Medicaid Eligibility Policy for Children in Foster Care

Prepared for the
State Institute on Improving Health Care for Children in Foster Care

by

Andy Schneider
Kristen Fennel
HEALTH POLICY GROUP
Washington, D.C. 20016

March 1999

Prepared at the request of the National Academy for State Health Policy with support from the Nathan Cummings Foundation

MMC50-30
ACKNOWLEDGMENTS

The authors thank the Nathan Cummings Foundation for their support of this paper and our program officer, Andrea Kyyd, for her support and encouragement.

We would also like to thank those state officials who took the time to review and comment on previous drafts of this paper. They are: Nancy Davis and Dave Sager of Alaska; Lou Del Gaudio and Maridee Gregory of California; Louise Bannister and Kathleen Betts of Massachusetts; Cindy Bourland and Dena Stoner of Texas; and Heidi Kaminski, Julie Olson, and Stephanie Robinson of Utah.

This paper is part of a larger National Academy for State Health Policy effort funded by the Cummings Foundation, the “State Institute on Improving Health Care for Children in Foster Care.” This project is a three-year effort (1996-1999) among five states to improve coordination and delivery of health care for a group of very vulnerable Medicaid beneficiaries — children in foster care. The project involves interagency collaboration and teamwork between Medicaid and Child Welfare services at the state level within each state. The five states participating in the Cummings Institute are Alaska, California, Massachusetts, Texas, and Utah.

These states established goals and specific projects to accomplish during the grant period. There is both diversity and commonality in what each state intends to accomplish. For example, all of the states decided to improve or implement a medical service record that resides with foster parents and the state or local government and that care givers can access regardless of changes in foster home placement or health care providers. All of the states are thinking through the opportunities and challenges posed by enrolling these children in risk-based Medicaid managed care. Four of the states intend to develop standards of care for these children, and three others are focusing on improving the level of understanding among foster parents and case workers about the importance of health and mental health care for children in foster care.

Through the Institute, state interagency teams access the advice and expertise of leaders in foster care and health care. Work done for the Institute by the National Academy for State Health Policy and project consultants will be made available to other states as the project progresses.
EXECUTIVE SUMMARY

According to a 1995 report by the General Accounting Office, the 300,000 children living in foster care are among the most vulnerable children in the U.S. As a group, they are sicker than homeless children and children living in the poorest sections of inner cities.

This high level of health care need makes health care coverage crucial to a state's ability to care effectively and adequately for children in foster care. In most cases, the Medicaid program is the primary source of such coverage. However, a child in foster care is not necessarily eligible for Medicaid. While states have the flexibility to provide Medicaid coverage to almost all children in foster care, they are not required to do so. As a result, a child in foster care may be eligible for Medicaid depending on the child's circumstances and the Medicaid eligibility rules in the state in which he or she resides.

States are required to extend Medicaid coverage to all foster care children receiving maintenance payments under Title IV-E. States are also required to cover other categories of children, such as those living in families with incomes below 100 percent (and in some cases, 133 percent) of the Federal poverty level. Children in foster care who are not receiving Title IV-E payments may still qualify for Medicaid under this "poverty level" pathway or under other mandatory eligibility pathways.

States also have options for covering foster care children they are not required to cover. In fact, states have more flexibility than is generally recognized in drawing down federal Medicaid matching dollars to provide Medicaid coverage to foster care children. This policy brief explains how, under current law, states have the option of covering all children in foster care, including those in kinship care, who do not receive Title IV-E payments and who do not have significant income or resources of their own. Implementation of this targeted eligibility option could substantially reduce the number of uninsured foster care children and assist foster care parents or relatives in meeting the health care needs of children in foster care.

Another barrier to Medicaid eligibility faced by foster care children in some states is the lag time between the child's placement in foster care and the child's receipt of a Medicaid card. Although foster care children often have an immediate need for health care services, the delay in establishing Medicaid eligibility can undermine their access to care. There is no "presumptive eligibility" mechanism under federal Medicaid law that is targeted to foster care children. However, as discussed above, states have the option of establishing an eligibility category for foster care children that would give the state the ability to issue a Medicaid card for a foster care child that is effective on the date the child is placed with a foster family (or in kinship care).
# Medicaid Eligibility Policy for Children in Foster Care

## Table of Contents

- **Introduction** .................................................. 1
- **Brief Overview of Medicaid Eligibility Policy** .................. 3
  - Categorical Eligibility ........................................... 3
  - Income Eligibility ............................................... 3
  - Resource Eligibility ............................................. 4
  - Immigration Status .............................................. 5
  - Residency .......................................................... 6
- **Medicaid Eligibility Pathways for Children** .................... 7
  - Poverty-level children ........................................... 7
  - Section 1931 Eligibility ........................................ 8
  - Welfare-to-Work Families ...................................... 9
  - Children with Disabilities ..................................... 9
- **Current Medicaid Eligibility Pathways for Foster Care Children** 10
  - Title IV-E Children ............................................ 10
- **Issues in Medicaid Eligibility for Foster Care Children** .......... 11
  - Kinship Care .................................................... 11
  - Application Procedures ....................................... 12
- **Targeted Medicaid Eligibility Option for State Coverage of Non-Title IV-E Foster Care Children** 13
- **Conclusion** ...................................................... 15
- **Appendices**

---

The National Academy for State Health Policy © March 1999
INTRODUCTION

Foster children are among the most vulnerable individuals in the welfare population. As a group, they are sicker than homeless children and children living in the poorest sections of inner cities.


The high level of health care need among the nation's more than 300,000 foster care children means that health care coverage is crucial to the effective provision of services to children in foster care. As Lutz and Horvath have observed, health care coverage is, in and of itself, insufficient to ensure that foster care children receive the health care services they need. But it is nonetheless essential to this result.

