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Third in a series on *Medicaid and the Michigan Budget*

Medicaid Eligibility

In Brief

Medicaid eligibility is determined by: the Michigan Family Independence Agency; the Social Security Administration; and the Michigan Department of Community Health. The Social Security Administration determines eligibility for Supplemental Security Income which automatically results in eligibility for Medicaid.

Requirements for eligibility are spelled out in federal law and regulation and in conforming Michigan policy and procedure found in manuals maintained by the Family Independence Agency and the Department of Community Health. Law and regulation and policy and procedure are highly complex, lengthy, and often difficult to understand.

Nationally, Medicaid covered some 44.3 million individuals in calendar year 2000 while the average monthly number of persons enrolled in Michigan was 1.0 million. The average number of persons eligible for the first three months of FY 2003 (October-December, 2002) was 1,261,774.

The income and asset limits for eligibility have not changed since 1996. Even so, the number of eligibles has increased each year since FY 2000 largely as a result of unfavorable economic conditions.

It is possible to both increase and decrease the number of persons eligible for Michigan Medicaid by altering income and asset tests, expanding or terminating eligibility groups, or by obtaining a federal waiver. Michigan is currently seeking two such waivers.

Significant difficulty is often encountered in analyzing the financial effect of changing eligibility options because of data limitations inherent in current computer and information input systems. The state would be well served by updating systems to permit a more complete analysis of the impact of various options available for the expansion or contraction of Medicaid eligibility criteria.

Federal Law and Regulation

Title XIX of the Social Security Act establishes Medicaid. It defines both those eligible to receive health care services through governmental funding and the services that must or may be provided to them. Medicaid is administered by states, and although states are not required to participate in the program, all do. (For an overview of the Medicaid program, see CRC Memorandum 1071 at http://www.crcmich.org/PUBLICAT/2000s/2003/memo1071.pdf).

When Medicaid was passed in 1965, there were four categories of persons eligible for what was commonly called "welfare." These were individuals receiving assistance from Aid to Families with Dependent Children (AFDC), Aid to the Disabled (AD), Aid to the Blind (AB) and Aid for the Aged (AA). These "categorically needy" persons were the primary focus of Medicaid and states were required to include them as "mandated eligibles." Since 1965, the nature of the categorical eligibility has changed somewhat, most particularly as the welfare reform program known as Temporary Assistance to Needy Families (TANF) replaced AFDC. Medicaid continues, however, to define these populations as categorically needy in law and regulation and certain requirements are still tied to the former AFDC program.

The second group of eligible persons is the "optionally eligible." Examples of optional groups are: families with income above federal standards; nursing home residents with incomes above the amount that would make them eligible for Supplemental Security Income (SSI); and, families, disabled or elderly persons with high medical expenses. The primary group

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of low-income individuals not eligible for Medicaid consists of childless adults who are not disabled or pregnant.

The types of eligibility are important because federal law and regulation require that certain services must be made available to mandated eligibles. The minimum possible state Medicaid program is the provision of mandated services to mandated individuals. Every state, however, has acted to include the optionally eligible in its program. If a state chooses to provide an optional service to its mandatory eligible population, it must also provide that service to its optionally eligible individuals. About two-thirds of all Medicaid spending is spent on optional services for mandated eligibles or for services to optionally eligible persons. (See CRC Memorandum 1072 for more detail on the relationship between eligibility and services at: http://www.crcmich.org/PUBLICAT/2000s/2003/memo1072.pdf.)

Medicaid is an entitlement program, which means that the federal government will pay its share of matching money to states that administer a Medicaid program according to a State Plan accepted by the federal government regardless of the number of eligible persons or the total program cost. The State Plan sets forth the ways in which reimbursement amounts are determined for providers, the nature of persons who are eligible for the program, the variety of services covered and other important definitions. But it cannot limit the number of persons who receive Medicaid services if they meet eligibility requirements or set restrictive limits on the quantity or nature of services they receive without a waiver from the federal government. Recent state budget problems have increased the number of states that are reducing or restricting eligibility and/or the services eligible persons may receive. According to a survey commissioned by the Kaiser Commission on Medicaid and the Uninsured published in September 2002, 8 states had acted to cut or restrict eligibility in fiscal year 2002, but another 27 were planning to take this action in 2003.[1]

Federal Eligibility Requirements

Federal law and regulation cover 5 broad areas: categorical eligibility; income eligibility; resource eligibility; immigration status; and, residency.[2]

Much of the information below is drawn from the Kaiser Family Foundation Commission on Medicaid and the Uninsured found at: http://www.kff.org/content/2003/2236/2236chapter1.pdf.

Categorical Eligibility

Federal law and regulation define 28 different mandatory eligible groups and 21 optional groups that qualify for federal Medicaid matching funds (http://cms.hhs.gov/medicaid/eligibility/elig0501.pdf). They can be grouped into 5 broad coverage groups: children; pregnant women; adults in families with dependent children; persons with disabilities; and, the elderly. There are also categories based on a specific disease. Examples are tuberculosis and breast cancer.

Income Eligibility

While a person must meet one or more of the categorical eligibility requirements, that is not sufficient to receive Medicaid benefits because Medicaid is directed toward financially needy individuals. Financial need has two components – income and resources.

All eligibility categories must meet an income test. These tests vary from category to category and from state to state. In some cases income eligibility is tied directly to specified percentages of the Federal Poverty Level (http://aspe.os.dhhs.gov/poverty/poverty.shtml) such as 100 percent or 133 percent or 250 percent. In other instances, income standards are tied to federal cash assistance programs like Supplemental Security Income (SSI) and the former AFDC program.

