

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1 - I-02  
(December 2002)

Subject: Medicaid Spend-down Eligibility Criteria

Presented by: Cyril "Kim" Hetsko, MD, Chair

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1 At the 2001 Interim Meeting, the House of Delegates adopted Resolution 102, as amended, which  
2 calls for the AMA to examine the appropriateness and cost-effectiveness of "the spend down  
3 option" to meet Medicaid eligibility criteria in the broader context of Medicaid reform. The Board  
4 of Trustees referred the requested study to the Council on Medical Service for a report back to the  
5 House at the 2002 Interim Meeting.

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7 In this report, which is presented for the information of the House, the Council explores the  
8 concerns of the sponsor of Resolution 102 (I-01); describes how the Medicaid spend-down  
9 operates; summarizes relevant laws and regulations impacting the operation of the spend-down;  
10 and assesses the appropriateness and cost-effectiveness of the spend-down in light of the spend-  
11 down's intended use.

### 12 BACKGROUND

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15 AMA policy is silent on the issue of the Medicaid spend-down. In response to an invitation to  
16 provide the Council with additional information, the sponsor of Resolution 102 (I-01), the Resident  
17 and Fellow Section (RFS), reiterated the concern of the resolution as presented to the House of  
18 Delegates pertaining to "patients with chronic illness, including chronic mental illness," who may  
19 return to their communities following a successful course of treatment. In particular, the concern is  
20 that in order to qualify for Medicaid coverage, some low-income patients will be required to  
21 "spend down" a portion of their savings. Resolution 102 (I-01) expresses the concern that such  
22 patients may lose the financial independence upon which their successful re-entry into the  
23 community may depend.

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25 The House of Delegates amended Resolution 102 (I-01) by eliminating the reference to patients  
26 with chronic illness and inserting the notion that the study of the spend-down's appropriateness and  
27 cost-effectiveness should be done in the context of broader Medicaid reform. The Council believes  
28 the sponsor's concern with the particular circumstances of chronically ill patients merits  
29 consideration in a discussion of the spend-down. Mindful of the House amendment to study  
30 eligibility for the spend-down in the context of overall Medicaid reform, the Council notes that  
31 Medicaid eligibility increases generate spending increases for state Medicaid programs, which are  
32 currently under considerable financial strain.

### 33 THE MEDICAID SPEND-DOWN

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36 In general, the Medicaid spend-down is used as a means to provide Medicaid services to people  
37 determined to be permanently disabled, and it is primarily used as a means for providing long-term  
38 care services to middle income and upper income patients. States are required to provide Medicaid  
39 coverage to those who receive Supplemental Security Income (SSI) benefits for disability. States  
40 may also receive federal funds for optional coverage of other individuals determined to be

1 “categorically needy,” including certain aged, blind, or disabled adults who have incomes above  
2 those for whom mandatory coverage is required. States may opt to extend coverage through a  
3 “medically needy” program, which allows individuals whose incomes may be too high for  
4 Medicaid eligibility otherwise to “spend down” a portion of their incomes or savings by incurring  
5 medical expenses to offset the portion of their assets that exceed the maximum allowed under  
6 eligibility criteria.

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8 Data do not exist to estimate how many people use the spend-down option in a given year, or how  
9 much income people typically spend down before they become eligible for Medicaid coverage.  
10 The National Association of State Medicaid Directors (NASMD), the trade association for  
11 Medicaid administrators, provides detailed information on its Web site concerning various  
12 Medicaid eligibility rules for each state. The NASMD site provides information on each relevant  
13 state’s income and resource standards for determining whether an individual can be considered  
14 medically needy. Whether a state has a spend-down provision is dependent upon whether it has  
15 opted to provide coverage to a “medically needy” eligibility group. The District of Columbia and  
16 39 states have some provision to allow “medically needy” individuals to spend down a portion of  
17 their assets in order to be eligible for Medicaid coverage. Accordingly, the remaining 11 states  
18 have no provision for medically needy individuals and, thus, do not have a relevant spend-down  
19 provision. In states without a “medically needy” eligibility group, poverty and medical expenses  
20 alone do not serve to qualify individuals for Medicaid coverage. Such states provide Medicaid  
21 coverage only for those whose eligibility is mandated according to federal law, including those  
22 meeting the SSI-criteria for disability.

23  
24 Because the medically needy group is optional, it is defined variously by the states, within federal  
25 guidelines set forth in the Social Security Act (SSA). The NASMD Web site provides information  
26 on the relevant income and asset exclusions in each state. The NASMD database of state Medicaid  
27 eligibility criteria for the aged, blind and disabled may be accessed at the following Web address:  
28 <http://www.masterpiecepublishers.com/eligibility/>.