In most cases, the Medicaid program is the primary source of such coverage. However, a child in foster care is not necessarily eligible for Medicaid. This is principally because states have great flexibility in administering their Medicaid programs and have used that flexibility to implement different policies toward covering children in foster care. As a result, a child in foster care may be eligible for Medicaid depending on the child's circumstances and the Medicaid eligibility rules in the state in which he or she resides.

This policy brief was commissioned by the National Academy for State Health Policy for the State Institute on Improving Health Care for Children in Foster Care. It draws heavily upon work done in 1997 by Sara Rosenbaum, J.D., Director of the George Washington Center for Health Policy Research for the Kaiser Commission on Medicaid and the Uninsured, as well as a policy brief on...

1 There are an estimated 308,000 children receiving Title IV-E foster care maintenance payments, and a substantial number of children in state-funded foster care. Committee on Ways and Means, 1998 Green Book (May 1998), Table 11-3, p. 732.
2 Lorie Lutz and Jane Horvath, National Academy for State Health Policy, Health Care of Children in Foster Care: Who's Keeping Track?, October 1997.
3 The State Institute to Improve Health Care for Children in Foster Care is a three year effort among five participating states to improve coordination and delivery of health care screening and treatment for children in foster care. Funded by the Nathan E. Cummings Foundation, the Institute involves interagency collaboration and teamwork among Medicaid and Child Welfare services in each state. The five participating states are Alaska, California, Massachusetts, Texas and Utah.
4 Sara Rosenbaum, "Children in Foster Care: An overview of Current Issue in Health Care Coverage and Access and their Policy Implications," (Draft, August, 1997), which incorporates and earlier research paper prepared for the Kaiser Commission by Abigail English, JD., of the Youth Law Center.
Medicaid eligibility for children prepared by the authors for the Kaiser Commission. This paper has also benefitted from the comments of participants at the August 8, 1998, meeting of the State Institute in San Diego, California. However, the authors bear sole responsibility for its contents.

The purpose of this policy brief is to review the rules governing Medicaid eligibility for foster care children, to identify some of the issues that children in foster care face in obtaining Medicaid coverage, and to review some of the options available to states for extending Medicaid to children in foster care. The brief begins with an overview of federal Medicaid eligibility rules. It then reviews the major federal Medicaid eligibility pathways for children generally, as well as those pathways specific to children in foster care. The brief then highlights issues in Medicaid eligibility policy specific to foster care children, including kinship care and application procedures. Finally, the brief concludes with an explanation of the options available to states for extending Medicaid eligibility to additional foster care children.

Medicaid eligibility policy in general, as well as policy with respect to foster care children in particular, varies from state to state. This policy brief does not identify the eligibility rules specific to each state. Instead, it explains both the federal requirements and the options that states have in designing Medicaid eligibility rules for children in foster care.

Similarly, the federal Medicaid statute does not specify the use of a particular application procedure. While all states are required to operate their Medicaid programs in a manner consistent with “simplicity of administration and the best interests of recipients,” they have broad discretion in designing their application forms and procedures for children in foster care as well as for others. This policy brief does not review the forms or procedures specific to each state.

A note on the use of this paper, which is designed both for those unfamiliar with Medicaid and for those who have some knowledge of the program: readers who are unfamiliar with Medicaid should find the Brief Overview and the discussion of Medicaid Eligibility Pathways for Children (pages 3-10) helpful. Those who are generally familiar with Medicaid may find it most efficient to proceed directly to the discussion of Medicaid Eligibility Pathways for Foster Care Children beginning on page 10.

---

BRIEF OVERVIEW OF MEDICAID ELIGIBILITY POLICY

Medicaid is a federal-state, means-tested, individual entitlement program. The federal government makes funds available on an open-ended basis to match the costs that states incur in covering hospital, physician, and other basic health care services on behalf of eligible individuals. In order to be eligible for Medicaid, an individual must fall into a certain category and meet certain requirements relating to income, resources, immigration status, and residency. Because of the flexibility that states enjoy in administering Medicaid, these categorical and financial requirements can and do vary from state to state.

States that elect to participate in Medicaid (as all states have chosen to do) must cover certain groups of children, including certain groups of foster care children. States also have the flexibility to cover other groups of children, including all children in foster care, and to receive federal Medicaid matching funds for the costs of covered care for these children. However, states are not required to cover all children in foster care. Thus, a foster care child who qualifies for Medicaid in one state may not qualify for Medicaid in another, even though the federal government is willing to make Medicaid matching payments for the cost of covered services provided to that child in any state. The following discussion explains why.

Categorical Eligibility

Medicaid eligibility is limited to individuals who fall into specified categories. The federal Medicaid statute identifies over 25 different eligibility categories for which federal matching funds are available. For policy purposes, however, there are five broad coverage categories: children, pregnant women, adults in families with dependent children, disabled individuals, and the elderly. Foster care children are a subset of a larger group of children who are eligible for Medicaid.

Income Eligibility

While an individual must fall into a Medicaid eligibility category in order to qualify for Medicaid coverage, doing so does not guarantee coverage. Because Medicaid assistance is limited to those in need, the program also imposes financial eligibility requirements. These requirements take two basic forms: income tests and resource (or assets) tests. These financial requirements vary from category to category. For example, both the income eligibility thresholds and the resource tests for children differ in most states from the income and resource tests applicable to the disabled or the elderly.

