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The Medicaid Medically Needy Program: Spending and Enrollment Update

The medically needy program provides states the option to extend Medicaid eligibility to individuals with high medical expenses whose income exceeds the maximum threshold, but who would otherwise be eligible for Medicaid. The program accounts for a small share of Medicaid enrollment, it is difficult for individuals to navigate, and it is cumbersome for states to administer. However, the medically needy program remains an important and consequential pathway to Medicaid eligibility, acting as a last-resort to Medicaid eligibility for those whose medical expenses overwhelm their income. Elderly living in nursing homes and children and adults with disabilities who live in the community and incur high health care costs comprise a large portion of spending in the medically needy program.

This brief provides updated enrollment and spending figures on the medically needy using data through federal fiscal year 2009. It then explains how individuals become eligible for the medically needy program. Finally, it provides key considerations for policy discussions, especially pertinent in light of the optional Medicaid expansion that states are now considering. The data in this brief comes from the 2009 Medicaid Statistical Information System (MSIS) maintained by the Centers for Medicare and Medicaid Services (CMS), with spending adjusted to align with CMS Form 64 levels. Among the findings from this work are:

- In federal fiscal year 2009, there were 2.8 million medically needy enrollees who spent a total of $36.7 billion. The medically needy accounted for 5 percent of total Medicaid enrollment, but 11 percent of total Medicaid spending.
- Among the 34 states with medically needy programs, there is variation between states. New York and California each provide Medicaid coverage to over 700,000 medically needy individuals - one quarter of the total medically needy population. Sixteen states do not offer medically needy coverage.
- The elderly and individuals with disabilities comprise 41 percent of medically needy enrollment, but make up nearly 88 percent of total medically needy spending. In contrast, non-disabled children and adults comprise the majority (59%) of medically needy enrollment, but only account for 12 percent of total medically needy spending.
- Dual eligible beneficiaries account for 28 percent of medically needy enrollees, but 68 percent of medically needy spending.

As financial eligibility for Medicaid and CHIP has expanded over the past decade, enrollment in medically needy programs has declined, most notably among children. However, the medically needy program continues to act as a safety net to those who are among the most vulnerable in our population. Medicaid expansion and the exchanges will provide medical insurance to some of the medically needy population. As states discuss implementing the Medicaid expansion, in addition to other policy decisions, they will undoubtedly take into consideration the great need of this population, as well as the efficiency and expense of providing care under the various options.

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Introduction

The medically needy program offers states the option to extend Medicaid coverage to individuals with high medical expenses, who would otherwise be ineligible for Medicaid because their incomes exceed eligibility limits. By subtracting incurred health care expenses from their income, individuals are permitted to "spend down" to Medicaid eligibility. The medically needy option is complicated for beneficiaries to understand and for state Medicaid programs to administer, but the opportunity to spend down is very important to elderly individuals residing in nursing facilities and children and adults with disabilities who live in the community and incur high health care expenses. As of 2009, 33 states and the District of Columbia had Medicaid medically needy programs that covered 2.8 million people. The medically needy population represented 5 percent of the total Medicaid population and accounted for 11 percent of Medicaid spending in 2009. The most expensive among the medically needy population are those who are dually eligible for both Medicaid and Medicare. This brief provides an overview of the medically needy program; describes how it works for persons with disabilities, the elderly, and low-income families; and highlights some key issues surrounding the program as states consider new Medicaid coverage options included in the Affordable Care Act (ACA).

How Do the Medically Needy Qualify for Medicaid?

The medically needy option enables states to provide Medicaid coverage to individuals who meet the categorically needy pathway eligibility requirements,[1] but exceed the income standards. In general, there are two ways individuals can become eligible for medically needy Medicaid coverage: 1) individuals with income below medically needy levels, but above categorically needy income levels are eligible under the medically needy option. This includes children up to age 21 in states where the medically needy program is either the only eligibility category for these individuals or where the medically needy program has the highest maximum allowable income for Medicaid eligibility; and 2) persons who spend down by incurring medical expenses so that, after medical expenses, their income falls below a state-established medically needy income limit (MNIL). The option does not permit states to provide Medicaid to individuals who are not categorically-related (e.g., non-disabled, non-pregnant adults age 19 to 64 without dependent children), regardless of how poor they are or how extensive their medical needs.

Financial eligibility standards for the medically needy program vary considerably across states, but are typically well below poverty. State MNILs are low because they remain tied to AFDC levels that were in place in 1996. Federal rules require MNILs to be no higher than 133 percent of the maximum state Aid to Families and Dependent Children (AFDC) level, as of July 16, 1996, for a family of two without income or resources.[2] Although AFDC was replaced in 1996 by the Temporary Assistance to Needy Families (TANF) program, Medicaid MNILs remain linked to the old AFDC standards. States can raise their MNIL if they increase their TANF income standards. States can also increase the MNIL as family size increases, but they are not allowed to decrease it as family size increases. States can also have different MNILs for urban and rural areas, taking into consideration differences in housing costs.[3]

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[1] For more information on the categorically needy pathway see Appendix A.
[2] 42 CFR § 435.1007.
[3] CMS State Medicaid Manual, § 3621.

State Medically Needy Eligibility Levels

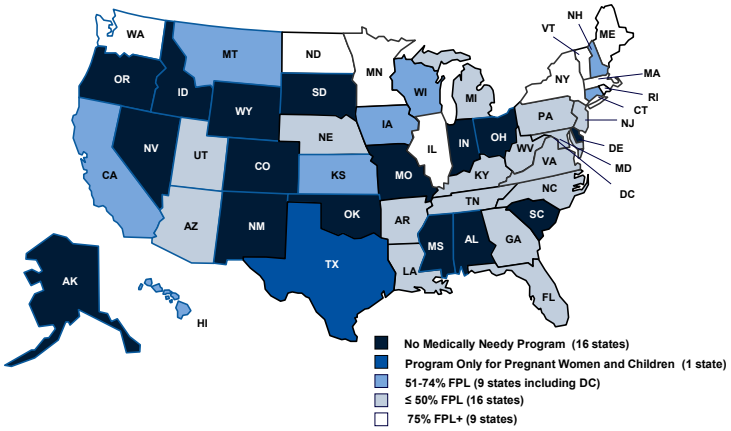
In 2009, the median MNIL for a single individual was $447 per month, or about 50 percent of the FPL (Figure 1 and Table 1).[4] In 16 states, the MNIL was below 50 percent of the FPL for non-institutionalized people with disabilities. In 25 states, the MNIL was below the SSI income level of $674 per month in 2009.

Resource limits are often the same as those used in the Supplemental Security Income (SSI) program, with 19 states setting resource limits at $2,000 for individuals and $3,000 for couples. States are permitted to use less restrictive methodologies in counting resources under the medically needy program than under the SSI program, but they may not be more restrictive (see Appendix B for further explanation).

In 11 states, known as 209(b) states, Medicaid eligibility rules for people with disabilities and the elderly are different from those under the federal SSI program—and some people who receive SSI do not qualify for Medicaid. When the Congress enacted the SSI program in 1972, it allowed states to use their 1972 state assistance eligibility rules for determining Medicaid eligibility in place of the federal SSI eligibility rules.[5] In 209(b) states, both the financial and non-financial eligibility criteria can be more restrictive than the federal standard, as long as they are no more restrictive than the rules they had in place in 1972. The states with 209(b) programs in 2012 are: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. In these states, people with disabilities and the elderly must be given the opportunity to spend down to the state's income standard for mandatory eligibility, whether or not the state permits spend-down through a medically needy program.[6] In 209(b) states that also have medically needy programs (all 209(b) states except Indiana, Missouri, Ohio, and Oklahoma), an individual must only spend down to the 209(b) income standard if they meet the SSI financial requirements (such as by receiving SSI or a state supplement).[7] All persons who do

Figure 1

Medically Needy Income Levels by State, 2009



SOURCE: *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities*, Kaiser Commission on Medicaid and the Uninsured analysis of data collected by Medicare Rights Center, 2009, February 2010.

[4] Kaiser Commission on Medicaid and the Uninsured and the Medicare Rights Center, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities," Kaiser Commission on Medicaid and the Uninsured, February 2010, available at http://www.kff.org/medicaid/8048.cfm.

[5] Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book," July 2002, available at http://www.kff.org/medicaid/2236-index.cfm.

[6] House Ways and Means Committee, "The Green Book, October 2000, (See p. 897).

[7] State Medicaid Manual, § 3613.3 (A). Individuals are also considered to be meet the financial requirements for SSI if they would be eligible for SSI or a state supplement with Old Age and Survivors Disability Insurance (OASDI) cost-of-living disregards applied under 42 CFR 214.134 and 435.13.

not meet the SSI income eligibility requirements must spend down to the state's MNIL in order to qualify for Medicaid as a medically needy individual.

