

HB

459

FISCAL NOTE

No: 4

STATE OF ALASKA
1998 LEGISLATIVE SESSION

Bill Version: CSHB 459 (HES)
(H) Publish Date: 3/11/98

Revision Date: _____
Title: Medicaid for certain disabled persons
Sponsor: House (HES)
Requestor: (H) HESS

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Non-Facility
COMPONENT SERIAL NO. 229
See also (SN#): 230, 243

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	40.1	136.0	116.3	116.0	115.4	114.8
MISCELLANEOUS						
TOTAL OPERATING	40.1	136.0	116.3	116.0	115.4	114.8

CAPITAL EXPENDITURES						
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CHANGES IN REVENUES ()						
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FUND SOURCE

(Thousands of Dollars)

1002 Federal Receipts	24.0	81.3	69.5	69.4	69.0	68.7
1003 GF Match	14.6	49.9	42.8	42.7	42.6	42.5
1004 GF						
1005 GF/Program Receipts	1.5	4.8	4.0	3.9	3.8	3.6
1037 GF/Mental Health						
Other (please specify)						
TOTAL	40.1	136.0	116.3	116.0	115.4	114.8

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: \$0.0

ANALYSIS: (Attach a separate page if necessary)

The Federal Balanced Budget Act of 1997 (P.L. 105-33) established a new optional Medicaid eligibility category for disabled persons who would be eligible for SSI and Medicaid, except that their earned income exceeds the limits for SSI and their family's earned income is below 250% of the federal poverty level for Alaska. States may impose a requirement that disabled workers pay a "buy-in" charge. This bill would elect this optional eligibility category for Alaska.

We believe that the only individuals who will take advantage of this new eligibility category will be existing SSI or APA applicants who would otherwise lose Medicaid because of their own increased earnings. We do not anticipate individuals using this new eligibility category to access Medicaid for the first time. Consequently, this option will not result in an increase in new Medicaid cases, but will only have the effect of extending the Medicaid eligibility of existing recipients for about one year.

EXISTING COPY

Prepared by: Kevin Henderson
Division: Medical Assistance
Approved by Commissioner: Karen Perdue
Agency: Department of Health & Social Services

Phone: 465-3355
Date: 02/25/98
Date: 3/2/98

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ANALYSIS (cont.):

This new eligibility category will benefit current SSI and APA recipients who are ready to go to work or increase their hours of work. Once in the work force for one year, we estimate that all of these individuals will be able to take advantage of employer based health insurance or will have earnings that make them ineligible for this eligibility group. Based upon analysis by the Division of Vocational Rehabilitation, we estimate that only 33 of the current SSI/APA and Medicaid recipients would taken advantage of this category if it were available for the entire FY 99. However, since EIS and MMIS system changes will delay implementation, only about half of those (17) would be able to participate in FY 99. In subsequent years, we would expect to see a general APA case load growth of 6.5% per year, but this would be offset by a reduction (about 3 per year) in the number of disabled individuals able to work. In addition, we expect about 25% of those who do go to work to acquire employer based health insurance immediately. The Medicaid buy-in for this group would begin January 1, 1999, meaning only one-half of the annual expenditures and program receipts would be realized in FY 99.

A nominal buy-in charge, determined using a sliding scale based on income, will be collected annually. We estimate the average buy-in charge to be equivalent to \$360 per year (\$12/month). The actual sliding fee schedule would be established through regulations.

Both expenditures and program receipts are allocated 48% to the Medicaid Non-Facilities component and 52% to the Medicaid Facilities component.

We anticipate the current federal financial participation rate to continue beyond FY 04. Currently the match rate is 59.8% federal and 40.2% state general funds.

We estimate an inflation factor of about 3% per year on the annual cost of providing medical care.

		FY99	FY00	FY01	FY02	FY03	FY04
Avg. Med. Cost Per Disable Worker		\$9,825	\$10,120	\$10,423	\$10,736	\$11,058	\$11,390
SSI/APA Recipients To work		17	32	31	30	29	28
Recipients into Health Insurance		0	4	8	8	7	7
Recipients with extended Medicaid		17	28	23	23	22	21
Additional Medicaid Expenditures		\$83,513	\$283,354	\$242,344	\$241,562	\$240,516	\$239,188
Non-Facilities	48%	\$40,086	\$136,010	\$116,325	\$115,950	\$115,448	\$114,810
Facilities	52%	\$43,427	\$147,344	\$126,019	\$125,612	\$125,068	\$124,378
<hr/>							
Avg. Annual Buy-in Fee =	\$360						
PROGRAM RECEIPTS		\$3,060	\$10,080	\$8,370	\$8,100	\$7,830	\$7,560
Non-Facilities	48%	\$1,469	\$4,838	\$4,018	\$3,888	\$3,758	\$3,629
Facilities	52%	\$1,591	\$5,242	\$4,352	\$4,212	\$4,072	\$3,931

STATE OF ALASKA
1998 LEGISLATIVE SESSION

FISCAL NOTE

No: 3

Bill Version: CSHB 459 (HES)
(H) Publish Date: 3/11/98

Revision Date: _____
Title: Medicaid for certain disabled persons
Sponsor: House (HES)
Requestor: (H) HESS

Dept. Affected: Health and Social Services
BRU: Medical Assistance Admin
Component: Health Purchasing Group
COMPONENT SERIAL NO. 243
See also (SN#): 229, 230

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	4.0					
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	4.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
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CHANGES IN REVENUES ()						
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FUND SOURCE

(Thousands of Dollars)

FUND SOURCE	FY99	FY00	FY01	FY02	FY03	FY04
1002 Federal Receipts	2.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	2.0	0.0	0.0	0.0	0.0	0.0
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	4.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

POSITIONS	FY99	FY00	FY01	FY02	FY03	FY04
FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: \$0.0

ANALYSIS: (Attach a separate page if necessary)

The Federal Balanced Budget Act of 1997 (P.L. 105-33) established a new optional Medicaid eligibility category for disabled persons who would be eligible for SSI and Medicaid, except that their earned income exceeds the limits for SSI and their family's earned income is below 250% of the federal poverty level for Alaska. States may impose a requirement that disabled workers pay a "buy-in" charge. This bill would elect this optional eligibility category for Alaska.

We believe that the only individuals who will take advantage of this new eligibility category will be existing SSI or APA applicants who would otherwise lose Medicaid because of their own increased earnings. We do not anticipate individuals using this new eligibility category to access Medicaid for the first time. Consequently, this option will not result in an increase in new Medicaid cases, but will only have the effect of extending the Medicaid eligibility of existing recipients for about one year.

Establishing of this new eligibility group will require the addition of a new Medicaid subtype code to the Medicaid Management Information System (MMIS). A one time expenditure for MMIS programming is shown for FY 99.

2/27/98
Prepared by: Kevin Henderson
Division: Medical Assistance
Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services

Phone: 465-3355
Date: 02/25/98
Date: 3/2/98

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FISCAL NOTE

No: 2

STATE OF ALASKA
1998 LEGISLATIVE SESSION

Bill Version: CSHB 459 (HES)
(H) Publish Date: 3/11/98

Revision Date: _____
Title: Medicaid for certain disabled persons
Sponsor: House (HES)
Requestor: (H) HESS

Dept. Affected: Health and Social Services
BRU: Public Assistance
Component: Adult Public Assistance
COMPONENT SERIAL NO. 222
See also (SN#): _____

Expenditures/Revenues:

(Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	(33.0)	(190.5)	(311.0)	(427.7)	(540.4)	(649.3)
MISCELLANEOUS						
TOTAL OPERATING	(33.0)	(190.5)	(311.0)	(427.7)	(540.4)	(649.3)

CAPITAL EXPENDITURES						
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CHANGES IN REVENUES ()						
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FUND SOURCE

(Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	(33.0)	(190.5)	(311.0)	(427.7)	(540.4)	(649.3)
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (please specify)						
TOTAL	(33.0)	(190.5)	(311.0)	(427.7)	(540.4)	(649.3)

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: \$0.0

ANALYSIS: (Attach a separate page if necessary)

The federal Balanced Budget Act of 1997 (P.L. 105-33) established a new optional Medicaid eligibility category for disabled persons who would be eligible for SSI and Medicaid, except that their earned income exceeds the limits for SSI and their family's earned income is below 250 percent of the federal poverty level for Alaska. These disabled workers may be obligated to pay a "buy-in" charge. This bill would elect this optional eligibility category for Alaska.

We believe that some Adult Public Assistance (APA) recipients who do not pursue working because of the fear of losing their Medicaid coverage will either begin working or will work longer hours and become ineligible for APA. Based on an analysis by the Division of Vocational Rehabilitation, we estimate that 33 APA recipients could potentially lose eligibility because of increased earnings in FY99. We expect this number to decrease over time.

