

Legal Basics: Medicaid 101

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Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since the organization's founding in 1972, we have focused our efforts on fighting for people who have been marginalized and excluded from justice, such as women, people of color, LGBT individuals, and people with limited English proficiency.

Key Lessons

- 1. Medicaid provides basic health care coverage.** A state's Medicaid program must cover physician services, hospital services, nursing facility services, and other specified services. A state has the option to cover home and community-based services (HCBS).
- 2. Medicaid coverage is available to persons who otherwise cannot afford coverage.** Medicaid programs offer coverage to families with children, older persons (age 65 and over), persons with disabilities and, in "expansion" states, low-income persons from age 18 to 64. Eligibility depends upon a Medicaid program's limits on an applicant's resources and income, which vary from state to state.
- 3. Certain coverage groups are particularly important to older adults.** Automatic eligibility is extended to persons receiving Supplemental Security Income (SSI) and/or State Supplemental Payments (SSP). Other low-income persons may be eligible through standards based on the federal poverty level. Persons with somewhat greater incomes may obtain eligibility as "medically needy."
- 4. Separate eligibility rules apply to most home and community-based services (HCBS) and to nursing facility services.** Eligibility for HCBS and for nursing facility services often is limited by an income cap of \$2,382 monthly, although an income cap's impact can be ameliorated by creating a qualified income trust or qualifying through a "spend down." Unmarried HCBS recipients likely will be able to retain some of their income to pay for housing and other expenses, but the income allocation for nursing facility residents is extremely limited.
- 5. Special financial rules protect couples when one spouse receives HCBS or nursing facility services.** Federal Medicaid law provides protections against impoverishment for the spouses of persons who receive HCBS or nursing facility services. Income and resources are allocated to the "community spouse," based on amounts set by states within ranges established by federal law.
- 6. Medicare Savings Programs (MSPs) are administered through Medicaid to cover Medicare premiums and out-of-pocket costs.** There are four Medicaid-administered MSPs available to low-income Medicare enrollees based on their income and assets that help to pay for Medicare premiums and Medicare out-of-pocket costs.

Medicaid Provides Basic Health Care Coverage

The Medicaid program is a collaboration between the federal government and individual states. Federal law and policy set the basic rules, but each state has significant flexibility to customize its program by adjusting benefit packages and eligibility standards, seeking rule waivers, and taking various other actions.

The Medicaid program provides basic health care coverage. A state is required to offer physician services, hospital services, nursing facility services, and other mandatory services. A state has the option of offering other services such as dental services, in-home personal care services, physical therapy, and case management services.

Home and community-based services (HCBS) are particularly important to older adults and persons with disabilities. HCBS are a package of services that are provided as an alternative to care provided in a nursing facility, intermediate care facility, or other institution. Since HCBS is not a required benefit, the exact package of services varies from state to state; HCBS commonly include personal care services, home modifications, home-delivered meals, respite care, assisted living services, and case management.

Medicaid Coverage is Available to Persons Who Otherwise Cannot Afford Coverage

Subject to financial eligibility, federal law requires that a state offer Medicaid coverage to families with minor children, persons with disabilities, older persons (age 65 and older), and persons in other specified groups. State Medicaid law also gives states the *option* to include other populations—most prominently, the “Medicaid expansion population” of persons from age 18 to 64 who were given an eligibility pathway through 2010’s Affordable Care Act (ACA).¹ Another optional group are the “medically needy”—persons who are not eligible for Medicaid until they first spend their “excess” income for health care (this is often called “spend down”).

Certain Coverage Groups are Particularly Important to Older Adults

SSI beneficiaries are automatically eligible for Medicaid

The Supplemental Security Income (SSI) program guarantees a minimum income to persons who are aged (at least age 65) or who have a disability, and who have countable resources of no more than \$2,000. The federal SSI level varies with inflation from year to year, and is \$794 for 2021. SSI recipients receive Medicaid coverage automatically, with no income spend down.²

In eight states, this SSI-linked Medicaid eligibility is slightly more restrictive.³ When SSI was created in 1972, these states declined to link their Medicaid eligibility to SSI, and instead are obligated to ensure that their comparable Medicaid eligibility standards are no more restrictive than they were in January 1972.⁴ These states are called “209(b) states” because it was section 209(b) of the 1972 legislation that established this option.⁵

NOTE

This chapter summary frequently will reference “countable” resources. Bank accounts and similar savings are considered countable, but retirement accounts may or may not be countable. Persons’ homes generally are not countable. To retain a home’s exempt status, a nursing facility resident should indicate that he or she intends to return to the home at the conclusion of the nursing facility stay.