The following examples illustrate the types of individuals who would benefit from a Medicaid medically needy spend-down program:

Family with recurring medical expenses – Sean, an 11 year-old boy with a behavioral health diagnosis, has been receiving outpatient therapy at a community health center. His symptoms are worsening, however, and he is exhibiting self-injurious behaviors and becoming violent toward family members. His doctor recommends a stay in a residential treatment center where he can receive more intensive services, but his family is uninsured, and the residential treatment center costs approximately $333 per day, or $10,000 per month. The social worker at the residential treatment center helps Sean's parents apply for Medicaid coverage for him.

In Sean's state, children qualify for Medicaid if their family income is less than 100 percent of the federal poverty level ($1,921 per month for a family of four in 2012). Sean's family earns $2,500 per month -- too much to qualify for Medicaid coverage-- but they live in a state that includes the medically needy spend-down option in its Medicaid program with a one month spend-down period. Sean has a spend-down amount of $579, the difference between his family's income of $2,500 and the $1,921 limit for Medicaid eligibility. Sean meets his spend-down amount after incurring $579 in medical bills, the cost of less than two days of his 30-day stay in the residential treatment center. After meeting his spend-down amount, Sean is eligible for Medicaid for the rest of the month, and the remainder of his inpatient stay is covered.

Adult with cancer diagnosis – 55-year-old Cynthia has metastasized colon cancer. She has been told she has less than six months to live. After her illness made it impossible for her to continue to work, Cynthia qualified for Social Security Disability Insurance (SSDI) benefits based on her work history and medical condition. After becoming eligible for SSDI, there is a 24-month waiting period before receiving Medicare, and Cynthia has no other health insurance. She needs chemotherapy, scans, and a hospital bed at home. She also needs prescription drugs for pain, depression and a blood clot. Her SSDI benefits are $1,100 per month, and her state provides Medicaid coverage to people with disabilities with incomes up to 100 percent of the federal poverty level, or $930 per month for an individual in 2012. Her treatments cost hundreds of dollars every month, much more than she can afford with her limited income. Her prescription drugs alone cost over $500 per month, and the hospital is allowing her to receive chemotherapy on a payment plan.

The Medicaid program in Cynthia's state includes the medically needy spend-down option with a six-month spend-down period. Cynthia's spend-down amount is $1,020 over a six month period, the difference between her monthly income of $1,100 and the financial eligibility limit for an individual of $930 over six months. Cynthia is able to meet her spend-down amount in the first week of her six month spend-down period because she gets all of her prescriptions filled and incurs a bill for chemotherapy – together her out-of-pocket medical costs exceed her $1,020 spend-down amount. After this point, Cynthia is eligible for Medicaid for the remainder of the six-month spend-down period. At the end of the six months, she will have to incur another $1,020 of expenses before becoming eligible for Medicaid again.

Table 1: Medically Needy Eligibility, 2009

State	Medically Needy or Comparable	Monthly Income Limit		Monthly Income Limit as a Percentage of Federal Poverty Level[1]		Asset Limit	
		Single	*Couple*	*Single*	*Couple*	*Single*	*Couple*
Alabama	No program	NA	NA	NA	NA	NA	NA
Alaska	No program	NA	NA	NA	NA	NA	NA
Arizona[2]	Comparable	$360	$485	40%	40%	May not exceed total of $100,000 including home, & no more than $5,000 can be liquid	May not exceed total of $100,000 including home, & no more than $5,000 can be liquid
Arkansas	Medically Needy	$108	$217	12%	18%	$2,000	$3,000
California	Medically Needy	$600	$750	66%	62%	$2,000	$3,000
Colorado	No program	NA	NA	NA	NA	NA	NA
Connecticut*[3]	Medically Needy	Depending on region $476 or $576	Ranges from $633 to $734	53% or 64%	52% to 60%	$1,600	$2,000
Delaware	No program	NA	NA	NA	NA	NA	NA
District of Columbia	Medically Needy	$577	$607	64%	50%	$4,000	$6,000
Florida	Medically Needy	$180	$241	20%	20%	$5,000	$6,000
Georgia	Medically Needy	$317	$375	35%	31%	$2,000	$4,000
Hawaii*	Medically Needy	$469	$632	45%	45%	$2,000	$3,000
Idaho	No program	NA	NA	NA	NA	NA	NA
Illinois*	Medically Needy	$903	$1,215	100%	100%	$2,000	$3,000
Indiana*	No program	NA	NA	NA	NA	NA	NA
Iowa	Medically Needy	$483	$483	54%	40%	$10,000	$10,000
Kansas	Medically Needy	$495	$495	55%	41%	$2,000	$3,000
Kentucky	Medically Needy	$217	$267	24%	22%	$2,000	$4,000
Louisiana[3]	Medically Needy	Urban counties: $100 Rural counties: $92	Urban counties: $192 Rural counties: $167	10% to 11%	14% to 16%	$2,000	$3,000
Maine	Medically Needy	$903	$1,215	100%	100%	$2,000	$3,000
Maryland	Medically Needy	$350	$392	39%	32%	$2,500	$3,000
Massachusetts	Medically Needy	$903; $1,200 those with Professional Care Assistance	$1,215; $1,615 for those with Professional Care Assistance	100% or 133%	100% or 179%	$2,000	$3,000
Michigan[3]	Medically Needy	Ranges from $341 to $408	Ranges from $458 to $541	38% to 45%	38% to 45%	$2,000	$3,000
Minnesota*	Medically Needy	$677	$911	75%	75%	$3,000	$6,000
Mississippi	No program	NA	NA	NA	NA	NA	NA
Missouri*	No program	NA	NA	NA	NA	NA	NA
Montana	Medically Needy	$625	$625	69%	51%	$2,000	$3,000
Nebraska	Medically Needy	$392	$392	43%	32%	$4,000	$6,000
Nevada	No program	NA	NA	NA	NA	NA	NA
New Hampshire*	Medically Needy	$591	$675	65%	56%	$2,500	$4,000
New Jersey	Medically Needy	$367	$434	41%	36%	$4,000	$6,000
New Mexico	No program	NA	NA	NA	NA	NA	NA
New York	Medically Needy	$767	$1,117	85%	92%	$2,000	$3,000
North Carolina	Medically Needy	$242	$317	27%	26%	$2,000	$3,000
North Dakota*	Medically Needy	$750	$1,008	83%	83%	$3,000	$6,000
Ohio*	No program	NA	NA	NA	NA	NA	NA
Oklahoma*	No program	NA	NA	NA	NA	NA	NA
Oregon	No program	NA	NA	NA	NA	NA	NA
Pennsylvania	Medically Needy	$425	$442	47%	36%	$2,400	$3,200
Rhode Island	Medically Needy	$800	$842	89%	69%	$4,000	$6,000
South Carolina	No program	NA	NA	NA	NA	NA	NA
South Dakota	No program	NA	NA	NA	NA	NA	NA
Tennessee	Medically Needy	$241	$258	27%	21%	$2,000	$3,000
Texas	Medically Needy for Pregnant Women and Children	NA	NA	NA	NA	NA	NA
Utah	Medically Needy	$370	$498	41%	41%	$2,000	$3,000
Vermont[4]	Medically Needy	$916 ($991 for Chittenden)	$916 ($991 for Chittenden)	101% or 110%	75% or 82%	$2,000	$3,000
Virginia*[3]	Medically Needy	Ranges from $281 to $421	Ranges from $358 to $508	31% to 47%	29% to 42%	$2,000	$3,000
Washington	Medically Needy	$674	$674	75%	56%	$2,000	$3,000
West Virginia	Medically Needy	$200	$275	22%	23%	$2,000	$3,000
Wisconsin	Medically Needy	$592	$592	66%	49%	$2,000	$3,000
Wyoming	No program	NA	NA	NA	NA	NA	NA

Source: *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities* , Kaiser Commission on Medicaid and the Uninsured analysis of data collected by Medicare Rights Center, 2009, February 2010.