There are some eligibility categories for which states are not required to apply a resource test. However, all Medicaid eligibility categories are subject to an income test. In the case of children, income eligibility standards are tied directly to specified percentages (e.g., 100 percent, 133
percent, 185 percent) of the federal poverty level. In 1998, the federal poverty level was $1,138 per month for a family of three. For many children with disabilities, income eligibility standards are linked to the Supplemental Security Income (SSI) payment standard. In 1998, this meant $494 per month for an individual in a state that does not provide state supplementary (SSP) payments.

In determining income eligibility, states rely on both standards and methodologies. An income **standard** is a dollar amount, such as $1,138 per month (100 percent of the 1998 federal poverty level for a family of three). An income **methodology** determines how the applicant’s income is counted for purposes of applying the income standard. For instance, a state’s income methodology may count all income received from any source, or it may disregard certain kinds of income, such as earned income. A state might liberalize its Medicaid eligibility without changing its Medicaid income standard by deciding to disregard the first $200 per month in earned income. In this example, a family of three with an income of $1,338 per month (or 118 percent of the federal poverty level) could qualify for Medicaid since $200 of earned income would be disregarded, bringing their countable income to the state’s income standards of $1,138, or 100% of the federal poverty level.

In the case of foster care children, federal Medicaid law prohibits states from attributing the income of foster care parents to foster care children. The income of biological parents is attributable to a foster care child only prior to the foster care placement and for one month thereafter (unless the state child welfare agency places the child with a biological parent). If a foster care child has any income, that amount is counted in determining his or her Medicaid eligibility.

**Resource Eligibility**

For most eligibility categories in most states, individuals must have resources of less than a specified amount in order to qualify for Medicaid. Resources include such items as cars, savings accounts, and savings bonds.

As in the case of income eligibility requirements, resource requirements encompass both standards and methodologies. A resource standard is a dollar amount, typically $1,000 in the case of an adult with one or more dependent children, or $2,000 in the case of an aged or disabled individual. In contrast to the Medicaid income standards that are tied to the federal poverty level, Medicaid resource standards generally are not indexed to inflation or otherwise adjusted on a regular basis. Therefore, over time, the resource standards tend to become more and more restrictive.

A resource methodology spells out what resources are counted, and how those resources are valued. For example, the home in which an individual lives is generally not a countable resource,

7 Section 1902(a)(17) of the Social Security Act, 42 U.S.C. §1396a(a)(17); 42 C.F.R. §435.602

The National Academy for State Health Policy © March 1999
regardless of its value. Similarly, a wedding ring or engagement ring is generally not a countable resource. Most other resources tend to be countable, some at full value, others at partial value.

For example, the basic resource methodology applicable to low-income families with dependent children does not count the first $1,500 in equity value of the first car. A state can make a resource standard less restrictive without changing the standard simply by adjusting its resource methodology. It could disregard more of the value of certain countable resources or exclude them from counting altogether. To continue with the above example, a state seeking to promote work could exclude the first $10,000 in market value of a car that is used primarily for commuting to employment, or it could disregard the car altogether, regardless of its value.

For certain eligibility categories, states have the discretion to liberalize or eliminate resource tests altogether. For instance, since 1986, states have had the option of not imposing a resource test on two specific categories: low-income pregnant women and children. As of January, 1992, all states but California, Iowa, and North Dakota had elected to drop the resource test for poverty-level women and children "to lessen barriers to eligibility for this high priority population." California eliminated its resource test for this group in 1998, and Iowa sets its resource standard at $10,000 in liquid assets.

As in the case of income methodologies, resource methodologies determine how individual or family resources are attributed. Federal Medicaid law prohibits states from attributing the resources of foster care parents to foster care children and the resources of biological parents to such children for more than one month after out-of-home placement.

**Immigration Status**

U.S. citizens – including the U.S.-born children of illegal immigrants – who meet the Medicaid program’s financial and non-financial eligibility requirements are entitled to Medicaid coverage. However, immigrants who are legally residing in the U.S. may not qualify for Medicaid even if they meet all other financial and non-financial eligibility requirements.

The 1996 welfare law created two categories of legal immigrants for Medicaid eligibility purposes: those who were residing in the U.S. prior to August 22, 1996, and those who entered the U.S. on or after that date. In general, legal immigrants who were residing in the U.S. before August 22, 1996, are, at state option, eligible for Medicaid if they are otherwise qualified, whether or not they were receiving Medicaid coverage prior to that date. (All states other than Wyoming have elected to cover this population.)

---


9 Letter from Donald Herman, Administrator, Division of Medical Services, Iowa Department of Human Services, to Neva Kaye, National Academy of State Health Policy, November 16, 1998.

10 Section 1902(a)(17) of the Social Security Act, 42 U.S.C. §1396a(a)(17); 42 C.F.R. §602.
Most immigrants entering the country legally on or after August 22, 1996, are ineligible for Medicaid (and other federal benefits) for five years from their date of entry into the U.S. The only exception to this five-year bar for most legal immigrants who are otherwise qualified for Medicaid is coverage for emergency care services. In addition, legal immigrants who are receiving SSI benefits on the basis of disability (or age) are also exempted from this 5-year bar in most states. After the five-year period has expired, states may, at their option, extend Medicaid coverage to these otherwise qualified immigrants or continue to deny them benefits until they become citizens.¹¹

While legal immigrant children who enter the foster care system are expressly exempted from the five-year bar for purposes of qualifying for Title IV-E foster care maintenance payments (payments meant to cover a foster child's living expenses), they are, nevertheless, subject to the same bar on non-emergency Medicaid coverage that applies to all legal immigrants who enter the U.S. on or after August 22, 1996 (and who are not receiving SSI benefits). Thus, even though (as discussed below) states are generally required to extend Medicaid eligibility to Title IV-E recipients, legal immigrant children who entered the U.S. after August 22, 1996 and who are IV-E recipients cannot qualify for Medicaid.¹²

**Residency**

Being a citizen (or a legal immigrant in the United States prior to August 22, 1996) is not sufficient to qualify for Medicaid, even if an individual meets the other categorical, income, and resource requirements. An individual must also be a resident of the state offering the Medicaid coverage for which the individual is applying. In general, an individual is considered a resident of a state if the individual is living there with the intention of remaining indefinitely. States are prohibited by federal law from denying Medicaid coverage because an individual has not resided in a state for a specified minimum period. For foster care children receiving Title IV-E payments, the state of residence is the state in which the child lives.¹³ For those who are not receiving Title IV-E payments, the state of residence is the state with custody of the child.