Two factors determine income eligibility: the standard and the methodology. The standard is a dollar amount. If income exceeds the standard, persons are ineligible. The methodology is the way in which components of an individual's income are counted for eligibility determination purposes. A common methodology impacting income eligibility is known as the "disregard." In many states a nominal amount of in-

[1] "Medicaid Spending Growth; Results from a 2002 Survey," September 2002: http://www.kff.org/content/2002/4064/4064.pdf and updated by a January 2003 report, "Medicaid Spending Growth: A 50 state Update for Fiscal Year 2003," January 2003: http://www.kff.org/content/2003/4082/4082.pdf.

[2] Website information on federal eligibility requirements is available at the following sites:
Centers for Medicare and Medicaid Services http://www.cms.hhs.gov/medicaid/eligibility/criteria.asp
Code of Federal Regulations http://www.access.gpo.gov/nara/cfr/cfrhtml_00/Title_42/42cfr435_00.html

come, say $20 per month or so, is "disregarded" in order to provide some money for discretionary spending by a nursing home resident. Certain employment income and expenses are also disregarded so that employment does not necessarily result in the loss of Medicaid eligibility.

The second factor affecting income eligibility is known as "spend down." An individual with income above the threshold to qualify for assistance may become eligible by spending a sufficient amount on qualified services. This most commonly occurs with nursing home care. Persons with social security and/or pension income spend down enough income each month in paying directly for care that they become eligible for the balance of the monthly payment to be met by Medicaid.

Resource (Asset) Eligibility

Resources (assets) are distinct from income and comprise such things as savings, investments, automobiles, homes and the like. In many cases, individuals cannot have resources that exceed a specified amount. Typically, the asset limit is $1,000 for a family with children, $2,000 for elderly or disabled persons and $3,000 for couples. In most states, these have not been increased for many years.

As with income eligibility, both the resource standard dollar amount and the methodology used to determine the resource value are important determinants of eligibility. Generally, states do not include the home regardless of its value and the first $1,500 in equity of a car value is excluded. There are other exceptions such as the total value of an automobile if it is necessary for employment or to obtain medical treatment.

Immigration Status

There are two types of legal immigrants: those that entered the country prior to August 22, 1996, and those who came on that date or later. Those entering before August 22, 1996, are, at each states' option, eligible for Medicaid if they otherwise meet all requirements. Others are eligible only for emergency services for five years after entering the country. At that time, they may, at each state's option, become eligible for full coverage until such time as they gain citizenship. Illegal immigrants cannot be eligible for basic Medicaid coverage, but are eligible to receive emergency care if they otherwise qualify.

Residency

Because states set eligibility requirements (within federal law and regulation) an individual must also be a resident of the state in order to qualify for Medicaid administered by that state. Sometimes, particularly in the case of nursing or institutional care, a person whose family lives in one state may receive care in another state. In these instances, the person's state of residence for Medicaid purposes is the state in which the care is received and that state's eligibility criteria are used.

Michigan Medicaid Eligibility

Michigan Medicaid (often called Medical Assistance, or MA) includes: families; children; pregnant women and newborns: women eligible for breast and cervical cancer screening and treatment; persons aged 19-64 who are blind or disabled; and, persons 65 and older. Single adults, aged 19-64, are not eligible unless they are blind, disabled, or pregnant. Disability includes both physical and mental health.

With three exceptions, the Family Independence Agency (FIA) makes Michigan Medicaid eligibility determinations. The exceptions are:

- The Social Security Administration determines Supplemental Security Income eligibility. SSI eligibility also results in Medicaid eligibility.

- The FIA and the Department of Community Health share eligibility determination for "Home Care Children."

- The Department of Community Health is responsible for the "Breast & Cervical Cancer" program.

The Program Eligibility Manual (PEM) issued by the Family Independence Agency (FIA) (http://www.mfia.state.mi.us/olmweb/ex/pem/pem.pdf) contains the policies and procedures under which eligibility is determined for persons not involved in the foster care, adoption or state ward programs. The Children's Foster Care Manual (http://www.mfia.state.mi.us/olmweb/ex/cff/cff.pdf) contains the policies and procedures for these. The detailed eligibility matrix in **Appendix A** contains pertinent reference numbers to the applicable manual items.

It should be noted that Michigan also administers "Medicaid-like" programs. These include: Michigan Transitional Medical Assistance; Michigan Transitional Medical Assistance Plus; State Medical Plan; Maternity Outpatient Medical Services; and, several county-based health plans funded by a combination of state, county and federal dollars. With the exception of the county plans, these are 100 percent state funded and do not receive federal funds. These are not included in this Memorandum.

Michigan Eligibility Categories

There are 21 mandatory and 10 optional eligibility categories in Michigan. **Table 1** provides a brief description of each; the key non-financial eligibility factor; whether the group is mandatory or optional under federal law; whether Medicaid eligibility is automatic as a result of another eligibility; and the federal and Michigan income and asset standards applicable to each type of eligibility.

The definitions below apply to both the summary level information found in **Table 1** and the full version to be found at **Appendix A**.[3]

Medicaid (Medical Assistance – MA) Category. Everyone eligible for Medicaid must meet a categorical requirement as briefly described in this section of the matrix.

PEM/CFF Item.* These reference the appropriate item numbers in the Program Eligibility Manual (PEM) and the Child Foster Care Manual (CFF) published by the Family Independence Agency.

Related Cash Assistance Program.* With the exception of breast and cervical cancer screening and treatment, all Medicaid eligibles are related to one of three cash assistance programs: Family Independence Payments (FIP); Supplemental Security Income (SSI); or foster care, adoption and state ward support.