* 209(b) eligibility states: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

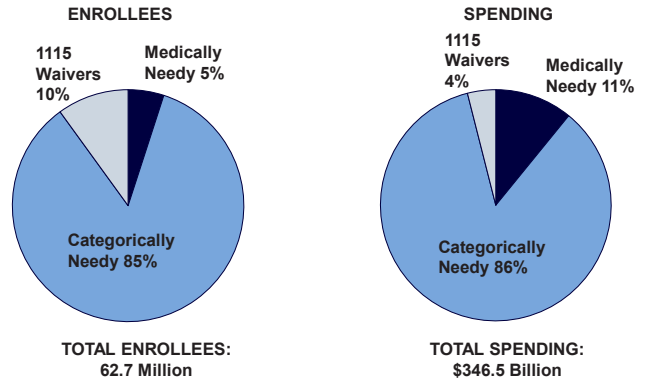
1. In 2009 the federal poverty level (FPL) equaled $10,830 for 1-person families and $14,570 for 2-person families in the 48 contiguous states and D.C. It equaled $12,460 for 1-person families and $16,760 for 2-person families in Hawaii.
2. Comparable program - Arizona's Medical Expense Deduction program allows for an individual whose income exceeds 100% FPL and who does not qualify for any other category of Medicaid, to qualify for Medicaid if they have a family income that does not exceed 40% FPL after deducting for allowable medical expenses. Please see http://law.justia.com/arizona/codes/title36/02901-04.html.
3. Income standards are based on the region in which the individual is living.
4. Vermont uses a higher income standard for Chittenden County only.

Enrollment and Spending in the Medically Needy Program

In federal fiscal year 2009, 2.8 million Medicaid beneficiaries were enrolled as medically needy at a total (federal and state) cost of $36.7 billion. Medically needy beneficiaries represent 5 percent of the entire Medicaid population and account for 11 percent of total spending (Figure 2). A 2001 analysis of the medically needy program found 3.6 million medically needy enrollees.[8] Over time, as financial eligibility for Medicaid and CHIP has expanded, enrollment in medically needy programs has declined, particularly among children.

Figure 2

Medically Needy as a Percentage of Medicaid Enrollment and Spending, 2009

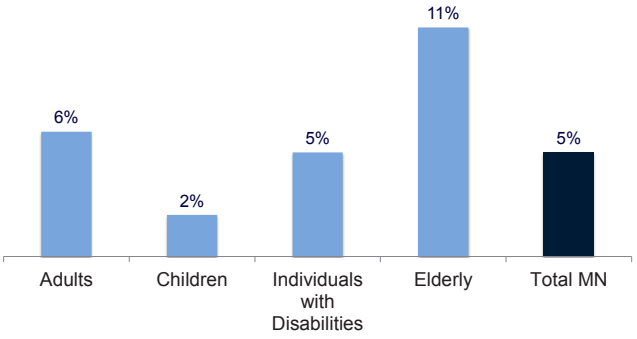


SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

While the medically needy account for just 5 percent of all Medicaid enrollees nationally (Figure 3), there is significant variation in their share of each state's Medicaid enrollment and spending (Table 2). The medically needy option accounts for 11 percent of overall elderly enrollment, reflecting the program's critical role in helping elderly individuals pay for nursing facility expenses. Medically needy coverage also is important to people with disabilities. It provides Medicaid coverage to poor and moderate-income beneficiaries who are ineligible for categorically needy Medicaid because their income (for example Social Security Disability Insurance (SSDI) payments or private pensions) is too high. The program plays a different role for non-disabled children and adults, who may qualify based on having health care costs related to an accident or severe illness.

Figure 3

Medically Needy Beneficiaries as a Percentage of Total Medicaid Enrollment, by Group, 2009



SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin.

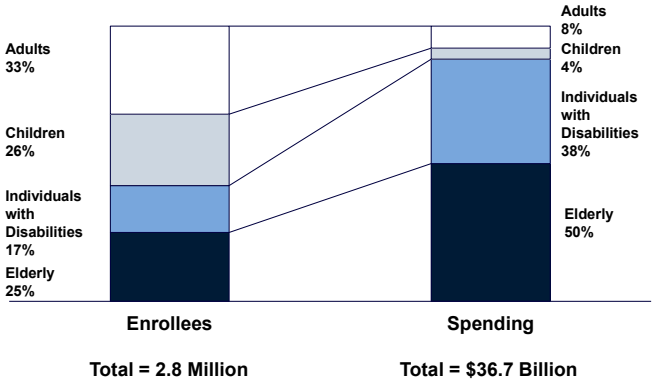
Within the medically needy population, non-disabled children and adults made up the majority of enrollees (59%) but accounted for just 12 percent of total spending. In contrast, the elderly and persons with disabilities made up 42 percent of enrollment and accounted for the vast majority of spending (88%) (Figure 4).

[8] Jeff Crowley, "Medically Needy Programs: An Important Source of Medicaid Coverage," Kaiser Commission on Medicaid and the Uninsured, January 2003, available at http://www.kff.org/medicaid/4096-index.cfm.

The distribution of medically needy enrollees varies across states. States with the highest medically needy enrollment include New York, California, and Illinois. These three states make up 68 percent of enrollment and nearly three-quarters of all spending on the medically needy. In states that offer the medically needy option, Hawaii, Montana, and Kansas had the fewest number of individuals enrolled, covering a combined 14,000 individuals. These variations reflect a state's demographic profile as well as state policy choices affecting the extent of Medicaid medically needy coverage they provide to the elderly and persons with disabilities versus other adults and children. As shown in Figure 1, 16 states do not cover any medically needy populations.

Figure 4

Medically Needy Enrollment and Spending, 2009



SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

Table 2: Medically Needy Enrollment and Spending, by State, 2009

State	Elderly		Individuals with Disabilities		Adults		Children		TOTAL	
	Enrollees (rounded to nearest 100)	$ (thousands)	Enrollees (rounded to nearest 100)	$ (thousands)	Enrollees (rounded to nearest 100)	$ (thousands)	Enrollees (rounded to nearest 100)	$ (thousands)	Enrollees (rounded to nearest 100)	$ (thousands)
TOTAL	696,800	$18,378,428	469,800	$13,771,388	929,300	$3,052,867	740,100	$1,452,001	2,836,000	$36,654,684
Alabama										
Alaska										
Arizona										
Arkansas	300	$1,830	2,400	$23,785	3,300	$10,703	600	$1,264	6,700	$37,582
California	204,600	$3,965,140	77,400	$2,554,291	112,600	$219,560	322,700	$518,325	717,200	$7,257,317
Colorado										
Connecticut	8,200	$178,901	11,200	$146,785	900	$2,634	2,500	$7,021	22,900	$335,341
Delaware										
District of Columbia	1,000	$56,398	7,700	$170,430	13,700	$45,121	22,800	$55,147	45,200	$327,097
Florida	6,000	$11,309	15,800	$161,524	109,400	$223,599	27,400	$44,347	158,600	$440,778
Georgia	2,800	$9,053	5,800	$66,633			200	$712	8,800	$76,398
Hawaii	2,700	$121,432	500	$20,712					3,100	$142,143
Idaho										
Illinois	73,600	$1,221,509	80,300	$1,833,708	267,100	$915,696	4,900	$5,870	425,900	$3,976,783
Indiana										
Iowa	600	$1,663	600	$8,852	4,900	$18,818	700	$1,329	6,700	$30,662
Kansas	1,000	$4,019	3,600	$42,352	500	$628	400	$750	5,500	$47,748
Kentucky	1,300	$10,964	3,700	$49,530	15,000	$73,748	7,600	$20,534	27,500	$154,776
Louisiana	1,600	$23,828	2,500	$47,322	5,900	$26,326	400	$984	10,400	$98,459
Maine	3,900	$134,018	900	$45,191	500	$885	700	$946	5,900	$181,040
Maryland	20,700	$900,441	19,500	$573,592	4,400	$14,576	2,400	$74,750	47,000	$1,563,359
Massachusetts	29,700	$1,182,586	8,200	$282,890					37,900	$1,465,476
Michigan	8,000	$149,015	8,900	$100,749	62,800	$224,728	40,200	$65,103	120,000	$539,595
Minnesota	15,900	$431,091	9,700	$310,873	6,800	$21,753	2,000	$2,434	34,500	$766,150
Mississippi										
Missouri										
Montana	3,000	$66,847	2,100	$40,659					5,100	$107,505
Nebraska	9,800	$285,520	2,300	$128,227	14,300	$44,282	500	$6,592	26,800	$464,621
Nevada										
New Hampshire	1,700	$34,892	3,700	$39,980	2,400	$8,184	1,400	$5,876	9,200	$88,932
New Jersey	4,700	$164,872	1,100	$18,945					5,800	$183,817
New Mexico										
New York	240,000	$8,130,854	145,900	$6,211,759	163,000	$681,509	228,900	$446,601	777,900	$15,470,724
North Carolina	21,500	$566,965	10,100	$281,897	18,900	$103,672	3,600	$10,626	54,100	$963,160
North Dakota	5,400	$174,058	2,500	$101,530	2,600	$8,688	400	$2,058	10,900	$286,334
Ohio										
Oklahoma										
Oregon										
Pennsylvania	8,200	$302,375	3,900	$47,699	34,500	$84,574	24,500	$55,181	71,000	$489,829
Rhode Island										
South Carolina										
South Dakota										
Tennessee	400	$2,206	500	$3,424	13,100	$36,819	36,000	$86,313	50,000	$128,763
Texas	100	$595	300	$2,574	52,900	$217,515	1,800	$12,979	55,100	$233,663
Utah	1,900	$17,342	3,100	$38,918	1,000	$4,964	1,100	$8,080	7,100	$69,304
Vermont	3,500	$11,972	4,500	$22,852	6,600	$20,031	2,600	$12,539	17,100	$67,394
Virginia	3,100	$38,915	5,600	$118,610	100	$174	100	$1,207	8,900	$158,906
Washington	5,500	$65,056	7,800	$87,345	100	$448	500	$1,151	13,900	$153,999
West Virginia	1,600	$33,295	15,000	$138,193	11,900	$42,914			28,400	$214,403
Wisconsin	4,500	$79,466	2,800	$49,557	100	$319	3,500	$3,282	10,900	$132,624
Wyoming										

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was then adjusted to 2009 CMS-64 spending levels.