---


¹³ 42 C.F.R. §435.403(f).
MEDICAID ELIGIBILITY PATHWAYS FOR CHILDREN

The proliferation of Medicaid eligibility categories means that a child can qualify for Medicaid through more than one category. For example, a child in foster care may qualify for Medicaid both because he or she receives assistance under Title IV-E and because he or she has no income or resources, thereby qualifying on the basis that countable income is below certain thresholds related to the federal poverty level. Again, within each of these categories, the particular income thresholds may vary from state to state. A brief overview of the major Medicaid eligibility categories for children follows.

Poverty-level children

One of the primary pathways to Medicaid eligibility for children is membership in a family with an income below specified income thresholds based on the federal poverty level. As Chart 1 (Appendix A) shows, children up to age 6 are automatically eligible for Medicaid if their family incomes are at or below 133 percent of the federal poverty level. Children from age 6 through age 18 are eligible for Medicaid if they live in families with incomes at or below 100 percent of the federal poverty level and if they were born on or after September 30, 1983. This latter provision expands Medicaid coverage for children in poverty so that, by 2002, all children up to age 19 in families with incomes at or below 100 percent of the federal poverty level will be eligible for Medicaid in all states.

As seen in Table 1 (Appendix B), as of October 1997, 27 states had accelerated the phase-in of coverage of children in families with incomes at or below 100 percent of the poverty level. (Among the states participating in the State Institute for Improving Health Care for Children in Foster Care, Massachusetts and Utah have elected to accelerate this phase-in of coverage.) In the states which have elected not to accelerate the phase-in, children aged 15 through 18 are covered only if their family income and resources meet the July 16, 1996, Aid to Families with Dependent Children (AFDC) requirements in the state. On average, the AFDC income standard is 45 percent of the federal poverty level.

Because the federal mandatory income thresholds for children vary by age, some family members may be covered by Medicaid while others are not. Consider a single-parent family with two children age 5 and age 16 and an income at 50 percent of the poverty level. In a state which had not accelerated the phase-in of coverage to 100 percent of poverty for children through 18, the 5-year-old would be eligible for Medicaid, while the 16-year-old would be ineligible. In a state which had accelerated, both children of the family would be covered.

---

14 Estimate by Jocelyn Guyer, Center on Budget and Policy Priorities.

The National Academy for State Health Policy©March 1999 7
As discussed above, states can modify these income standards through adjustments to the methodologies used to determine family income or resources. Section 1902(r)(2) of the Social Security Act allows states to use “less restrictive” — i.e., more liberal — income or resource methodologies than those which apply under the former AFDC program or under the SSI program. For example, Pennsylvania disregards 50 percent of a parent’s earned income in determining Medicaid eligibility, thereby enabling a single parent with two children with earnings below 74 percent of the federal poverty level to remain on Medicaid. North Carolina exempts the first $5,000 in fair market value of a car.\(^\text{15}\) States can adopt these less restrictive methodologies without obtaining a waiver from the Secretary of the Department of Health and Human Services; they need simply submit a state plan amendment.

There is no upper limit on the amount of income or resources that a state can choose to disregard in adopting less restrictive methodologies under section 1902(r)(2).\(^\text{16}\)

**Section 1931 Eligibility**

In 1996 AFDC was repealed and replaced with the Temporary Assistance to Needy Families (TANF) program. At the same time section 1931 of the Social Security Act was created. This section requires states to continue to provide Medicaid to those families who meet the eligibility criteria in place at the time of the repeal of AFDC. This section also allows states to cover more families by changing the income and resource methodologies (but not the family composition requirements) in place at that time.

Prior to the repeal of AFDC, adults and children in families receiving AFDC cash assistance were automatically eligible for Medicaid. This is no longer the case; families receiving cash assistance under TANF are no longer automatically eligible for Medicaid. Instead, as shown in Chart 2 (Appendix A), a new eligibility category, described in section 1931 of the Social Security Act, was created for these adults and children. Under section 1931, a state Medicaid program must cover families that meet the AFDC eligibility criteria (income and resources) that were in effect in a state as of July 16, 1996. The family’s status in the TANF program has no bearing on Medicaid eligibility. Finally, under the family composition requirements of section 1931, a family must be a single-parent family or a two-parent family in which the principal wage-earner is unemployed in order to qualify for Medicaid.

As under section 1902(r)(2), states have the authority under section 1931 to apply “less

---

\(^{15}\) Letter from Paul Perruzzi, Division of Medical Assistance, North Carolina Department of Human Resources, to Neva Kaye, National Academy of State Health Policy, November 17, 1998.