Prepared by: [Signature]
Division: Public Assistance
Approved by Commissioner: [Signature]
Agency: Department of Health & Social Services

Phone: 465-3347
Date: 02/25/98
Date: 3/2/98

ANALYSIS (cont.):**Assumptions:**

Of the 33 persons potentially ineligible under this legislation, we expect that one-half will increase their earnings and become ineligible for APA in FY99.

In the start-up year of FY99, savings are calculated using 6 months.

The savings assume that persons who become ineligible for assistance because of this legislation will remain ineligible.

Calculations:

	FY99	FY00	FY01	FY02	FY03	FY04
APA recipients affected each year	17	32	31	30	29	28
Cumulative # of APA recipients	17	49	80	110	139	167
Average monthly APA benefit	\$324	\$324	\$324	\$324	\$324	\$324
APA Program Savings	(\$33.0)	(\$190.5)	(\$311.0)	(\$427.7)	(\$540.4)	(\$649.3)

FISCAL NOTE

No: 1

STATE OF ALASKA
1998 LEGISLATIVE SESSION

Bill Version: CSHB 459 (HES)
(H) Publish Date: 3/11/98

Revision Date: _____
Title: Medicaid for certain disabled persons
Sponsor: House (HES)
Requestor: (H) HESS

Dept. Affected: Health and Social Services
BRU: Medical Assistance
Component: Medicaid Facilities
COMPONENT SERIAL NO. 230
See also (SN#): 229, 243

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY99	FY00	FY01	FY02	FY03	FY04
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	43.4	147.3	126.0	125.6	125.1	124.4
MISCELLANEOUS						
TOTAL OPERATING	43.4	147.3	126.0	125.6	125.1	124.4

CAPITAL EXPENDITURES						
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CHANGES IN REVENUES ()						
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FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	26.0	88.1	75.3	75.1	74.8	74.4
1003 GF Match	15.8	54.0	46.3	46.3	46.2	46.1
1004 GF						
1005 GF/Program Receipts	1.6	5.2	4.4	4.2	4.1	3.9
1037 GF/Mental Health						
Other (please specify)						
TOTAL	43.4	147.3	126.0	125.6	125.1	124.4

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of any current year (FY98) cost: \$0.0

ANALYSIS: (Attach a separate page if necessary)

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2/27/98
2004
Prepared by: Kevin Henderson
Division: Medical Assistance
Approved by Commissioner: Karen Perdue, Commissioner
Agency: Department of Health & Social Services

Phone: 465-3355
Date: 02/25/98
Date: 3/2/98

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Facilities	52%	\$1,591	\$5,242	\$4,352	\$4,212	\$4,072	\$3,931

SENATE COMMITTEE REPORT

DATE: 4/8/98

FURTHER: Finance

DATE TURNED
IN TO OFFICE: 4/17/98

HESS Committee considered CS FOR HOUSE BILL NO. 459(FIN) am
MEDICAID FOR LOW-INCOME DISABLED

and recommends:

- be replaced with S CS CSHB 459 (HES)
- adopt previous CS ()
- attached amendment(s)
- adopt Letter of Intent by Committee
- further referral to the Committee

- Senate Bill:**
- same title
 - new title
- House Bill:**
- same title
 - technical title
 - new: SCR#

SIGNING/DO PASS	DP	OTHER RECOMMENDATIONS	NR	DNP	AM
<i>James D. Leman</i>	✓	<i>Jim Wal</i>	✓		
<i>J. Ellis</i>	✓	<i>Lylee Green</i>	✓		
CHAIR: <i>Gene White</i>	✓	CHAIR:			

NEW FISCAL NOTE(S):

Department	Date	Zero	Fiscal

Applies to SB + CSSB

PREVIOUS FISCAL NOTE(S):*

Department	Date	Zero	Fiscal
H+SS	3/2/98		40.1
H+SS	3/2/98		4.0
H+SS	3/2/98		(33.0)
H+SS	3/2/98		43.4

APPROPRIATION -- no fiscal note

*include fiscal notes accompanying Governor's bill

Adopted to CSHB 459 (FIN)am

AMENDMENT

OFFERED IN THE SENATE

TO: SB 253, Working Draft "E"

1 Page 4, line ¹⁵~~4~~, following "provision":

2 Insert "who"

3 Page 4, line ¹⁵~~4~~, following "is":

4 Insert "otherwise"

5 Page 4, line ¹⁶~~5~~, following "under":

6 Delete "AS 47.07 without the payment of "

7 Insert "under sec. 1 of this Act, beginning in the third month after a person becomes
8 eligible under sec. 1, shall pay"

9 Page 4, line ¹⁶~~5~~, following "premium"

10 Delete "or other cost-sharing charges until the effective date of regulations adopted
11 by the Department of Health and Social Services that set the"

12 Insert "calculated as a percentage of the net income of the person's family
13 according to the formula of $Y = [(X - 100) \div 15] - [0.75(N - 1)]$, where Y represents the total
14 annual premium to be paid, X represents the family income of the person expressed as a
15 percentage of the federal poverty level for the family of the size involved, and N represents
16 family size. A person in a family with a net income less than the applicable federal poverty
17 level for the family of the size involved shall pay no premium under this transitional

Provided by Robert Briggs

1 section. If a premium as calculated according to the formula in this section results in a
2 negative figure, then the person shall pay no premium under this transitional section. The
3 annual premium may be apportioned and paid on a monthly basis, and may be prorated
4 for eligibility provided for less than a full year. If a disabled person is unemployed at the
5 time of applying for this benefit, there shall be a grace period of two (2) months during
6 which no premium shall be required under this transitional section. The premium
7 required under this section shall be payable until the Department of Health and Social
8 Services by regulation establishes a system for setting and collection of a"

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM

April 16, 1998

SUBJECT: Medicaid for Certain Disabled Persons
(SCS CSHB 459(HES), draft version "H")

TO: Senator Gary Wilken
Attn: Sheila Peterson

FROM: Terri Lauterbach
Legislative Counsel *TLauterbach*

Enclosed is a Senate CS for HB 459. It is in draft form for your review.

I have talked with Bob Briggs about his intent and believe that the enclosed draft coincides with his intent, but he has not reviewed the language.

Mr. Briggs sent me material to clarify the use of "net income" in his amendment. That material related to HCFA's determination that the term "income," as used in AS 47.07.020(b)(12), added by sec. 1 of this bill, does not mean "gross income," but, rather, refers to income computed according to SSI standards, with various deductions, including the SSI earned income disregard. So, I have added a reference to federal regulations in sec. 1, as well as in sec. 4, of the enclosed SCS.

Please let me know if I can be of further assistance on this matter. I recommend review of the SCS by DHSS staff for their input as to whether the bill is clear enough for them to implement.

TML:lmb
98-056.lmb
Enclosure

0-LS1504\H
Lauterbach
4/16/98

SENATE CS FOR CS FOR HOUSE BILL NO. 459(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

A BILL

FOR AN ACT ENTITLED

1 "An Act establishing new eligibility for medical assistance for certain disabled
2 persons and giving their eligibility for services the highest priority among optional
3 services and groups under the medical assistance program; amending the definition
4 of 'personal care services in a recipient's home' as used in the medical
5 assistance program; moving midwife services from being the first to being the
6 14th service eliminated under the medical assistance program when there is
7 insufficient funding; and adjusting the priority of optional services and optional
8 eligible groups under the medical assistance program in order to reflect the new
9 priorities given to the newly-eligible disabled persons and to midwife services but
10 without otherwise changing the relative order of the other optional services and
11 optional groups."

12 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

1 * **Section 1.** AS 47.07.020(b) is amended by adding a new paragraph to read:

2 (12) disabled persons, as described in 42 U.S.C.
3 1396a(a)(10)(A)(ii)(XIII), who are in families whose net income, as determined under
4 applicable federal regulations or guidelines, is less than 250 percent of the official
5 poverty line applicable to a family of that size according to the federal Office of
6 Management and Budget, and who, but for earnings in excess of the limit established
7 under 42 U.S.C. 1396d(q)(2)(B), would be considered to be individuals with respect
8 to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c;
9 a person eligible for assistance under this paragraph who is not eligible under another
10 provision of this section shall pay a premium or other cost-sharing charges according
11 to a sliding fee scale that is based on income as established by the department in
12 regulations.