Key Non-financial Eligibility description indicates what characteristics must be met, in addition to limited income and assets, in order for an individual to be Medicaid eligible. These include: family status; legal status; age; and disability.

The **Client Information System program code*** is assigned by the Family Independence Agency and is used to categorize the distinct groups for reporting purposes. Over time, several of the groups have been combined and historic information about Medicaid eligibility uses these combinations.

Automatic Medicaid eligibility status is indicated if it is granted simultaneously with another eligibility determination.

Spend Down Applied and Financial Eligibility Group* means that individuals can become eligible for Medicaid even if their countable income exceeds the income standard. Medical expenses incurred during a specified period are deducted from the income during that period so that they become eligible as "medically needy." These individuals most often become eligible as a result of high medical expenses associated with

[3] Items with an asterisk (*) are only in **Appendix A**.

Eligibility Groupings Used in Table 1 and Appendix A

It is possible to group many of the categories as having similar characteristics. Low income and limited assets are associated with all of the categories.

- Low-income families with dependent children are the focus of categories 1-4.
- Children who have been removed from their family by the court and are placed in foster care, are subject to an adoption agreement, or are the responsibilities of the state (called both "State Wards" and "Department Wards") make up categories 5-7.
- Pregnant women are eligible under categories 8 & 9.
- Infants, children, adolescents and persons under age 21 comprise categories 10-13.
- Caretaker relatives of a dependent child are category 14.
- Supplemental Security Income recipients are categories 15 & 16.
- Persons who would lose their Medicaid eligibility due to special provisions in Federal law or due to cost of living increases in Social security payments (Retirement, Survivor, Disability Income – RSDI) are identified as categories 17-21.
- Low income aged or disabled persons not eligible for Supplemental Security Income cash assistance are category 22.
- Aged, blind or disabled individuals who have been or are expected to be in a hospital or long-term care facility for at least 30 days comprise category 23.
- Low-income Medicare eligible persons may have Medicaid pay for co-payments and deductibles and/or Part B premiums on their behalf – categories 24-7.
- Medically needy individuals, those whose spending for medical expenses has brought their income down to the Michigan income standard, are included in categories 9, 12, 13,14, and 28.
- Waiver covered persons are those who are covered by the Michigan Medicaid program by reason of special exceptions granted by the federal government known as waivers. These are categories 29 and 30.
- Women whose income is 250 percent of the federal poverty level or less are eligible for breast and cervical cancer screening and treatment as category 31.

Table 1
Medicaid (Medical Assistance) Eligibility Categories

Category Number	Medicaid (MA) Category	Key Non-financial Eligibility Factor	Automatic MA Eligibility	Federal Eligibility Status	Income Standard		Asset Standard	
					Federal	Michigan	Federal	Michigan
LOW-INCOME FAMILIES WITH DEPENDENT CHILDREN								
1	Persons receiving cash assistance through the Family Independence Program (FIP) are automatically eligible for Medicaid	Family with dependent children	Yes	Mandatory	Not Applicable	$459 or less per month for a family of 3 living in County Shelter Area IV*	Not Applicable	$3,000
2	Low Income Family (LIF) Medicaid is for families who meet former AFDC (7/16/96) criteria but are not eligible for FIP cash assistance.	Family with dependent children	No	Mandatory	Title XIX Section 1931(b)(2). AFDC criteria as of 7/16/96 with states having the option to lower income standards to those in effect 5/1/88 or to increase both income and asset standards up to the consumers price index increase	$459 or less per month for a family of 3 living in County Shelter Area IV*	$1,000	$3,000
3	Transitional MA: Families who lose FIP or LIF eligibility because of excess income from employment of the specified relative are eligible for MA for up to 12 months. Effective date 4/1/90	Family with dependent children - Must have received FIP and/or LIF for 3 of the last 6 months	Yes	Mandatory	Title XIX Section 1925. Not Applicable the first 6 months - 185% of FPL second 6 months	Not Applicable the first 6 months - 185% of FPL second 6 months	None	None
4	Special N/Support: Families who lose LIF eligibility (in whole or in part) because of increased child support payments are eligible for MA for up to 4 months. Effective date 10/1/84	Family with dependent children - Must have received LIF for 3 of the last 6 months	Yes	Mandatory	Title XIX Section 1902(a)(10)(A)(i)(l). Covered for 4 months if Medicaid terminated due to increase in child support	Covered for 4 months if Medicaid terminated due to increase in child support	None	None
CHILDREN IN FOSTER CARE, CHILDREN SUBJECT TO AN ADOPTION AGREEMENT, OR "STATE WARDS"								
5	Title IV-E Recipients: Children receiving Title IV-E foster care maintenance payments. Medicaid eligibility is granted by the state where the child lives even if the source of foster care payment is another state.	Under age 21	Yes	Mandatory	The child must have been receiving or be eligible to receive cash assistance under the terms applicable for AFDC as of 7/16/96 prior to removal from the home of a relative and placement in foster care.	$375 or less per month for a family of 1 living in County Shelter Area IV*	State AFDC level as of 7/16/96	$10,000 - only child's assets counted
6	Adoption Assistance Recipients: Children who are under a Title IV-E adoption agreement and children with special needs who require a guarantee of medical services in order to obtain an adoption assistance agreement.	Adoption Assistance Agreement	Yes	Mandatory	The child must have been receiving or be eligible to receive cash assistance under the terms applicable for AFDC as of 7/16/96 or be eligible for Supplemental Security Income (SSI).	AFDC criteria: $375 or less per month for a family of 1 living in County Shelter Area IV* or SSI eligible	State AFDC level as of 7/16/96 or SSI	$10,000 - only child's assets counted
7	State Wards: Children who have been removed from their families by the courts because they have been abused or neglected may be state wards until they are placed in adoption. Effective date 5/1/82	Children (under age 21) who are wards of the Family Independence Agency	Yes	Optional	The child must have been receiving or be eligible to receive cash assistance under the terms applicable for AFDC as of 7/16/96 prior to removal from the home of a relative and placement in foster care.		State AFDC level as of 7/16/96	

