWD Medicaid enrollees since 1/1/2000 have also had Medicare.
- Given current employment patterns for people with an employment disability, as defined by the Social Security Administration, it is estimated that approximately 68% of the population of potential WPWD eligibles are currently enrolled in the program, leaving 153 to 305 potential enrollees not on the program. An unknown portion of those individuals may currently be on other forms of Medicaid in Vermont, however, possibly due to low earnings. If the employment rate for individuals with SSA-defined disabilities were to increase statewide, the eligibility pool for WPWD would increase proportionally.
- A lack of clear written policy currently prevents potential consumers of the Developmental Services (DS) Waiver program from either accessing DS services through the WPWD Medicaid program or earning and saving as much as they would be allowed under the WPWD program.
- There is a potential for the State to achieve substantial cost savings in Medicaid claims expenditures in the WPWD program if it were to pay Medicare Part B premiums for some WPWD enrollees who would otherwise drop their Medicare Part B coverage. Further study would be required to precisely estimate the amount of potential savings, but for every WPWD enrollee who drops Part B coverage, one or two Part-B-covered outpatient expenditures a month would likely exceed the cost of the Part B premium to the State, currently set at \$96.40 per month.

Recommendations Regarding Options

The following are options<sup>21</sup> available to the State for increasing utilization of the WPWD Medicaid program and/or enhancing its work incentive function, along with associated general cost implications. More specific cost/benefit analyses would be required, however, for any particular changes considered for the WPWD program that might involve new expenditures, expand eligibility, or involve information technology (IT).

1. Vermont has the option to increase or effectively eliminate the income limits and/or the asset limits of the WPWD Medicaid program, through the provisions of Section 1902(r)(2) of the Social Security Act. If Vermont were to do so, population estimates presented suggest that such a change could increase the potential eligibility pool for WPWD by up to 44%, or from 956 to 1,372 individuals, at current rates of employment among SSA disability beneficiaries. If a significantly greater proportion of SSDI beneficiaries in Vermont were to engage in employment than is consistent with historical experience, however, the potential eligibility pool for WPWD Medicaid would increase proportionally beyond that level.
  - a. DCF has indicated that they will need more staff if the WPWD program were to expand.
2. In order to protect the healthcare coverage of enrollee spouses who are on non-WPWD Medicaid to support a consistent work incentive under WPWD Medicaid, the State could consider disregarding the earnings of WPWD enrollees for all Medicaid eligibility determinations, for any individuals, and not just those of the WPWD enrollees themselves. Because few WPWD enrollees would be likely to sacrifice their spouse's Medicaid coverage for moderately higher personal income, this change would be unlikely to substantially affect enrollment levels or expenditures under the program, but it would enhance the work incentive function of the WPWD program for enrollees with Medicaid-covered spouses.
3. Vermont has the option to disregard spousal income in WPWD eligibility determination, as 15 other states do, and to disregard spousal assets, as 17 other states do. If Vermont were to disregard spousal income and assets completely for WPWD eligibility, Rows f through l of Table 1 above suggest that such a change could increase the potential eligibility pool for WPWD by up to 44% (from 956 to 1,372 individuals, at current rates of employment among SSA disability beneficiaries). (An increase in the eligibility pool by a full 44% is unlikely, however, because that would only occur if all VT SSDI workers screened out by WPWD financial eligibility rules fail the tests due to spousal income or spousal assets.)
4. The State could consider adding a grace period, or work stoppage protection, to the program, during periods of hospitalization and during receipt of unemployment compensation, for those individuals who were on WPWD Medicaid immediately prior to those events. Limiting this grace period only to individuals who were on WPWD Medicaid immediately prior to hospitalization or the period of unemployment would likely avoid new costs, because those individuals would otherwise be returning to the regular Medicaid rolls anyway, and the grace period would simply reduce disruptions in coverage and the administrative costs of enrollment "churning" across programs.

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<sup>21</sup> While these options have been numbered for easier reference, no attempt is made here to prioritize among them.

5. An explicit statement could be added to the State Plan under the Global Commitment Waiver to make it clear that WPWD Medicaid enrollment establishes financial eligibility for the Developmental Services (DS) Waiver program. WPWD enrollees, however, would still need to meet the clinical eligibility and priority-of-funding criteria of the Waiver to obtain Waiver services. Because the latter criteria would still limit enrollment levels of the DS Waiver, the primary effect of such a change would be to open up the work incentive provisions of the WPWD program to DS Waiver enrollees.
6. The State could explore paying the Medicare Part B premiums of all WPWD enrollees who would otherwise drop Medicare Part B coverage. Maintaining Medicare Part B coverage for WPWD enrollees has potential financial benefits for both the State and beneficiaries. Further study would be required to precisely estimate the amount of potential savings, but for every WPWD enrollee who drops Part B coverage, one or two Part-B-covered outpatient expenditures a month for that individual would likely exceed the cost of the Part B premium to the State, currently set at \$96.40 per month. Maintaining the Medicare Part B coverage of enrollees would protect individuals from financial penalties they would otherwise face in the future when they need to re-enroll.
7. DAIL could work through the benefits counselors of the Division of Vocational Rehabilitation and the Vermont Center for Independent Living to conduct outreach for increasing awareness of the Medicaid for Working People with Disabilities program and other work incentives. Such outreach could include regional trainings for service providers, regional trainings for consumers and their families, and website materials supported by print and radio campaigns. Costs would depend on the extent and nature of any new outreach implemented.

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## List of Appendices

- Appendix A: Letter to Senator Virginia V. Lyons from the Commissioner of the Department of Disabilities, Aging and Independent Living, March 21, 2008.
- Appendix B: Text of Senate Bill 279, of the 2007-2008 Legislative Session.
- Appendix C: Index of Policy Sources for WPWD Medicaid.
- Appendix D: Selected Characteristics of State Buy-In and Medicaid Programs, 2006. Reprinted with permission from: Table A2. Gimm, Gilbert, et al.. The Three E's: Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2006. Washington DC: Mathematica Policy Research, Inc., April 11, 2008.
- Appendix E: "Vermont's Medicaid Buy-In Program - Options for Change," memo from Sara Salley of the National Consortium for Health Systems Development, September 30, 2004.
- Appendix F: Centers for Medicare and Medicaid Services. Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers. May 11, 2001.

**Appendix A: DAIL Letter to Senator Virginia V. Lyons**

Commissioner's Office  
103 South Main Street, Weeks 2  
Waterbury VT 05671-1601  
Voice 241-2401/TTY 241-3557  
Fax (802) 241-2325

March 21, 2008

Senator Virginia V. Lyons  
Statehouse  
115 State Street  
Montpelier, Vermont 05633-5301

Re: S.279

Dear Senator Lyons:

I wanted to provide you with some information about S.279, which you introduced during this session. I believe we can satisfy the intent of the bill without legislation. The bill mandates that the Secretary of the Agency of Human Services (AHS) convene a task force to study the impact of current financial eligibility rules on population eligibility for the Medicaid for Working People With Disabilities (WPWD) program. The task force would be required to report findings and recommendations to the Legislature by January 1, 2009.

The bill also states that this study would be conducted "in order to promote greater employment opportunities and ensure access to health coverage for Vermonters with disabilities"; a goal shared by this Department. We have communicated with the Office of Vermont Health Access (OVHA), and the Economic Services Division of the Department for Children and Families (DCF) and both divisions have agreed to assist with this study. We have all agreed that we have the resources and commitment within AHS to conduct the study as proposed, without the need for legislation.

Please accept this letter as my commitment that our Department will work with OVHA and DCF to produce the study and report called for by S.279, as introduced, and that we will send you that report by January 1, 2009. I hope you will agree that legislation is not needed for us to accomplish the action called for in the bill.

I would be glad to discuss this with you and can be reached at 241-2401, by cell phone (505-8996) or e-mail ([joan.senecal@ahs.state.vt.us](mailto:joan.senecal@ahs.state.vt.us)).

Sincerely,

Joan K. Senecal  
Commissioner

cc: Deborah Lisi-Baker, Director, Vermont Center for Independent Living

**Appendix B: Text of Senate Bill 279  
of the 2007-2008 Legislative Session.**

S.279

Introduced by Senator Lyons of Chittenden District

Referred to Committee on

Date:

Subject: Health care; health insurance; disabilities; employment

Statement of purpose: This bill proposes to expand incentives for access to employment and Medicaid for Vermonters with disabilities.

AN ACT RELATING TO THE WORKING PEOPLE WITH DISABILITIES TASK FORCE

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. WORKING PEOPLE WITH DISABILITIES TASK FORCE

(a) In order to promote greater employment opportunities and ensure access to health coverage for Vermonters with disabilities, the secretary of human services shall convene a task force to determine the impact of the state's limits on assets and household income on the ability of employed individuals to access Vermont's Medicaid for Working People with Disabilities benefit.

(b) Members of the task force shall include representatives from the vocational rehabilitation division of the department of disabilities, aging, and independent living; the office of Vermont health access; the economic services division of the department for children and families; the Vermont Center for Independent Living; and Vermont Protection and Advocacy.

(c) The task force shall review available data on the health insurance status of employed individuals with disabilities to determine whether their ability to access needed health coverage or retain employment has been affected by the state's current asset and income limits. The task force shall also consider the effect of spousal income on these individuals' access to health care.

(d) The task force shall report to the senate committee on health and welfare and the house committees on health care and on human services by January 1, 2009 regarding its findings, any administrative barriers to collecting information, its recommendations for changes to the asset and income limits, if any, and viable outreach strategies for increasing awareness of the Medicaid for Working People with Disabilities program and other work incentives.

**Appendix C: Index of Policy Sources for Medicaid for Working People With Disabilities  
(WPWD)**

As of 11/11/2008

**Legislative Authority: Federal**

(WPWD Medicaid is referred to at the federal level as the Medicaid Buy-In Program.)

**Balanced Budget Act of 1997, PL 105-33, Sec. 4733:**

SEC. 4733. STATE OPTION TO PERMIT WORKERS WITH DISABILITIES TO BUY INTO MEDICAID.

Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended--

- (1) in subclause (XI), by striking `or' at the end;
- (2) in subclause (XII), by adding `or' at the end; and
- (3) by adding at the end the following:

`(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income (subject, notwithstanding section 1916, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);'

**Social Security Act, Sec. 1902. [42 U.S.C. 1396a]**

SEC. 1902(r)(2)

(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1905(p) may be less restrictive, and shall be no more restrictive, than the methodology—

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be “no more restrictive” if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

**Legislative Authority: State**

**Vermont Act 62, Section 121h** (1999)

**Vermont Act 66, Section 147**

**Vermont Act 122, Section 129** (6/10/04; Elimination of Premiums)

**Vermont Act 56 (H.543), Section 4** (signed 6/14/05; Increase in unearned income disregards and resource limits; evidence of work specified).

Sec. 4. Sec. 121(h) of No. 62 of the Acts of 1999 is repealed and 33 V.S.A. § 1902 is amended to read:

§ 1902. QUALIFICATION FOR MEDICAL ASSISTANCE

(b) Workers with disabilities whose income is less than 250 percent of the federal poverty level shall be eligible for Medicaid. The income also must not exceed the Medicaid protected income level for one or the supplemental security income (SSI) payment level for two, whichever is higher, after disregarding all earnings of the working individual with disabilities, any Social Security disability insurance benefits, and any veteran's disability benefits. Earnings of the working individual with disabilities shall be documented by evidence of Federal Insurance Contributions Act tax payments, Self-employment Contributions Act tax payments, or a written business plan approved and supported by a third-party investor or funding source. The resource limit for this program shall be \$5,000.00 for an individual and \$6,000.00 for a couple at the time of enrollment in the program. Assets attributable to earnings made after enrollment in the program shall be disregarded.