Note: Due to data security measures, the values of cells with fewer than 50 enrollees are neither reported nor included in the final totals. Without these exclusions total national enrollment rises to 2,836,100 and total national spending rises to $36,655,010,000.
The FFY 2009 MSIS data did not report any medically needy enrollees in Rhode Island, although at the time, there was a medically needy program in place. There were 4,400 medically needy enrollees in Rhode Island in FFY 2008.

Table 3: Medically Needy Enrollment as a Share of Total Enrollment, by State, 2009

State	Elderly	Disabled	Adults	Children	TOTAL
TOTAL	11.4%	5.1%	5.6%	2.4%	4.5%
Alabama					
Alaska					
Arizona					
Arkansas	0.5%	1.8%	2.9%	0.2%	1.0%
California	20.5%	7.6%	2.5%	7.3%	6.5%
Colorado					
Connecticut	11.9%	15.4%	0.7%	0.8%	3.9%
Delaware					
District of Columbia	6.4%	20.9%	34.2%	29.4%	26.6%
Florida	1.3%	2.8%	16.3%	1.6%	4.6%
Georgia	1.7%	2.0%		0.0%	0.5%
Hawaii	10.9%	1.7%			1.3%
Idaho					
Illinois	35.1%	25.2%	38.1%	0.3%	15.8%
Indiana					
Iowa	1.4%	0.7%	3.2%	0.3%	1.3%
Kansas	2.7%	4.9%	0.9%	0.2%	1.5%
Kentucky	1.4%	1.6%	10.8%	1.8%	3.1%
Louisiana	1.4%	1.2%	2.8%	0.1%	0.9%
Maine	6.5%	1.3%	0.5%	0.5%	1.7%
Maryland	28.3%	14.6%	2.0%	0.6%	5.4%
Massachusetts	17.4%	3.2%			2.3%
Michigan	5.8%	2.7%	14.3%	3.6%	5.9%
Minnesota	16.6%	7.7%	2.9%	0.5%	3.9%
Mississippi					
Missouri					
Montana	27.9%	10.2%			4.4%
Nebraska	40.8%	6.4%	35.9%	0.3%	10.6%
Nevada					
New Hampshire	10.9%	13.4%	11.2%	1.5%	5.8%
New Jersey	3.2%	0.6%			0.6%
New Mexico					
New York	40.5%	21.8%	8.4%	11.4%	14.9%
North Carolina	11.8%	3.3%	5.3%	0.4%	3.0%
North Dakota	58.6%	22.3%	16.6%	1.1%	14.4%
Ohio					
Oklahoma					
Oregon					
Pennsylvania	3.5%	0.7%	8.1%	2.5%	3.2%
Rhode Island					
South Carolina					
South Dakota					
Tennessee	0.3%	0.1%	4.6%	4.7%	3.3%
Texas	0.0%	0.1%	9.0%	0.1%	1.2%
Utah	12.1%	8.4%	1.3%	0.7%	2.4%
Vermont	17.4%	19.3%	9.2%	3.8%	9.4%
Virginia	3.0%	3.3%	0.0%	0.0%	0.9%
Washington	6.3%	4.3%	0.0%	0.1%	1.2%
West Virginia	3.7%	13.0%	19.7%		6.8%
Wisconsin	3.1%	1.9%	0.0%	0.8%	1.1%
Wyoming					

Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FFY 2009 MSIS, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was then adjusted to 2009 CMS-64 spending levels.

Note: Due to data security measures, the values of cells with fewer than 50 enrollees are neither reported nor included in the final totals. The FFY 2009 MSIS data did not report any medically needy enrollees in Rhode Island, although at the time, there was a medically needy program in place. Two percent of the total Rhode Island Medicaid population was medically needy in FFY 2008.

Children and Families. In federal fiscal year 2009, over 929,000 non-disabled adults and 740,000 non-disabled children were enrolled in a state medically needy program. California enrolled the highest number of medically needy children (322,700), representing 44 percent of all medically needy child enrollment, 36 percent of spending on medically needy children, and 7 percent of all Californian non-disabled children enrolled in Medicaid. California uses a higher income eligibility threshold than other states to determine financial eligibility which translates into greater opportunities for children with large medical bills to spend-down to Medicaid eligibility. Illinois had the largest adult medically needy population (267,100) followed by New York (163,000). Spending on medically needy adults in these two states represented half of all adult medically needy spending.

For non-disabled children, the medically needy program provides a pathway to Medicaid for those who exceed categorically needy income eligibility levels. Federal rules require that states provide Medicaid to children under age 6 up to 133 percent of the Federal Poverty Level ($30,656 for a family of 4 in 2012) and for those ages 6 to 18 up to 100 percent of the FPL ($23,050 for a family of 4 in 2012). Most states have expanded eligibility for children above the minimum levels. As of January 2012, half of the states (26, including DC) cover children in families with incomes up to at least 250 percent FPL.[9] Children in families with higher incomes can qualify for the Children's Health Insurance Program (CHIP). States that cover children under CHIP receive a higher FMAP than under Medicaid, so children in this higher income range are not likely to be enrolled in a medically needy option. Children with incomes above the CHIP income range could potentially spend down to Medicaid medically needy eligibility. Together Medicaid and CHIP function as key sources of coverage for low- and moderate-income children.

The federal minimum level at which states must cover parents through Medicaid is below poverty in every state and below half of poverty in nearly all states. Most states have expanded parent eligibility above this minimum through optional Medicaid authority or waiver or state-funded programs but often with more limited benefits and higher cost sharing than Medicaid. Parents can qualify for Medicaid medically needy coverage by having income below the state's MNIL or by incurring out-of-pocket health expenses that would reduce their income below the applicable MNIL.

The Elderly and People with Disabilities. In federal fiscal year 2009, the elderly accounted for one-quarter (696,800) of total medically needy beneficiaries and people with disabilities accounted for 17 percent (469,800) of total medically needy enrollment. Overall, the elderly were responsible for half of medically needy spending and non-elderly people with disabilities were responsible for 38 percent of total medically needy spending. New York and California enrolled the largest number of elderly medically needy individuals, representing 64 percent of all medically needy elderly enrollment and 66 percent of total spending on elderly medically needy beneficiaries. New York also enrolled the largest number of individuals with disabilities in a medically needy program (145,900).

The medically needy program is an important source of coverage for some elderly and persons with disabilities who are ineligible for SSI because their income is too high. For these

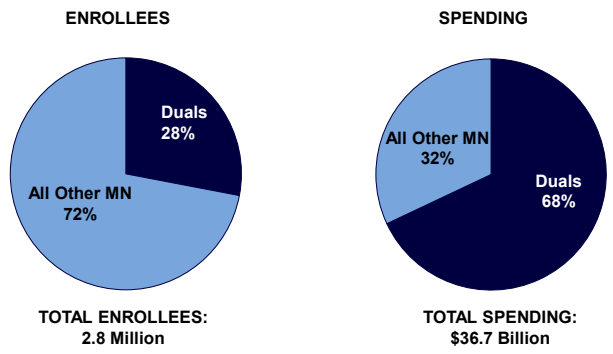
[9] Kaiser Commission on Medicaid and the Uninsured, "Where are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-disabled Adults," March 2012, available at http://www.kff.org/medicaid/7993.cfm.

individuals, the medically needy pathway may be the only way they can qualify for Medicaid. States also have the option to cover persons with disabilities and the elderly up to 100 percent FPL with resources at the SSI level. Most people with disabilities, who qualify under the medically needy option, receive services in the community (85%) compared to 58 percent of elderly medically needy who live in the community. For elderly and persons with disabilities living in the community, Medicaid coverage is often the only way they are able to pay for personal care, prescription drugs, or other medical services. While Medicare assists the elderly and some people with disabilities, it leaves many expenses uncovered, including long-term institutional or community-based services and supports.