Table 1 (continued)

Category Number	Medicaid (MA) Category	Key Non-financial Eligibility Factor	Automatic MA Eligibility	Federal Eligibility Status	Income Standard		Asset Standard	
					Federal	Michigan	Federal	Michigan
PREGNANT WOMEN								
8	Healthy Kids for Pregnant Women: Pregnant women with income up to 185% of the poverty level are eligible for MA. Eligibility continues for the 2 calendar months following the termination of pregnancy. There is no asset test. Effective date 1/1/88	Pregnant or recently pregnant	No	Mandatory	133% of FPL - $1,691 per month for a family of 3	185% of FPL - $2,353 per month for a family of 3	Optional but no more restrictive than Supplemental Security Income (SSI) test - $2,000	None
9	Group 2 Pregnant Women: Pregnant women who incur medical expenses which result in their income being lowered to the 185% federal poverty level (spend down) become eligible for Medicaid. Women who are receiving MA when pregnancy ends and remain otherwise eligible may continue receiving MA for the two calendar months following the month the pregnancy ends. Effective date 10/1/84	Pregnant or recently pregnant	No	Optional	State set income standard	AFDC criteria $532 or less per month for a family of 3 living in County Shelter Area IV* OR SSI eligible	Optional but no more restrictive than AFDC level of 7/16/96 - $1,000	None
INFANTS, CHILDREN, ADOLESCENTS AND PERSONS UNDER AGE 21								
10	Healthy Kids for Children Under Age 1: A child under age 1 whose family's income is at or/below 185% of the poverty level is eligible for MA. There is no asset test. Effective date 10/1/88	Under age 1	No	Mandatory	185% of FPL - $2,353 for per month family of 3	185% of FPL - $2,353 per a family of 3	Optional but no more restrictive than AFDC level of 7/16/96 - $1,000	None
11	Healthy Kids for Other Children: A child age 1 to under age 19 whose family's income is at or below 150% of the poverty level is eligible for MA. Teenagers (16-19) between 100% and 150% of FPL are eligible for SCHIP rather than MA. There is no asset test. Effective date 7/1/94	Greater than age 1 and under age 19	No	Mandatory	133% of FPL for ages 1-5 - $1,691 per month for a family of 3 - 100% of FPL for ages 6-19 - $1,272 per month for a family of 3	150% of FPL- $1,908 per month for a family of 3	Optional but no more restrictive than AFDC level of 7/16/96 - $1,000	None
12	Group 2 Persons Under Age 21: Persons under age 21 who meet the Group 2 requirement are eligible for MA. Incurred medical expenses may be used in determining income eligibility (spend-down). There is no asset test. Effective date 1966	Under age 21	No	Optional	State set income standard	$375 or less per month for a family of 1 living in County Shelter Area IV*	Optional but no more restrictive than AFDC level of 7/16/96 - $1,000	None
13	Newborns: A child whose mother is receiving MA on the date of the child's birth is eligible for MA through the month of his first birthday if the child lives with his mother who remains an MA recipient or resides in Michigan and the mother cooperates with the pursuit of third party payments, and is not in prison. There is no asset test. Effective date 10/1/84	Newborn of MA recipient	Yes	Mandatory	Title XIX Section 1902(e)(4). Covered for one year regardless of income	Covered for one year regardless of income	None	None

Table 1 (continued)

Category Number	Medicaid (MA) Category	Key Non-financial Eligibility Factor	Automatic MA Eligibility	Federal Eligibility Status	Income Standard		Asset Standard	
					Federal	Michigan	Federal	Michigan
CARETAKER RELATIVES OF A DEPENDENT CHILD								
14	Group 2 Caretaker Relatives: Caretaker relatives of a dependent child who meet the Group 2 requirements are eligible for MA. Incurred medical expenses may be used in determining income eligibility (spend-down). There is no asset test. Effective date 1966 – To be modified if waiver request recently submitted to the federal government is approved	Caretaker of dependent child	No	Optional	State set income standard	$532 or less per month for a family of 3 living in County Shelter Area IV*	Optional but no more restrictive than AFDC level of 7/16/96 - $1,000	None
SUPPLEMENTAL SECURITY INCOME RECIPIENTS								
15	SSI Recipients: Supplemental Security Income is a cash benefit to needy persons who are aged (65 or older), blind or disabled. It is administered by the Social Security Administration. States may supplement the federal payment with a state supplement. All SSI recipients are automatically eligible for MA. Effective date 1/1/74	Aged, blind or disabled	Yes	Mandatory	As defined by Title 16 of the Social Security Act	$552 federal payment standard plus a Michigan supplement of $14 for those living independently. The supplement varies by other living arrangements. See Note Below	$2,000 single $3,000 couple	Not Applicable
16	SSI Termination Appeals: Persons who appeal termination from SSI because the Social Security Administration determines them to be no longer eligible as blind or disabled remain Medicaid eligible pending the outcome of the appeal.	Aged, blind or disabled	No	Mandatory	As defined by Title 16 of the Social Security Act	$552 federal payment standard plus a Michigan supplement of $14 for those living independently. The supplement varies by other living arrangements. See Note Below	$2,000 single $3,000 couple	Not Applicable
MEDICAID PROTECTION FOR CERTAIN SOCIAL SECURITY RECIPIENTS								
17	Special Disabled Children (Zebley Children). For children who were being paid SSI on August 22, 1996 and would be eligible for SSI but for the change in the definition of disability (SSA 4913). Effective date 7/1/97 - Being phased out per federal policy changes.	Disabled and receiving SSI payments on 8/22/96	No	Mandatory	As defined by Title 16 of the Social Security Act and Title XIX section 1902(a)(10)(A)(i)(II)	Varies by Living Arrangement See Note below	$2,000 single $3,000 couple	$2,000 single $3,000 couple
18	Pickle Amendment (503) Individuals: If non-financial factors are met, a former SSI recipient who receives Social Security benefits and who now would be eligible for SSI if cost of living increases paid since SSI eligibility ended were excluded is eligible for MA. Effective date 7/1/77	Aged, blind or disabled	No	Mandatory	Would meet SSI standard but for Social Security cost of living increases	Varies by Living Arrangement See Note below	$2,000 single $3,000 couple	$2,000 single $3,000 couple