**Sec. 5. EFFECTIVE DATE**

This act shall take effect upon passage.

**State Medicaid Director (SMD) Letters from the Centers for Medicare and Medicaid Services**

SMD Letter Dated November 24, 1997

Introduces the BBA Medicaid Buy-In option, and specifies the two-step financial eligibility determination process.

<http://www.cms.hhs.gov/smdl/downloads/SMD112497c.pdf>

SMD Letter Dated March 9, 1998

Revises the two-step financial eligibility determination process from use of gross income in Step 1 to the use of SSI net income in Step 1.

<http://www.cms.hhs.gov/smdl/downloads/SMD030998.pdf>

**Medicaid State Plan**

Page 23d, Attachment 2.2-A

Page 12c, Attachment 2.6-A

Page 3, Supplement 8b to Attachment 2.6A

Initial Amendment: Transmittal Number 00-001, Submitted 03/31/2000:

[\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD\\_Regulations2008+\StatePlanAmendTransmittal\VT00\\_001.pdf](\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD_Regulations2008+\StatePlanAmendTransmittal\VT00_001.pdf)

**DCF Policy Manual Citations**

(WPWD Medicaid Category Codes: BD = Fee-For-Service; B6 = Managed Care)

Manual

Reference      Topic and Link(s)

7101.2

(M103.2) C. Managed Care Cost Sharing (Co-payments)

[\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD\\_Regulations2008+\B03\\_17F.pdf](\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD_Regulations2008+\B03_17F.pdf)  
(10/27/2003)

7101.3

(M103.3) E. Cost Sharing for Primary Care Case Management Program (Co-payments)

[\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD\\_Regulations2008+\B03\\_17F.pdf](\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD_Regulations2008+\B03_17F.pdf)  
(10/27/2003)

4124

(M115) Choice of Category

Option to split the household for financial eligibility determination, if there is an ANFC-eligible child in the household.

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(10/01/1990)

[\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD\\_Regulations2008+\B93\\_02x.pdf](\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD_Regulations2008+\B93_02x.pdf)  
(02/01/1993)

[\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD\\_Regulations2008+\PP&D950503.pdf](\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD_Regulations2008+\PP&D950503.pdf)  
(05/03/1995)

4161

(M150.1)

Cost Sharing Requirements

(Premiums; Fee-For-Service Co-payments; Exemptions from Co-payments)

Partial Update: [http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin\\_05\\_09.pdf](http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin_05_09.pdf)  
(03/21/05)

Full Text:

[\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD\\_Regulations2008+\B03\\_17F.pdf](\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD_Regulations2008+\B03_17F.pdf)  
(10/27/2003)

Note: Premiums for WPWD formally eliminated in VT Act 122, Section 129, effective 06/10/04.

4202.3

(M200.23) c.

Long-Term Care Medicaid Coverage Group Inclusion for Personal Assistance Services.

Qualification for home-based care under the waiver serving the aged and disabled [Home & Community Based Services Personal Assistance Services]. "Clarifies that the special income group is a distinct optionally categorically needy coverage group from the working people with disabilities group. Both groups qualify for home-based waiver services if additional criteria are met."

[http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin\\_05\\_19F\\_0.pdf](http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin_05_19F_0.pdf)

4202.4

(M200.24) b.

Eligibility for Medicaid for Working People With Disabilities (WPWD) (Two-Step Test), and Resource Maximums.

[http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin\\_05\\_25F.pdf](http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin_05_25F.pdf) (9/22/2005)

4213.1

(M211.21)

Exemption from Substantial Gainful Activity (SGA) in Disability Determination

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(07/16/2003)

4248.8

(M232.88)

Savings from Earnings as Excluded Income

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(07/16/2003)

4280.1

(M242.1) f.

Earned Income Exclusions for Eligibility, Specific to WPWD

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(07/16/2003)

4280.2

(M242.2) gg. Unearned Income Exclusions for Eligibility, Specific to WPWD  
[http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin\\_05\\_25F.pdf](http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin_05_25F.pdf) (09/22/2005)  
& Interpretive Memo dated 07/01/2004.

4281

(M243) General Rules for Determining Countable Income  
[\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD\\_Regulations2008+/B02\\_11.pdf](http://ahs.ahsfiles\DAIL\Share\ALLDAIL\WPWD_Regulations2008+/B02_11.pdf)  
(07/16/2003)

4281.5-.6

(M243.5-.51) Countable Income for Long-Term Care Waiver Services  
[http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin\\_05\\_19F\\_0.pdf](http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin_05_19F_0.pdf) (08/30/2005)

4281.7

(M243.52) Countable Income Exception for WPWD in Long-Term Care Eligibility  
Determinations for Home & Community Based Services Personal Assistance  
Services.  
[http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin\\_05\\_19F\\_0.pdf](http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin_05_19F_0.pdf) (08/30/2005)

4283

(M245.1) SSI Earned Income Deduction for Eligibility (\$65 plus one-half remainder)  
[\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD\\_Regulations2008+/B02\\_11.pdf](http://ahs.ahsfiles\DAIL\Share\ALLDAIL\WPWD_Regulations2008+/B02_11.pdf)  
(07/16/2003)

4284

(M245.2) SSI General (Unearned) Income Deduction for Eligibility (\$20)  
[\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD\\_Regulations2008+/B02\\_11.pdf](http://ahs.ahsfiles\DAIL\Share\ALLDAIL\WPWD_Regulations2008+/B02_11.pdf)  
(07/16/2003)

7501.1

(M801) Prescription Drug Coverage for Dual Medicare/Medicaid Beneficiaries  
[http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin\\_05\\_24F\\_0.pdf](http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin_05_24F_0.pdf)

P-2420 B.1. Monthly Income Standards based on Federal Poverty Level  
[http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin\\_07\\_50.pdf](http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin_07_50.pdf)

P-2420 B.3. Ranges for Program Fees (Premiums) [None- discontinued in 2004]  
[http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin\\_07\\_50.pdf](http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin_07_50.pdf)

P-2421 E Medicaid for Working People With Disabilities (WPWD) Procedures  
[http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin\\_06\\_38F.pdf](http://dcf.vermont.gov/sites/dcf/files/pdf/Bulletin_06_38F.pdf) (11/01/2006)

P-2441 D. Good Cause and Hardship Related to Medicare Part D Prescription Drug Plans  
[\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD\\_Regulations2008+\B06\\_03.pdf](\\ahs\ahsfiles\DAIL\Share\ALLDAIL\WPWD_Regulations2008+\B06_03.pdf)  
(05/10/2006)

### Appendix D: Selected Characteristics of State Buy-In and Medicaid Programs, 2006

(Reprinted with permission; Table A2, "The Three E's: Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2006", Mathematica Policy Research, Inc., April 2008; with supplemental information for TX and VA from Mathematica Policy Research, Inc., September 12, 2008\*.)

	Alaska	Arizona	Arkansas	California
Implementation date	July 1999	January 2003	February 2001	April 2000
Federal authority	BBA	Ticket Act Basic and Medical Improvement	Ticket Act Basic	BBA
Income eligibility	Earned income: Up to 250% FPL for Alaska <sup>a</sup> (includes spousal income) Unearned income must be at or below \$1,119 per month	Up to 250% FPL of earned income (excluding spousal income).	Up to 250% FPL net personal income (earned plus unearned, after SSI income exclusions); unearned income must be less than SSI standard plus \$20. Spousal income not counted.	Up to 250% FPL (includes spousal income, excludes SSDI benefits)
Individual asset limit	\$2,000 (individual) \$3,000 (couple)	N/A	\$4000 individual,	\$2,000 (excludes spousal resources)
Medically needy income limit (monthly)	N/A	N/A	\$108	\$600
Income standard for poverty-level Medicaid (monthly)	\$1,119	\$851	N/A	\$1,047 (includes a \$230 disregard)
SSI Benefit (combined federal and state) (monthly)	\$965 <sup>b</sup>	\$623	\$603	\$836
1619(b) income threshold (monthly)	\$4,126	\$2283.41	\$2,207	\$2,562
Premium threshold	100% FPL	\$500 of monthly earned income	N/A	Net countable income of \$1
Premium structure	A sliding-scale premium as a fixed percentage of income. The maximum premium is 10 percent of net family income.	Sliding scale premium not to exceed 2% of net earned income	No premium required. Co-payments higher than those for regular Medicaid are required when income is above 100% FPL.	A sliding-scale premium is based on net countable income. For income from \$1 up to 250% FPL, premiums range from \$20 to \$250 for an individual and \$30 to \$375 for a couple.
Income verification requirements	Eligibility is based entirely upon receipt of earned income, which includes spousal income. Not required to demonstrate that income and FICA taxes are being paid.	Must document social security and FICA taxes are being paid	Required to demonstrate that earned income is reported to the IRS (see statement at comment DHS5)	Proof of employment (e.g., pay stubs or written verification from the employer). Self-employed or contractor provide records (e.g., W-2 forms, 1099 IRS form). Not required to demonstrate that income and FICA taxes are being paid.
Work stoppage protection	None	N/A	Up to six months given that participant states his/her intention to return to work	If an enrollee is out of work "for good cause" – such as being laid-off, a worksite closure, health problems due to one's disability, or a loss of current transportation with no other means of transportation – a 2 month grace period is granted

<sup>a</sup>Federal poverty guidelines for Alaska are higher than those for the 48 contiguous states

<sup>b</sup>Alaska provides Medicaid coverage to people with disabilities receiving only the SSI supplement who have countable income up to \$1,075 per month.

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	Connecticut	Illinois	Indiana	Iowa
Implementation date	October 2000	January 2002	July 2002	March 2000
Federal authority	Ticket Act Basic and Medical Improvement & BBA (added 10/2006)	Ticket Act Basic	Ticket Act Basic	BBA
Income eligibility	Up to \$75,000 per year (excludes spousal income)	Up to 200% FPL (includes spousal income)	Up to 350% FPL (excludes spousal income)	Up to 250% FPL (includes spousal income)
Individual asset limit	\$10,000 (individual) \$15,000 (couple)	\$10,000 (includes spousal resources)	\$2,000 (excludes spousal resources)	\$12,000 (individual) \$13,000 (couple)
Medically needy income limit (monthly)	\$477	\$283	\$564	\$483
Income standard for poverty-level Medicaid (monthly)	N/A	\$816	N/A	N/A
SSI Benefit (combined federal and state) (monthly)	\$771	Individually budgeted	\$579	\$579
1619(b) income threshold (monthly)	\$3,935	\$2,390	\$2,433	\$1,891
Premium threshold	200% FPL	100% FPL	150% FPL	150% FPL
Premium structure	Premiums equal 10% of total income above 200% FPL	Premium payment categories are calculated based on the sum of 7.5% of unearned and 2% of earned income.	Based on percentage of applicant and spouse's gross income according to family size.	Based on sliding scale premium schedule with 16 premium brackets, ranging from \$27 to \$422
Income verification requirements	Must have payroll taxes, including FICA, taken out of wages, unless self-employed. If self-employed, must provide tax forms or legitimate business records.	Employment must be verified by pay stubs and employer documents that income is subject to income taxes and FICA.	Must have pay stubs and documentation that enrollee is paying income and FICA taxes.	Must have earned income verifiable by pay stubs, completed tax forms, or a signed statement from a person's place of work. Not required to demonstrate that income and FICA taxes are being paid.
Work stoppage protection	Enrollees may continue enrollment for up to 12 months if job loss due to (1) health crisis or (2) involuntary job dismissal and participant intends to return to work. The participant must continue to pay monthly premium based on remaining income.	Up to 90 days if premiums are paid and a letter from a physician is submitted stating that the enrollee is unable to work due to health problems.	Enrollment can continue for up to 1 year after losing employment.	6 months