For people living in nursing facilities, the medically needy program is particularly important because the cost of care is expensive and many people do not have sufficient income or assets to pay for this care. In states without a medically needy program, an individual with $1 of income more than the 300 percent of SSI limit is ineligible for Medicaid, regardless of the cost of nursing home care.[10] Institutionalized individuals whose income exceeds the state's MNIL or categorically needy must spend-down to the state's MNIL to qualify for Medicaid. Depending on the state, the income limit for institutionalized individuals could be either the SSI-related income standard or a higher income eligibility level permitted under the "300 percent rule." Thirty-eight states allow people needing nursing home care to qualify for Medicaid with income up to 300 percent of the benefit amount payable to an individual with no income or resources ($2,094/month in 2012).[11] Once an institutionalized individual has established Medicaid eligibility, most of the income that the individual receives is applied to the cost of the institutional care,[12] with the exception of a small "personal needs allowance," typically $50 or less per month. Individuals are also

Figure 5

Medically Needy as a Percentage of Medicaid Enrollment and Spending, by Dual Status, 2009



SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

[10] In a 209(b) state, spend-down is mandatory as a condition for maintaining more restrictive eligibility standards than SSI. Individuals may spend down to the 209(b) income level to qualify for Medicaid. Another exception occurs in a state that recognizes Miller Trusts – a trust used specifically to meet the state's income threshold for Medicaid eligibility. In Miller Trust states, individuals with income that exceeds the Special Income Limit may assign the "excess" to the Trust. Monies in the trust may be used only to pay for specific costs, such as the support of a community spouse.

[11] Kaiser Commission on Medicaid and the Uninsured and the Medicare Rights Center, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities," Kaiser Commission on Medicaid and the Uninsured, February 2010, available at http://www.kff.org/medicaid/8048.cfm. This is an optional categorically needy group that some states cover as an alternative to covering the medically needy because it bounds their financial exposure for the costs of institutional and home and community-based services.

[12] An exception to this occurs within the context of spousal impoverishment protections that allow states to disregard the income of the community spouse and allow the community spouse to keep half of the couple's joint assets subject to minimum and maximum thresholds.

required to meet the medically needy resource requirements, typically those used in the SSI program.

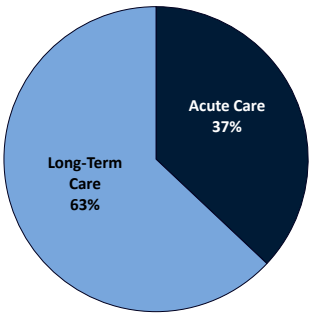
Dual Eligible Beneficiaries. People who are dually eligible for both Medicare and Medicaid accounted for about one-quarter of the medically needy population but two-thirds of medically needy spending (Figure 5), reflecting their more intensive need for services. Medicaid provides coverage to more than 9 million Medicare beneficiaries helping them with Medicare's premiums and cost sharing requirements, and paying for the services that are not covered by Medicare, such as long-term services and supports. Many states have efforts underway to improve integration of care for individuals dually eligible for Medicare and Medicaid, including providing more community-based options for beneficiaries who are in need of long-term services and supports.[13]

What Services Do Medically Needy Enrollees Rely On?

Medically needy beneficiaries rely on a range of Medicaid services to meet their acute and long-term services and supports needs. In federal fiscal year 2009, total federal and state Medicaid spending on services was $36.7 billion (Figure 6). Spending on acute care services, including payments to managed care, inpatient, outpatient/physician services and prescription drugs, totaled $13.5 billion. In contrast, spending on long-term services and supports was nearly double, totaling $23.2 billion. Within long-term care services, the vast majority of spending went toward the cost of providing institutional services (81%), including nursing facility, ICF/MR, and inpatient psychiatric services (Figure 7). The remainder of long-term services spending went toward home and community-based services. Payment of Medicare premiums and DSH payments were excluded from this analysis.

Figure 6

Medically Needy Spending by Service, 2009

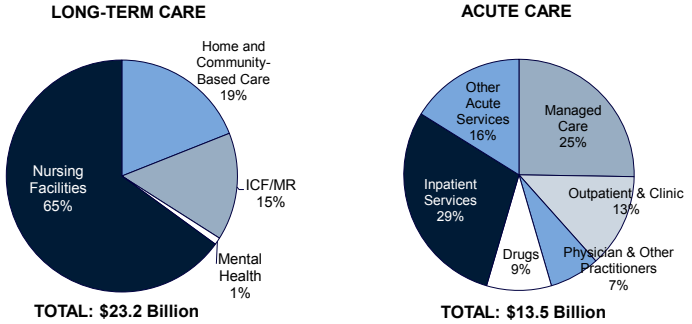


TOTAL: $36.7 Billion

SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

Figure 7

Medically Needy Spending by Service, 2009



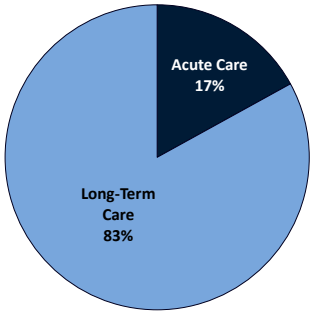
TOTAL: $23.2 Billion **TOTAL: $13.5 Billion**

NOTE: The Managed Care grouping includes HMO, PHP, and PCCM.
SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

[13]MaryBeth Musumeci, "State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS," Kaiser Commission on Medicaid and the Uninsured, October 2012, available at http://www.kff.org/medicaid/8369.cfm

Figure 8

Medically Needy Spending by Service for Dual Eligible Beneficiaries, 2009



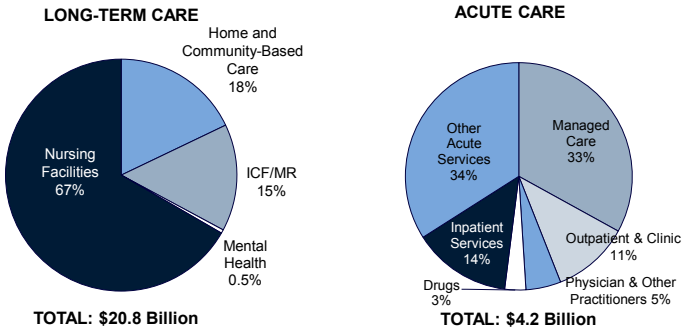
TOTAL: $25.0 Billion

SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

Medically needy beneficiaries who are dually eligible for Medicare and Medicaid accounted for $25 billion (or 68%) of total Medicaid medically needy spending (Figure 8). When Medicare premiums are excluded, 83 percent of Medicaid expenditures for medically needy dual eligible beneficiaries are for long-term services and supports. Amongst dual eligible beneficiaries, Medicaid coverage is supplemental to Medicare, which is the primary payer for acute care, resulting in only 17 percent of Medicaid expenditures for medically needy dual eligible beneficiaries going to acute care. Sixty-seven percent of long-term services and supports spending for dually eligible medically needy beneficiaries went toward nursing facilities (Figure 9). Most of the remaining long-term services and supports spending was on home and personal care services, which are composed of home and community-based services, home health, and personal care. Only 3 percent of 2009 acute care expenditures for medically needy dual eligible beneficiaries were for prescription drugs, as nearly all prescription drug spending for dual eligible beneficiaries was absorbed into Medicare in January 2006 with the implementation of Medicare Part D. However, states are required to make a substantial contribution towards this benefit through monthly "clawback" payments to the federal treasury. The remaining acute care spending on medically needy dual eligible beneficiaries went toward payments to managed care, Medicaid's financing of Medicare-covered acute care services (e.g., hospital, physician, and lab/x-ray services) and other acute care services that are not covered by Medicare, such as dental care, vision, and hearing services.