\(^{16}\) See 42 C.F.R. §435.601(d)(ii). Section 1903(f) of the Social Security Act bars federal matching payments with respect to “medically needy” income eligibility standards in excess of 133 percent of the former AFDC payment amount. This limitation on federal matching does not apply to “poverty-level” children. See section 1903(f)(4), 42 C.F.R. §435.1007(a).
restrictive" income and resource methodologies than those in effect in the state's former AFDC program in order to expand eligibility to families with children who otherwise would be ineligible. However, states do not, under section 1931, have the authority to liberalize the family composition rules that applied under the state’s AFDC program as of July 16, 1996. Thus, the range of families that can be covered under section 1931 is narrower than those that can be covered under the "poverty-level" eligibility categories, which contain no restrictions against employed parents.

Welfare-to-Work Families

As shown in Chart 2 (Appendix A), another eligibility pathway for children in AFDC-related, one-parent and two-parent families is transitional Medicaid coverage for families leaving the welfare rolls because they find a job or increase their hours of work. Under current federal law, states must provide 12 months’ Medicaid coverage to families and children who lose cash assistance due to earnings and who continue to report earnings on a quarterly basis.17 Under section 1115 welfare demonstration waivers, some states have extended this transitional coverage period to 24 months.

Children with Disabilities

Chart 3 (Appendix A) shows Medicaid eligibility pathways for children with disabilities. These children may qualify for Medicaid via other pathways, including the poverty-level or section 1931 pathways described above. However, there are eligibility pathways specific to these children. The principal ones are receipt of SSI benefits and "medically needy" status.

Under the SSI program, children with disabilities qualify for cash assistance if they are under age 18, unmarried, and have a "medically determinable" physical or mental impairment which appears on a list promulgated by the Social Security Administration. Most states automatically extend Medicaid eligibility to children receiving SSI benefits. However, some states have invoked their option under federal law (the "209(b)" option) to apply disability criteria or financial requirements that are more restrictive than those under SSI when making Medicaid eligibility determinations.

A child's status as "medically needy" can also serve as a pathway to Medicaid eligibility. If a state elects to cover the "medically needy," it must include in this group all children under 18 who, except for family income and resources, would be eligible for Medicaid.18 The "medically needy" option allows states to permit these families and children to “spend down” into Medicaid eligibility by subtracting incurred medical expenses from income; if, after subtracting medical expenses, the income of the family or child is below the state's medically needy income level, the family or child is eligible for Medicaid coverage. (Children eligible for Medicaid based on

---

18 42 C.F.R. § 435.145.
poverty-level status may not qualify by "spending down." States may also, at their option, extend Medicaid coverage to children over 18 but under 21 who are placed in foster homes or private institutions by a public or private agency. 19

**CURRENT MEDICAID ELIGIBILITY PATHWAYS FOR FOSTER CARE CHILDREN**

Currently, states provide Medicaid coverage to foster care children through one of two major pathways: Medicaid eligibility unrelated to foster care status, and Title IV-E eligibility. The first group, foster care children who are not receiving Title IV-E payments, may qualify for Medicaid through the poverty-level, section 1931, or disability-related pathways, as described above, depending upon their individual circumstances. Their eligibility is determined by considering the income, resources, and, where relevant, composition of the child’s biological family, not those of the foster care parents. Title IV-E eligibility, which triggers Medicaid coverage for qualifying children, is described below.

**Title IV-E Children**

Title IV-E of the Social Security Act provides federal matching funds (at Medicaid matching rates) to states for maintenance payments made for eligible children in foster care family homes and certain other settings. In order to qualify for Title IV-E payments, a child must have been receiving (or have been eligible to receive) cash assistance payments prior to removal from the home of a relative and placement in foster care. In determining eligibility for cash assistance, states must apply the deprivation criteria and the income and resource standards and methodologies in effect under their AFDC programs as of July 16, 1996. In addition, certain other requirements must be met, such as the making of reasonable efforts to eliminate the need for removal of the child from the home. 20 Children receiving Title IV-E maintenance payments are automatically eligible for Medicaid in every state. 21

Title IV-E eligibility is determined by considering the income and resources of the child’s biological family, not her foster care family. 22 Once she is placed in a foster care family, the child's income from federal maintenance payments is neither attributed to her biological family nor to her foster care family. 23 Thus, the child’s federal maintenance payment “income” does not

---

19 45 C.F.R. § 206.10.
21 42 C.F.R. §435.145.
22 45 C.F.R. §206.10.
23 45 C.F.R. §233.20.
affect the Medicaid eligibility of other biological or foster care family members. Of course, the child’s receipt of such income is the basis for her Medicaid eligibility.

ISSUES IN MEDICAID ELIGIBILITY FOR FOSTER CARE CHILDREN

At a meeting of the State Institute on Improving Health Care for Children in Foster Care in August, 1998, participants raised a number of technical issues that relate to the current process for determining Medicaid eligibility for foster care children. These issues were concerned chiefly with children placed in kinship care and application procedures.

Kinship Care

Federal Medicaid statute and regulations do not speak specifically to kinship care (in which children in foster care are placed in the homes of relatives), and there is no written guidance from HCFA on this issue. As is discussed in the next section, states have the flexibility to extend Medicaid eligibility to “reasonable” categories (or classifications) of children under 21, including children in foster care who are not receiving Title IV-E payments. There appears to be no reason that a state, under this broad authority, could not include in its “reasonable” category (or classification) of foster care children those placed in kinship care by (and subject to the supervision of) a state child welfare agency.

A related issue concerns the continuity of Medicaid coverage for a child who is moved from a foster home to a relative or kinship placement. Some state agencies indicate that they are required to disenroll a foster care child from Medicaid once the child leaves the foster care home for a kinship placement until the relative with whom the child is placed re-enrolls the child. The legal basis for such a requirement is unclear. Under federal law a state Medicaid agency may not terminate Medicaid coverage for a child who loses eligibility on one basis (i.e., no longer in a foster home) unless the agency determines that the child is not eligible on any other basis (i.e.,

---

24 The regulations governing Title IV-E define “foster care” as follows: “Foster care means 24 hour substitute care for all children placed away from their parents or guardians and for whom the State agency has placement and care responsibility. This includes, but is not limited to, family foster homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and pre-adoptive homes regardless of whether the foster care facility is licensed and whether payments are made by the State or local agency for the care of the child or whether there is Federal matching of any payments that are made.” (Emphasis added). 45 C.F.R. §1355.20. This definition clearly does not preclude children in kinship care.