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	Kansas	Louisiana	Maine	Maryland
Implementation date	July 2002	January 2004	August 1999	April 2006
Federal authority	Ticket Act Basic and Medical Improvement	Ticket Act Basic	BBA	Waiver 1115
Income eligibility	Up to 300% FPL (includes spousal income)	Up to 250% FPL (excludes spousal income)	Up to 250% FPL on total income, up to 100% FPL on unearned income (includes spousal income)	Up to 250% FPL (including spousal income)
Individual asset limit	\$15,000 (includes spousal resources)	\$25,000 (excludes spousal resources)	\$8,000 (includes spousal resources)	\$10,000 (includes spousal resources)
Medically needy income limit (monthly)	\$475	\$100	\$315	
Income standard for poverty-level Medicaid (monthly)	N/A	N/A	\$872	
SSI Benefit (combined federal and state) (monthly)	\$603	\$603	\$603 + \$55 income disregard for state SSI supplement and \$10 state supplemental check	Ranges from \$669-\$1,269 depending on level of supervision needed
1619(b) income threshold (monthly)	\$2,405	\$2,090	\$3,153	\$2,772
Premium threshold	100% FPL	150% FPL	150% FPL	Flat rate
Premium structure	Sixteen premium amounts based on income brackets from \$55 to \$152 for individual and \$74 to \$205 for two or more. Cannot exceed 7.5% of income.	\$80 for 150%- 200%, \$110 for 200%-250% FPL	\$10 premium for 150%-200% FPL, \$20 for 200%-250% FPL	
Income verification requirements	Employment must be verifiable by pay stubs and employer documents that income is subject to FICA taxes.	Required to demonstrate that income and FICA taxes are being paid	Must have earned income. Not required to demonstrate that income and FICA taxes are being paid.	
Work stoppage protection	6 months	Individuals in the Buy-In who lose their jobs can retain their MPP eligibility for up to 6 months provided they intend to return to the workforce.	None.	

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	Massachusetts	Michigan	Minnesota	Mississippi
Implementation date	July 1997	January 2004	July 1999	July 1999
Federal authority	1115 Demonstration Waiver	Ticket Act Basic	BBA (prior to Oct 2000), Ticket Act Basic (as of Oct 2000)	BBA
Income eligibility	No limit	No earned income limit. Unearned income limit is 100% FPL (excludes spousal income)	No upper income limit. Must have monthly wages or self-employment earnings of more than \$65. (Excludes spousal income)	Earned income limit is 250% FPL; Unearned income limit is 135% FPL.
Individual asset limit	No limit	\$75,000 (excludes spousal resources)	\$20,000 (excludes spousal resources)	\$24,000 (individual) \$26,000 (couple)
Medically needy income limit (monthly)	N/A <sup>a</sup>	\$350	\$798	N/A
Income standard for poverty-level Medicaid (monthly)	The income standards are variable depending on the population, ranging from 100% - 200% FPL (\$797 - \$1595 for a family of 1)	\$817	\$798	135% FOL for aged/disabled individuals without Medicare coverage (1115c waiver). Individuals with Medicare are covered under the Medicare cost-sharing groups
SSI Benefit (combined federal and state) (monthly)	\$693	\$617 (Includes \$603 federal and \$14 state supplement)	\$645	\$603
1619(b) income threshold (monthly)	\$2,649	\$1,780	\$3,294	\$1901
Premium threshold	100% FPL	250% FPL	All enrollees must pay a minimum premium of \$35.	150% FPL
Premium structure	Premiums based on two different sliding scales—one for enrollees with other health coverage, one for enrollees without it. Premiums begin at <b>100%</b> and increase in increments of <b>\$5 to \$16</b> based on 10% increments of the FPL.	Based on sliding scale ranging from \$50 to \$920 per month.	Premiums based on a minimum of \$35 or a sliding fee scale based on income and household size. The premium gradually increases to 7.5% of income for incomes equal to or above 300% of FPL. Must also pay 0.5 percent of unearned income. No maximum premium amount.	Premiums payable on a sliding scale based on 5% of countable earnings up to 250% FPL limit. Unearned income is not factored into premium structure.
Income verification requirements	Demonstrate at least 40 hours of work per month.	Must be employed on a regular and continuing basis. Not required to demonstrate the income or FICA tax payment.	Earned monthly income above \$65. Required to demonstrate that FICA taxes are being paid.	All earnings and work hours are verified. A minimum of 40 hours per month of paid activity must exist to qualify.
Work stoppage protection	Up to 3 months if the participant maintains premium payments.  Eligibility is re-determined when the participant reports job loss.	Up to 24 months if the result of an involuntary layoff or determined to be medically necessary	Up to 4 months if no earned income due to medical condition or involuntary job loss.	N/A.

<sup>a</sup> Massachusetts is unique in that, rather than have a medically needy or spend down program as many other states do, all persons with disabilities who are not eligible for the working benefit plan of CommonHealth (i.e., the state's Buy-In program) are eligible for the non-working benefit plan, which requires that participants meet a one-time deductible to receive coverage.

<sup>b</sup>Massachusetts covers nonworking people with disabilities with incomes at or below 133 percent of the FPL through its Section 1115 demonstration waiver.

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	Nebraska	Nevada	New Hampshire	New Jersey
Implementation date	July 1999	July 2004	February 2002	February 2000
Federal authority	BBA	Ticket Act Basic	Ticket Act Basic	Ticket Act Basic
Income eligibility	Two-part income test: (1) sum of spouse's earned income and applicant's unearned income must be less than SSI standard (\$564 in 2004) <sup>a</sup> ; (2) countable income up to 250% FPL (includes spousal income)	Up to 250% FPL on earned income and \$699 unearned income	Up to 450% FPL on earned income (includes spousal income)	Up to 250% FPL on earned income; up to 100% FPL on unearned income disregarding SSDI benefits received under individual's account (SSN, not survivor's SSN)
Individual asset limit	\$4,000 (includes spousal resources)	\$15,000 (excludes spousal resources)	\$22,694 for an individual; \$34,041 for a married coupleb	\$20,000 (excludes spousal resources)
Medically needy income limit (monthly)	\$392	N/A	\$591	\$367
Income standard for poverty-level Medicaid (monthly)	\$776	\$1060	N/A	\$817
SSI Benefit (combined federal and state) (monthly)	\$687	\$579	\$603	\$634.25
1619(b) income threshold (monthly)	\$2,567	\$2,228	\$3,229	\$2,337
Premium threshold	200% FPL	All enrollees pay at least 5%	150% FPL	150% FPL
Premium structure	Sliding scale based on income ranging from 2% of income if income is from 200% to 210% of FPL to 10% of income if income is from 240% to 250% of FPL.	Enrollees who earn a monthly net income \$1,595 or less pay 5% of income. Those earning more than \$1,595 (up to \$1,994) pay 7.5% of income.	Six brackets from \$91 to \$245 for individuals. Individuals with gross income (spousal included) that exceeds \$75,000 are required to pay premiums of 7.5% of the adjusted gross income starting March 2006 through February 2007.	Flat rate <sup>c</sup> \$25 individual \$50 couple
Income verification requirements	Must have earned income based on pay stubs, employer forms, or tax returns. Not required to demonstrate that income and FICA taxes are being paid.	Must provide proof of employment (pay stub) or self-employment (tax return).	Must be employed (proven with a pay stub or 1099 estimated tax statement for self-employment). Must demonstrate that appropriate FICA contributions are being made. Must not be earning less than the hourly federal minimum wage.	Be employed full or part time. Not required to demonstrate that income and FICA taxes are being paid.
Work stoppage protection	None	Three months, as long as premiums continue to be paid.	Six months with a possible subsequent 6-month grace period if the individual demonstrates medical necessity or has documentation of a proven job search to employers.	Up to 26 weeks if the person has employer paid sick leave, worker's compensation or Temporary Disability Insurance and intends to return to work

<sup>a</sup>In Nebraska, the applicant's unearned income is disregarded if he or she is in an SSDI trial work period.

<sup>b</sup>Participants in New Hampshire who disenroll from the Buy-In program but remain enrolled in Medicaid have "asset continuity," allowing them to keep the assets acquired during Buy-In enrollment in a separate bank account that is excluded from Medicaid eligibility requirements.

<sup>c</sup>New Jersey does not collect premiums because the revenue would be insufficient to offset the administrative costs.

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	New Mexico	New York	North Dakota	Oregon
Implementation date	January 2001	July 2003	May 2004	February 1999
Federal authority	BBA	Ticket Act Basic and Medical Improvement	Ticket Act Basic	BBA
Income eligibility	Up to 250% FPL on earned income, and up to \$1,226/month on unearned income (includes spousal income). Must earn at least \$970 per quarter.	Up to 250% FPL (includes spousal income)	Up to 225% FPL (excludes spousal income)	Up to 250% FPL on adjusted earned income (excludes spousal income) Participants must have minimum earnings of \$900 per quarter.
Individual asset limit	\$10,000 (excludes spousal resources)	\$10,000 (includes spousal resources)	\$13,000 (includes spousal resources)	\$5000 (excludes spousal resources)
Medically needy income limit (monthly)	N/A	\$667	\$500	N/A
Income standard for poverty-level Medicaid (monthly)	N/A	N/A	N/A	\$624.70
SSI Benefit (combined federal and state) (monthly)	\$603 (individual) \$904 (couple)	\$666	\$623	\$624.70 (includes a \$1.70 state supplement) <sup>b</sup>
1619(b) income threshold (monthly)	\$2,512	\$3,131	\$2,747	\$2333
Premium threshold	Not applicable	150% of FPL	All participants are required to pay a premium	After 6 months, income in excess of \$2,400/month; Unearned income above the SSI level
Premium structure	No premium required. Co-payments higher than those for regular Medicaid are required at all income levels; clients' responsibility to keep track of co-payments	3% of net earned income plus 7.5% of net unearned income. Premiums not collected until automated premium collection and tracking processes are available.	5% of an individual's gross income	"Cost share" equal to 100% of unearned income above SSI standard. Premium equal to gross income plus unearned income remaining after "cost share" is paid minus (1) mandatory taxes; (2) approved employment and independence expenses; and (3) 200 percent of FPL, and multiplying the remainder by 2% to 10%.
Income verification requirements	Show that the applicant earned or expects to earn sufficient wages in calendar quarter to count toward Social Security coverage (\$970 in a quarter in 2006) <sup>a</sup> Proof of income or FICA tax payment is required.	Must have earned income and demonstrate that income and FICA taxes are being paid.	May verify earned income with a letter from an employer or a pay stub. Not required to demonstrate that income or FICA taxes are being paid.	Must have at least \$920 per quarter. Not required to demonstrate that income and FICA taxes are being paid.
Work stoppage protection	None	Up to 6 months in a 12-month period for medical reasons and involuntary job loss with intent of returning to work.	May continue enrollment if job loss is due to health problems. If over 3 months, must have a physician's statement.	Must retain a relationship with employer after job loss. Those otherwise eligible for Medicaid will not lose coverage.

<sup>a</sup>New Mexico waives its work requirement for SSDI recipients in the two-year waiting period for Medicare.

<sup>b</sup>Only the participant's income is counted if spousal income is less than half of the SSI standard.