Figure 9

Medically Needy Spending by Service for Dual Eligible Beneficiaries, 2009



TOTAL: $20.8 Billion

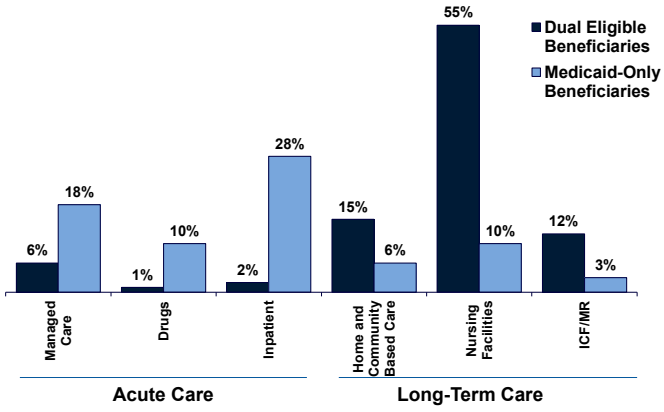
TOTAL: $4.2 Billion

NOTE: The Managed Care grouping includes HMO, PHP, and PCCM.
SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

Compared to all other medically needy beneficiaries, medically needy beneficiaries who are dually eligible for Medicare and Medicaid had a higher percentage of spending on long-term services and supports (Figure 10). Notably, the duals had a higher percentage of spending on nursing facility services (55% versus 10%), all home and community-based services including HCBS, home health and personal care (15% versus 6%), and ICFs/MR (12% versus 3%).

Figure 10

Medically Needy Spending by Service for Dual Eligible and Medicaid-Only Beneficiaries, 2009



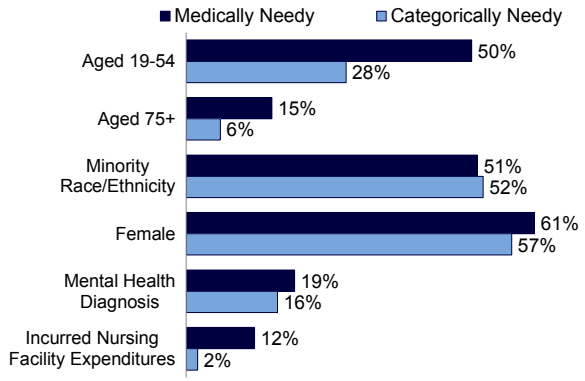
NOTE: The Managed Care grouping includes HMO, PHP, and PCCM.
SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

How Do Medically Needy Enrollees Compare to Categorically Needy Enrollees?

Individuals who qualify for Medicaid through the medically needy option differ from others on Medicaid who qualify through categorically needy pathways in their age and nursing facility spending. By definition, the medically needy have more income than the categorically needy. In general, the medically needy incur medical expenses in order to qualify and, to remain eligible, repeatedly incur medical expenses. The medically needy option plays a large role for elderly Medicaid beneficiaries. With 15 percent of the medically needy age 75 or older, the medically needy population is generally more aged than the categorically needy, of whom only 6 percent are age 75 or older. In addition, 12 percent of the medically needy incurred nursing home expenditures, while only 2 percent of the categorically needy did (Figure 11). In other ways, such as race and ethnicity, gender, and mental health diagnoses, the composition of the medically needy is similar to the categorically needy, with the exception of income.

Figure 11

Comparison of Medically Needy and Categorically Needy, 2009

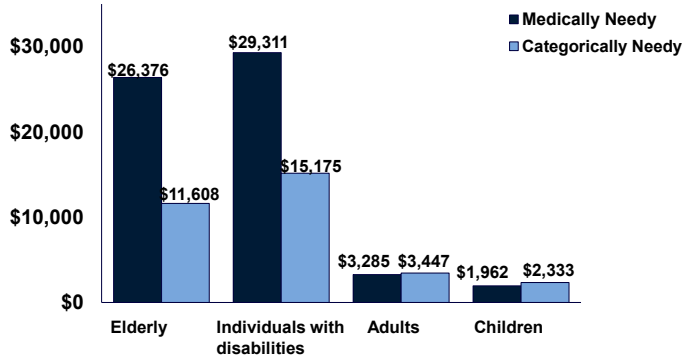


SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

Spending per medically needy enrollee varied by eligibility group and differed from spending for categorically needy enrollees. Among medically needy enrollees, individuals with disabilities and elderly individuals had the highest average annual per capita spending (at $29,311 and $26,376, respectively) compared to significantly lower costs for adults and children ($3,285 and $1,962) (Figure 12). Moreover, for elderly individuals and individuals with disabilities, medically needy enrollees had significantly higher spending compared to categorically needy individuals. In contrast, spending for adults and children was similar for both medically needy and categorically needy enrollees. Higher per capita expenditures for the elderly and individuals with disabilities, relative to adults and children, reflect their intensive use of both acute and long-term services and supports.

Figure 12

Medicaid Expenditures Per Enrollee, 2009



SOURCE: KCMU and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. Because 2009 data was unavailable, 2008 MSIS data was used for Pennsylvania, Utah, and Wisconsin. Spending for these states was adjusted to 2009 CMS-64 spending levels.

Policy Implications

The medically needy option is complicated for individuals to navigate and for states to administer; however, it provides an important safety net for people whose medical costs overwhelm their income. The opportunity to spend down is very important to elderly individuals residing in nursing facilities and children and adults with disabilities who live in the community and incur high health care expenses. Still, the process of accounting for incurred expenses during a specific budget time period (one to six months) and paying claims after the spend-down has been met adds administrative complexity for states and can make medically needy coverage less consistent for individuals, especially for those who do not have high, recurring medical expenses. Presumably, a number of individuals cycle in and out of medically needy eligibility, depending on whether or not their expenses are sufficient to meet the spend-down obligation for a specific budget period. For example, if an individual has a $400 monthly spend-down obligation, but she resides in a state with a six-month budget period, she must incur $2,400 of expenses before her Medicaid coverage begins. Her medically needy eligibility would extend only during the portion of the 6-month budget window after she had met her spend-down obligation, and then the $400 per month spend-down obligation would reset. In contrast, in a state that redetermines eligibility for children (or any other group) once every 12 months, an individual who is determined eligible would remain eligible until redetermination unless there is a change in circumstances that may affect his or her eligibility.[14]

States have tools to simplify medically needy eligibility with authority to offer income deductions beyond those offered by SSI in order to loosen eligibility standards for potential medically needy beneficiaries, commonly referred to as the 1902(r)(2) regulations.[15] These regulations also allow states to increase the allowable resource limit. Iowa, for example, has an asset limit of $10,000 for an individual or couple. This flexibility, however, is not unlimited. Guidance from the Centers for Medicare and Medicaid Services (CMS) states that a state may not limit deductions only to waiver beneficiaries, or only to persons in institutions. Targeting can only be based on eligibility groups such as the medically needy aged or medically needy disabled persons or a combination of both groups.[16] At least initially, these targeting rules appear to significantly limit the viability of income deductions due to the potential financial burden on states.[17] However, CMS has stated that a state can choose to disregard specific kinds of income – examples include Social Security Disability Income, interest from savings accounts, income put into a medical savings account, or used to maintain or repair a home.[18] These types of income disregards may be particularly important for elderly and disabled individuals who wish to avoid entering a nursing home and remain living in the community by having to incur fewer expenses before they gain Medicaid eligibility.

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[14] 42 CFR 435.916
[15] 42 CFR 435.601
[16] CMS, Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers (May 11, 2001).
[17] National Senior Citizens Law Center, "Medicaid Payment for Assisted Living, Overview of Medically Needy Eligibility: A Resource for Advocacy and Policy Development," February 2011, available at http://medicaidalseries.org/wp-content/uploads/White-Paper-Medically-Needy-Feb-2011-FINAL1.pdf.
[18] CMS, Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and Resources: Questions and Answers (May 11, 2001).

Despite tight budget conditions, states have maintained medically needy programs over the past several years. During the most recent recession, states experienced strong enrollment and spending growth along with diminished state revenues. As a result, many sought to reduce Medicaid costs by restricting provider rates and benefits and implementing new controls on prescription drug spending.[19] However, eligibility for Medicaid has remained stable due to the maintenance of eligibility (MOE) requirement included in ARRA and extended in the ACA.[20] Moreover, several states made positive changes to their medically needy programs over the last several years ranging from increases in the MNILs (North Dakota raised its MNIL from 58% to 83% of FPL)[21] to increases in asset levels (New York raised its asset levels from $3,000 to $13,000 for a family of one with the asset limit further rising with household size). Montana increased the general income deduction to $100 for the medically needy population.[22]

Experience with severe budget shortfalls over the past decade, however, demonstrates that without the MOE requirement, Medicaid medically needy programs can be vulnerable during tight budget years. In 2003, Oklahoma and Oregon both eliminated their programs due to shortfalls in their state budgets. When Oregon's program was discontinued, 8,750 people lost coverage.[23] When Oklahoma eliminated its medically needy program a few months later, an estimated 800 children, 6,500 parents, and 1,000 seniors lost coverage.[24] Reducing medically needy coverage could result in greater financial burden on these individuals, in these individuals going without necessary care, and in providers absorbing costs of uncompensated care.