Table 1 (continued)

Category Number	Medicaid (MA) Category	Key Non-financial Eligibility Factor	Automatic MA Eligibility	Federal Eligibility Status	Income Standard		Asset Standard	
					Federal	Michigan	Federal	Michigan
19	COBRA Widow(er)s: A person who was entitled to Social Security payments in December 1983 and who was entitled and received them as a disabled widow(er) in January 1984, and who continued to receive Social Security but whose SSI ended due to a special increase for certain disabled widow(er)s and subsequent Social Security cost of loving increases, and who would be eligible for SSI if those increases had not been paid is eligible for MA. Effective date 11/7/86.	Aged, blind or disabled	No	Mandatory	Would meet SSI standard but for Social Security cost of living increases and a special increase for disabled widow(er)s	Varies by Living Arrangement See Note below	$2,000 single $3,000 couple	$2,000 single $3,000 couple
20	Early Widow(er)s: A person who receives at least some Social Security payments as early widow(er) under Section 202(e) or (f) of the Social Security Act, who is not eligible for Medicare Part A, and who lost SSI eligibility due to the receipt of payments under Section 202, and who would be eligible for SSI except for the payments received under Section 202, is eligible for MA. Effective date 2/23/89.	Blind or disabled	No	Mandatory	Would meet SSI standard but for Social Security cost of living increases and a special increase for disabled widow(er)s	Varies by Living Arrangement See Note below	$2,000 single $3,000 couple	$2,000 single $3,000 couple
21	Disabled Adult Child (DAC): A person age 18 or older who received SSI but who lost eligibility for SSI due to the receipt of DAC payments and who would be eligible for SSI except for their receipt is eligible for MA. Effective date 5/15/89	Blind or disabled	No	Mandatory	Would meet SSI standard but for Disabled Adult Child payments	Not Applicable	$2,000 single $3,000 couple	$2,000 single $3,000 couple
LOW INCOME AGED OR DISABLED PERSONS								
22	AD-Care: Aged or disabled persons not eligible for any other MA category whose income does not exceed 100% FPL and whose assets do not exceed $2,000 for one/$3,000 for a couple. Disability determination is made by Disability Determination Services in the Family Independence Agency. Effective date 1/1/95	Aged or disabled	No	Optional	Up to 100% of FPL - $749 per month for a family of 1	100% of FPL - $749 per month for a family of 1	$2,000 single $3,000 couple	$2,000 single $3,000 couple
AGED, BLIND OR DISABLED INDIVIDUALS IN A HOSPITAL OR LONG-TERM CARE FACILITY								
23	Extended-Care: Aged, blind or disabled persons not eligible for another Medicaid category who reside (or are expected to reside) for at least 30 days in hospitals or long-term care facilities or who are MIChoice waiver clients and meet certain income and asset requirements are eligible for Medicaid. Effective date 5/1/92	Aged, blind or disabled	No	Optional	300% of the Income Supplemental Security standard	$1,656	$2,000 single $3,000 couple	$2,000 single $3,000 couple

Table 1 (continued)

Category Number	Medicaid (MA) Category	Key Non-financial Eligibility Factor	Automatic MA Eligibility	Federal Eligibility Status	Income Standard		Asset Standard	
					Federal	Michigan	Federal	Michigan
MEDICAID PAYMENTS FOR MEDICARE CO-PAYMENTS AND DEDUCTIBLES								
24	Qualified Medicare Beneficiaries (QMB) - For persons entitled to Medicare Part A with income up to 100% of the poverty level. MA will pay Medicare premiums, coinsurances and deductibles only. QMB effective date 1/1/91.	Medicare Part A	No	Mandatory	100% of FPL - $753 per month for a family of 1	100% of FPL - $753 per month for a family of 1	$4,000 single $6,000 couple	$4,000 single $6,000 couple
25	Specified Low-income Medicare Beneficiaries (SLMB) - For persons entitled to Medicare Part A with income between 100% and 120% of the Medicare poverty level, MA will pay Part B premiums only. SLMB effective date 1/1/93	Medicare Part A	No	Mandatory	Between 100% and 120% of FPL - $754 to $904 per month for a family of 1	Between 100% and 120% of FPL - $754 to $904 per month for a family of 1	$4,000 single $6,000 couple	$4,000 single $6,000 couple
26	Additional Low-income Medicare Beneficiaries (ALMB): For persons entitled to Medicare Part A with income between 120-135% of poverty level. Medicaid will pay Medicare Part B premiums. 100% federally funded. This is a first come, first serve program subject to an annual federal funding cap although the cap has never been reached in Michigan. Persons who are receiving ALMB in December of each year are given first priority for next year. No MA eligibility. Effective 1/1/98	Medicare Part A	N/A	Mandatory	120%-135% of FPL - $749-$1,018 per month for a family of 1	120%-135% of FPL - $904 -$1,016 per month for a family of 1	$4,000 single $6,000 couple	$4,000 single $6,000 couple
27	Qualified Disable Working Individuals: Persons entitled to Medicare Part A under section 1818A of the Social Security Act who have income up to 200% of the poverty level and who are not eligible for MA under any other category are eligible for MA payment of Medicare part A premiums only. No MA eligibility. Effective date 7/1/90.	Medicare Part A	N/A	Mandatory	200% of FPL - $1,497 per month for a family of 1	200% of FPL - $1,497 per month for a family of 1	$4,000 single $6,000 couple	$4,000 single $6,000 couple
MEDICALLY NEEDY INDIVIDUALS (also includes categories 9, 12, 13, 14)								
28	Group 2 Aged, Blind and Disabled: Aged, blind or disabled persons who meet the Group 2 requirements are eligible for MA. Incurred medical expenses may be used in determining income eligibility (spend-down). Disability determination is made by Disability Determination Services in the Family Independence Agency. Effective date 1966	Aged, blind or disabled	No	Optional	State set income standard	$375 or less per month for a family of 1 living in County Shelter Area IV*	Optional but no more restrictive than SSI test - $2,000	$2,000 single $3,000 couple