Appendix D

	Pennsylvania	Rhode Island	South Carolina	South Dakota
Implementation date	January 2002	January 2006	October 1998	October 2006
Federal authority	Ticket Act Basic and Medical Improvement	BBA	BBA	BBA
Income eligibility	Up to 250% FPL (includes spousal income)	Up to 250% FPL (excludes spousal income)	Up to 250% FPL (includes spousal income), unearned income must be below SSI standard (\$579)	Up to 250% FPL (excludes spousal income)
Individual asset limit	\$10,000 (includes spousal resources)	\$10,000 (individual) \$20,000 (couple)	\$2,000 (excludes spousal resources)	\$8,000 (excludes spousal resources)
Medically needy income limit (monthly)	\$425	\$753	N/A	N/A
Income standard for poverty-level Medicaid (monthly)	\$817	\$850.83 plus \$20 disregard (individual) \$1140.83 plus \$20 disregard (couple)	\$851	
SSI Benefit (combined federal and state) (monthly)	\$630.40	\$660.35	\$623	\$618
1619(b) income threshold (monthly)	\$2,204	\$2768	\$2,134	\$2,434
Premium threshold	All participants pay a premium	100% FPL	N/A	N/A
Premium structure	5% of countable income. Premiums of less than \$10 are waived.	Dollar for dollar over \$753 for an individual	Premium not required.	No premium is required.
Income verification requirements	Must provide verification of earned income. Not required to demonstrate that income and FICA taxes are being paid.	Must provide verification of earned income. Not required to demonstrate that income and FICA taxes are being paid.	Income verification required, FICA and income tax payment is not.	Must provide verification of earned income and demonstrate that income and FICA taxes are being paid.
Work stoppage protection	May remain in program and have premium waived for up to 2 months if unable to work due to job loss or health problems.	May remain in program and have premium waived for up to 4 months if unable to work due to job loss or health problems.	None	Enrollment may continue for 3 months if enrollee is unable to verify employment.

Appendix D

	*Texas	Utah	Vermont	*Virginia
Implementation date	September 2006	June 2001	January 2000	January 2007
Federal authority	BBA	BBA	BBA	TWWIIA Basic
Income eligibility	Up to 250% FPL (excludes spousal income; must earn \$1,000 per quarter)	Up to 250% FPL (includes spousal income).	Two-part test for family income: 1) Income less than 250% FPL, 2) Income does not exceed either the Medicaid protected income level for one or the SSI/AABD payment level for two, whichever is higher, after disregarding the earnings, SSDI benefits, and any veteran's disability benefits of the individual working with disabilities.	Up to 80% FPL (includes spousal income)
Individual asset limit	\$5,000 (excludes spouse)	\$15,000 (includes spousal resources)	\$5,000 (individual) \$6,000 (couple) Disregards assets accumulated from earnings since enrollment	\$2,000 (includes spousal resources)
Medically needy income limit (monthly)		\$817	\$841	
Income standard for poverty-level Medicaid (monthly)		\$817	N/A	
SSI Benefit (combined federal and state) (monthly)		\$603	\$655	
1619(b) income threshold (monthly)	\$2,315	\$2,193	\$2,638	\$2,298
Premium threshold	150% FPL	100% FPL	N/A	N/A
Premium structure	All unearned income above SSI federal benefit rate (\$623 in 2007), plus \$20-\$40/month depending on FPL category of earned income	100%-110% FPL: 5% premium charged 110%-120% FPL: 10% premium charged Over 120% FPL: 15% premium charged	Premium eliminated in June 2004.	No premiums charged at this time.
Income verification requirements		For wage employment, worker must demonstrate that FICA taxes are being paid. For self-employment, worker must have a tax return or business plan.	Earnings of the working individual with disabilities shall be documented by evidence of FICA tax payments, Self-employment Contributions Act tax payments, or a written business plan approved and supported by a third-party investor or funding source.	
Work stoppage protection		None.	None	

Appendix D

	Washington (State)	West Virginia	Wisconsin	Wyoming
Implementation date	January 2002	May 2004	March 2000	July 2002
Federal authority	Ticket Act Basic and Medical Improvement	Ticket Act Basic and Medical Improvement	BBA	Ticket Act Basic
Income eligibility	220% FPL (includes spousal income) <sup>a</sup>	Up to 250% FPL, unearned income must be equal to or less than SSI benefit (\$584 in 2005) plus \$20 (excludes spousal income)	Up to 250% FPL (includes spousal income)	\$1,809 (applicant gross countable income only)
Individual asset limit	No limit	\$2000 (\$5000 liquid asset exclusion)	\$15,000 (excludes spousal resources)	None
Medically needy income limit (monthly)	\$603	\$200	\$592	N/A
Income standard for poverty-level Medicaid (monthly)	N/A	N/A	N/A	N/A
SSI Benefit (combined federal and state) (monthly)	\$603	\$623	\$683	\$603
1619(b) income threshold (monthly)	\$1,997	\$2,029	\$2,493	N/A
Premium threshold	\$65 earned income and/or \$579 unearned income	All enrollees must pay a minimum premium of \$15	150% FPL	All participants pay a premium
Premium structure	The lesser of (1) 7.5% total income or (2) a total of the following: 50% unearned income above MNIL plus 5% total unearned income plus 2.5% earned income after deducting \$65	Premiums are 3.5% of countable income with a \$15 minimum amount. Enrollees must also pay an enrollment fee of \$50, which includes the first month's premium.	Equal to the sum of (1) 3% of an individual's earned income, and (2) 100% of unearned income minus certain needs and expenses and other disregards. If the second calculation is less than \$25, this component of the premium is \$0.	7.5% earned income and 7.5% of unearned annual income over \$600
Income verification requirements	Must have payroll taxes taken out of wages, unless self-employed. If self-employed, must provide tax forms or legitimate business records	Must be employed and earning at least the minimum wage. Not required to demonstrate that income or FICA taxes are being paid.	Required to either work or participate in an employment counseling program, which one can do for up to a year. Not required to demonstrate that income and FICA taxes are being paid.	Must be employed. No requirement to earn a certain amount of income or work a minimum number of hours each month. Verification of employment must be obtained.
Work stoppage protection	Enrollees may continue enrollment for up to 12 months if job loss due to (1) health crisis or (2) involuntary job dismissal and participant intends to return to work. The participant must continue to pay the monthly premium based on remaining income.	Coverage can continue for up to 6 months after an involuntary loss of employment if participant continues to pay premiums and show proof of job search efforts	Work requirement may be waived for up to one year after initial enrollment provided an employment plan is approved by the Medicaid Agency. <sup>a</sup>	No.

<sup>a</sup>Wisconsin limits the duration and frequency (twice in a five-year period) of enrollment in employment counseling.

## DEFINITIONS OF TERMS [IN APPENDIX D]

Category	Description
Income eligibility	This information describes how much income a program participant is allowed to have in each state. Income eligibility is presented as a percentage of the federal poverty line (FPL). The table also indicates whether the state counts spousal income when determining Medicaid Buy-In eligibility.
Resource limit	This is the maximum level of resources that a participant can accumulate and remain eligible for the Buy-In program.
Medically needy income limit	This is the maximum amount of income a person may have to be eligible for the medically needy or spend down program; one means for persons with disabilities to obtain Medicaid coverage. If a person's income is above this limit, he or she must spend down until his or her income is below it to become eligible for Medicaid through the medically needy program.  We present the monthly limit for an unmarried person with disabilities
Income standard for other categorical Medicaid	This is the income threshold below which an individual with disabilities is categorically eligible for Medicaid.  We present the monthly income threshold for an unmarried person with disabilities to qualify for categorical Medicaid eligibility (for example, the poverty-level option).
SSI benefit (combined state and federal)	SSI benefit (combined state and federal) is the total amount of cash benefits that an SSI recipient receives from the federal and state governments.  The monthly combined federal and state SSI benefit is for an unmarried person with disabilities.
Premium threshold	This is the income level above which Buy-In participants are required to pay a premium.
Premium structure	This determines who pays a premium, how much each participant pays, and how premiums are graded across different income brackets.
Income verification requirements	This describes the procedures for verifying participants' income.
Work stoppage protection	These provisions allow a person with disabilities to remain enrolled in the Buy-In program without earnings

**Appendix E: "Vermont's Medicaid Buy-In Program - Options for Change," memo from Sara Salley of the National Consortium for Health Systems Development, September 30, 2004.**

**NCHSD**

**Memorandum**

**To:** Tim Tremblay  
**From:** Sara Salley  
**Date:** September 30, 2004  
**Re:** Vermont's Medicaid Buy-In Program – Options for Change

Vermont's Medicaid Buy-In program – called *Medicaid for Working People with Disabilities (WPWD)* – allows workers with disabilities to have higher income than the state's other Medicaid categories so they may continue employment without losing access to healthcare coverage. The program serves people age 18 and older.

**States have Authority to Customize their Medicaid Buy-In Programs**

In response to overwhelming evidence that losing access to healthcare coverage is a major barrier to employment for people with disabilities, states received authority to implement optional Medicaid programs with higher income and asset limits first under the Balanced Budget Act of 1997 (BBA), and subsequently the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). These programs are known as "Medicaid Buy-In" programs because workers with disabilities can purchase Medicaid coverage by paying a monthly premium, similar to employer-sponsored health insurance programs.

States may choose to use either the BBA or TWWIIA to create a Medicaid Buy-In (MBI) program to allow people with disabilities to work more and save more. Each law provides a different set of options for states to use in designing their own Buy-In programs.

The BBA authorizes a Buy-In that has no upper age limit, but sets income and asset limits. The BBA's family income limit is 250% of the federal poverty level (FPL) after SSI disregards (\$65 and ½ of unearned income). In addition, enrollees' own unearned income must be below the SSI income standard. The BBA sets an asset limit of \$2,000 per individual.

The TWWIIA law allows states to set their own income and asset limits, but sets an upper age limit of 64. TWWIIA also allows states to cover individuals who are "medically improved" – they enroll in the Buy-In, lose eligibility for federal disability benefits because of medical improvement, but still have a severe impairment.

Table 1 below highlights the differences between the BBA and TWWIIA laws.

Table 1

<b>Medicaid Buy-In Program Features: BBA versus TWWIIA</b>		
	<b>BBA</b>	<b>TWWIIA</b>
<b>Income</b>	Up to 250% FPL (after SSI disregards) and unearned income under SSI standard	State determined
<b>Assets</b>	Up to \$2,000/individual	State determined
<b>Premiums</b>	Sliding fee scale based on income	No more than 7.5% of income
<b>Age Limit</b>	Age 18+	Age 16-64
<b>Medically Improved Group</b>	Not available	State determined

In 2000, Vermont was one of a handful of innovative states to implement a Medicaid Buy-In program. Vermont established this program – called *Medicaid for Working People with Disabilities* or WPWD – under the BBA law for working individuals age 18 and older.

Vermont has already customized its Medicaid Buy-In program to some extent. The WPWD program has a two-part income test. In the first step, unearned income plus ½ of earnings, after certain disregards, must be at or below 250% of FPL. In the second step, certain amounts are deducted from total income and the remainder must be below the Medicaid Protected Income Level for an individual (about \$766 in 2003), or the SSI Payment Level for a couple.<sup>22</sup> The WPWD program also allows enrollees to save their earnings from work without counting them toward the \$2,000 Medicaid asset limit, whether they stay in the WPWD eligibility category or move into a different Medicaid eligibility category.

Currently, more than 500 working people with disabilities in Vermont have Medicaid coverage through WPWD.

Vermont is considering a variety of changes to its WPWD program, such as adjusting the income and asset eligibility tests, changing the premium structure, developing a medically-improved coverage group, and adding a “grace period” if a person loses their job. This memo presents some options for Vermont as it considers modifications to the program.

### **Federal Buy-In Authority Gives Vermont Flexibility to Meet the Healthcare Needs of Employed People with Disabilities**

Vermont has several options to implement changes to WPWD. Below are some key policy questions and responses.

*Can Vermont change the income and asset tests that apply to the existing WPWD Medicaid Buy-In program?* Yes. Even though it was established under the BBA law, which has certain income and asset limits, Vermont has the ability to increase those limits through the use of a specific federal statute – Section 1902(r)(2) of the Social Security Act.