25 Section 303(a)(1) of the Adoption and Safe Families Act of 1997 (ASFA), P.L. 105-89, indirectly defines “kinship care” as placement in the care of a relative. ASFA requires the Secretary of HHS to prepare a comprehensive report on kinship care issues, including state kinship care policies, kinship care provider characteristics, the cost of and funding sources of kinship care (including Medicaid), and the circumstances under which children enter kinship care. This report is to be submitted to the House Ways and Means Committee and the Senate Finance Committee by June 1999.
poverty-related eligibility) under the state’s Medicaid program. In making this determination, an agency may request relevant information from the child or the responsible adult. But there is no legal basis for termination of the child’s eligibility while such information is being obtained.

Application Procedures

Federal Medicaid regulations stipulate that, in order to establish eligibility for Medicaid, the state Medicaid agency must require a written application from the applicant or, if the applicant is “incompetent” (as children are considered to be), from “someone acting responsibly for the applicant.” The application must be signed under penalty of perjury. In the case of foster care children, HCFA interprets this requirement to enable foster care parents, biological parents, state child welfare agency caseworkers, or anyone else acting responsibly to submit Medicaid applications on behalf of children in foster care. HCFA requires a written signature of the individual acting responsibly even in cases where applications are in electronic form.

According to participants in the State Institute, the application process can present another barrier to Medicaid eligibility for foster care children. In some states there is a considerable lag time between the child’s placement in foster care and the child’s receipt of a Medicaid card. Although foster care children often have an immediate need for health care services, the delay in establishing Medicaid eligibility sometimes impairs their access to care. States do have the option of establishing “presumptive eligibility” for children in Medicaid under the 1997 Balanced Budget Act. If a state chooses to adopt this eligibility option, it must do so for all children under age 19; it cannot limit “presumptive eligibility” to subcategories, such as foster care children.

---

26 42 C.F.R. §435.930(b) provides that state Medicaid agencies must “continue to furnish Medicaid regularly to all eligible individuals until they are found to be ineligible.” See also Letter from Health Care Financing Administration to State Medicaid Directors, February 6, 1997, www.hcfa.gov/medicaid/wrdl2697.htm. The state Medicaid agency is responsible for making a determination, but the agency can request that (in this case) the relative with whom the child is placed provide information needed to determine whether the child remains eligible and can terminate coverage if the relative does not provide the information.

27 42 C.F.R. §435.907(a), (b).


30 Section 4912 of the Balanced Budget Act of 1997 created a new option for states to establish “presumptive eligibility” for children at §1920A of the Social Security Act. (States had previously been given the option of establishing “presumptive eligibility” for pregnant women under §1920 of the Act). The new “presumptive eligibility” option for children applies to all children under 19. Without a waiver from the Secretary of HHS, states do not have the authority to limit this option to children under 19 in foster care.
TARGETED MEDICAID ELIGIBILITY OPTION FOR STATE COVERAGE OF NON-TITLE IV-E FOSTER CARE CHILDREN

As discussed above, states are required under federal Medicaid law to cover all foster children receiving Title IV-E payments, and, through the mandatory eligibility categories applicable to all children (e.g., “poverty level”), must cover foster care children who qualify under those categories. States also have an option under current law of extending Medicaid coverage to all foster care children who are not receiving Title IV-E payments and who do not qualify through the poverty-level, section 1931, or disability-related pathways. They can do so by creating an eligibility category for foster care children under the statutory and regulatory provisions described below.

Federal Medicaid law gives states considerable discretion in establishing optional Medicaid eligibility groups. At least 50 percent, and as much as 80 percent, of the cost of providing covered services to individuals in these groups is borne by the federal government, depending on the state. These federal Medicaid matching funds are available to states without a waiver from the Secretary of HHS. Instead, a state must simply file an amendment to its state Medicaid plan; approval of state plan amendments by the Health Care Financing Administration is generally a routine matter when those amendments are consistent with the Medicaid statute and regulations.

This targeted foster care eligibility option is not expressly set forth in the federal Medicaid statute. Rather, it is the product of two separate statutory provisions: (1) the option to cover “reasonable categories” of children, and (2) the prohibition against attributing the income and resources of either the biological or foster care parents to the child. More specifically:

- Section 1905(a)(i) of the Social Security Act, as implemented by federal regulations, authorizes states to extend Medicaid coverage to “reasonable classifications” of children under age 21 who are not receiving cash assistance. The statute does not specify what a "reasonable classification" is, but the implementing regulations expressly list as one example foster care children.

- Section 1902(a)(17) of the Social Security Act, as implemented by federal regulations, prohibits states, in determining Medicaid eligibility, from attributing the income or

---

31 42 C.F.R. §435.601(d)
32 42 C.F.R. §435.222(b)(1) provides the following example of a reasonable classification: “Individuals in foster homes or private institutions for whom a public agency is assuming a full or partial financial responsibility. If the agency covers these individuals, it may also provide Medicaid to individuals of the same age placed in foster homes or private institutions by private nonprofit agencies.”
33 42 C.F.R. §435.602(a)(1).
resources of biological parents or foster care parents to a child in foster care placement, whether or not the child is receiving Title IV-E maintenance payments.