The medically needy option helps facilitate access to Medicaid home and community-based services. The vast majority of medically needy people with disabilities use community-based services (85%) and over half (58%) of the medically needy elderly access care in the community. Community-based care is an important option for dual eligible beneficiaries, who account for over a quarter of medically needy enrollment and 68 percent of medically needy spending. States utilize HCBS waivers in order to provide services in the community as an alternative to institutional care provided in a nursing facility, ICF/MR or hospital. These waiver programs permit Medicaid beneficiaries who meet requirements for admission to an institutional setting (or

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[19] Vern Smith et al, "Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends," Kaiser Commission on Medicaid and the Uninsured, October 2011, available at http://www.kff.org/medicaid/8248.cfm.

[20] As a condition of accepting additional federal fiscal relief through the ARRA, states were required to ensure that the eligibility standards, methodologies, or procedures under their Medicaid State Plan as well as under any waivers or demonstration programs were not more restrictive than those in effect on July 1, 2008. The ARRA enhanced funding and MOE requirements expired on June 30, 2011, but the ACA extended MOE requirements. Under the ACA, states must maintain eligibility standards and enrollment and renewal procedures that were in place on March 23, 2010 until 2014 for adults and until 2019 for children with some limited exceptions. Ibid.

[21] Vern Smith et al., "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends," Kaiser Commission on Medicaid and the Uninsured, available at http://www.kff.org/medicaid/8105.cfm.

[22] Vern Smith et al., "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession," Kaiser Commission on Medicaid and the Uninsured, September 2009, available at http://www.kff.org/medicaid/7985.cfm.

[23] Judy Zerzan. "Oregon's Medically Needy Program Survey," Office for Oregon Health Policy and Research, February 2004.

[24] Leighton Ku and Sashi Nimalendran. "Losing Out: States are cutting 1.2 to 1.6 Million Low-Income people from Medicaid, SCHIP and Other State Health Insurance programs." Center on Budget and Policy Priorities, December 22, 2003.

who would meet these requirements absent the HCBS waiver services) to receive appropriate services and supports in their homes or a community-based setting and maintain both their independence and ties to family and friends. States may impose a special income disregard for Medicaid HCBS waiver applicants whose incomes are above waiver limits. Louisiana has adopted this authority with an income disregard equal to the state's average monthly cost of nursing facility care for individuals who do not qualify under the 300 percent of SSI category. Without this authority, individuals not categorically eligible would have to meet spend-down requirements each month to maintain Medicaid waiver eligibility.[25]

Conclusion

In 2009, 2.8 million Medicaid beneficiaries received coverage through the medically needy option at a federal and state cost of nearly $37 billion per year. These individuals represent a small but costly segment of the Medicaid population. Medicaid medically needy programs have always been complicated for individuals to navigate and for states to administer, but these programs have provided an important safety net for many whose medical costs overwhelm their income. Many states have successfully used medically needy programs to expand benefits to individuals with high-cost conditions who would otherwise be ineligible for Medicaid coverage. Through medically needy programs, states also have a vehicle to expand Medicaid coverage to populations that may otherwise be ineligible for Medicaid.

It will be important to consider what happens to Medicaid medically needy programs and to the individuals who currently receive coverage under the medically needy option post-2014. The ACA did not change any current requirements for medically needy eligibility under section 1902(a)(10)(C) of the Act. However, under the ACA as interpreted by the Supreme Court, states have the option to expand Medicaid coverage to non-disabled adults under age 65 with incomes at or below 138 percent FPL ($15,415 per year for an individual in 2012), beginning in January 2014.[26] States also will have the option to cover non-elderly individuals who are not otherwise eligible for Medicaid with incomes above 138 percent FPL, up to a maximum income limit set by the state.[27] In addition, the Exchanges will provide a new coverage option for millions of currently uninsured individuals with advance premium tax credits (APTC) available to individuals up to 400 percent FPL to help offset the costs of coverage. These new optional coverage expansions have the potential to reach individuals who currently qualify for Medicaid through the medically needy option.

Looking forward, since the elderly are not affected by the ACA coverage expansion, the medically needy option remains an important source of coverage for this population, by providing access to care for individuals with long-term services and supports needs in both community and institutional settings. States may continue to offer medically needy coverage to this population post-2014 but would still be required to extend coverage to children and pregnant women. The medically needy option would also continue to help children such as Sean, an 11-

[25] Gene Coffey, "Helping Medicaid's Medically Needy Stay at Home," presentation to NASUAD's 2011 HCBS Conference, National Senior Citizens Law Center, September 13, 2011.
[26] MaryBeth Musumeci, "A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion," Kaiser Commission on Medicaid and the Uninsured, August 2012, available at http://www.kff.org/healthreform/8347.cfm.
[27] 42 C.F.R. § 435.218.

year old boy with behavioral health problems, afford the cost of a $10,000 per month residential treatment center. Ultimately, states that elect the ACA's Medicaid expansion will have to decide if covering an individual through the Medicaid expansion or the Exchange can substitute for medically needy coverage. States will likely consider whether they can save money and reduce administrative burden by covering some medically needy individuals under other eligibility pathways, without compromising on scope of services and affordability.

This brief was prepared by Molly O'Malley Watts, Principal of Watts Health Policy Consulting and Katherine Young of the Kaiser Commission on Medicaid and the Uninsured. The authors wish to thank Andy Schneider, Samantha Artiga and MaryBeth Musumeci for their helpful comments and review of the brief.

Appendix A

BACKGROUND ON MEDICALLY NEEDY ELIGIBILITY

The medically needy option provides a pathway to Medicaid coverage for people who have extensive health care needs, yet start out with too much income to qualify for cash assistance and therefore, Medicaid. The role of the medically needy option is unique in that it provides a last chance opportunity for becoming eligible for Medicaid for individuals not eligible as categorically needy. Under current law, in exchange for receiving federal Medicaid matching funds, states are required to cover certain federal core groups, listed in Appendix Table 1. States also have flexibility to expand Medicaid eligibility beyond federal minimum standards to cover additional "optional" groups and receive federal Medicaid matching funds for the costs of their services.

The term "medically needy" was used by the architects of the Medicaid program in 1965 to distinguish this population from other populations eligible for Medicaid known as the "categorically needy." At that time, in order to qualify for Medicaid, it was not sufficient for an individual to be poor. An individual also had to fit into a certain category – i.e., aged, blind, disabled, a dependent child, or a parent or caretaker relative of a dependent children. These categories reflected cash assistance policy of the day, to which Medicaid eligibility was closely linked. (Poor working-age adults without disabilities who did not have dependent children could not qualify for Medicaid because they were not categorically eligible). Within the categorically needy, there were some populations that, as a condition of participating in Medicaid, states were required to cover – e.g., individuals receiving cash assistance through the Aid to Families with Dependent Children (AFDC) program. States also had the option of covering other categorically needy populations, such as children aged 20, 19, or 18 who were no longer receiving AFDC benefits (because cash assistance eligibility ended at age 18) but who still met the income and resource requirements of the state AFDC program. Both mandatory and optional categorically needy groups have income and resource eligibility thresholds tied to specific dollar amounts; an individual with countable income or resources even one dollar above those amounts cannot qualify. As with the optional categorically needy populations, coverage of the "medically needy" is also optional. This option allows states to receive federal Medicaid matching funds for the costs of health and long-term care services for individuals who meet categorical eligibility requirements but whose incomes exceed the income eligibility thresholds for coverage as a categorically needy individual.

States may choose to provide medically needy coverage to one or more groups: the elderly, individuals with disabilities, parents and caretaker relatives, and certain other financially eligible children up to age 21. However, states which elect to implement the medically needy option are required to include certain children under age 19 and pregnant women who, except for income and resources, would be eligible as categorically needy. Moreover, income standards under the medically needy option must be the same for all covered groups, including low-income families, the elderly, and people with disabilities.