<sup>22</sup> The following income is disregarded: \$20 unearned income; all earned income of the enrollee; \$65 plus ½ of spouse's earned income; \$500 of any SSDI payment.

*What is Section 1902(r)(2)?* Section 1902(r)(2) (hereafter called “Section 1902”) is a provision of federal Medicaid law that permits states to create income and asset methodologies for certain Medicaid eligibility groups. The methodologies must be *less restrictive* than the limits that apply to cash assistance groups (which includes most Medicaid groups).<sup>23</sup> The federal Centers for Medicare and Medicaid Services (CMS) has made it clear that a BBA Medicaid Buy-In constitutes an “eligibility group” to which Section 1902 applies.<sup>24</sup> Section 1902 allows states to raise income and asset limits, or disregard certain kinds of income or assets, or both. For example, Vermont could use Section 1902 to increase or remove the WPWD income cap, raise or remove the asset limit, change how it treats unearned income under the program, or change the type or amount of income that is disregarded in the income calculation.

*Could Vermont use Section 1902 to cover the medically-improved group under its existing WPWD program?* No. Section 1902 only applies to income and asset methodologies. It does not give states the authority to add this coverage group. A Medicaid Buy-In under the TWWIIA law is the only way to cover medically improved individuals.

*Why not replace the existing BBA program with a new TWWIIA altogether?* This is an option for Vermont. A TWWIIA Buy-In would give Vermont the ability to add a medically improved eligibility group as well as the flexibility to implement a range of income, asset and premium options. However, a TWWIIA Buy-In would not cover anyone age 65 or older. (Section 1902 does not offer a way for states to change TWWIIA's age limit.) Vermont's existing BBA Buy-In covers older individuals – they would lose WPWD coverage if Vermont replaced its BBA Buy-In with a TWWIIA Buy-In.<sup>25</sup> Whether these individuals would qualify for other Medicaid coverage in the absence of the WPWD program is something Vermont may want to evaluate.

*How can Vermont provide Medicaid Buy-In coverage to employed people with disabilities of all ages, as well as medically improved individuals?* Instead of *replacing* its existing BBA Buy-In, Vermont could add a *second* Medicaid Buy-In under the TWWIIA authority. The income and asset limits of the existing WPWD program could be changed as desired using Section 1902. And a second TWWIIA Buy-In could be created to cover medically improved individuals, at least up to age 64. Vermont could operate both Buy-In programs with the same income and asset tests, premium structure, and other features. Enrollees in either program would have the same eligibility criteria and benefit package.

*What would happen to people who were in the “medically improved” group when they turn 65?* People in the medically improved group who turn 65 would become eligible for Social Security benefits as “aged” rather than “disabled.” This should protect most people's eligibility for WPWD. However, there may be a coverage gap for people who turn 65 but do not become eligible for Social Security retirement benefits until they are older than that, due to new rules that are gradually raising the Social Security retirement age for future beneficiaries.

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<sup>23</sup> The text of Section 1902(r)(2) can be found in the Appendix. In 2001, the Centers for Medicare and Medicaid issued regulations that clarified how states could apply the less restrictive income limits. See CMS Q&A in Appendix 1.

<sup>24</sup> See CMS Q&A, p. 21.

<sup>25</sup> Among all those who had enrolled in WPWD at any time up to 2003, six percent were age 65 or older.

*Have any other states used both BBA and TWWIIA authorities?*

No, though several states are currently considering using a combination of the BBA and TWWIIA Medicaid Buy-In authorities to establish a program to meet the needs of *all* their workers with disabilities. CMS has stated that operating concurrent TWWIIA and BBA Buy-In programs is an acceptable approach.

*What are the practical implications of operating a second Buy-In program?* Vermont will face additional costs associated with designing and implementing a second Medicaid Buy-In program to cover the medically improved group. These will include staff resources to develop the program, costs associated with modifying information systems to add the new eligibility category, and training, outreach and education to make sure staff, providers and others understand the new Buy-In program. In addition, Vermont may want to invest in outreach to potentially eligible people with disabilities so they are aware of the new Buy-In option. Making the new Buy-In identical to the existing WPWD program, in terms of financial eligibility criteria and other features, will help minimize the training and outreach needs.

*What if Vermont just changes its existing WPWD program, without adding a new Buy-In?* If eligibility criteria are changed to create stronger incentives for workers with disabilities to increase earnings and savings, training and outreach will be very important to make sure staff, providers and the public know about the new incentives.

### **Covering the Medically Improved Group Presents a Challenging Opportunity**

TWWIIA's provisions for the medically improved coverage group offer a unique opportunity for Vermont and other states. The medically improved group includes individuals who may not be eligible for any other category of Medicaid for people with disabilities, regardless of income, because they no longer meet the SSA disability definition. This group may include people whose health is particularly unstable, making access to a stable source of health insurance coverage very important. For example, people whose physical or mental health depends on taking certain medications may experience a marked improvement in health when they have the medications and a marked deterioration when they do not.

In addition, CMS allows states to include a minimum work effort requirement in the eligibility criteria for the medically improved coverage group, which is not permitted under the BBA or TWWIIA's basic coverage group. CMS has stated that 40 hours per month at minimum wage is an acceptable work requirement for eligibility under the medically improved group.<sup>26</sup>

On the other hand, designing and implementing a medically improved coverage group presents certain challenges. Estimating how many individuals might qualify under this coverage group is difficult. Seven states have Medicaid Buy-In programs that cover the medically improved group, but none of them have enrolled anyone in the coverage group. One reason may be states' uncertainty about how to interpret the statutory definition of the coverage group. CMS has provided little guidance to help states define "medically improved." Although promised in 2000, specific guidelines have not yet been issued.

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<sup>26</sup> See August 29, 2000, letter from CMS to State Medicaid Directors, excerpts in Appendix 1.

In the absence of state experience, there is little data to support confident predictions of how many people can be expected to “medically improve.” Social Security data for 2002 show that only a small fraction – about 3% – of SSDI beneficiaries who lost benefits lost them because of medical improvement. Less than 6% of SSI benefit suspensions were due to the beneficiary no longer being disabled.<sup>27</sup>

In summary, Vermont will want to give careful to the following issues as it considers developing a Medicaid Buy-In to cover medically improved individuals:

- ▶ Who would most likely enroll in a medically improved coverage group and what type of services would they most likely use? This will help determine a profile of potential enrollees and their potential Medicaid expenditures.
- ▶ How many people in Vermont are likely to experience medical improvement? SSA data may provide some data to help answer this. Benefits counseling experience may also provide insight.
- ▶ How should Vermont define medical improvement? In the absence of guidance from CMS, Vermont will need to determine its own definition.
- ▶ Does Vermont want to include a minimum work requirement for eligibility in the medically improved group? Vermont must decide whether this is a desirable eligibility criteria.
- ▶ Will access to Medicaid coverage for people with medical improvement serve the goals of Vermont’s Medicaid Buy-In program? Vermont must consider whether the expected outcomes of adding the coverage group are consistent with the program’s goals.

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<sup>27</sup> [Annual Statistical Report on the Social Security Disability Insurance Program, 2003, Table 46;](#) [SSI Annual Statistical Report, 2002, Table 59.](#)

## Appendix

### Social Security Act, Section 1902(r)(2)

(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1905(p) may be less restrictive, and shall be no more restrictive, than the methodology--

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

### Balanced Budget Act of 1997, PL 105-33

SEC. 4733. STATE OPTION TO PERMIT WORKERS WITH DISABILITIES TO BUY INTO MEDICAID.

Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended--

(1) in subclause (XI), by striking ``or" at the end;

(2) in subclause (XII), by adding ``or" at the end; and

(3) by adding at the end the following:

``(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income (subject, notwithstanding section 1916, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);".

### CMS Q&A

Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources Questions and Answers, dated May 11, 2001, on the Web at <http://www.cms.hhs.gov/medicaid/eligibility/elig0501.pdf>.

### August 29, 2000, CMS Letter to State Medicaid Directors (excerpts):

#### Employed Individual with a Medically Improved Disability

To be eligible under the Medical Improvement Group, an individual must be employed, and have a medically improved disability. In the interest of clarity, the following addresses the definitions of "employed individual" and "medically improved disability" as separate topics.

#### B. Employed Individual

For purposes of determining eligibility under the Medical Improvement Group, an employed individual is one who:

- Is at least age 16 but less than 65 years of age; and
- Is earning at least the Federally required minimum wage AND is working at least 40 hours per month; OR is engaged in a work effort that meets an alternate definition of substantial and reasonable threshold criteria for hours of work, wages, or other measures as defined by the State and approved by the Secretary.

**State-Defined Work Effort**

As noted above, a State may establish its own definition of employment that differs from the minimum level of earnings and hours worked per month set forth in the statute. A State's alternative definition of work effort must be approved by HCFA. If a State wishes to establish an alternative definition of work effort, it should do so as part of an amendment to its Medicaid plan to cover the Medical Improvement Group.

At this time HCFA does not plan to approve alternative definitions of work effort that involve an across-the-board change in the statutory number of hours worked per month or level of earnings described above. We believe that Congress intended those levels to serve as the reasonable baseline for work effort for the Medical Improvement Group as a whole, and thus should serve as the standard most individuals eligible under the group should be expected to meet.

However, we recognize that there is considerable diversity among people with disabilities, including relative degrees of disability, the employment opportunities available to them, and many other considerations that can affect types and amounts of work people with disabilities do, and consequently how work effort can be measured. Therefore, we will consider alternative definitions of work effort involving different levels of earnings and/or hours worked for identifiable groups of individuals with disabilities provided the State can clearly define the group involved and explain why the proposed alternative definition is in fact reasonable and necessary for members of that group.

We will also consider alternative definitions of work effort using threshold criteria (and ways of determining if those criteria are met) that do not necessarily rely on measuring earnings levels and/or hours worked. It is quite possible that people with disabilities have access to employment and work opportunities where the number of hours worked or level of earnings is not the best or most valid measurement of the quality of the work effort. An example might be people who are self-employed. We believe States are in the best position to identify such situations and address them through alternative definitions and measurements of work effort. Therefore, we will definitely consider such alternative definitions, where appropriate, as part of an amendment to your Medicaid plan to cover the Medical Improvement Group.

**Appendix F: Centers for Medicare and Medicaid Services. Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers. May 11, 2001.**

[Formatting note: The following content has been merged from a separate .pdf file, and as a result has independent headers, footers, and pagination.]

## **Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources**

### **Questions and Answers**

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On January 11, 2001, CMS published in the Federal Register a final regulation which allows States to take full advantage of the flexibility offered by section 1902(r)(2) of the Medicaid statute (use of less restrictive income and resource methodologies when determining eligibility for Medicaid). Prior to publication of the final regulation, States were greatly restricted in their ability to use less restrictive income methodologies under section 1902(r)(2). The final regulation became effective on May 11, 2001, giving States greater flexibility to use less restrictive income methodologies.

In addition to increasing the flexibility available to States under section 1902(r)(2), CMS has clarified the definition of what an "eligibility group" is for purposes of determining Medicaid eligibility. Under this clarified definition, States can more specifically define the eligibility groups they want to cover under their Medicaid programs. The clarified definition of "eligibility group" also allows States to more specifically target eligibility groups for purposes of using less restrictive methodologies under section 1902(r)(2).

Section 1902(r)(2) is an important tool States can use to improve their long-term care systems for people with disabilities and the elderly. Although the 1902(r)(2) regulation and the clarified definition of Medicaid eligibility groups have implications for families and children, the questions and answers below specifically relate to the aged, blind and disabled. The questions and answers below are meant to provide information on how the 1902(r)(2) regulation and the clarified definition of an eligibility group increase State flexibility to creatively build effective long term care systems for people with disabilities and the elderly.