13 * **Sec. 2.** AS 47.07.035 is amended to read:

14 **Sec. 47.07.035. Priority of medical assistance.** If the department finds that
15 the cost of medical assistance for all persons eligible under this chapter will exceed
16 the amount allocated in the state budget for that assistance for the fiscal year, the
17 department shall eliminate coverage for optional medical services and optionally
18 eligible groups of individuals in the following order:

- 19 (1) [MIDWIFE SERVICES;
20 (2)] clinical social workers' services;
21 (2) [(3)] psychologists' services;
22 (3) [(4)] chiropractic services;
23 (4) [(5)] advanced nurse practitioner services;
24 (5) [(6)] adult dental services;
25 (6) [(7)] emergency hospital services;
26 (7) [(8)] treatment of speech, hearing, and language disorders;
27 (8) [(9)] optometrists' services and eyeglasses;
28 (9) [(10)] occupational therapy;
29 (10) [(11)] mammography screening;
30 (11) [(12)] prosthetic devices;
31 (12) [(13)] medical supplies and equipment;

- 1 (13) [(14)] targeted case management services;
- 2 (14) midwife services:
- 3 (15) rehabilitative services for substance abusers and emotionally
- 4 disturbed or chronically mentally ill adults;
- 5 (16) clinic services;
- 6 (17) physical therapy;
- 7 (18) personal care services in a recipient's home;
- 8 (19) prescribed drugs;
- 9 (20) hospice care;
- 10 (21) long-term care noninstitutional services;
- 11 (22) inpatient psychiatric facility services;
- 12 (23) intermediate care facility services for the mentally retarded;
- 13 (24) intermediate care facility services;
- 14 (25) individuals described in AS 47.07.020(b)(11);
- 15 (26) individuals under age 21 who are not eligible for benefits under
- 16 the federal program designated as the successor to the aid to families with dependent
- 17 children program because they are not deprived of one or more of their natural or
- 18 adoptive parents;
- 19 (27) skilled nursing facility services for persons under age 21;
- 20 (28) aged, blind, and disabled individuals who, because they do not
- 21 meet the income requirements, do not receive supplemental security income under Title
- 22 XVI of the Social Security Act, but who are eligible, or would be eligible if they were
- 23 not in a skilled nursing facility or intermediate care facility, to receive an optional state
- 24 supplementary payment;
- 25 (29) individuals in a hospital, skilled nursing facility, or intermediate
- 26 care facility whose income while in the facility does not exceed 300 percent of the
- 27 supplemental security income benefit rate under Title XVI of the Social Security Act,
- 28 but who, because of income, are not eligible for the optional state supplementary
- 29 payment;
- 30 (30) individuals under age 21 under supervision of the department for
- 31 whom maintenance is being paid in whole or in part from public money and who are

1 in foster homes or private child-care institutions;

2 (31) individuals under age 21 who the department has determined
3 cannot be placed for adoption without medical assistance because of a special need for
4 medical or rehabilitative care and who the department has determined are hard-to-place
5 children eligible for subsidy under AS 25.23.190 - 25.23.220;

6 (32) individuals who are eligible under AS 47.07.020(b)(12).

7 * Sec. 3. AS 47.07.900(15) is amended to read:

8 (15) "personal care services in a recipient's home" means services
9 authorized under a service plan [PRESCRIBED BY A PHYSICIAN] in accordance
10 with applicable federal and state law [THE RECIPIENT'S PLAN OF TREATMENT
11 AND PROVIDED BY AN INDIVIDUAL WHO IS

12 (A) QUALIFIED TO PROVIDE THE SERVICES;

13 (B) SUPERVISED BY A REGISTERED NURSE; AND

14 (C) NOT A MEMBER OF THE RECIPIENT'S FAMILY];

15 * Sec. 4. TRANSITIONAL PROVISION. Notwithstanding AS 47.07.020(b)(12), added
16 by sec. 1 of this Act, an individual described in that provision is eligible for medical
17 assistance under AS 47.07 without the payment of a premium or other cost-sharing charges
18 for the first two months of the individual's receipt of assistance under AS 47.07.020(b)(12).
19 Beginning in the third month of the individual's receipt of assistance under
20 AS 47.07.020(b)(12), the individual shall pay one-twelfth of an annual premium that is
21 determined by applying a percentage to the annual net income of the individual's family. The
22 applicable percentage, Y, shall be calculated according to the formula of $Y = (X-100)/15 -$
23 $0.75(N-1)$, where X is the annual net income of the individual's family expressed as a
24 percentage of the official federal poverty line for a family of the size involved and N is the
25 number of persons in the individual's family; however, an individual is not required to pay
26 a premium under this section if the individual's family has a net income that is less than the
27 applicable federal poverty line for a family of the size involved or if the value of Y calculated
28 under this section is a negative number. The premium required under this section is payable
29 until the Department of Health and Social Services, by regulation, establishes another system
30 for setting and collecting a premium or other cost-sharing charges for persons who receive
31 medical assistance because they are eligible under AS 47.07.020(b)(12), as enacted by sec. 1

1 of this Act. For purposes of this section, the annual net income of the individual's family
2 shall be determined under applicable federal regulations and guidelines.

3 * Sec. 5. REGULATIONS. The Department of Health and Social Services shall adopt
4 regulations establishing the sliding fee scale for premiums or other cost-sharing charges
5 described in this Act by July 1, 1999.

SENATE CS FOR CS FOR HOUSE BILL NO. 459(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

A BILL

FOR AN ACT ENTITLED

1 "An Act establishing new eligibility for medical assistance for certain disabled
2 persons and giving their eligibility for services the highest priority among optional
3 services and groups under the medical assistance program; amending the definition
4 of 'personal care services in a recipient's home' as used in the medical
5 assistance program; moving midwife services from being the first to being the
6 14th service eliminated under the medical assistance program when there is
7 insufficient funding; and adjusting the priority of optional services and optional
8 eligible groups under the medical assistance program in order to reflect the new
9 priorities given to the newly-eligible disabled persons and to midwife services but
10 without otherwise changing the relative order of the other optional services and
11 optional groups."

12 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

1 * Section 1. AS 47.07.020(b) is amended by adding a new paragraph to read:

2 (12) disabled persons, as described in 42 U.S.C.
 3 1396a(a)(10)(A)(ii)(XIII), who are in families whose income, as determined under
 4 applicable federal regulations or guidelines, is less than 250 percent of the official
 5 poverty line applicable to a family of that size according to the federal Office of
 6 Management and Budget, and who, but for earnings in excess of the limit established
 7 under 42 U.S.C. 1396d(q)(2)(B), would be considered to be individuals with respect
 8 to whom a supplemental security income is being paid under 42 U.S.C. 1381 - 1383c;
 9 a person eligible for assistance under this paragraph who is not eligible under another
 10 provision of this section shall pay a premium or other cost-sharing charges according
 11 to a sliding fee scale that is based on income as established by the department in
 12 regulations.

13 * Sec. 2. AS 47.07.035 is amended to read:

14 **Sec. 47.07.035. Priority of medical assistance.** If the department finds that
 15 the cost of medical assistance for all persons eligible under this chapter will exceed
 16 the amount allocated in the state budget for that assistance for the fiscal year, the
 17 department shall eliminate coverage for optional medical services and optionally
 18 eligible groups of individuals in the following order:

- 19 (1) [MIDWIFE SERVICES;
 20 (2)] clinical social workers' services;
 21 (2) [(3)] psychologists' services;
 22 (3) [(4)] chiropractic services;
 23 (4) [(5)] advanced nurse practitioner services;
 24 (5) [(6)] adult dental services;
 25 (6) [(7)] emergency hospital services;
 26 (7) [(8)] treatment of speech, hearing, and language disorders;
 27 (8) [(9)] optometrists' services and eyeglasses;
 28 (9) [(10)] occupational therapy;
 29 (10) [(11)] mammography screening;
 30 (11) [(12)] prosthetic devices;
 31 (12) [(13)] medical supplies and equipment;

- 1 (13) [(14)] targeted case management services;
- 2 (14) midwife services;
- 3 (15) rehabilitative services for substance abusers and emotionally
4 disturbed or chronically mentally ill adults;
- 5 (16) clinic services;
- 6 (17) physical therapy;
- 7 (18) personal care services in a recipient's home;
- 8 (19) prescribed drugs;
- 9 (20) hospice care;
- 10 (21) long-term care noninstitutional services;
- 11 (22) inpatient psychiatric facility services;
- 12 (23) intermediate care facility services for the mentally retarded;
- 13 (24) intermediate care facility services;
- 14 (25) individuals described in AS 47.07.020(b)(11);
- 15 (26) individuals under age 21 who are not eligible for benefits under
16 the federal program designated as the successor to the aid to families with dependent
17 children program because they are not deprived of one or more of their natural or
18 adoptive parents;
- 19 (27) skilled nursing facility services for persons under age 21;
- 20 (28) aged, blind, and disabled individuals who, because they do not
21 meet the income requirements, do not receive supplemental security income under Title
22 XVI of the Social Security Act, but who are eligible, or would be eligible if they were
23 not in a skilled nursing facility or intermediate care facility, to receive an optional state
24 supplementary payment;
- 25 (29) individuals in a hospital, skilled nursing facility, or intermediate
26 care facility whose income while in the facility does not exceed 300 percent of the
27 supplemental security income benefit rate under Title XVI of the Social Security Act,
28 but who, because of income, are not eligible for the optional state supplementary
29 payment;
- 30 (30) individuals under age 21 under supervision of the department for
31 whom maintenance is being paid in whole or in part from public money and who are

1 in foster homes or private child-care institutions;

2 (31) individuals under age 21 who the department has determined
3 cannot be placed for adoption without medical assistance because of a special need for
4 medical or rehabilitative care and who the department has determined are hard-to-place
5 children eligible for subsidy under AS 25.23.190 - 25.23.220;

6 (32) individuals who are eligible under AS 47.07.020(b)(12).

