5/11/01

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

Questions and Answers

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.

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.

D. Miscellaneous

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 furthe r 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	

Group Description	Group Statutory Citation	1902(r)(2) Available ?	Notes
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)).

<u>NOTES</u>

- 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 "TWWIIA" 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 *	
Would be eligible for cash assistance (AFDC or SSI) if they were not in a medical institution. Receiving, or would be eligible to receive if they were not in a medical institution, a State supplement payment.	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 TWWIIA Basic Coverage Group.	1902(a)(10)(A)(ii)(XV)	Yes	
Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group.	1902(a)(10)(A)(ii)(XVI)	Yes	
Children under age 21 who were in foster care on 18th 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 *	