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**Answers are grouped in the following categories:**

- A. General Application of 1902(r)(2)**
- B. Supporting Community Integration**
- C. Providing Work Incentives**
- D. Miscellaneous**
- E. Technical Issues**

## **A. General Application of 1902 (r)(2)**

### **A1. What is section 1902(r)(2), and what does it do?**

1902(r)(2) is the section number of a provision in the Medicaid statute, and is used as a kind of shorthand expression when describing what the provision itself does. Under the general Medicaid rules for determining eligibility for Medicaid, States are required to follow the same rules and processes used by the most closely related cash assistance program to determine eligibility. For aged, blind or disabled individuals, those would be the rules of the Supplemental Security Income (SSI) program, except in States that have elected the option of not providing Medicaid for all SSI recipients (209(b) States). For everyone else, those would be the rules of the former Aid to Families with Dependent Children (AFDC) program.

Using the same rules as the cash assistance programs means the State starts with the same amounts and types of gross income and resources as the cash programs, disregards (i.e., subtracts) the same things from the person's gross income and resources (a process known as a "methodology"), and arrives at the same amount of countable income and resources that the cash assistance programs would if they were determining eligibility for their own programs.

However, while the Medicaid statute requires States to start by using the same rules and processes (or methodology) as the cash assistance programs, the statute also gives States some options to use different rules and methodologies. One such option is found in section 1902(r)(2). This section allows States to use less restrictive income and resource methodologies in determining eligibility for most Medicaid eligibility groups than are used by the cash assistance programs. This means that States can elect to disregard different kinds or greater amounts of income and/or resources than the cash assistance programs do. This in turn gives States more flexibility to design and operate their Medicaid programs than they would have if they were required to follow only the cash assistance program rules.

### **A2. What does the new regulation do?**

The new regulation removes an administrative restriction that prevented States from taking full advantage of the flexibility to use less restrictive income methodologies that section 1902(r)(2) was intended to provide. For many groups, the old regulations required that when States used less restrictive income methodologies under section 1902(r)(2), the limits on Federal Financial Participation (FFP) applied before the use of any less restrictive income methodologies. Without going into the technical details of why, this essentially meant that States could not use less restrictive income

methodologies for many eligibility groups. Under the new regulation, the FFP limits will apply after, rather than before, the use of less restrictive income disregards. This change removes the existing regulatory restriction on the use of less restrictive income methodologies, allowing States to use such methodologies for all eligibility groups covered under section 1902(r)(2).

**A3. Does the new regulation also apply to the use of less restrictive resource methodologies under section 1902(r)(2)?**

No, because use of less restrictive resource methodologies was never restricted the way less restrictive income methodologies were. The old regulatory restriction only applied to income methodologies. States have always been able to take full advantage of the option to use less restrictive resource methodologies under section 1902(r)(2).

**A4. What eligibility groups are affected by the change in the way FFP limits apply to less restrictive income methodologies under section 1902(r)(2)?**

The technical answer is that the change applies to the medically needy and to any other eligibility groups not already exempt under the statute from the FFP limits. This includes most of the optional categorically needy groups. The eligibility groups that were already exempt are listed in section 1903(f)(4) of the Social Security Act.

However, an easier way to understand what eligibility groups are affected by the change may be to look at the chart at the end of these Qs and As. The chart explains how "eligibility group" is defined under the clarified definition of the term, and lists virtually all of the current Medicaid eligibility groups. It also identifies which groups are covered under section 1902(r)(2), and shows which of those groups are affected by the new regulation.

**A5. What is the definition of an "eligibility group"?**

Under the clarified definition, the medically needy and optional categorically needy groups are defined primarily by the list of groups found in section 1905(a) of the Act. Using this approach, a State can establish a medically needy group that includes only the aged, or only the disabled, or the aged and disabled but not the blind, etc.

This means that States can "target" their eligibility groups in general, as well as the use of less restrictive income and resource disregards under section 1902(r)(2), to specific groups of individuals as listed in section 1905(a) within the broader eligibility groups if they wish to do so.

However, while States can "target" less restrictive disregards to the specific groups listed in section 1905(a), they cannot further subdivide most of those groups by such factors as living arrangement (e.g., whether the individual is in a medical institution) or diagnosis. The only exception is the group described in section 1905(a)(i) (individuals under the age of 21 or, at the option of the State, under age 20, 19, or 18). Under the statute States can

establish reasonable categories of such individuals. A reasonable category can be based on factors such as living arrangements.

**A6. How does 1902(r)(2) apply to 209(b) states?**

209(b) States are States that use more restrictive criteria to determine Medicaid eligibility than are used by the Supplemental Security Income (SSI) program. As a result, receipt of SSI benefits does not guarantee eligibility for Medicaid in a 209(b) State. Unlike other States, where section 1902(r)(2) does not apply to groups receiving cash benefits (such as SSI), in a 209(b) State section 1902(r)(2) applies to all aged, blind, and disabled eligibility groups covered under the State's Medicaid plan.

**A7. What is the effect of low medically needy income levels, and how will the change help?**

Currently there are 35 States with medically needy programs. Of those 35, only 13 have income standards that are higher than the standard for eligibility for Supplemental Security Income (SSI) benefits (currently \$530 a month for an individual). There are 14 States with medically needy income levels below the SSI level, and 7 of those have levels below one-half of the SSI level, or \$256 a month.

A person with income below the SSI level gets Medicaid automatically without a spenddown in most States. However, a person in the majority of medically needy States whose income is even slightly above the SSI level must spend some of that income for medical care to be eligible for Medicaid. Depending on the State, the person may have to spend several hundred dollars for medical care each month, while a person with just a little less income can get Medicaid at no cost.

The new regulation gives States a way to deal with this problem by allowing them to not count some of the income of a person whose income is above the SSI level. This in turn would reduce or even eliminate the amount of income such a person would have to spend on medical care to become eligible for Medicaid.

**A8. Are States allowed to apply 1902(r)(2) differently for Medicaid applicants than they do for Medicaid recipients?**

No. Applicants and recipients must be treated the same under section 1902(r)(2).

**A9. Are States allowed to apply 1902(r)(2) to individuals receiving home and community-based waiver services?**

While section 1902(r)(2) disregards can apply to individuals receiving home and community-based waiver services (HCBS), States cannot target such methodologies specifically to HCBS waiver recipients alone.

People do not become eligible for Medicaid because they receive HCBS. HCBS are just that; services that a State can elect to provide to individuals who are eligible for Medicaid. To receive HCBS, though, a person must be eligible for Medicaid under one of the eligibility groups covered under the State Medicaid plan. If a State elects to apply section 1902(r)(2) disregards to a particular eligibility group, and the State has elected to provide HCBS to people eligible for Medicaid under that group, the section 1902(r)(2) disregards applicable to the eligibility group as a whole also apply to the individuals receiving the HCBS. However, a State cannot apply section 1902(r)(2) disregards only to individuals within a group who receive HCBS. The 1902(r)(2) disregards must be applied to the group as a whole.

**A10. How can States apply 1902(r)(2) methodologies to individuals receiving home and community-based services?**

As explained previously, a State must apply section 1902(r)(2) methodologies to an eligibility group as a whole, not just to those individuals in the group who are receiving HCBS services.

**A11. Are children eligible under the TEFRA criteria an eligible group, so that disregards under 1902(r)(2) can be limited to them?**

The TEFRA group (section 1902(e)(3) of the Act) is made up of disabled individuals under age 18 who would require an institutional level of care, but who can be cared for at home. The TEFRA group can be considered an "eligibility group." However, section 1902(r)(2) lists the specific eligibility groups to which less restrictive income and resource methodologies can be applied. The TEFRA group is not included in that list; therefore, section 1902(r)(2) methodologies cannot be applied directly to this group.

However, as an alternative a State could potentially cover individuals defined in this group as a reasonable group of individuals under age 21 under section 1905(a)(i) of the Act, and apply section 1902(r)(2) disregards to them through an optional group listed in section 1902(a)(10)(A)(ii) of the Act.

**A12. Can a disregard of assets be applied to people within an eligibility category who have purchased long term care insurance?**

Yes. Several States have such a disregard, which usually provides for disregarding a certain amount of resources if an individual purchases and receives benefits from a long term care insurance policy that meets criteria set by the State. However, there are estate recovery consequences when a State adopts a long term care insurance disregard. Under the Medicaid statute, except for certain States which had already adopted these disregards in a plan amendment approved as of May 14, 1993, States are specifically required to seek recovery of their expenses for nursing facility and other long-term care services, regardless of the age of the individual at the time these services were received. Also, these States must use an expanded definition of "estate" that is broader than the definition under their probate laws.

**A13. Can income or asset disregards within the medically needy group for aged, blind and disabled be different for people who are institutionalized and those who are not?**

No. Less restrictive income or resource disregards cannot be applied based on living arrangement or institutional vs. non-institutional status.

**A14. Can States disregard just a specific kind of income (either earned or unearned)? For example, can States disregard just Social Security Disability Insurance (SSDI) income, or just interest income from savings accounts?**

Yes, States can choose to disregard specific kinds of income. Either or both of the types of income in the example could be disregarded for an eligibility group under section 1902(r)(2).

**A15. Can States also disregard income that is used for a particular purpose, such as income put into a medical savings account, or income a person uses to maintain or repair a home?**

Yes, a State can choose to disregard income that is used for a particular purpose. For example, a State could have a disregard (which could, but does not have to, be limited by dollar amount) for income used for home maintenance or repair. However, if such a disregard is adopted, a State may want to structure the disregard to ensure that only income that is actually used for the purpose intended is disregarded. This could be as simple as a requirement that the individual provide evidence (such as receipts for maintenance or repair work performed and paid for) that the income in question was spent for the intended purpose.

**A16. Can section 1902(r)(2) also be used to disregard income as part of the post-eligibility treatment of income process?**

No. The Medicaid statute limits the use of section 1902(r)(2) disregards specifically to determinations of eligibility. Post-eligibility treatment of income (sometimes referred to as share-of-cost), as the name implies, is a process that takes place after eligibility is determined, and is completely separate from determining eligibility. Since post-eligibility treatment of income is not part of an eligibility determination, section 1902(r)(2) disregards cannot be applied to income used in the post-eligibility treatment of income process.

## **B. Supporting Community Integration**

### **B1. How can the new regulation assist persons with significant disabilities who are living in the community and are at risk of institutionalization?**

Under the broader rules of the regulation, States can reduce or eliminate many kinds of income which, if they were counted, could keep persons with disabilities from qualifying for Medicaid while still living in the community. For example, States can choose not to count as income items such as the value of food or shelter provided to a person by a family member, or the income of a parent or a spouse. Not counting such items as income makes it easier for a person with a significant disability to qualify for Medicaid, enabling the person to remain in his or her home rather than go to an institution to qualify for Medicaid.

In addition, States can use the broader rules to provide Medicaid coverage to individuals with higher incomes. These individuals may have high medical needs but have income levels that prevent them from immediately qualifying for Medicaid. As a result, they often have to spend large sums of money on medical bills before they can be eligible for Medicaid as medically needy. Spending most of their income on medical needs often leaves them with not enough money to pay for things like rent and food. Often their only alternative is to live in an institution where it is usually easier to qualify for Medicaid. The broader rules of this new regulation give States the option of allowing such individuals to keep more of their income for regular expenses in the community by, for example, disregarding additional amounts of income for the medically needy, thereby avoiding the need for institutionalization.

### **B2. How can this rule assist persons who live in institutions but who wish to live in the community?**

Under the broader rules of the new regulation, States can help people move from an institution to the community. Many people living in institutions would like to move to a community setting, but cannot afford to do so because once they leave the institution the only way they can continue to be eligible for Medicaid is under a medically needy program.