7 * Sec. 3. AS 47.07.900(15) is amended to read:

8 (15) "personal care services in a recipient's home" means services
9 authorized under a service plan [PRESCRIBED BY A PHYSICIAN] in accordance
10 with applicable federal and state law [THE RECIPIENT'S PLAN OF TREATMENT
11 AND PROVIDED BY AN INDIVIDUAL WHO IS

12 (A) QUALIFIED TO PROVIDE THE SERVICES;

13 (B) SUPERVISED BY A REGISTERED NURSE; AND

14 (C) NOT A MEMBER OF THE RECIPIENT'S FAMILY];

15 * Sec. 4. TRANSITIONAL PROVISION. Notwithstanding AS 47.07.020(b)(12), added
16 by sec. 1 of this Act, an individual described in that provision is eligible for medical
17 assistance under AS 47.07 without the payment of a premium or other cost-sharing charges
18 for the first two months of the individual's receipt of assistance under AS 47.07.020(b)(12).
19 Beginning in the third month of the individual's receipt of assistance under
20 AS 47.07.020(b)(12), the individual shall pay one-twelfth of an annual premium that is
21 determined by applying a percentage to the annual net income of the individual's family. The
22 applicable percentage, Y, shall be calculated according to the formula of $Y = (X-100)/15 -$
23 $0.75(N-1)$, where X is the annual net income of the individual's family expressed as a
24 percentage of the official federal poverty line for a family of the size involved and N is the
25 number of persons in the individual's family; however, an individual is not required to pay
26 a premium under this section if the individual's family has a net income that is less than the
27 applicable federal poverty line for a family of the size involved or if the value of Y calculated
28 under this section is a negative number. The premium required under this section is payable
29 until the Department of Health and Social Services, by regulation, establishes another system
30 for setting and collecting a premium or other cost-sharing charges for persons who receive
31 medical assistance because they are eligible under AS 47.07.020(b)(12), as enacted by sec. 1

1 of this Act. For purposes of this section, the annual net income of the individual's family
2 shall be determined under applicable federal regulations and guidelines.

3 * Sec. 5. REGULATIONS. The Department of Health and Social Services shall adopt
4 regulations establishing the sliding fee scale for premiums or other cost-sharing charges
5 described in this Act by July 1, 1999.

Fiscal Note Summary for HB 459

The Federal Balanced Budget Act of 1997 (P.L. 105-33) established a new optional Medicaid eligibility category for disabled persons who would be eligible for SSI and Medicaid, except that their earned income exceeds the limits for SSI and their family's earned income is below 250% of the federal poverty level for Alaska. States may impose a requirement that disabled workers pay a "buy-in" charge. This bill would elect this optional eligibility category for Alaska.

We believe that the only individuals who will take advantage of this new eligibility category will be existing SSI or APA applicants who would otherwise lose Medicaid because of their own increased earnings. We do not anticipate individuals using this new eligibility category to access Medicaid for the first time. Consequently, this option will not result in an increase in new Medicaid cases, but will only have the effect of extending the Medicaid eligibility of existing recipients for about one year.

Some who return to work will be able to access employer-based private health insurance.

The cost of providing additional Medicaid expenditures under this bill is more than offset by the savings incurred when individuals who return to work or extend their hours will not longer need (or qualify for) Adult Public Assistance cash payments. Nominal revenue would be received through the collection of "buy-in" charges.

See fiscal notes for more explanation.

COST/SAVINGS SUMMARY	FY99	FY00	FY01	FY02	FY03	FY04
Continued Medicaid	83.5	283.4	242.3	241.6	240.5	239.2
Computer Programming	4.0	0.0	0.0	0.0	0.0	0.0
Savings from APA reductions	(33.0)	(190.5)	(311.0)	(427.7)	(540.4)	(649.3)
Net Program Expenditures	54.5	92.9	(68.7)	(188.1)	(299.9)	(410.1)
Less Revenue from Buy-in Charge	(3.1)	(10.1)	(8.4)	(8.1)	(7.9)	(7.5)
NET COST/SAVINGS	51.4	82.8	(77.1)	(194.2)	(307.8)	(417.6)

FUNDING SOURCES	FY99	FY00	FY01	FY02	FY03	FY04
Federal Receipts	52.0	169.4	144.8	144.5	143.8	143.1
GF Match	32.4	103.9	89.1	89.0	88.8	88.6
GF	(33.0)	(190.5)	(311.0)	(427.7)	(540.4)	(649.3)
GF/Program Receipts	3.1	10.1	8.4	8.1	7.9	7.5
TOTAL	54.5	92.9	(68.7)	(186.1)	(299.9)	(410.1)

ANALYSIS OF CSHB 459 (FIN)

Introduction

Disabled persons seeking to re-enter the work force sometimes face a hurdle to re-employment. Those who have high monthly medical costs, or are medically fragile, need adequate medical insurance to pay their medical bills, and to provide a safety net if their medical condition worsens while they are employed. Many disabled persons are prevented by their disability from engaging in the same type of job as they did before becoming disabled. Typically, on re-entry to the work force, they may be compelled to choose low-skill, entry-level positions or part-time employment. Characteristic of these types of jobs is low pay and inadequate health insurance benefits, or no health insurance at all.

Federal law permits certain recipients of Supplemental Security Income (SSI) to continue to receive Medicaid after they have gone back to work, if they can demonstrate (1) that their earnings are insufficient to provide the reasonable equivalent of Medicaid, and (2) that termination of Medicaid benefits would seriously inhibit their ability to continue employment. This program is referred to as the Section 1619 program, in reference to the section of the Social Security Act that provides the benefit. The statute creating the program is codified at 42 United States Code § 1382h.

Section 4733 of the Balanced Budget Act of 1997 permits states to exercise the option to expand the class of disabled person who can work while continuing to receive Medicaid. This section permits a state to provide Medicaid to disabled individuals so long as their family income does not exceed 250% of the federal poverty thresholds, and so long as they contribute towards the Medicaid program by paying premiums or charges on a sliding scale according to their income. The federal act gives the State discretion to determine the sliding scale.

CSHB 459 if adopted would exercise the option of Section 4733 of Public Law No. 105-33.

Midwife services are currently first in the list of optional medical services and optionally eligible groups for elimination of coverage during periods of shortage of Medicaid funding. Moving midwife services to a lower position on the eligibility list will increase competition among providers for birthing and related services, thereby lowering overall Medicaid costs. CSHB 459 moves midwife services from first to fifteenth on the priority list, but does not otherwise change the relative order of other optional services and optional eligibility groups.

Sectional Analysis

Section 1: Under state law, addition of further categories of persons eligible for Medicaid may occur only by legislative revision of AS 47.07.020. See AS 47.07.020(d). This section of the bill amends AS 47.07.020(b) to add disabled workers, subject to the eligibility criteria, to the list of persons who may receive Medicaid.

Section 2: Because of limits in appropriations from year to year, the Legislature is not able to fund all services for all persons who may be eligible for medical assistance, including Medicaid. It is necessary to create a priority in allocation of appropriated funds to guide the Department of Health and Social Services (Department). AS 47.07.035 establishes a priority list for optional medical services and eligibility groups. This section of the bill amends AS 47.07.035 to place the category of disabled workers eligible for benefits under the bill thirty-second on the priority list, meaning that disabled workers would be the last to lose Medicaid benefits during periods of limited funding. This section also moves midwife services from first on the priority list, to fifteenth, while not changing the relative order of other optional services and optional groups.

Section 3: This section revises a definition regarding personal care services to give more flexibility in the way that these services may be delivered to a disabled person. This modification will help make personal care service delivery more efficient and expand the employment opportunities for disabled persons.

Section 4: This section contains a transitional provision that directs the Department to provide this benefit to disabled workers immediately upon the effective date that the bill becomes law prior to the adoption of regulations to implement the act.

Section 5: This section directs the Department to adopt regulations to implement the option, with a deadline for adoption of regulations of July 1, 1999. Because the Department's regulations are to provide a sliding fee scale that is reflective of need, workers who receive health insurance benefits from a private insurance program might reasonably be required to demonstrate their need for additional coverage under the Medicaid program. For example, a new employee with a probationary period before private health insurance benefits begin, who also must satisfy a one-year period of non-coverage for a pre-existing medical condition, would benefit from receiving Medicaid coverage under the bill until his or her private medical insurance began to apply. The bill gives the Department discretion in establishing this program to adopt regulations that are reflective of need, subject however that the regulations should not be so restrictive as to frustrate the purpose for which the option is provided. Thus a worker should not be made ineligible for the benefit just because the worker has health insurance through employment, if the worker can demonstrate need because of limitations or exemptions in the private insurance policy, unusually high regular medical expenses or other inadequacy in the private health insurance benefits received.