Table 1 (continued)

Category Number	Medicaid (MA) Category	Key Non-financial Eligibility Factor	Automatic MA Eligibility	Federal Eligibility Status	Income Standard		Asset Standard	
					Federal	Michigan	Federal	Michigan
WAIVER COVERED PERSONS								
29	Home Care Children: Unmarried disabled children under age 18 who require institutional care but who can be cared for at home for less cost are eligible for MA. Only the child's (and not the parent's) income and assets are considered in determining eligibility. Determination of eligibility is shared by DCH and FIA. Effective date 10/1/87	Disabled	No	Optional	Not Applicable - Waiver Granted	Only the child's own income is counted and cannot exceed $552 per month	Not Applicable - Waiver Granted	$2,000 - only child's assets counted
30	Children's Waiver: Disabled children less than 18 years of age who require institutional care but can be cared for at home for less cost are eligible for MA. Only the child's (and not the parent's) income and assets are considered in determined by DCH. Effective date 1/1/92	Receiving at least one waiver service	No	Optional	Not Applicable - Waiver Granted	Only the child's own income is counted and cannot exceed $1,656 per month	Not Applicable - Waiver Granted	$2,000 - only child's assets counted
BREAST AND CERVICAL CANCER SCREENING AND TREATMENT								
31	Breast Cancer: P.L. 106-354 added an optional MA eligibility category for certain women under age 65 in need of treatment for breast and cervical cancer. Women are eligible only if they have been screened at an early detection program funded by the Centers for Disease Control (CDC)	Women Aged 18 through 64	No	Optional	None	Women whose income is 250% of FPL or less - $1,883 per month are eligible to receive the CDC funded screening required to receive this MA benefit.	None	None
The following does not represent a separate eligibility category but is a distinct program for those eligible by reason of one of the above categories.								
	MIChoice Waiver: Aged and physically disabled adults who, but for the provision of waiver services, would otherwise require a nursing home level of care with Medicaid eligibility. Eligibility is based on nursing home criteria even though the beneficiary resided in the community. Waiver granted under SSA section 1915(c) Effective 1993.	Aged or disabled - Age 18 or over	No	Optional	Not Applicable - Waiver Granted	Cost of services must be less than what would be the cost of care to Medicaid if in a nursing home.	Not Applicable - Waiver Granted	$2,000 single $3,000 couple

* Michigan income standard varies among 6 shelter areas from $424 to $489 for a family of three. Area IV used in Table 1 and Appendix A includes Wayne County (PRT200 and 210).

Note: The income standard for certain Supplemental Security Income eligible persons varies by living arrangement (See http://www.mfia.state.mi.us/olmweb/ex/prt/245.pdf):

SSI Living Arrangement	Fiscal Group Members	SSI Amount	Michigan Supplement	Protected Level
Independent Living	Individual	$552	$14*	$552
	Individual & Spouse	$829		$829
Living in Another Household	Individual	$368	$9*	$368
	Individual & Spouse	$553		$553
Domiciliary Care	Individual	$552	$87	$639
Personal Care	Individual	$552	$158	$710
Home for Aged	Individual	$552	$180	$732
Institution- Long-term Care	Individual	$30	$7	$37

* Not included in protected level

hospital and/or nursing home care. Those categories where spend down may be applied are referred to as "Group 2" while those where it cannot be applied are known as "Group 1."

Federal Eligibility Status reflects whether the group must be Medicaid eligible under federal law (mandatory) or is an optional group.

Federal Income Standard is the income limit for eligibility. States are permitted, in some circumstances and within limits, to set higher limits. Both federal and state law and regulation permit some income to be "disregarded" or "not countable."

Michigan Income Standard is the maximum income an individual or family can have and be eligible. Both federal and state limits permit some income to be "disregarded" or "not countable." See *income* in Michigan *Eligibility Determination* section.

Federal Asset Standard is amount of assets that an individual or family may have and yet be eligible for Medicaid.

Michigan Asset Standard is the upper limit on assets that an individual or family may have and yet be eligible for Medicaid.

Both federal and state policies permit some assets to be "disregarded" or "not countable." See *assets* in Michigan *Eligibility Determination* section.