In many States the medically needy income standard is so low that these people would have to use too much of their income to purchase medical services (i.e., spend down their income to the State's medically needy income level), leaving very little to pay for living expenses in the community. The broader rules give States the option of allowing individuals to retain more income to pay for food, clothing, and shelter, once they move

to a community setting, by disregarding additional amounts of income when determining medically needy eligibility. This may make it easier for them to make the choice of community living.

However, it is important to note that while States can allow individuals to retain more income, any less restrictive income disregard used to accomplish that must be applied to the eligibility group in question as a whole. Such a disregard cannot, under the statute, be limited to a subset of individuals within the eligibility group. For example, while a State can use an income disregard for an eligibility group defined as disabled individuals who are medically needy, it cannot restrict use of the disregard only to those members of the group who are receiving home and community-based waiver services, or those who are moving from an institution to the community.

**B3. Can a State treat as a group, for purposes of an income disregard, disabled children who become eligible for home and community-based services with a waiver of the deeming of parental income?**

Under section 1905(a)(i), a State can establish as a reasonable category of individuals under age 21 (or 20, 19, or 18 as the State may choose) disabled individuals receiving home and community-based waiver services. To establish those individuals as an "eligibility group" to which additional income disregards could be applied under section 1902(r)(2), the individuals would then have to meet the requirements of an optional categorically needy group (or the medically needy) that is covered under the State's Medicaid plan. See the chart at the end of these Qs and As for a list of those groups.

**B4. Can a State treat as a group, for purposes of an income disregard, adult individuals who become eligible for home and community-based services with a waiver of the deeming of spousal income and assets?**

No. While, as explained in the answer to B3 above, States can establish reasonable categories of individuals under age 21, there is no comparable provision for establishing reasonable categories of adults.

**C. Providing Work Incentives**

**C1. What does this regulation do that the existing work incentives and State buy-in legislation does not allow for?**

The existing work incentives programs are targeted to individuals with disabilities who are working or who want to work. Because of this relatively narrow focus, the existing work incentives programs do not reach the majority of people with disabilities. Under the broader rules of the new regulation, States will have greater flexibility to determine

Medicaid eligibility for people with disabilities as a whole. As a result, States may be able to use section 1902(r)(2) to complement their existing work incentives programs by encouraging more people to return to work or continue to work. This could be done, for example, by establishing additional disregards of earned income for individuals with disabilities under eligibility groups such as the medically needy, thereby allowing those individuals to keep more of the income they earn and still retain Medicaid coverage.

**C2. How can section 1902(r)(2) be used to mirror a work incentives group such as the Balanced Budget Act of 1999 (BBA) working disabled buy-in group?**

Section 1902(r)(2) can be used to disregard income and resources for individuals with disabilities under specific eligibility groups. This flexibility may enable States to effectively establish income and resource eligibility levels for such individuals that approximate the levels that would normally apply under one of the work incentives groups.

However, it would be difficult to actually "mirror" a work incentives group beyond income and resource eligibility criteria. For example, section 1902(r)(2) cannot be used to create an entirely new eligibility group. Less restrictive disregards can only be applied to individuals in groups covered under the State's Medicaid plan. Also, section 1902(r)(2) is specifically limited to income and resource methodologies. It cannot be used, for example, to change the basic SSI definition of disability, or to directly establish age limits if such limits do not already apply to the eligibility group in question. Section 1902(r)(2) also could not be used to establish a premium and cost-sharing process similar to what may be allowed under the statute for existing work incentives groups such as the BBA group.

**C3. How could a State use the clarified interpretation of a group to preclude individuals over age 65 who are not disabled from being eligible under the BBA group?**

A State could limit eligibility for Medicaid under the BBA group by defining the group as including only individuals who meet the SSI definition of disability; i.e., who are disabled. By limiting eligibility under the BBA to disabled individuals a State would not have to cover individuals who are aged but not disabled.

However, States should be aware that there are limitations to this approach. A State would have to cover any individual who meets the SSI definition of disability, regardless of age. Thus, a State would have to cover someone age 65 or older who is also disabled, but it would not have to cover someone who is age 65 or older who would not meet SSI's definition of disability.

**D1. Will the State plan preprint be revised based on the clarified definition of an eligibility “group”?**

While States are required under regulations at 42 CFR 430.12(a) to use the State plan preprint, they should remember that the preprint is intended primarily as a convenience to States by providing a consistent check-off format that States can use to describe their Medicaid programs. The preprint was never intended to be something that States cannot change if they find that the preprint as written does not meet their needs. Thus, until such time as a major revision of the preprint to incorporate the new interpretation of "eligibility group" is issued, States are encouraged to make any revisions to the published preprint material they believe are needed to enable them to accurately describe the eligibility groups covered under their Medicaid State plans.

**D2. Will CMS provide further guidance through a State Medicaid Director letter on the new interpretation of an eligibility group?**

Yes. As more information is available, CMS will issue further guidance via State Medicaid Director letter, or on the CMS website.

**E. Technical Issues**

**NOTE: As the title of this section implies, the following questions are technical in nature, rather than the general questions covered in previous sections. Therefore, of necessity the answers to these questions will be more technical than the answers to the questions in previous sections.**

**E1. The regulation at 42 CFR 435.601(d)(iv) says that less restrictive methodologies can be applied to "Optional categorically needy individuals under groups established under subpart C of this part and section 1902(a)(10)(A)(ii)..." If a State has chosen to cover all of the applicable groups listed in section 1905(a) under one of the descriptions of individuals listed under 1902(a)(10)(A)(ii), is the State actually covering several "eligibility groups" - essentially all the groups that can be created by combining that description with the groups at 1905(a)? (For example, see the State Plan Preprint, Attachment 2.2-A, Page 19, item 12.) Does this mean that the**

**State can apply a less restrictive methodology to a smaller group of individuals than what is listed just in the group descriptions in 1902(a)(10)(A)(ii), without being in violation of the above regulation?**

An "eligibility group" consists of one of the groups listed in section 1905(a), in conjunction with the requirements described in one of the categories listed in section 1902(a)(10)(A)(ii). If a State elects to include more than one of the groups listed in section 1905(a) under a category listed in section 1902(a)(10)(A)(ii), it is really covering a number of separate eligibility groups, each defined by a group listed in section 1905(a). Under section 1902(r)(2), a State can apply less restrictive income and resource disregards to any, or any combination, of the separate eligibility groups it has elected to cover under a category listed in section 1902(a)(10)(A)(ii).

For example, section 1902(a)(10)(A)(ii)(I) is the category of individuals who meet the income and resource criteria of one of the cash programs (SSI or the former AFDC program). A State could elect to cover under that category individuals who are aged, blind or disabled. Since the aged, blind and disabled constitute three separate groups under section 1905(a), the State is actually electing to cover three "eligibility groups" under this category. (As a side note, the State does not have to actually identify each group individually in its State plan; it can just indicate that it covers the aged, blind and disabled who meet the requirements of section 1902(a)(10)(A)(ii)(I).) Since the State is covering three separate eligibility groups under this category, it could elect to apply a less restrictive disregard only to the aged, or to the aged and disabled but not the blind, under section 1902(r)(2). If a State elects to apply a less restrictive disregard only to the aged and disabled but not the blind, the three groups should be identified separately in the State plan.

**E2. How should we interpret 42 CFR 435.601(4)(d)? There it says that less restrictive methodologies "must be comparable for all persons within each category of assistance (aged, or blind, or disabled, or AFDC related) within an eligibility group." How should we define "category of assistance"?**

In the context of the cited regulation, "category of assistance" refers to the groups listed in section 1905(a), and "eligibility group" refers to the categories listed in section 1902(a)(10)(A)(ii) (and the medically needy). This actually comports with the clarified definition of an "eligibility group" explained previously in these Qs and As, although the terminology we are using now is somewhat different. Now, "eligibility group" refers to the combination of a group listed in section 1905(a) and a category listed in section 1902(a)(10)(A)(ii) (or the medically needy). The term "category of assistance" used in the cited regulation should be taken to mean the groups listed in section 1905(a).

**E3. 42 CFR 435.601 (d)(2)(i) refers to "groups of aged, blind, and disabled individuals." How should this be interpreted? Should this read instead "groups of aged, or blind or disabled individuals to be in sync with the clarified definition? 42 CFR 435.201(c) also makes reference to groups of aged, blind and disabled individuals.**

Under section 1905(a), the aged, blind and disabled constitute three separate groups. Therefore, references such as those cited in the question should be taken to mean three separate groups, not one group consisting of all aged, blind or disabled individuals.

**E4. In the State Plan Preprint, Attachment 2.2-A, Page 22, item 16, States are given the option to cover individuals who are 65 years of age or older or who are disabled and who have income up to 100% of the Federal poverty level (section 1902(a)(10)(A)(ii)(X) of the Act). The preprint states that, "Both aged and disabled individuals are covered under this eligibility group." Does the clarified interpretation of an eligibility group allow a State to only cover only the aged, or only the disabled, under this group? How should a State indicate in its State Plan that it wants to limit the coverage of this optional group (or any of the others under 1902(a)(10)(A)(ii)) by one of the descriptions at 1905(a), if it is not currently given that option in the preprint?**

Yes, a State could elect to limit eligibility under the optional poverty level group cited in the question to only the aged, or only the disabled. Further, even if a State covers both the aged and disabled under this group, it could elect to apply less restrictive income or resource disregards only to the aged, or only to the disabled.

With regard to how a State should indicate that it wants to limit coverage under this group (or any other group), a State electing such an option should just insert language indicating that on the appropriate preprint page. States are not precluded from making such elections just because the existing preprint does not make specific provision for them.

It is important to point out that the State plan preprint was created primarily for the convenience of the States by providing a consistent, easily used check-off format to describe the provisions of each State plan. States are required to use the preprint as a starting point, but when it does not accommodate statutory, regulatory or policy changes, States are certainly free (and even encouraged) to amend preprint pages as needed to accurately reflect the State's Medicaid program.

**E5. There are eleven different descriptions given at 1905(a), yet the preprint only gives the option to limit coverage by, at the most, six of these. (Aged; Blind; Disabled; Under 21 or reasonable classifications of those individuals; Caretaker relatives of dependent children; or Pregnant women.) What about the groups that are not listed in the preprint?**

Actually, at this point there are thirteen different groups listed in section 1905(a). The reason that only six of those groups are listed in the preprint is that only those six have broad applicability in defining what is an "eligibility group". The other seven, for various reasons, have only limited applicability in defining what is an eligibility group. For example, some groups are applicable only in those territories (Guam, Puerto Rico, and the Virgin Islands) that do not have an SSI program. Others are included in section 1905(a) because individuals in those groups can be eligible for Medicaid, but for various reasons they do not fit into the more commonly used groups. For example, individuals with TB are listed as a group in section 1905(a), but they can only be eligible for Medicaid under the optional categorically needy group created specifically for them at section 1902(a)(10)(A)(ii)(XII).

The chart at the end of these Qs and As discusses all of the groups listed in section 1905(a), and explains the status of those that are not listed in the preprint.

# Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources

## Mandatory Eligibility Groups

### NOTES

- References to "AFDC" mean the rules in effect on July 16, 1996 under the Aid to Families with Dependent Children (AFDC) program (as modified under section 1931 of the Act).
- References to "SSI" mean the most current rules of the Supplemental Security Income (SSI) program.
- References to "AABD" mean the Aid to the Aged, Blind and Disabled program in effect in some of the territories.
- References to "title IV-E" mean the Federal Payments for Foster Care and Adoption program.
- References to "COLA" mean cost-of-living increases.
- An asterisk (\*) in the "1902(r)(2) Available?" column indicates that full flexibility under section 1902(r)(2) is now available under the new regulation changing the way FFP limits apply to less restrictive income methodologies that became effective on May 11, 2001.