April 3, 1998

By hand delivery

Hon. Gary Wilken
Chair, Health, Education and Social Services Committee
Alaska State Senate
State Capitol, Room 510
Juneau, AK 99801

Re: SB 253/HB 459: Medicaid Buy-in for Disabled Workers

Dear Senator Wilken:

This will respond to some of the issues raised during the hearing on April 1 regarding draft "E" adopted by the Senate HESS committee as a working draft in lieu of the original SB 253.

Transition

Concern was expressed about whether it was appropriate to permit disabled persons to receive Medicaid at no cost under the bill during the transition period when regulations are being prepared.

After consulting with the Department, I have prepared language which would require a buy-in charge to be applied during the transition period based on a non-regressive formula that would result in a payment of zero, for a single person, if the person's income is equal to the Federal poverty threshold, and up to 10% of income if a person income is 250% of the federal poverty threshold. Note that the proposed language is in terms of net (after-tax) income, not gross income.

This proposed fee scale is represented by the following formula:

$$Y = [(X - 100) \div 15] - [(0.75)(N-1)]$$

where: Y = premium (expressed as a percentage of income),
X = family income (expressed as a percentage of the federal poverty level) =
(family income) ÷ (federal poverty level for the applicable family), and
N = the number of persons in the family involved

MEMBER OF THE
NATIONAL
ASSOCIATION OF
PROTECTION &
ADVOCACY
SYSTEMS

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To avoid penalizing disabled persons with families, I have included a factor which decreases the premium (expressed as a percentage of income) with family size. Since this premium is buying Medicaid only for one person, it does not seem fair to expect a person with a disability living in a family to pay a much larger premium for this health insurance than a single individual. On the other hand, persons in larger families can live more efficiently than a single person. To resolve these two competing ideas, I have developed a "family factor" $[0.75(N-1)]$ that reduces the percentage of income to be paid as a premium. However, as shown in the spreadsheet, at the threshold income levels a person in a family still ends up paying a higher premium than a single individual, it is just at a lower rate of overall family income.

Application of the formula is represented in the attached spreadsheet and graph. The spreadsheet shows the maximum annual and monthly premiums, both as a percent of income and in dollar figures, at the threshold of eligibility. The graph shows the change in percentage of family income to be paid as a premium, as a function of family income relative to the federal poverty levels. Each line represents a different fee scale based on the size of the family (N). Note that under this proposed formula, some families with lower incomes would pay no premium even though their family income is above the federal poverty line. I do not have the mathematical ability to come up with a "family factor" that makes these lines converge to zero at 100% of the poverty line.

It is my personal estimation that this formula would roughly effectuate the intent of the Balanced Budget Act of 1997, which was to remove a current impediment to re-employment of disabled persons, with a reasonable contribution to the program by those who would benefit.

However, I urge the committee to refrain from adopting a particular premium scale as a permanent part of the legislation, since any premium formula may need adjustment in final regulations. In fact, I would advocate for a "family factor" that is logarithmic rather than linear; it is beyond my rusty mathematical abilities to come up with one.

I think it is better for the Department to have the discretion to set a fee scale by regulation, and if in future years the Department errs in setting a fee scale either too high or too low, the problem can be addressed by revision of the regulation or further legislative action.

Definition of disability

Committee members expressed concern that the term "disability" was not defined in the bill. It is important to understand that the category of persons eligible under this Medicaid option is controlled by the federal law that creates the option. That definition is more restrictive than, for example, the definitions used for determining the scope of rights under the federal Americans with Disabilities Act.

The option is quite specific about the population of persons who would be eligible. Those eligible are:

“all individuals ...who are in families whose income is less than 250 percent of the income official poverty line ... applicable to the family of the size involved, and who but for earnings in excess of the limit established under [42 U.S.C.] section 1396d(q)(2)B) ..., would be considered to be receiving supplemental security income ...”¹

In short, to be eligible for this program, a person must be able to demonstrate disability sufficient to satisfy criteria for receiving SSI benefits (whether or not the person is actually receiving those benefits).

A federal Health Care Financing Administration (HCFA) letter explaining the new buy-in option explains the second criterion:

“Assuming the individual has met the gross income test,² the second step is a determination of whether he or she meets the disability, assets, and unearned income standards to receive an SSI benefit.... SSI methodologies are used in making this determination except that all earned income received by the individual is disregarded.”³

The SSI disability methodologies are quite complex, involving application of many separate Social Security statutes and regulations, and are not susceptible to an easy and simple distillation. I caution the committee against venturing into this field, because a definition that is too broad would conflict with federal law and risk HCFA disapproval of implementation of the option. A definition that is too narrow would risk legal challenge by a person claiming to have been wrongfully excluded by the definition. Truly, it is not necessary for the state to define disability in this legislation, since disability for purposes of eligibility is defined by federal law and regulations.

¹ 42 U.S.C.A. § 1396a(a)(10)(A)(ii)(XIII) (Supp. Nov. 1997)(copy attached).

² A subsequent HCFA interpretive letter has pointed out that the appropriate test of eligibility looks at *net* income, not *gross* income. S.K. Richardson, Dir., Center for Medicaid and State Operations, Health Care Financing Administration, to State Medicaid Directors (Mar. 9, 1998), *published at* <http://www.hcfa.gov/mediucaid/bba4733.htm> (Apr. 2, 1998)

³ S.K. Richardson, Dir. Center for Medicaid and State Operations, Health Care Financing Administration, to State Medicaid Directors (Nov. 24, 1997), at page 2-3, *published at* <http://www.hcfa.gov/mediucaid/bbawkdis.htm> (Apr. 2, 1998).

If the committee still wishes to adopt a definition of disability, I have provided one attached to this letter that is consonant with the guidance of the HCFA.

Fiscal impact

Sen. Wilken correctly noted that the fiscal notes for CSHB 459 (FIN) (which is the identical bill for the working draft "E") calculate a cumulative savings in Adult Public Assistance monies, but project non-cumulative Medicaid expenses. I have urged the Department to further explain why the fiscal notes take this approach, but I have also discussed this issue with Department personnel, and this is my best layman's explanation of what I have been told.

Savings are accumulated because for each year that the program is implemented, it is expected that persons who are enabled to go back to work because of this bill will *not* be receiving Adult Public Assistance benefits. Thus in the first year, 17 people are projected to go back to work. In the second year, 28 additional people are projected to go back to work, which when added to the first year's, means a total of 45 people are projected to be taken off the Adult Public Assistance rolls as a result of the bill. During FY 2001, 31 additional people are projected to be removed from the APA rolls, meaning a total of 80 persons are projected to be removed from APA rolls as a result of the bill, and so on for each of the projected years. Without having removed these persons from the APA rolls, it is presumed these disabled persons would have continued to draw APA. By removing them, savings is realized during each year they have been successfully employed as a result of this bill.

Savings per person is based on an average monthly APA benefit of \$324 per person, which when calculated on a yearly basis results in the projected savings. See Fiscal Note for CSHB 459 (HES), Dept. of Health and Social Services, Public Assistance BRU, Adult Public Assistance Component (Fiscal Note No. 2, dated March 2, 1998), at page 2.

Expenses are calculated differently, based on the assumption that the bill will primarily help persons who are currently not working. The bill is focused on a population of people who are currently receiving Adult Public Assistance, and therefore Medicaid. This population of persons is *therefore already presenting a Medicaid expense to the state*. The continued use of Medicaid by this population will not result in an additional expense as a result of the bill – if they had not worked, and stayed on Adult Public Assistance, they would continue to receive Medicaid.

Other assumptions of the fiscal note for expenses are that: (1) persons who benefit from the buy-in option are persons who are ready to go to work or to increase their hours of work, but who have not done so in order to continue the availability of public health coverage to meet their medical needs; (2) that persons who benefit from the buy-in option will be eligible for this

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benefit, on average, for one year before their private health insurance benefits or earnings make them ineligible for the program; (3) that 25% of the eligible population will immediately gain access to private health insurance rendering them ineligible for this benefit. See, e.g., Fiscal Note for CSHB 459 (HES), Dept. of Health and Social Services, Medical Assistance BRU, Medicaid Facilities Component (Fiscal Note No. 1, dated Mar. 2, 1998), at page 2.

Thus, unlike the savings which are expected to accumulate as the program is implemented, the expenses are not projected to accumulate because this program is expected to provide a bridge between dependence on public benefits and employment with private health insurance.

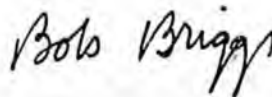
Revision of definition of PCA services

The current definition of personal care attendant (PCA) services in AS 47.07.900(15) should be revised to be consistent with federal law on the subject. Section 3 of the working draft does this.