SSP beneficiaries also are automatically eligible for Medicaid

Many states provide a State Supplemental Payment (SSP) on top of SSI, since the SSI amount of \$794 monthly is relatively meager. For example, a state may pay a SSP of \$200 monthly to bring the beneficiary’s total monthly income to \$994. Under federal law, a state must offer Medicaid coverage to any person receiving a SSP.⁶

Many states offer Medicaid eligibility for older persons who have income below a federal-poverty-level-based standard, and very limited resources

Federal Medicaid law gives states an option to provide Medicaid coverage even if the person's income exceeds SSI/SSP levels. Eligibility is based upon having income that does not exceed the federal poverty level, which is \$1,073 in 2021.⁷ Importantly, however, a state may increase its eligibility level by exempting a certain portion of an applicant's income. Maine, for example, exempts \$75 and currently offers eligibility under its "poverty level" program to persons whose income does not exceed \$1,148 in 2021. California, effective December 1, 2020, expanded eligibility under its poverty program by disregarding any countable income over 100% of the federal poverty level (FPL) up to 138% FPL so that individuals with incomes up to \$1,467 in 2021 are eligible.

Resources also are relevant for older adults' eligibility under the poverty-level category. In most states except Arizona, which has no limit, a person's countable resources must not exceed a state-set amount in the range from \$1,500 to \$7,560 depending on the state.⁸ Notably, this differs from the eligibility standards for the "expansion" population of persons from age 18 to 64, as those standards do not include a resource limit.

Persons with "excess" income may obtain eligibility as "medically needy"

A state has the option of offering "medically needy" eligibility to older adults (65 and over) and persons with disabilities, for persons whose income exceeds the income limits for Medicaid eligibility linked to SSI, SSP, or the federal poverty level. Medically needy eligibility requires that the person spend down her "excess" income prior to receiving Medicaid coverage. Medically needy eligibility also requires that a person's countable resources not exceed the resource limit used in other Medicaid eligibility categories. This resource limit is generally in the neighborhood of \$1,600 to \$5,000, depending on the state. There are a couple states that have much higher resource limits including Iowa (\$10,000) and New York (\$15,150).⁹

Unfortunately, the income level for "medically needy" eligibility is based on a state's 1996 eligibility standards for Aid for Families with Dependent Children (AFDC), which tends to keep the "medically needy" income standard below the SSI/SSP levels.¹⁰ Maryland, for example, has a medically needy income level of \$350, which means that a person with monthly income of \$900 has to incur medical expenses of \$550 monthly in order to access medically-needy eligibility, even though her monthly income exceeds Maryland's SSI amount of \$794 by only \$106. It should be noted that a state has some flexibility to escape the regulatory link to 1996 AFDC levels, pursuant to a 2001 change that allows for use of certain income deductions.¹¹

PRACTICE TIP

Purchase limited insurance to push countable income below the eligibility threshold. As described above, "extra" monthly income of just a few dollars can disqualify a person for automatic Medicaid and increase out-of-pocket health care costs by hundreds of dollars monthly. In many states, a slightly over-income applicant is well advised to buy a limited health care policy (dental coverage, for example) in order to qualify him or her for eligibility. The monthly premium amount generally will be subtracted from the person's countable income, and the subtraction can bring the income under the Medicaid eligibility threshold.

Separate Eligibility Rules Apply to Most Home and Community-Based Services (HCBS) and to Nursing Facility Services

In many states, HCBS eligibility depends on having income of no more than \$2,382 monthly

In general, financial eligibility standards are slightly more accommodating for HCBS and for nursing facility services, in recognition of the fact that HCBS recipients and nursing facility residents have a greater need for health care. In most cases, eligibility for HCBS depends upon the person having income of no more than a "special income level" of three times the federal SSI amount.¹² In 2021, the federal SSI amount is \$794, which translates to a monthly income limit of \$2,382 ($794 \times 3 = 2,382$).

As is generally the case for Medicaid eligibility based on age or disability, the applicant must have relatively few countable resources. The resource limit frequently is in the range from \$1,600 to \$4,000 monthly, at state option.

It should be noted that, depending on the state, the HCBS recipient may or may not have to contribute towards the cost of his or her health care. In some programs, the HCBS recipient may be allowed to retain all of his or her income up to the income limit of (usually) \$2,382. In other programs, the recipient may be required to make a “post-eligibility” payment from his or her income towards the cost of health care. This post-eligibility payment will be calculated in a way that allows the recipient to retain a specified amount of income to pay for housing costs and other living expenses.

These post-eligibility payments, as is the case for the spend down required for medically needy eligibility, do not necessarily have to be directed towards current Medicaid-covered health care expenses. As discussed above, health care premiums are countable against a required spend down or post-eligibility payment. Also countable are “[n]ecessary medical or remedial care” that is “recognized under State law” but not Medicaid-covered.¹³ This category generally includes “old” health care expenses if they were incurred within a few months before the first month of the person’s Medicaid eligibility.