Group Description	Group Statutory Citation	1902(r)(2) Available ?	Notes
Low Income Families.	1902(a)(10)(A)(i)(I) 1931	No	Separate authorization for less restrictive methodologies exists in 1931. FFP cap does not constrain flexibility to establish less restrictive methodologies.
Individuals receiving AABD in Territories with no SSI.	1902(a)(10)(A)(i)(I)	No	
Children receiving IV-E payments (IV-E foster care or adoption assistance).	1902(a)(10)(A)(i)(I)	No	Less restrictive methods not available; depends on receiving coverage under another program.

Group Description	Group Statutory Citation	1902(r)(2) Available ?	Notes
Individuals who lose eligibility under 1931 due to employment.	1902(a)(10)(A)(i)(I) 402(a)(37) 1925	No	Less restrictive methods not available; depends on receiving coverage under another group.
Individuals who lose eligibility under 1931 because of child or spousal support.	1902(a)(10)(A)(i)(I) 406(h)	No	Less restrictive methods not available; depends on receiving coverage under another group.
Individuals participating in a work supplementation program who would otherwise be eligible under 1931.	1902(a)(10)(A)(i)(I) 482(e)(6)	No	Less restrictive methods not available; depends on receiving coverage under another group.
Individuals receiving SSI cash benefits.	1902(a)(10)(A)(i)(II)	No	
Children no longer eligible for SSI because of change in definition of disability.	1902(a)(10)(A)(i)(II)	No	Less restrictive methods not available; depends on receiving coverage under another group.
Qualified pregnant women.	1902(a)(10)(A)(i)(III) 1905(n)(1)	Yes	
Qualified children.	1902(a)(10)(A)(i)(III) 1905(n)(2)	Yes	Group no longer needed for any purpose.
Poverty level pregnant women.	1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	Yes	
Poverty level infants.	1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	Yes	
Qualified family members.	1902(a)(10)(A)(i)(V)	N/A	Group no longer exists.
Poverty level children under age 6.	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	Yes	
Poverty level children under age 19.	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	Yes	

<b>Group Description</b>	<b>Group Statutory Citation</b>	<b>1902(r)(2) Available ?</b>	<b>Notes</b>
Disabled individual whose earnings exceed SSI substantial gainful activity level.	1619(a)	No	Receives SSI cash benefits and Medicaid.
Disabled individual whose earnings are too high to receive SSI cash benefit.	1619(b)	No	Receives Medicaid but does not receive SSI cash benefit.
Disabled individual whose earnings are too high to receive SSI cash benefit.	1902(a)(10)(A)(i)(II) 1905(q)	No	Medicaid counterpart to 1619(b) eligibility group.
Pickle amendment - Would be eligible for SSI if title II COLAs were deducted from income.	Section 503 of P.L. 94-566	No	Deemed to be receiving SSI for Medicaid purposes.
Disabled widows/widowers.	1634(b) 1935	No	Deemed to be receiving SSI for Medicaid purposes.  Closed group - no new applications after 7/1/88.
Disabled adult children.	1634(c) 1935	No	Deemed to be receiving SSI for Medicaid purposes.
Early widows/widowers.	1634(d) 1935	No	Deemed to be receiving SSI for Medicaid purposes.
Qualified Medicare Beneficiaries.	1902(a)(10)(E)(i) 1905(p)(1)	Yes	Benefit limited to payment of Medicare Part A and B premiums, deductibles and co-payments.
Qualified Disabled and Working Individuals.	1902(a)(10)(E)(ii) 1905(s)	No	Cannot be otherwise eligible for Medicaid. Benefit limited to payment of Medicare Part A premium.
Specified Low Income Beneficiaries.	1902(a)(10)(E)(iii)	Yes	Benefit limited to payment of Medicare Part B premium.

Group Description	Group Statutory Citation	1902(r)(2) Available ?	Notes
Qualified Individuals - I.	1902(a)(10)(E)(iv)(I)	Yes	Cannot be otherwise eligible for Medicaid. Benefit limited to payment of Medicare Part B premium.
Qualified Individuals - II.	1902(a)(10)(E)(iv)(II)	Yes	Cannot be otherwise eligible for Medicaid. Benefit limited to partial payment of Medicare Part B premium.
209(b) States - State uses more restrictive criteria to determine eligibility than are used by the SSI program.	1902(f)	Yes *	1902(r)(2) applies to all eligibility groups in a 209(b) State.

# Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources

## Optional Eligibility Groups

Each of the following groups of individuals, in conjunction with the requirements specific to a category listed in the chart below, constitutes an "eligibility group." These groups are set forth in the Medicaid statute at section 1905(a). The following are the most common groups used to define an "eligibility group." However, section 1905(a) also includes other groups of individuals which will be discussed below.

Individuals who are:

- Aged (1905(a)(iii)).
- Disabled (1905(a)(vii)).
- Blind (1905(a)(vii)).
- Under 21 (or, at State option, under age 20, 19, or 18) or reasonable classifications of these individuals (1905(a)(i)).
- Pregnant women (1905(a)(viii)).
- Caretaker relatives of dependent children (1905(a)(ii)).

For example:

- One eligibility group can be defined as aged individuals who meet the income and resource requirements of the SSI program (the first category in the chart below).
- A separate eligibility group can be defined as disabled individuals who met the income and resource requirements of the SSI program.
- Yet another eligibility group can be defined as caretaker relatives of dependent children who meet the income and resource requirements of the former AFDC program.

States can define each eligibility group separately, as in the example above, or they can combine more than one of the groups listed above that meet the requirements of a category in the chart to form a single eligibility group. For example, a State can define all aged, disabled, or blind individuals who meet the income and resource requirements of the SSI program as a single eligibility group, rather than as three separate groups.

States can apply less restrictive methodologies under section 1902(r)(2) (when that section applies) separately to each eligibility group defined under the State plan. Less restrictive methodologies applied to one eligibility group may, but do not have to, be applied to other eligibility groups.

In addition to the commonly used groups listed above, section 1905(a) also includes other groups which, for various reasons, have only limited applicability in defining what is an "eligibility group". For example, some groups are applicable only in those territories (Guam, Puerto Rico and the Virgin Islands) that do not have an SSI program. Others are included in section 1905(a) because individuals in those groups can be eligible for Medicaid, but for various reasons they do not fit into the commonly used groups listed above. Listed below are these groups, with an explanation of their status.

Individuals who are:

- Blind in a territory without an SSI program (1905(a)(iv)).
- Age 18 or older and disabled in a territory without an SSI program (1905(a)(v)).
- Essential persons; involves individuals who met certain eligibility requirements in 1973; few individuals remain in this group today. (1905(a)(vi)).
- Individuals provided extended benefits under section 1925; Basically, Medicaid eligibility is based on prior receipt of Medicaid under section 1931 (1905(a)(ix)).
- Individuals receiving COBRA continuation benefits under section 1902(u)(1); individuals in this group do not have to meet any categorical requirements such as age, blindness or disability (1905(a)(x)).
- TB-infected individuals eligible under section 1902(z)(1); individuals in this group do not have to meet categorical requirements (1905(a)(xi)).
- Employed individuals with a medically improved disability eligible under section 1902(a)(10)(A)(ii)(XVI); individuals in this group do not meet categorical requirements (1905(a)(xii)).
- Individuals screened for breast and cervical cancer under a Centers for Disease Control (CDC) program eligible under section 1902(a)(10)(A)(ii)(XVIII); individuals in this group do not meet categorical requirements (section 1905(a)(xiii)).

## NOTES

- References to "AFDC" mean the rules in effect on July 16, 1996 under the Aid to Families with Dependent Children (AFDC) program (as may be modified under section 1931 of the Act).
- References to "SSI" mean the most current rules of the Supplemental Security Income (SSI) program.
- References to "BBA" mean the Balanced Budget Act of 1997.
- References to "TWWIA" mean the Ticket to Work and Work Incentives Improvement Act of 1999.
- References to "TEFRA" mean the Tax Equity and Fiscal Responsibility Act of 1982.
- References to "HCBS" mean home and community-based waiver services.
- References to "COBRA" mean the Consolidated Omnibus Budget Reconciliation Act of 1985.

- An asterisk (\*) in the "1902(r)(2) Available?" column indicates that full flexibility under section 1902(r)(2) is now available under the new regulation changing the way FFP limits apply to less restrictive income methodologies that became effective on May 11, 2001.

Group Description	Group Statutory Citation	1902(r)(2) Available ?	Notes
Meet the income and resource requirements of the appropriate cash assistance program (SSI or AFDC).	1902(a)(10)(A)(ii)(I)	Yes *	
Would meet the income and resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency.	1902(a)(10)(A)(ii)(II)	Yes *	
Would be eligible for AFDC if State AFDC plan were as broad as allowed under Federal law.	1902(a)(10)(A)(ii)(III)	Yes *	
<p>Would be eligible for cash assistance (AFDC or SSI) if they were not in a medical institution.</p> <p>Receiving, or would be eligible to receive if they were not in a medical institution, a State supplement payment.</p>	1902(a)(10)(A)(ii)(IV)	Yes *	Separate authority to use less restrictive income disregards than SSI for State supplement payment recipients exists under section 1616(c)(2).
Special income level group - In a medical institution for at least 30 consecutive days with gross income that does not exceed 300 percent of the SSI income standard.	1902(a)(10)(A)(ii)(V)	Yes *	

Group Description	Group Statutory Citation	1902(r)(2) Available ?	Notes
Receiving home and community-based waiver services who would only be eligible for Medicaid under the State plan if they were in a medical institution.	1902(a)(10)(A)(ii)(VI)	Yes *	1902(r)(2) methodologies must apply to an entire State plan eligibility group (e.g., the special income level group); they cannot be applied solely to HCBS waiver recipients.
Are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care.	1902(a)(10)(A)(ii)(VII)	Yes *	
Individuals under age 21 who are under State adoption agreements.	1902(a)(10)(A)(ii)(VIII)	Yes *	
Poverty-related pregnant women and infants.	1902(a)(10)(A)(ii)(IX)	Yes	States can also use mandatory groups in conjunction with 1902(r)(2) to cover the same population.
Aged or disabled individuals with income that does not exceed 100 percent of the Federal poverty level.	1902(a)(10)(A)(ii)(X)	Yes	
Receiving only an optional State supplement which is more restrictive than the criteria for an optional State supplement under title XVI.	1902(a)(10)(A)(ii)(XI)	Yes *	
TB-infected individuals.	1902(a)(10)(A)(ii)(XII) 1902(z)(1)	Yes *	
Working disabled individuals who buy in to Medicaid (BBA working disabled group).	1902(a)(10)(A)(ii)(XIII)	Yes	
Targeted low income children.	1902(a)(10)(A)(ii)(XIV)	Yes *	

Group Description	Group Statutory Citation	1902(r)(2) Available ?	Notes
Working disabled individuals who buy into Medicaid under TWWIA Basic Coverage Group.	1902(a)(10)(A)(ii)(XV)	Yes	
Employed medically improved individuals who buy into Medicaid under TWWIA Medical Improvement Group.	1902(a)(10)(A)(ii)(XVI)	Yes	
Children under age 21 who were in foster care on 18 <sup>th</sup> birthday.	1902(a)(10)(A)(ii)(XVII)	Yes, but not material.	Income and resource test not required. States may set income and resource tests above a certain level.
Individuals screened for breast or cervical cancer under CDC program.	1902(a)(10)(A)(ii)(XVIII)	Yes, but not material.	No Medicaid income or resource test permitted.
Individuals receiving COBRA continuation benefits.	1902(a)(10)(F) 1902(u)	No	
Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 kids).	1902(e)(3)	No	Deemed to be receiving SSI cash benefits for Medicaid purposes.
Medically Needy.	1902(a)(10)(C)	Yes *	