Currently, AS 47.07.900(15) requires that PCA services must be prescribed by a physician and supervised by a nurse. These criteria are not required by federal law, and we believe unnecessarily increase the Medicaid costs for these PCA services. The current language of the bill would delete the requirement of a physician's prescription for a PCA plan and would delete the requirement that all PCA services in all cases be supervised by a nurse. That is not to say that some PCA services should not be supervised by a nurse, but we believe the Department can by regulation specify those situations where nursing supervision is appropriately required.

I hope that this clarifies the issues regarding the working draft/HB 459, and will be happy to discuss this with yourself, members of the committee, and your staff.

Very truly yours,



Robert B. Briggs
Staff attorney

Encls.

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cc: (w/ encls.)

Hon. Loren Lemman
Hon. Lyda Green
Hon. Jerry Ward
Hon. Johnny Ellis
Hon. Con Bunde

cc: (w/o encls.)

Jim Parker, DLC - Anchorage
Dawn Pederson

PROPOSED TRANSITION PREMIUMS
(maximum premiums at threshold of eligibility)

<u>Family Size (N)</u>	<u>Percent of Income</u>	<u>Eligibility Threshold</u>	<u>Annual Premium</u>	<u>Monthly Premium</u>
1	10.0	\$25,175	\$2,518	\$210
2	9.3	\$33,925	\$3,138	\$262
3	8.5	\$42,675	\$3,627	\$302
4	7.8	\$51,425	\$3,985	\$332
5	7.0	\$60,175	\$4,212	\$351
6	6.3	\$68,925	\$4,308	\$359
7	5.5	\$77,675	\$4,272	\$356
8	4.8	\$86,425	\$4,105	\$342

Formula: $Y = [(X-100)/15] - [(0.75)(N-1)]$, where:

Y= annual premium as percent of income;

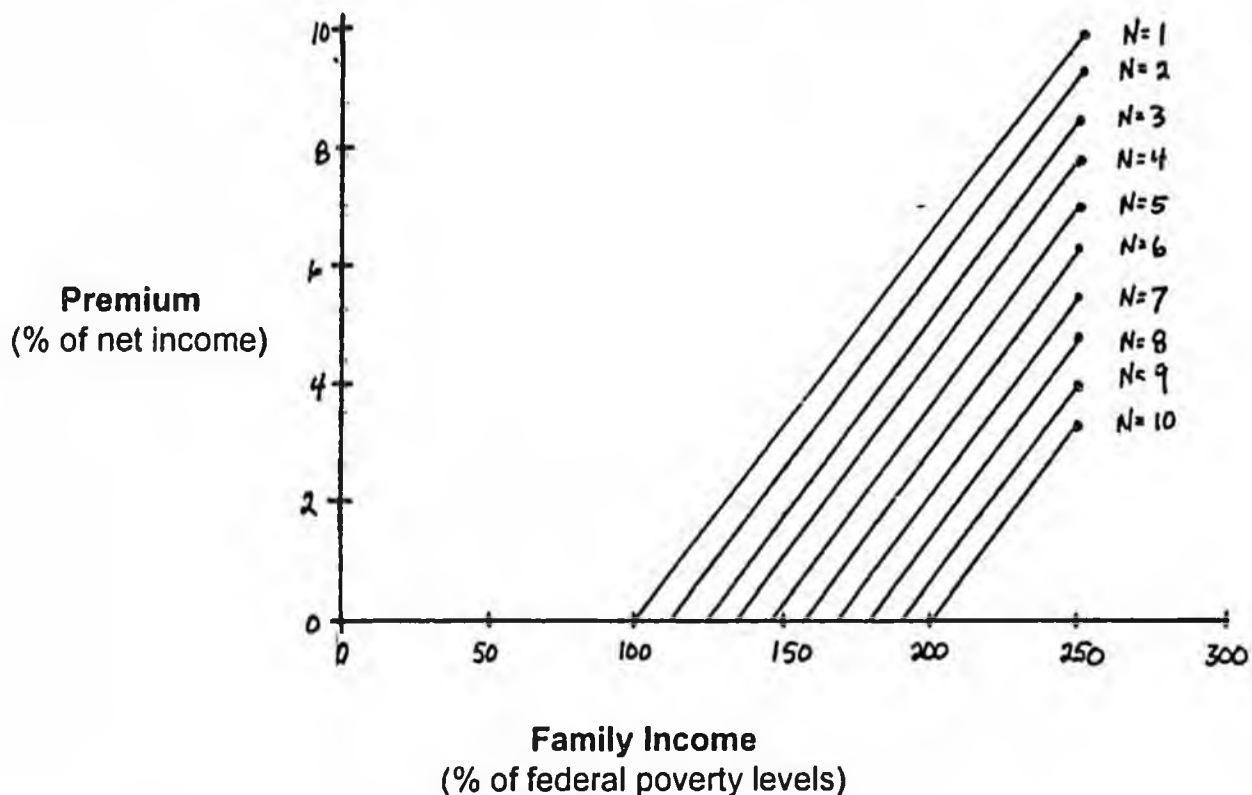
X=income as percent of federal poverty levels; and

N= family size

April 3, 1998

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Medicaid Buy-in: Proposed Transition Premiums (premium as a function of family income)



Formula: $Y = [(X - 100) \div 15] - [(0.75)(N-1)]$, where:

Y = annual premium (expressed as a percentage of income),

X = family income (expressed as a percentage of the federal poverty level) = (family income) \div (federal poverty level for the applicable family), and

N = the number of persons in the family involved

AMENDMENT

OFFERED IN THE SENATE

TO: SB 253, Work Draft "E"

1 Page 4, line 3, insert the following and renumber subsequent sections accordingly:

2 **Sec. 4. As used in this Act, "disability" means that a person meets the disability.

3 assets, and unearned income standards to receive a federal Supplemental Security Income

4 benefit under applicable federal laws and regulations, without regard to

5 (1) earned income received by the individual;

6 (2) whether the individual is receiving a federal Supplemental Security Income

7 benefit at the time of application; or

8 (3) whether the individual has ever received a federal Supplemental Security

9 Income benefit."

10

Provided by Robert Briggs

HB 459: Calculation of Threshold for Eligibility

<u>Size of Family Unit</u>	<u>Alaska Poverty Guideline (1998)*</u>	<u>250% of 1998 Guideline</u>
1	\$ 10,070	\$ 25,175
2	13,570	33,925
3	17,070	42,675
4	20,570	51,425
5	24,070	60,175
6	27,570	68,925
7	31,070	77,675
8	34,570	86,425
For each additional person. add:	3,500	8,750

* Source: 63 Federal Register, pages 9235-9238 (Feb. 24, 1998), reprinted in U.S. DHHS, *The 1998 HHS Poverty Guidelines*, [Http://aspe.os.dhhs.gov/poverty/98poverty.htm](http://aspe.os.dhhs.gov/poverty/98poverty.htm) (Mar. 10, 1998)

THE 1998 HHS POVERTY GUIDELINES

One Version of the [U.S.] Federal Poverty Measure

There are two slightly different versions of the federal poverty measure:

- the poverty thresholds, and
- the poverty guidelines.

The **poverty thresholds** are the original version of the federal poverty measure. They are updated each year by the **Census Bureau** (although they were originally developed by Mollie Orshansky of the Social Security Administration). The thresholds are used mainly for **statistical purposes**--for instance, preparing estimates of the number of Americans in poverty each year.

The **poverty guidelines** are the other version of the federal poverty measure. They are issued each year in the *Federal Register* by the **Department of Health and Human Services (HHS)**. The guidelines are a simplification of the poverty thresholds for use for **administrative purposes**--for instance, determining financial eligibility for certain federal programs. (The full text of the *Federal Register* notice with the 1998 poverty guidelines is [available here](#).)

1998 HHS Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$ 8,050	\$10,070	\$ 9,260
2	10,850	13,570	12,480
3	13,650	17,070	15,700
4	16,450	20,570	18,920
5	19,250	24,070	22,140
6	22,050	27,570	25,360
7	24,850	31,070	28,580
8	27,650	34,570	31,800
For each additional person, add	2,800	3,500	3,220

SOURCE: *Federal Register*, Vol. 63, No. 36, February 24, 1998, pp. 9235-9238.

(The separate poverty guidelines for Alaska and Hawaii reflect Office of Economic Opportunity administrative practice beginning in the 1966-1970 period. Note that the poverty thresholds--the original version of the poverty measure--have never had separate figures for Alaska and Hawaii.)

Programs using the guidelines (or percentage multiples of the guidelines--for instance, 130 percent of the guidelines) in determining eligibility include Head Start, the Food Stamp Program, the National School Lunch Program, and the Low-Income Home Energy Assistance Program. Note that in general, public assistance programs (Aid to Families with Dependent Children and its block grant successor, and Supplemental Security Income) do NOT use the poverty guidelines in determining eligibility. The Earned Income Tax Credit program also does NOT use the poverty guidelines to determine eligibility.