Unmarried nursing facility residents generally must spend most of their income for health care

For nursing facility residents, certain eligibility rules are relatively consistent across states. The resource limit is set at the low level that is common in Medicaid programs—generally \$1,500 to \$5,000. Also, since the resident will be receiving food and shelter in the nursing facility, the resident will be allowed to retain relatively little of his or her monthly income. The federal minimum is \$30 monthly, and most states set the level from \$30 to \$200 with the average around \$50.¹⁴

One significant difference between states is whether the state imposes an income limit. If a state is an “income cap” state, it denies eligibility for nursing facility coverage to any person with income exceeding \$2,382, which is 300% of the federal SSI amount for 2021. To obtain eligibility, an over-income person may put the excess income into a qualified income trust, also known as a “Miller trust.” The trust assets can be used for the benefit of the Medicaid enrollee. Following his or her death, the remainder of the trust assets pass to the Medicaid program, up to the amount of expenses incurred by the Medicaid program on the enrollee’s behalf.¹⁵

If the state is not an income cap state, there is no official upper limit on a enrollee’s income, and eligibility for persons with relatively higher incomes will be granted through medically needy status. Assume, for example, that a nursing facility resident has monthly income of \$3,000 in a state that utilizes medically needy eligibility. He is eligible with no need to create a qualified income trust, although he will be required to spend almost all of his income on nursing facility expenses and other health care expenses, retaining only a monthly personal needs allowance in the range of \$30 to \$200, depending on the state.

Special Financial Rules Protect Couples when One Spouse Receives HCBS or Nursing Facility Services

Medicaid law provides financial protections for the spouse of a person who is receiving HCBS or nursing facility services

Federal Medicaid law includes financial protections for the spouse of a person receiving HCBS or nursing facility services, as long as the spouse is not also receiving HCBS or nursing facility services. Such a “community spouse” is allowed to retain specified amounts of resources and income, so that he or she is not driven into poverty by the ill spouse’s health care needs. These “spousal impoverishment” protections are mandatory for nursing facility residents, and mandatory through September 30, 2023 for persons receiving HCBS.¹⁶ Absent

further congressional action, spousal impoverishment protections for HCBS recipients will be at a state's option from October 2023 onwards.¹⁷

A specified amount of a couple's available resources are reserved for the community spouse

As discussed above, Medicaid rules generally allow an enrollee to retain very few countable resources. Under spousal impoverishment protections, however, the community spouse can retain a certain amount of the couple's total countable resources to protect the community spouse from impoverishment. The community spouse is entitled to half of the couple's countable resources, up a limit of \$130,380 (in 2021). Alternatively, the community spouse can retain resources up to a state-set amount ranging from \$26,076 to \$130,380 (in 2021), even if this amount exceeds one-half of the couple's total countable resources.¹⁸

EXAMPLE

A couple has \$100,000 in countable resources, and the state's "community spouse resource allowance" is \$40,000. The community spouse can retain \$50,000, which is half of the total countable resources. If, however the state's community spouse resource allowance is set at \$120,000, the community spouse can retain all of the couple's resources, except for the \$2,000 (more or less) that will be allocated to the spouse receiving services.

Under certain circumstances, the community spouse can obtain an order from an administrative law judge or a court to increase his or her resource allocation, if the extra resources are necessary to generate adequate income.¹⁹ This process can be very useful for the many frugal couples whose significant savings are in dramatic contrast to their limited incomes.

A community spouse can retain some of the recipient's income if necessary to bring the community spouse's total income up to a specified level

Federal Medicaid law also sets standards for how much income a community spouse can keep. The state sets the protected income level within a specified range: for 2021, this range extends from \$2,155 to \$3,259.50. The community spouse can retain as much of the Medicaid recipient's income as needed to bring his or her income up to the state-set level. Under certain circumstances, the community spouse also can retain additional income to account for documented excess housing costs, provided that the community spouse's total monthly income does not exceed \$3,295.50.²⁰

There is no income limit for any income the community spouse receives in his or her own name. The income limits apply only to the community spouse's ability to obtain allocations from the Medicaid enrollee's income. If a community spouse is employed, for example, he or she will be entitled to retain all of that income. However, depending on the amount of the earnings, this income may disqualify him or her from receiving any allocation from the Medicaid enrollee's income.

EXAMPLE

In a state with a community-spouse income allocation of \$2,500 monthly, a nursing facility resident and their spouse each have monthly incomes of \$1,500. The community spouse will be able to retain \$1,000 of the resident's monthly income, for a total income of \$2,500. The resident will be able to retain a small personal needs allowance of \$50 (for example), and the remaining \$450 is paid for nursing facility expenses or other health care expenses.

If the community spouse's income is increased to \$3,500 monthly, they will be able to retain all of that income. The resident again will retain a \$50 personal needs allowance, and will pay the remaining \$1,450 for nursing facility expenses or other health care expenses.