The result is that a state may, if it so chooses, extend Medicaid eligibility to almost all children in foster care, regardless of the income or resources of the biological parents or the foster care parents, and regardless of whether the child is receiving Title IV-E payments.\textsuperscript{34} The state would be entitled to receive federal Medicaid matching funds at its regular matching rate for the costs of providing Medicaid-covered services to all children qualifying under this option.

More specifically, a state could define as a “reasonable classification” all children under 21 in foster care who are not receiving Title IV-E payments and who do not have income or resources of their own that are in excess of the state’s July 16, 1996 AFDC standards. In determining income and resource eligibility, neither the biological or foster care family’s income or resources would be counted. Only those of the child would apply. Presumably, few children in non-Title IV-E foster care would have any income or resources of their own that might disqualify them from coverage.

Note that under this option, eligibility would not be open-ended. Instead, it would be co-terminous with placement in foster care. That is, Medicaid eligibility would be effective on the date of a child’s placement in foster care and would end on the date the child’s placement ends, regardless of when the child’s Medicaid application is actually processed. The child welfare agency would simply certify that the child was in foster care and had no income or resources in his or her own name. The state Medicaid agency could then issue a Medicaid card for a foster care child that is effective on the date the child is placed with a foster family (or in kinship care). In the infrequent cases where a foster care child has income or resources of their own, the child welfare agency could make the determination as to whether these exceeded the state’s applicable AFDC income or resource standards. As discussed above, before terminating Medicaid eligibility for a child leaving foster care, the state Medicaid agency would be obligated to determine that there is no other basis (such as falling below the applicable poverty-income threshold) on which the child could continue to qualify for Medicaid.

\textsuperscript{34} One exception would be legal immigrant children who arrived in the U.S. after August 22, 1996, have not lived here for 5 years, and are not receiving SSI benefits.
CONCLUSION

The health needs of foster care children are substantial, and Medicaid is often the only available source of health care coverage for these children. States have more flexibility than is generally recognized in drawing down federal Medicaid matching dollars to provide Medicaid coverage to foster care children. While States are required to cover those foster care children who are receiving payments under Title IV-E, they also have the option of covering other foster care children, including those in kinship care. Implementation of this option could reduce the number of uninsured foster care children and assist foster care parents or relatives in meeting the health care needs of children in foster care.
LIST OF APPENDICES

A. Medicaid Eligibility Pathways: Charts 1-4
B. Table 1: Medicaid Eligibility Levels for Pregnant Women and Children
Appendix A

Chart 1: Medicaid Eligibility for Poverty-Level Children

Chart 2: AFDC-Related Eligibility Pathways for Children

Chart 3: Medicaid Eligibility Pathways for Poverty-Level Children

Chart 4: AFDC-Related Eligibility Pathways for Children
<table>
<thead>
<tr>
<th>Mandatory Coverage</th>
<th>Eligibility Criteria</th>
<th>Optional Coverage</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants under age 1</td>
<td>$\leq 133%$ FPL&lt;sup&gt;1&lt;/sup&gt; Optional, but no more restrictive than $1,000 per family</td>
<td>Infants under age 1</td>
<td>$\leq 185%$ FPL&lt;sup&gt;2&lt;/sup&gt; Optional, but no more restrictive than $1,000 per family</td>
</tr>
<tr>
<td>Children age 1 to 6</td>
<td>$\leq 133%$ FPL Optional, but no more restrictive than $1,000 per family</td>
<td>Children age 1 to 6</td>
<td>State sets % of FPL Optional, but no more restrictive than $1,000 per family</td>
</tr>
<tr>
<td>Children age 6 to 19&lt;sup&gt;3&lt;/sup&gt;</td>
<td>$\leq 100%$ FPL&lt;sup&gt;4&lt;/sup&gt; Optional, but no more restrictive than $1,000 per family</td>
<td>Children age 6 to 19</td>
<td>State sets % of FPL Optional, but no more restrictive than $1,000 per family</td>
</tr>
</tbody>
</table>

* Mandatory and optional pathway thresholds may be expanded in states using Section 1902(r)(2) “less restrictive” methodologies for income and resources<sup>5</sup>

* Note: A child may be eligible for Medicaid via more than one pathway.

1. In 1998, 133 percent of the federal poverty level (FPL) for a family of three was $18,155/year, or $1,513/month. 63 Fed. Reg. 9235 (1998).

2. In 1998, 185 percent of the FPL for a family of three was $25,253/year, or $2,105/month.

3. Social Security Act requires coverage of children to age 19 under 100 percent of the FPL born on or after September 30, 1983. Under this provision, coverage is phasing in one year at a time. By 2002, all of these children will be covered.

4. In 1998, 100 percent of the FPL for a family of three was $13,650/year, or $1,138/month.
<table>
<thead>
<tr>
<th>Mandatory Coverage</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Income</td>
<td>Resource Test</td>
</tr>
<tr>
<td>Section 1931 children</td>
<td>State AFDC level as of 7/16/96</td>
</tr>
<tr>
<td>Children in welfare-to-work families (12 month</td>
<td>Family would meet state AFDC level as of 7/16/96 but</td>
</tr>
<tr>
<td>transitional coverage)</td>
<td>for increased earnings (to 185% FPL)</td>
</tr>
<tr>
<td></td>
<td>State AFDC level as of 7/16/96</td>
</tr>
</tbody>
</table>

Mandatory pathway thresholds may be expanded in states using section 1931(b) “less restrictive” methodologies for income and resources.2

* Note: An individual may be eligible for Medicaid via more than one pathway.