The poverty guidelines (unlike the poverty thresholds) are designated by the year in which they are issued. For instance, the guidelines issued in February 1998 are designated the 1998 poverty guidelines.

issued. For instance, the guidelines issued in February 1998 are designated the 1998 poverty guidelines. However, the 1998 HHS poverty guidelines only reflect price changes through calendar year 1997; accordingly, they are approximately equal to the Census Bureau poverty thresholds for calendar year 1997. (The 1997 thresholds will be issued in final form about September or October 1998; a preliminary version of the 1997 thresholds is now available from the Census Bureau.)

The poverty guidelines are sometimes loosely referred to as the "federal poverty level," but that term is ambiguous, and should be avoided in situations (e.g., legislative or administrative) where precision is important.

Poverty guidelines for recent years for the 48 contiguous states and the District of Columbia can be calculated by addition using the figures shown below:

Year	First Person	Each Additional Person	(Four-Person Family)
1985	\$5,250	\$1,800	(\$10,650)
1986	5,360	1,880	(11,000)
1987	5,500	1,900	(11,200)
1988	5,770	1,960	(11,650)
1989*	5,980	2,040	(12,100)
1990*	6,280	2,140	(12,700)
1991	6,620	2,260	(13,400)
1992	6,810	2,380	(13,950)
1993	6,970	2,460	(14,350)
1994	7,360	2,480	(14,800)
1995	7,470	2,560	(15,150)
1996	7,740	2,620	(15,600)
1997	7,890	2,720	(16,050)
1998	8,050	2,800	(16,450)

(However, note that this simple calculation procedure does NOT reflect the procedure by which the poverty thresholds were originally developed or the procedure by which the poverty guidelines are calculated from the poverty thresholds each year.)

* Note that 1989 and 1990 poverty guidelines figures should NOT be used in connection with determining poverty population figures from 1990 Decennial Census data. Poverty population figures are calculated using the Census Bureau poverty thresholds, not the poverty guidelines.

Poverty guidelines for the years shown above can be found in the *Federal Register* as follows:

- 1985--Vol. 50, No. 46, March 8, 1985, pp. 9517-9518
- 1986--Vol. 51, No. 28, February 11, 1986, pp. 5105-5106
- 1987--Vol. 52, No. 34, February 20, 1987, pp. 5340-5341
- 1988--Vol. 53, No. 29, February 12, 1988, pp. 4213-4214
- 1989--Vol. 54, No. 31, February 16, 1989, pp. 7097-7098
- 1990--Vol. 55, No. 33, February 16, 1990, pp. 5664-5666
- 1991--Vol. 56, No. 34, February 20, 1991, pp. 6589-6861
- 1992--Vol. 57, No. 31, February 14, 1992, pp. 5455-5457
- 1993--Vol. 58, No. 28, February 12, 1993, pp. 8287-8289
- 1994--Vol. 59, No. 28, February 10, 1994, pp. 6277-6278
- 1995--Vol. 60, No. 27, February 9, 1995, pp. 7772-7774
- 1996--Vol. 61, No. 43, March 4, 1996, pp. 8286-8288
- 1997--Vol. 62, No. 46, March 10, 1997, pp. 10856-10859
- 1998--Vol. 63, No. 36, February 24, 1998, pp. 9235-9238

[Click here](#) to go to the page of Information Contacts and References on the Poverty Guidelines, the Poverty Thresholds, and the Development and History of U.S. Poverty Lines.

[Click here](#) to return to the main Poverty Guidelines, Research and Measurement page.

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March 9, 1998

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Balanced Budget Act.

We are writing to alert you to a change in policy on section 4733 of the Balanced Budget Act of 1997 (BBA) from that set forth in our State Medicaid Director letter dated November 24, 1997. Section 4733 created an optional categorically needy group designed to provide Medicaid eligibility to disabled working individuals who, because of relatively high earnings, cannot qualify for Medicaid under one of the other statutory provisions under which disabled working individuals may be eligible for medical assistance.

In an enclosure to the November 24 letter, we described a two-step eligibility process consisting of a family income test of 250 percent of the Federal poverty level, followed by an individual eligibility determination. The family income test required that the family's gross income, essentially without deductions or exemptions, be compared to 250 percent of the poverty level for a family of the size involved.

Since release of the November 24 letter, concerns have been raised about the use of the family's gross income for the family income test. The primary objection is that using the family's gross income limits the amount of income individuals could have and still qualify for eligibility under this group to a point where, in approximately half the States, the income standard under section 4733 is lower than the income standard under section 1619(b) of the Act.

In view of these concerns, and after careful consideration of the options available, we have decided to change our policy on the family income test. Instead of using the family's gross income, States wishing to cover this group should measure the family's net income against the 250 percent family income standard. The family's net income is determined by applying all appropriate SSI income disregards, including the earned income disregard, to the family's total income. The result, i.e., the family's net income, is then compared to the 250 percent income standard.

Use of the family's net, rather than gross, income will have the affect of greatly increasing the amount of income a disabled individual can have and still qualify for eligibility under this group. This in turn will enable States to provide Medicaid to a greater number of disabled individuals, who without such coverage might not be able to work.

The revised enclosure explains use of the net, rather than gross, family income test. It also provides information, which was not included in the earlier version, on use of section 1902(r)(2) more liberal methodologies, as well as use of more restrictive policies in 209(b) States. We also make it clear that the SSI income standard, which is used to determine the individual's eligibility following the family net income test, includes optional State supplementary payments. Finally, the revised enclosure discusses the use of substantial gainful activity (SGA) as a criterion in determining eligibility under this group.

We apologize for any inconvenience issuance of our previous policy may have caused. Any questions about this provision or this letter should be directed to Roy Trudel of my staff at (410) 786-3417.

Sincerely,

/s/

Sally K. Richardson
 Director
 Center for Medicaid and State Operations

Provided by Robert Briggs

Enclosure

cc:

All HCFA Regional Administrators
All HCFA Associate Regional Administrators for Medicaid and State Operations
Lee Partridge - American Public Welfare Association
Joy Wilson - National Conference of State Legislatures
Jennifer Baxendell - National Governors' Association
HCFA Press Office

Enclosure

Determining Eligibility for Individuals Under Section 4733 of BBA

The eligibility determination for individuals in this group is essentially a sequential two-step process.

1. The first step is a net income test, based on the family's combined income, including all earnings. (A family can also be just one individual; i.e., a family of one.) The family's net combined income must be less than 250 percent of the federal poverty level for a family of the size involved. Family income is determined by applying all appropriate SSI disregards and exemptions, including the earned income disregard, to the family's total income. If the family's income, after all deductions and exemptions have been applied, is equal to or exceeds 250 percent of the appropriate poverty level, the individual is not eligible for Medicaid under this provision.

It is up to the State to determine what constitutes a "family" in the context of this provision. As one example, a State could choose to consider a disabled adult living with his or her parents as a family of one for purposes of meeting the 250 percent family income standard.

2. Assuming the individual has met the net family income test, the second step is a determination of whether he or she meets the disability, assets, and unearned income standards to receive an SSI benefit. Income of other family members used in Step 1 is not included (unless the individual has an ineligible spouse whose income is subject to the SSI deeming rules). To be eligible under this provision, the individual must meet all SSI eligibility criteria (including categorical requirements).

SSI methodologies are used in making this determination except that all earned income received by the individual is disregarded. The individual's countable unearned income (e.g., title II disability benefits) must be less than the SSI income standard (in 1998, \$494 for an individual), or the standard for optional State supplementary payments (SSP) if the State makes such payments. If unearned income equals or exceeds the SSI/SSP income standard, the individual is not eligible for Medicaid under this provision.

The individual's countable resources must be equal to or less than the SSI resource standard (\$2,000 for an individual).

Under section 1902(r)(2) of the Act, States may use more liberal income and resource methodologies than are used by the SSI program in determining eligibility for this group. Also, 209(b) States may, but are not required to, apply their more restrictive eligibility policies in determining eligibility for this group.

There is no requirement that the individual must at one time have been an SSI recipient to be eligible under this provision. However, if the individual was not an SSI recipient, you must do a disability determination to ensure that the individual would meet the eligibility requirements for SSI. A disability determination for an individual who was not previously an SSI recipient should not consider whether the individual engaged in substantial gainful activity (SGA), since use of SGA as an eligibility criterion would in almost all instances result in the individual not being

eligible under this group, effectively negating the intent of this provision.



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Last updated March 10, 1998

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November 24, 1997

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Balanced Budget Act.

We are writing to provide you information on section 4733 of the Balanced Budget Act of 1997 (BBA), which is designed to provide Medicaid eligibility to disabled working individuals who, because of relatively high earnings, cannot qualify for Medicaid under one of the other statutory provisions under which disabled working individuals may be eligible for medical assistance.