Medicare Savings Program (MSPs) Help Low-Income Medicare Beneficiaries Pay for Premiums, Deductibles, and Co-Pays

Medicare Savings Programs (MSPs) are Medicaid programs that help to pay for Medicare costs for Medicare enrollees. MSPs accordingly do not offer additional health coverage. Rather, they pay for Medicare enrollees' premiums and out-of-pocket costs. While Medicare is administered at the federal level, MSPs are administered through state Medicaid programs.

MSPs cover Medicare Part A and/or Part B costs and vary depending on the enrollee's income and resource limits. The chart below describes each MSP, the assistance provided, and the federally required minimum income and resource limit for enrollees in 2021. States may offer higher eligibility levels than the federal minimum. Because the MSP income and resource limits are higher than a lot of states' Medicaid eligibility limits, many Medicare enrollees are only eligible for an MSP and not eligible for full Medicaid health coverage.

Program	Assistance Provided	% of FPL	2021 Income Limit* Single/Married	2021 Resource Limit Single/Married
Qualified Medicare Beneficiary (QMB)	Parts A and B premiums, co-insurance, deductibles, and co-pays	100%	\$1,094/\$1,474	\$7,970/\$11,960
Specified Low-Income Medicare Beneficiary (SLMB)	Part B premiums	100-120% FPL	\$1,308/\$1,762	\$7,970/\$11,960
Qualified Individual (QI)	Part B premiums	120-135% FPL	\$1,469/\$1,980	\$7,970/\$11,960
Qualified Disabled Working Individual (QDWI)	Part A premiums	Up to 200% FPL	\$4,314/\$5,828	\$4,000/\$6,000

*Includes \$20 income disregard

The Low-Income Subsidy (LIS) also called "Extra Help" is available to low-income Medicare enrollees to cover Medicare Part D costs. However, LIS is administered through the Social Security Administration, not Medicaid.

PRACTICE TIP

Many Medicaid enrollees are not enrolled in an MSP even though they are eligible because the state may already be paying for their Medicare premiums and cost sharing. However, it is important to still enroll in an MSP because MSPs can provide additional protections from improper billing and out-of-pocket costs.

Conclusion

Medicaid programs provide health care coverage for persons who otherwise could not afford it. Of particular importance for older adults is Medicaid's long-term coverage of HCBS and nursing facility services, since the Medicare program does not provide such coverage. Federal Medicaid law sets the parameters for Medicaid coverage across the country, although each state has significant flexibility to individualize its program.

Additional Resources

- Medicaid Statute: 42 U.S.C. §§ 1396- 1396w-5
- Medicaid Regulations: 42 C.F.R. §§ 430.1- 435.1015
- [Centers for Medicare & Medicaid Services Website](#)
- NCLER: [Dual Eligibles Chapter Summary](#)
- NCLER: [Medicare Savings Programs Chapter Summary](#)
- NCLER: [Medicaid Long-Term Services and Supports Chapter Summary](#)
- [Justice in Aging Resources](#)

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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Endnotes

- 1 To date, 39 states (including DC) have expanded Medicaid under the ACA and 12 states have not adopted expansion. Kaiser Family Foundation, “Status of State Medicaid Expansion Decisions: Interactive Map,” last accessed Feb. 18, 2021, available at kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/
- 2 42 C.F.R. § 435.120.
- 3 The eight states are Connecticut, Hawaii, Illinois, Minnesota, Missouri, New Hampshire, North Dakota, and Virginia.
- 4 42 C.F.R. § 435.121.
- 5 Pub. L. No. 92-603, § 209(b), 86 Stat. 1329, 1381-82 (1972).
- 6 42 C.F.R. § 435.130.
- 7 42 U.S.C. § 1396a(m).
- 8 Kaiser Family Foundation, “Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey,” (Jun. 14, 2019), available at kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-findings-from-a-50-state-survey-appendix-tables/
- 9 Id.
- 10 42 C.F.R. § 435.1007.
- 11 66 Fed. Reg. 2,316 (2001).
- 12 42 C.F.R. § 435.236
- 13 See, e.g., 42 C.F.R. §§ 435-700- 435.735.
- 14 42 U.S.C. § 1396a(q)(2).
- 15 42 U.S.C. § 1396p(d)(4)(B).
- 16 42 U.S.C. § 1396r-5.
- 17 Affordable Care Act, Pub. L. 111-148, § 2404 (2010).
- 18 42 U.S.C. § 1396r-5(c); Eric Carlson, Long-Term Care Advocacy § 7.401 (Lexis Publishing) (state-specific list of allocations for resources and income).
- 19 42 U.S.C. § 1396r-5(e).
- 20 42 U.S.C. § 1396r-5(d).