---

1. Although states may use “less restrictive” income and resource methodologies under section 1931(b), this flexibility does not allow states to liberalize the AFDC family composition rules.
<table>
<thead>
<tr>
<th>Mandatory Coverage</th>
<th>Eligibility Criteria</th>
<th>Optional Coverage</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family Income</td>
<td>Resource Test</td>
<td>Family Income</td>
</tr>
<tr>
<td>SSI recipients</td>
<td>&lt;$494 per month for individual, &lt;$741 per month for couple&lt;sup&gt;1&lt;/sup&gt;</td>
<td>&lt;$3,000 for couple, &lt;$2,000 for individual&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Medically needy children under age 18</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>State sets income standard; individual may not “spend down” or dispose of resources to qualify</td>
</tr>
<tr>
<td>Title IV-E foster care children</td>
<td>State AFDC income level as of 7/16/96</td>
<td>State AFDC level as of 7/16/96</td>
<td>Non Title IV-E foster care children</td>
</tr>
<tr>
<td>Children in “209(b)” states&lt;sup&gt;3&lt;/sup&gt;</td>
<td>State sets income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income</td>
<td>State sets resource standard; individual may not “spend down” or dispose of resources to qualify</td>
<td>Katie Beckett children&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Title IV-E adoption assistance children with disabilities&lt;sup&gt;5&lt;/sup&gt;</td>
<td>&lt;$494 per month for individual, &lt;$741 per month for couple</td>
<td>&lt;$3,000 for couple, &lt;$2,000 for individual</td>
<td>Non Title IV-E adoption assistance children under age 21</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Home or community-based waiver children&lt;sup&gt;6&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: An individual may be eligible for Medicaid via more than one pathway.

1. SSI income level as adjusted annually based on the 12-month change in the Consumer Price Index (CPI). Parents’ income is attributed to children under age 18, living in the same household with their parents, but the needs of the parents and other children in the household are taken into account.

2. Parents’ countable resources are deemed to children under 18 living in the same household as the parents, but only to the extent that they exceed the applicable resources limits.

3. Section 209(b) states that use more restrictive eligibility requirements than those in effect under the SSI program. These state may not impose requirement that are more restrictive than those in effect in state’s Medicaid plan as of January 1, 1972

4. States selecting this option must cover, on a statewide basis, all children in this category.

5. Children covered under Title IV-E adoption assistance agreements are defined as "special needs" children, with respect to whom the state determines there is a specific condition or situation (such as disability, age, or membership in a minority group) that prevents placement without special assistance.

6. The home and community-based services option does not require a state extent coverage to all such children throughout the state.
**MEDICAID ELIGIBILITY PATHWAYS FOR FOSTER CARE CHILDREN**

<table>
<thead>
<tr>
<th>Mandatory Coverage</th>
<th>Eligibility Criteria</th>
<th>Optional Coverage</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title IV-E foster care children</strong></td>
<td>AFDC level as of 7/16/96</td>
<td>Non Title IV-E foster care children under age 21</td>
<td>AFDC level as of 7/16/96</td>
</tr>
<tr>
<td></td>
<td>AFDC level as of 7/16/96</td>
<td></td>
<td>AFDC level as of 7/16/96</td>
</tr>
</tbody>
</table>

*Note: A child may be eligible for Medicaid via more than one pathway.*

*For children in Title IV-E foster care, their income from federal maintenance payments is the basis for Medicaid eligibility, but does not affect the Medicaid eligibility of other family members.*
Appendix B

Table 1: Medicaid Eligibility Levels for Pregnant Women and Children
### Table 1: Medicaid Eligibility Levels for Pregnant Women and Children

<table>
<thead>
<tr>
<th>State</th>
<th>Pregnant Women and Infants (as of May 20, 1998)</th>
<th>Other Eligibility Categories</th>
<th>Max Medicaid Payments (7/10/90)</th>
<th>N/A</th>
<th>Needy, 1995</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Max AFDC Payments</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>United States</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alabama</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arizona</td>
<td>140</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arkansas (2,3,4)</td>
<td>133 (200)</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>California (1)</td>
<td>200</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorado (1,4)</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>165</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delaware</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District of Columbia</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Florida (1)</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hawaii</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Idaho (4)</td>
<td>160</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>200</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>150</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iowa (4)</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td>150</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>165</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maryland (2)</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Massachusetts (1)</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minnesota (3)</td>
<td>275</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missouri</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montana (4)</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td>150</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nevada (4)</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>260</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Jersey (1)</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New York (1)</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Carolina</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Dakota (4)</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ohio</td>
<td>150</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oklahoma</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon (4)</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pennsylvania (1)</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhode Island (2,4)</td>
<td>250</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tennessee (3)</td>
<td>400</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas (4)</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utah (4)</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vermont (3)</td>
<td>200 (225)</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washington (1)</td>
<td>185 (200)</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td>150</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>185</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wyoming (4)</td>
<td>133</td>
<td>45</td>
<td>49</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


**Note:** The 1998 Federal poverty guideline for a family of three was $13,660; for Alaska $17,070 and Hawaii $15,700.

1. The states operate separate child health insurance programs for children not eligible for Medicaid. Such programs may provide benefits similar to Medicaid or they may provide a limited benefits package and may include premiums and cost-sharing.

2. Children covered under Medicaid expansion programs in Arkansas and Maryland receive reduced benefits package pursuant to federal waivers.

3. The Medicaid programs in AR, MN, RI, TN, and VT may impose some cost-sharing—premiums and/or co-payments for some children pursuant to federal waivers.

4. The states noted count assets, in addition to income, in determining Medicaid eligibility for children; Utah does not considered assets for young children. An assets test is NOT required in Arkansas for its Medicaid expansion program.

5. The United States figure represents the median maximum AFDC payment level.