Eligibility Determination

Eligibility determination is as complex as the various circumstances in which people relate, have income, hold assets, and otherwise live. It is beyond the scope of this Memorandum to identify all of these but some appreciation for the myriad considerations is gained by examining the determination of what comprises a family. In order to be eligible for Medicaid as a part of a Low Income Family (LIF) individuals must be part of a family. The family is defined as that group of people who live together and whose income and needs are used to determine eligibility. Five pages of the Program Eligibility Manual (PEM 110, pages 3-8) indicate which persons must be included in the group; may be included in the group; and must be excluded from the group. (http://www.mfia.state.mi.us/olmweb/ex/pem/110.pdf)

Income

While the dollar standards for income and assets are straightforward, their determination and calculation are not.

The purpose of reviewing the income determination policies and procedures is not to provide a definitive explanation of all that is included in determining Medicaid eligibility but to suggest the complexities involved. Other eligibility categories have similar characteristics.

The section of the Program Eligibility Manual that defines income is 41 pages long and includes such topics as: jointly received income; asset conversion; inconsequential income; replacement money as in insurance payments; student earnings; adoption subsidies; and more (http://www.mfia.state.mi.us/olmweb/ex/pem/500.pdf).

As detailed in the FIA manuals, certain income is disregarded, some is treated as deemed and some counted as diverted in determining eligibility for Michigan's Family Independence and Low Income Family programs (FIP & LIF).

Disregarded Income. Certain earned income is disregarded in determining Medicaid eligibility for Low Income Families (LIF). One treatment is known as the "Standard Work Expense and $30 Plus 1/3" and the other as "$200 plus 20%."

Standard Work Expense and $30 Plus 1/3 is applied to a person who has countable earnings for the month being tested of more than $600 and the person received FIP or LIF in at least 1 of the 4 calendar months preceding the month being tested. For these persons countable earnings are reduced by $90 for working expenses and by another $30 and then by 1/3 of the persons remaining earned income. It is that amount that is then measured against the income standard to determine income eligibility. For example, if earned income is $809 for a month, that amount is reduced by the $90 and the $30 resulting in $689. The $689 is the reduced by 1/3 or $230 resulting in countable income of $459. The income limit for a family of three living in Wayne County is $459 per month.

$200 plus 20% is for those who do not meet the conditions for the first. In these cases, $200 is deducted from countable earnings and then additional 20 percent is deducted before applying the standard income test.

Deemed income is income from a person who is not included in the potentially eligible group whose income is being tested (the income test group) but that is added to the group's income whether or not the money is actually contributed to the group. Examples include spouses of group members who are not included in the income test group, parents and stepparents of LIF qualified group members who are under the age of 18 and certain others. The purpose of deemed income is to include income that could be expected to be available to the income test group even though the income is that of someone outside that test group.

Diverted income is the reverse of deemed income. It is income of an income test group not to be included in the income test. It is deducted from countable income in performing the income test. An example of this is the income of a person in the income test

group who receives Supplemental Security Income. Because an SSI payment is made specifically for the SSI recipient it is not considered as a part of the group's income.

Separate policies and procedures govern Group 2 or "spend down" eligible persons. (http://www.mfia.state.mi.us/olmweb/ex/pem/545.pdf)

Assets

Asset determinations also cover myriad considerations in a 36-page section of the manual (http://www.mfia.state.mi.us/olmweb/ex/pem/400.pdf). Topics include: investments; retirement plans; trusts; joint assets; homestead and personal vehicle exemptions; and more. Some categories, chiefly those involving children and pregnant women, have no asset test.

Divestment

For those receiving Medicaid in long-term care facilities or who are participating in the waiver for elderly and disabled program, a divestiture penalty may be applied if the transfer of a resource from one person to another occurs within 36-60 months before applying for eligibility and represents a transfer of assets for "less than market value." If this occurs, the person is not eligible for payments for long-term care services or waiver for elderly and disabled services for a period of time. They do remain eligible for other Medicaid services. (http://www.mfia.state.mi.us/olmweb/ex/pem/405.pdf)

Non-Income Eligibility Requirements

There are several non-income requirements that must be satisfied in order to receive Medicaid. Because Medicaid is a state administered federal health insurance program, state residence must be confirmed. With few exceptions, such as newborns, persons must supply a Social Security number or make application for a number. Citizenship or alien status must be confirmed. Individuals must also identify all third party resources such as Medicare or being covered by the health insurance of a person not included in the family group – a parent living outside the home for example. They must also participate in the pursuit of benefits for which they are eligible. These include Social Security, child support, worker's compensation, Veteran's Administration benefits, Railroad Retirement benefits, unemployment compensation, and other potential resources.

Number of Persons Eligible for Michigan Medicaid

Chart 1 shows the average number of persons enrolled in the Medicaid program since FY 1990. Both the Blind MA Only and Blind Disabled categories are too small to be represented on the chart (Detailed figures can be found in **Appendix B**). The number of persons in the Medicaid program as a percent of total population has varied from a low of 10.1 percent in FY 1990 to a high of 12.2 percent in FY 1994. The percent for FY 2002 was 12.1. The percent for FY 2003 is not yet available.

The most significant change in the composition of Medicaid eligibles has been the decrease in those eligible by reason of cash assistance to families (AFDC prior to July, 1996 and FIP thereafter) and the increase in those eligible as pregnant women, children, and families and caretaker relatives eligible for Medicaid but not for cash assistance through AFDC or FIP. This indicates in a broad sense that the effort to remove individuals from the cash assistance programs – welfare reform – while keeping Medicaid available to low income families, pregnant women and children has occurred in Michigan.