29  
30 States may allow individuals to meet the medically needy eligibility criteria by paying monthly  
31 premiums to the state in an amount equal to the difference between family income (reduced by any  
32 unpaid medical expenses) and the state’s income eligibility standard. NASMD provides the  
33 following example of the spend-down process:

34  
35 Assume the state's medically needy income level is \$450 per month. An elderly individual  
36 with a \$650 monthly income would have a monthly "spend-down" of \$200 (\$650-\$450).  
37 The state has opted to use six months as the "budget period" for the program. The \$200  
38 spend-down is multiplied by the state's budget period of six months for a total spend-down  
39 requirement of \$1200. Once the medical expenses total more than \$1200, the individual is  
40 covered by the Medicaid program for the remainder of the budget period.

41  
42 As such, the spend-down operates much like health insurance deductibles, calculated on a monthly  
43 rather than yearly basis. In such an analogy, the size of the spend-down “deductible” is dependent  
44 upon the individual’s income and resources relative to the methodology standards. Once the  
45 individual’s expenses are greater than the surplus income, the individual is eligible to receive  
46 Medicaid benefits for the remainder of that month. Medicaid coverage may start retroactive to any  
47 or all of the three months prior to application, if the individual would have been eligible during the  
48 retroactive period.

1 RELEVANT LEGISLATION AND REGULATION

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3 Chief among the laws relevant to the spend-down are various sections of the SSA, which specifies  
4 federal definitions for purposes of determining what income (Section 1612) and resources (Section  
5 1613) are excluded from spend-down consideration. For example, Section 1612 of the SSA  
6 defines various meanings of income, and specifies exclusions from income for purposes of  
7 determining an individual's income. Similarly, Section 1613 of the SSA specifies that the home,  
8 household goods, an automobile, and various other properties and possessions shall be excluded  
9 from the calculation of an individual's resources. States may apply less restrictive standards to the  
10 medically needy group when determining how to count income and resources. States may also  
11 offer a more restrictive benefit package for this group than for the categorically needy group.

12  
13 Section 1613(4) of the SSA specifically excludes from resource calculation such resources of an  
14 individual "who has a plan for achieving self-support...as may be necessary for the fulfillment of  
15 such plan." Accordingly, for some instances, Section 1613(4) may address the concern of the  
16 sponsor of Resolution 102 (I-02) that those who recover sufficiently from their disabilities may  
17 nevertheless have financial difficulty returning to community living because of the requirements of  
18 the spend-down that they fulfilled in order to obtain Medicaid coverage.

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20 For individuals with serious mental illness, Section 1905(a)(27)(B) of the SSA prohibits Medicaid  
21 payments for care in Institutions for Mental Diseases (IMDs) for persons aged 21-65. Because of  
22 Title XVI's statutory prohibition of federal payments for IMD care, and because Medicaid waiver  
23 rules require states to demonstrate that waiver programs for coverage of home and community-  
24 based care will be budget-neutral to the federal government, state Medicaid programs have not  
25 been able to obtain approval of post-IMD funding for people with serious mental illness, whose  
26 care prior to home and community-based care (i.e., the IMD) was not financed by the federal  
27 government. The IMD exclusion was designed to reinforce that states, which have had a historical  
28 responsibility for the provision of institutional psychiatric services, continue to have sole  
29 responsibility for these services, rather than sharing them with the federal government via the  
30 Medicaid program.

31  
32 As summarized below, several other laws, federal regulations, and proposals affect how the spend-  
33 down is operated by states and used by individuals.

34  
35 Medicare Catastrophic Coverage Act of 1988

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37 The Medicare Catastrophic Coverage Act of 1988 (MCCA) provided guidance on determining the  
38 eligibility for those who need to "spend down" their assets. Although much of the MCCA was  
39 repealed, significant portions that were not repealed provided for accelerated Medicaid eligibility  
40 for some nursing home patients and protected the institutionalized person's spouse (i.e., the  
41 "community spouse") from impoverishment. MCCA requires that before the institutionalized  
42 person's income is used to pay for the cost of institutional care, a minimum monthly allowance for  
43 the community spouse is deducted from the institutionalized spouse's income. It is this community  
44 spouse provision combined with the eligibility criteria for the spouse in need of long-term care, that  
45 is most typically the topic of controversy surrounding the Medicaid spend-down.

46  
47 In order to weigh the potentially competing needs of the spouses, most states use what is known as  
48 the "income-first method." Under the income-first method, a state considers first whether potential

1 income transfers from the institutionalized spouse will suffice to meet monthly needs of the  
2 community spouse once the institutionalized spouse qualifies for Medicaid. On February 20, 2002,  
3 the U.S. Supreme Court held in *Wisconsin Department of Health and Family Services v. Irene*  
4 *Blumer*, that the "income-first" method is permissible under MCCA's protection against  
5 impoverishment of the community spouse, and appropriately prevents couples with substantial  
6 resources from obtaining Medicaid. The maintenance of the community spouse's income and  
7 assets, including the couple's home, assures that the living needs of the community spouse are met  
8 at the same time that Medicaid covers the medical needs of the institutional spouse. If the  
9 institutionalized spouse recovers to a degree that allows him or her to return to the community,  
10 such maintenance will provide a safety net.