While Medicaid is designed primarily to cover individuals with limited income and resources, current law provides for continued Medicaid coverage for working disabled individuals with incomes above the normal income standards. Specifically, under

Section 1619(a) of the Social Security Act, individuals can continue to receive Supplemental Security Income (SSI) and Medicaid even if their earned income exceeds the "substantial gainful activity" (SGA) limit of \$500 a month; and

Sections 1619(b) and 1905(q) of the Social Security Act, individuals whose earned income exceeds the maximum amount that will permit payment of an SSI benefit can still receive Medicaid (but not SSI) if they continue to be disabled, meet all other non-disability SSI requirements except for earned income, need Medicaid to continue working, and do not have sufficient income to replace the value of the SSI benefits and the Medicaid benefits they would lose. The amount of income this represents varies from State to State and year to year, but is much higher than the income standards normally applied to Medicaid. The range is from about \$12,000 to over \$32,000 a year. However, individualized calculations can be made in certain instances.

While many persons with disabilities fall within the income levels for eligibility under one of the programs described above, more persons with disabilities may increase their earnings or consider returning to work if they are assured of continued Medicaid coverage beyond the 1619(b) maximums. Because they are disabled and usually have high medical expenses, and often use long-term support services available under Medicaid, they often do not have access to private health insurance coverage, whether through an employer or direct purchase from an insurer. Without access to private health insurance or Medicaid, these individuals, who are estimated to number very few, often cannot afford to pay for their medical care. Under this circumstance, their only alternative may be to stop working, or reduce their work effort, thus reducing their income to a point where they again become eligible for Medicaid.

Section 4733 of BBA allows States to provide Medicaid to these individuals by creating a new optional categorically needy eligibility group. If a State chooses to cover this group, individuals can become eligible for Medicaid if:

they are in a family whose income is less than 250 percent of the federal poverty level for a family of the size involved; and
except for their earned income, they would be considered to be receiving SSI benefits.

Section 4733 also provides that States can require individuals to pay such premiums or other cost-sharing charges, set on a sliding scale based on income, as the State may determine. The amount of the premium or other cost-sharing to be paid, if any, is entirely within each State's discretion. Section 4733 does not require a premium or cost-sharing charges.

This provision is now in effect. We are developing a State Medicaid Manual instruction related to coverage of this group. States wishing to cover this group should submit a Medicaid State Plan

Provided by Robert Briggs

amendment so indicating to their HCFA Regional Office. The amendment should indicate that the State covers this optional categorically needy group and the effective date of the amendment, and should include information on the premiums and cost-sharing charges the State plans to impose.

Enclosed is an explanation of how eligibility is determined for this group.

Any questions about this provision or this letter should be directed to Roy Trudel of my staff at (410) 786-3417.

Sincerely, Sally K. Richardson
Director
Center for Medicaid and State Operations

Enclosure

cc:
All HCFA Regional Administrators

All HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge
American Public Welfare Association

Joy Wilson
National Conference of State Legislatures

Jennifer Baxendell
National Governors' Association

bcc:
CMSO Senior Staff

NOTE: The Policy Described Below Has Been Changed - See the SMD Letter Dated March 9, 1998

Enclosure

Determining Eligibility for Individuals Under Section 4733 of BBA

The eligibility determination for individuals in this group is essentially a sequential two-step process.

1. The first step is a gross income test, based on the family's total combined income, including all earnings. The family's total combined income must be less than 250 percent of the federal poverty level for a family of the size involved. Family income is determined without deductions or exemptions, except for types of income generally excluded under laws other than the Social Security Act; e.g., Agent Orange payments, certain reparations payments, various payments to Native Americans, etc. If the family's income is equal to or exceeds 250 percent of the appropriate poverty level, the individual is not eligible for Medicaid under this provision.

It is up to the State to determine what constitutes a "family" in the context of this provision.

2. Assuming the individual has met the gross income test, the second step is a determination of whether he or she meets the disability, assets, and unearned income standards to receive an SSI benefit. Income of other family members used in Step 1 is not included (unless the individual has an ineligible spouse whose income is subject to the SSI deeming rules). To be eligible under this provision, the individual must meet all SSI eligibility criteria (including categorical requirements).

SSI methodologies are used in making this determination except that all earned income received by the individual is disregarded. The individual's countable unearned income (e.g., title II disability benefits) must be less than the SSI income standard (in 1997, \$484 for an individual). If unearned income equals or exceeds the SSI income standard, the individual is not eligible for Medicaid under this provision.

The individual's countable resources must be equal to or less than the SSI resource standard (\$2,000 for an individual).

There is no requirement that the individual must at one time have been an SSI recipient to be eligible under this provision. However, if the individual was not an SSI recipient, you must do a disability determination to ensure that the individual would meet the eligibility requirements for SSI.



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November 1997
Pamphlet Number 4A
Titles 28 to End

Supplementing 1997 Pocket Parts
and U.S.C.A. Pamphlets Numbered 1, 2, and 3

LAWS

July 3, 1997 to August 13, 1997
Public Laws 105-23 to 105-41

Executive Orders
Rules and Regulations

Tables and Index

Titles 1 to 27 are contained
in Pamphlet No. 4

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expanded without there being a cost to such health care program or to the Federal Government;

(B) whether to extend the demonstration project or make the project permanent; and

(C) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.

(Aug. 14, 1935, c. 531, Title XVIII, § 896, as added Aug. 5, 1997, Pub.L. 105-33, Title IV, § 4016(a), 111 Stat. 337.)

HISTORICAL AND STATUTORY NOTES

Revision Notes and Legislative Reports

1997 Acts. House Report No. 106-149, House Conference Report No. 106-217, and Statement by President, see 1997 U.S. Code Cong. and Adm. News, p. —

Implementation Plan For Veterans Subvention

Section 4016(b) of Pub.L. 105-33 provided that: "Not later than 12 months after the start of the demonstration project, the Secretary of Health and Human Ser-

vice and the Secretary of Veterans Affairs shall jointly submit to Congress a detailed implementation plan for a subvention demonstration project (that follows the model of the demonstration project conducted under section 1896 of the Social Security Act (as added by subsection (a)) [this section] to begin in 1999 for veterans (as defined in section 101 of title 38, United States Code) that are eligible for benefits under title XVIII of the Social Security Act [this subchapter]."

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness:

(See 1997 Pamphlet No. 2 for text of (3))

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1396aa(a) of this title), shall be responsible for establishing and maintaining health standards for private

or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1396x(e)(9) of this title or paragraphs (16) and (17)¹ of section 1396x(a) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1396x(aa)(2)(G) of this title;

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) of this title, to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37), 606(h), or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6) of this title),

(II) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193)) and would continue to be paid but for the enactment of that section or who are qualified severely impaired individuals (as defined in section 1396d(q) of this title),

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) of this section and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) of this section for such a family;¹

(V) who are qualified family members as defined in section 1396d(m)(1) of this title;¹

(VI) who are described in subparagraph (C) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) of this section for such a family, or

(VII) who are described in subparagraph (D) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) of this section for such a family;

(ii) at the option of the State, to any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(1) of this title, to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment;¹

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,

(VI) who would be eligible under the State plan under this subchapter if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1396n of this title they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1396n of this title.

(VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1396d(o) of this title;¹

(VIII) who is a child described in section 1396d(a)(i) of this title—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV of this chapter) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV of this chapter were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV of this chapter;¹

(IX) who are described in subsection (l)(1) of this section and are not described in clause (l)(IV), clause (i)(VI), or clause (i)(VII);¹

(X) who are described in subsection (m)(1) of this section;¹

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI of this chapter), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1382e or 1383c of this title;

(XII) who are described in subsection (z)(1) of this section (relating to certain TB-infected individuals);

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income (subject, notwithstanding section 1396o of this title, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine); or

(XIV) who are optional targeted low-income children described in section 1396d(u)(2)(C) of this title;¹

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A) or (E), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single

standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (6) and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services; and

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title;

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1396d(p)(3)(A)(i) of this title for qualified disabled and working individuals described in section 1396d(a) of this title;

(iii) for making medical assistance available for medicare cost sharing described in section 1396d(p)(3)(A)(ii) of this title subject to section 1396d(p)(4) of this title, for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

(iv) subject to sections 1396u-3 and 1396d(p)(4) of this title, for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2002)—

(I) for medicare cost-sharing described in section 1396d(p)(3)(A)(ii) of this title for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title and is at least 120 percent but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan, and

(II) for the portion of medicare cost-sharing described in section 1396d(p)(3)(A)(ii) of this title that is attributable to the operation of the amendments made by (and subsection (e)(3) of) section 4611 of the Balanced Budget Act of 1997 for individuals who would be described in subclause (I) if "135 percent" and "175 percent" were substituted for "120 percent" and "135 percent" respectively; and

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2) of this section) for qualified COBRA continuation beneficiaries described in subsection (u)(1) of this section;

except that (i) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (ii) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1396v of this title or by reason of the payment of premiums under such