Relationship between Eligibility and Costs

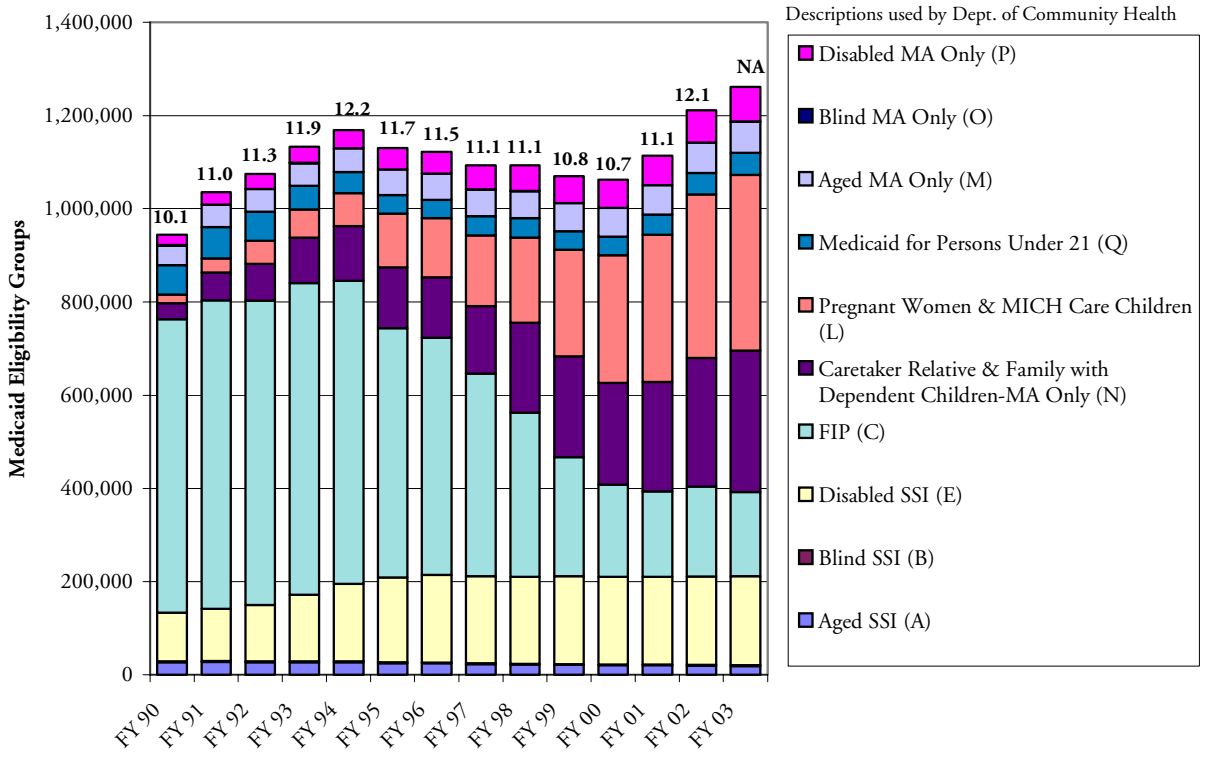
Data

One factor making analysis of the costs associated with each of the eligibility groups difficult is that there is little detailed data relating eligibility and costs. This is because the eligibility system (the Client Information System – CIS) collapses the 31 different eligibility groups into 10 letter codes. Six of these mix mandatory and optional groups. For example, code L contains the *mandatory* eligible categories of: pregnant women; newborns; children under age 1; and children 1-18. It also includes persons under age 21 who are *optionally* eligible by reason of medical indigence under the spend down provisions for Group 2 individuals. **Appendix C** shows the various combinations. Only SSI Medicaid people who are aged, blind or disabled are identified by a unique letter code.

As a result there is no table which shows Medicaid costs for each eligibility group and for the various services they receive. The cost of physician services for newborn eligibles or the expenses associated with outpatient hospital costs for each of the optional eligible groups is not readily available, for example.

When the option to drop Medicaid coverage for responsible relatives was being explored, special analyses were required to determine an estimated cost

Chart 1
Average Number of Eligible Persons by Category by Year
Fiscal Years 1990, 1995 and 2000-2003



Source: Department of Community Health
See Appendix B for details.

reduction amount. Executive Order 2002-22 eliminated eligibility for some 40,000 caretaker relatives (Item 13 in **Table 1**) with anticipated annual savings of some $124.8 million of which $55.7 million was general fund. A subsequent court order stopped the implementation of this change and a new waiver request by the current administration will alter this action.

Income and Asset Limits

There has been relatively little attention given to increasing the income or asset limitations for Medicaid eligibility in recent years. Medicaid has been a significant part of the overall state budget shortfall and little consideration has been given to measures that would result in additional costs. The upper limits for income and asset amounts for what was AFDC and now is the Family Independence Program (FIP) and Low Income Families (LIF) program have not changed since 1996.

As noted under "Federal Income standard" in item 2 of **Table 1**, states are permitted to set the income and asset limits at a figure between May 1, 1988, and that of July 16, 1996, with the option to update the July 16, 1996, amounts by the consumers price index.

Waivers

Requests for waivers that enable states to limit eligibility and/or benefits appear to be the option of choice for the future since they can permit a more targeted approach to cost control than the wholesale elimination of an optionally eligible group of individuals. Improved data reporting would be of assistance in weighing the financial impact of various options available for reducing or expanding Medicaid eligibility.

Michigan is currently seeking two waivers. The first would establish a limited Medicaid benefit for childless adults aged 18-64 not currently eligible for Medicaid resulting in overall savings to the state because it permits the use of federal funds that require a lower state match. The second would constrain benefits for non-disabled adults under 65 and make "caretaker relatives" eligible for these constrained benefits rather than totally exclude them from Medicaid eligibility as was the case under Executive Order 2002-22.