Appendix Table 1:
Medicaid Eligibility Groups, 2011

Federal Core Enrollees	State Expansion Enrollees
• Pre-school children ≤133% FPL ($24,645 per year for a family of three) • School-age children ≤100% FPL ($18,530 per year for a family of three) • Pregnant women ≤133% FPL • Parents <state's AFDC limit as of July 1996 (median = 64% FPL or $11,859 for a family of three) • Elderly and disabled individuals receiving SSI (<75% FPL $8,168 per year for an individual) • Certain working people with disabilities • Medicare buy-in groups (QMB, SLMB, QI)	• Low-income children above federal core minimum income thresholds • Low-income parents >1996 AFDC limits • Pregnant women >133% FPL • Adults ≤133% FPL* • Disabled and elderly individuals above SSI level, but <100% FPL ($10,890 for an individual) • Nursing home residents above SSI level, but below 300% of SSI ($2,022 per month) • Individuals at risk of needing nursing facility or ICF-MR care (HCBS waiver enrollees) • Certain working people with disabilities above SSI levels • Section 1115 waiver enrollees (including family planning waiver enrollees) • Medically needy

* Effective April 2010, the ACA provides states with a new option to receive federal funds to cover, non-pregnant, non-disabled adults age 19 to 64 without dependent children with incomes up to 133% FPL.
Source: Courtot, Lawton, and Artiga, *Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options*, Kaiser Commission on Medicaid and the Uninsured, January 2012.

Most states offer the full Medicaid benefit package to medically needy individuals, but states are permitted to offer a more limited benefit package than for categorically needy beneficiaries.[28] States are also permitted to place different limitations on covered services for the medically needy and charge higher cost sharing for medically needy beneficiaries. Services furnished to the medically needy are matched at a state's regular federal medical assistance percentage (FMAP).

Federal requirements for medically needy programs are:

- If a state covers institutional services for any medically needy individual, it must also cover ambulatory services for that individual;
- States must provide ambulatory services to medically needy children age 18 and under;
- States must cover prenatal care and delivery services for medically needy pregnant women; and
- If a state provides medically needy coverage for services in Institutions for Mental Diseases (IMDs) or Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) (or

[28] Barbara Edwards, Sandy Kramer and Linda Elam, "The Impact of Part D on Dual Eligibles Who Spend-Down to Medicaid," Kaiser Commission on Medicaid and the Uninsured, April 2007, available at http://www.kff.org/medicaid/7629.cfm.

both), then it must provide to all medically needy beneficiaries either (1) all required services for the categorically needy (except nurse practitioner services and free-standing birth center services) or (2) the following services: inpatient hospital services, outpatient hospital services, laboratory and x-ray services, nursing facility services, physician services, and nurse-midwife services.[29]

[29] Jeff Crowley, "Medically Needy Programs: An Important Source of Medicaid Coverage," Kaiser Commission on Medicaid and the Uninsured, January 2003, available at http://www.kff.org/medicaid/4096-index.cfm.

Appendix B

HOW TO CALCULATE SPEND-DOWN

States may choose to provide medically needy coverage to one or more groups: the elderly, individuals with disabilities, parents and caretaker relatives, and certain other financially eligible children up to age 21. States must use a single income eligibility standard for all medically needy recipients (regardless of whether they are families or SSI-related) that takes into account the number of persons in the assistance unit.[30] This single income standard is called the "medically needy income level" (MNIL). By federal law, the MNIL may not exceed 133 percent of the maximum payment for a similar family under the state's AFDC program in place on July 16, 1996. Individuals who have incomes above the state's MNIL, but who fall below that level once their medical expenses are deducted, can qualify for Medicaid coverage as medically needy through spend-down.

To spend down, an individual must incur (but not necessarily pay) medical and remedial care expenses that bring their countable income below the MNIL. Federal rules identify expenses that count toward the spend-down requirements including expenses for Medicare and other health insurance premiums, deductibles and coinsurance; expenses for necessary medical and remedial services recognized under state law but not included in the Medicaid state plan; and, expenses for necessary medical and remedial services that are included in the Medicaid state plan, including those that exceed limitations on amount, duration or scope of services. Several factors affect the determination of Medicaid eligibility through spend-down, including:

- Income eligibility
- Budget period
- Pay-in spend-down

Income Eligibility

There are two components to determining income eligibility, the income standard and the income methodology. The standard is the maximum amount of countable monthly income an individual can have and still be eligible for Medicaid. The methodology is used to determine how much of a person's income is counted toward the income standard.

In most circumstances, federal regulations require a state to use a single income standard for all medically needy beneficiaries. States have broad discretion in setting the income standard, although they can only receive federal matching payments for individuals whose income is below a maximum of 133 percent of the state's 1996 AFDC payment level. States can adjust this level for inflation, but adjustments cannot exceed increases in the consumer price index. The MNIL can also vary between urban and rural areas based on differences in housing costs. States are permitted, but not required, to increase the MNIL as family size increases, but they are prohibited from decreasing MNIL as family size increases. In most states, the income standard must be set at an amount no lower than the lowest income standard used to determine eligibility under the related cash assistance programs. The 209(b) states are allowed an exception to

[30] 42 CFR 435.811

establish a more restrictive income standard for medically needy blind and disabled individuals than for medically needy families with children.

States have flexibility in establishing income methodology, and the rules that each state chooses to apply can vary dramatically. Elements of the methodology include: definitions of income, exclusions or disregards of income, composition and number of persons included in the budgetary unit, deeming of income from spouses and parents, treatment of regular and periodic income, and ownership of income. Except for 209(b) states, the methodology that a state uses to count income can be no more restrictive than those that are used in the most closely related cash assistance program. Therefore, a state may have a single income standard for all groups, but use a different methodology for determining whether income falls below the standard for children, parents, people with disabilities, and the elderly. However, states are still bound by the 133 percent of AFDC payment standard constraint.

Budget Period

In determining eligibility, the state selects a budget period of between one and six months, during which time an applicant will be assessed to determine whether they meet their spend-down obligation.[31] If, after deducting medical costs, the individual's income is below the state established MNIL, the individual will qualify for Medicaid coverage for the remainder of the period. There is no Medicaid coverage until the point in the spend-down period that the individual has hit the MNIL and continues through the last day of the states spend-down period.

Depending on an individual's circumstance, and whether or not his or her medical expenses are incurred on an ongoing basis, the length of the budget period can make it easier or harder for an individual to meet the spend-down requirement. States are permitted to use more than one budget period. For example, the state could establish one budget period for institutionalized individuals and another for non-institutionalized individuals. Further, the state could establish two budget periods for non-institutionalized individuals. In this case, however, the state must allow the applicant to select which budget period will be applied.

The length of the budget period can pose a significant barrier to Medicaid coverage for people in certain circumstances, including persons in need of home and community based services or persons desiring to live in an assisted living center. This is because the full spend-down for the length of the budget period must be incurred before Medicaid coverage begins. In this case, either the individual needs to pay the full spend-down with his or her own funds or the provider must be willing to wait for payment until Medicaid coverage begins. Institutional providers and larger providers may be more willing to begin caring for an individual before they are determined to be eligible for Medicaid, something that smaller, community based providers are unable to do.

There are advantages to both a short and a long budget period. Presumably, a long budget period is administratively preferable. However, for many beneficiaries, a shorter budget period makes it easier to qualify for Medicaid because they only need to meet the spend-down requirement one month at a time. For some individuals, however, a longer budget period may be preferable if they have recurring high-cost health conditions. In this case, they may prefer to meet their

[31] 42 CFR 435.831

spend-down and then have a longer period of Medicaid coverage before having to spend down once again.

Appendix Table 2 shows an example of how the spend-down amount is calculated. Assume a state has a 6-month spend-down period. The applicant has a monthly income of $650 and the eligibility standard is $450 a month. To meet the eligibility level, the applicant must incur health-related expenses of $1,200 ($200 x 6) before she is eligible for Medicaid. To remain qualified, the applicant must incur enough health expenses to reduce her income to the eligibility standard each month.

Appendix Table 2: Spend Down Example for the Medically Needy

Individual's Countable Monthly Income	$650
State's Medically Needy Monthly Income Limit	$450
Income Over State Limit	$200
State Spend-Down Period	6 months (Varies by state from 1 - 6 months)
Individual's Spend-Down Amount	$1,200 Income over state's limit times spend down period ($200 x 6 months)

Pay-In Spend-down

States can also provide an alternative method for individuals to meet the spend-down requirement, called Pay-in Spend-down. This involves individuals making a cash payment to the state to satisfy the spend-down requirement. For example, if an individual has a spend-down obligation of $500, which is partially satisfied through incurring $300 of medical expenses, the state can accept a cash lump sum or installment payment of $200 for the balance. It can be beneficial to allow individuals to use a pay-in spend-down. For example, if an individual pays in, then they can be eligible for Medicaid before any medical expenses are incurred. This would mean that all expenses are billable at Medicaid payment rates. If an individual must incur expenses before they are eligible, then the services would not be billed at Medicaid rates or they would not be eligible for discounts and rebates negotiated by Medicaid. The following states utilize the pay-in option: Illinois, Minnesota, Missouri, Montana, New York, Ohio and Utah.

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