#### 11 12 Ticket to Work and Work Incentives Improvement Act of 1999

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14 The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIA) modified  
15 eligibility for those who plan to resume community life, including work. For individuals whose  
16 chronic condition is disabling, the TWWIA created additional categories as of October 1, 2000, at  
17 the option of states, of "categorically needy" individuals for purposes of Medicaid eligibility. One  
18 of these categories, the "medical improvement group" includes employed individuals with  
19 medically improved disabilities who would otherwise have lost Medicaid coverage because their  
20 medical conditions had improved to the point where they no longer are considered disabled  
21 according to SSI. For individuals whose chronic condition is not disabling, and who are  
22 unmarried, the Medicaid spend-down functions as originally intended, which is to allow  
23 individuals whose financial resources are slightly too high for Medicaid coverage to become  
24 Medicaid eligible by spending a portion of their incomes and/or other assets on their health care.

#### 25 26 Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable Income and 27 Resources

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29 In January 2001, Centers for Medicare and Medicaid Services (CMS) published a final regulation  
30 entitled "Medicaid Eligibility Groups and Less Restrictive Methods of Determining Countable  
31 Income and Resources" that allows flexibility in how states apply SSA's provisions regarding  
32 income and resource determinations for Medicaid eligibility. Prior to the rule, states were  
33 restricted in their ability to use less restrictive methods for determining the income and resources of  
34 Medicaid applicants than are used by cash assistance programs.

#### 35 36 The New Freedom Initiative

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38 A Bush Administration proposal termed the "New Freedom Initiative" potentially would address  
39 the IMD conundrum. The initiative notes that individuals seeking to return to the community from  
40 institutions are faced with many one-time expenses, such as those needed to secure an apartment  
41 and utility services. The Administration states that, as one component of a comprehensive plan to  
42 facilitate individuals with disabilities living in their communities, the Department of Health and  
43 Human Services would clarify for states that such one-time expenses may be included in home and  
44 community-based waiver requests for individuals transitioning from institutional living. In  
45 addition, the initiative would remind states of their responsibility to continue Medicaid enrollment  
46 for eligible institutionalized individuals even if the institutional care itself receives no federal  
47 funding. The Administration believes that such eligibility lapses create continuity of care

1 problems, particularly with regard to medications for people with mental illness or HIV/AIDS,  
2 when individuals leave institutions for community living.

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4 APPROPRIATENESS AND COST EFFECTIVENESS OF THE SPEND-DOWN

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6 The “appropriateness and cost effectiveness” of the spend-down option can be assessed in terms of  
7 how well it works, in theory at least, to provide needed coverage to those with chronic illness who  
8 would not otherwise be able to afford treatment. In general, the spend-down is used by people  
9 determined to be permanently disabled. Specifically, the spend-down is often used by middle and  
10 higher-income individuals wishing to access Medicaid long-term care benefits. It would appear  
11 that there is no question about the “appropriateness and cost-effectiveness” of the spend-down for  
12 patients who enter long-term care facilities with no intention of ever transitioning back to  
13 community living.

14  
15 Access to Medicaid via the spend-down would be too costly for those with middle and high  
16 incomes, unless their expected usage will be sufficiently expensive to warrant forfeiting large sums  
17 of income and resources. For individuals who are more financially limited, the spend-down may  
18 be an attractive option at lower levels of anticipated health care service usage because their medical  
19 expenses could deplete all of their assets absent use of the spend-down option.

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21 DISCUSSION

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23 In its study of this issue, the Council did not find evidence that the spend-down operates in a  
24 manner that is inappropriate and cost-excessive. In fact, the spend-down is more likely to be  
25 discussed in the news as a program which some try to access inappropriately, rather than as a  
26 program that may inappropriately exclude some who are legitimately eligible.

27  
28 For example, some persons with acutely chronic illnesses may avoid seeking Medicaid coverage  
29 because they do not want to be judged as being permanently disabled. The incidence of individuals  
30 being determined to be permanently disabled, and then recovering sufficiently to no longer be  
31 considered permanently disabled, is low. Accordingly, the Council believes the current spend-  
32 down, by responding to the needs of those determined to be permanently disabled, the vast majority  
33 of whom remain permanently disabled, is appropriate. The Council also believes the spend-down  
34 appears to be cost-effective in that it requires individuals to meet income and resource standards in  
35 order to receive potentially very extensive Medicaid benefits. Provisions in the Medicaid statute  
36 exempting certain resources and meanings of income are an appropriate means of protecting the  
37 assets of those individuals who might subsequently return to community living.

38  
39 Regarding those individuals with chronic mental illness who use the spend-down option and for  
40 whom at least partial recovery is highly possible given pharmaceutical advances, Section 1613(4)  
41 of the SSA provides for the specific exclusion from resource calculation those resources that the  
42 individual can demonstrate are necessary for achieving self-support. The Council notes that the  
43 Administration proposal, the “New Freedom Initiative,” would potentially address some of the  
44 difficulty states face when trying to extend home and community-based services to those  
45 individuals leaving institutional care.