Introduction

This chapter was adapted, with permission, from materials previously published by Neighborhood Legal Services, Inc. of Buffalo, NY.

Medicaid, also known as Medical Assistance, is a cooperative federal-state program authorized by Title 19 of the Social Security Act. Medicaid may be known by a name that is unique to your state, such as California’s MediCal program or Tennessee’s TennCare program. On a federal level, Medicaid is administered through the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration, within the U.S. Department of Health and Human Services. On a state level, overall responsibility will rest with one state agency in each state. Actual administration of Medicaid is often delegated to any number of other entities, including: one or more other state agencies; local Medicaid units; or health maintenance organizations (if your state uses a managed care model for any part of its Medicaid delivery system).

Persons with disabilities, who are recipients of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI), frequently cite the fear of losing health care coverage as a major barrier to successful employment. Medicaid is typically the most important health care program serving SSI or SSDI recipients who are working, or plan to work. Because Medicaid is so important to recipients, a Benefits Specialist must develop a general understanding of what Medicaid has to offer in your state and the various methods of establishing or retaining eligibility.

In an effort to provide the Benefits Specialist with a solid grounding on Medicaid, this chapter will: explain what services are available, or potentially available, to Medicaid recipients; explain the various ways that individuals with disabilities become eligible for Medicaid; explain Medicaid’s appeals system; and provide a number of Medicaid-related resources available to advocates on the Internet.

Services Covered by Medicaid

Medicaid’s “required services” must be a part of every state plan, and include:

- Inpatient Hospital Care
- Outpatient Hospital Care
- Physician’s Services
- Laboratory and X-Ray Services
- Nurse Midwife Services
- Rural Health Clinic Services
- Prenatal Care
- Family Planning Services
- Skilled Nursing Facility Services For Persons Over Age 21
Home Health Care Services to Persons Over 21, Eligible For Skilled Nursing Services (Includes Medical Supplies and Equipment)
Pediatric and Family Nurse Practitioner Services
Early Periodic Screening, Diagnosis and Treatment for Persons Under Age 21
Vaccines for Children
Federally Qualified Health Center

Optional services that may be incorporated in a state plan include:

Podiatrists Services
Optometrist Services and Eyeglasses
Chiropractor Services
Private Duty Nursing
Clinic Services
Dental Services
Physical Therapy
Occupational Therapy
Speech, Hearing and Language Therapy
Prescribed Drugs
Dentures
Prosthetic Devices
Diagnostic Services
Screening Services
Preventive Services
Rehabilitative Services
Transportation Services
Services for Persons Age 65 or Older in Mental Institutions
Intermediate Care Facility Services
Intermediate Care Facility Services for Persons with Mental Retardation/Developmental Disabilities and Related Conditions
Inpatient Psychiatric Services for Persons under Age 22
Christian Science Schools
Nursing Facility Services for Persons under Age 21
Emergency Hospital Services
Personal Care Services
Hospice Care
Case Management Services
Respiratory Care Services
Home and Community Based Services for Individuals with Disabilities and Chronic Medical Conditions
For those working with children and young persons with disabilities under age 21, it is important to note that the Early Prevention, Screening, Diagnosis and Treatment (EPSDT) program is a mandatory Medicaid service in every state. The importance of this is that EPSDT recipients are entitled to services through all the optional categories, including those which a particular state has not opted to cover as part of its state Medicaid Plan for adults.

A Benefits Specialist must become familiar with the Medicaid waiver provisions available in your state (discussed below). Some Medicaid waivers will provide, to selected categories of recipients, a number of services not included in the state plan. These waiver services may include optional services not available to the general Medicaid population and services not traditionally available as required or optional services.

The experience of Benefits Specialists and other advocates is that certain categories of service, because of their expense and/or unavailability through many private insurance plans, tend to be the most important to SSI and SSDI recipients who work. These include inpatient hospital care, home health care (including personal care services and private duty nursing), medical equipment or assistive technology (typically covered under the required home health care category as durable medical equipment or under several optional categories, including prosthetic devices), psychiatric services, and prescription drugs. Since many states will not cover some of the expensive optional services, such as private duty nursing or prescriptions, it is important to determine whether those are available as part of your state plan or through a special waiver program.

NOTE: Effective January 1, 2006, individuals who are dually eligible for Medicaid and Medicare will be required to obtain their prescription drugs through the new Medicare Part D program. It is important in most cases, however, that these individuals retain their eligibility for Medicaid. This is because: 1) Medicaid will continue to be available for all services, other than prescription drugs, that are part of its state Medicaid plan; 2) Medicaid may, through something known as a “wraparound plan,” pay for drugs not otherwise available through Medicare Part D; and 3) eligibility for Medicaid ensures automatic eligibility for the Medicare Part D low-income subsidy program, drastically limiting out-of-pocket expenses for participants in the Part D program.

Medicaid is often the only health insurance plan for persons with disabilities who have limited income. For those dually entitled to Medicaid and Medicare, Medicaid is usually the better of the two programs. An increasing number of individuals with disabilities are looking to Medicaid as their primary health insurance plan, notwithstanding higher levels of income. Medicaid may be available to those individuals through state-specific waivers, through optional buy-in programs, or through the 1619(b) provisions, all discussed below.
During the past 20 years, many new ways have been created to qualify for Medicaid. For example, the Medicaid provisions in Title 19 have been amended to create the optional waiver and buy-in programs. The SSI provisions in Title 16 of the Social Security Act have been amended to make four separate classes of former SSI recipients eligible for continued Medicaid. Since these provisions are not well publicized or well understood, many individuals who could be eligible never obtain Medicaid. Without that eligibility, any discussion about Medicaid funding for the variety of expensive health-related services becomes purely academic.

**Using SSI as the Conduit to Automatic Medicaid Eligibility**

In most states, Medicaid eligibility is automatic for SSI recipients. SSI recipients automatically qualify for Medicaid in 39 states the District of Columbia, and the Northern Mariana Islands. If the SSI check is as little as $1, Medicaid eligibility is automatic. In most of these states, the SSI recipient does not need to take any action as their eligibility is automatically certified. In some of these states, eligibility is automatic, but the individual SSI recipient must file a Medicaid application to establish that eligibility. The states in which a separate Medicaid application must be filed include: Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, Utah, and the Northern Mariana Islands.

In 11 states, known as section 209(b) states, Medicaid eligibility is not automatic for SSI recipients. These states use their own Medicaid eligibility criteria, which differs from SSI criteria. The Medicaid eligibility employed by 209(b) states will vary greatly from state to state, and may be more restrictive or more liberal than SSI’s criteria. The states which exercise the 209(b) option include: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. If you reside in one of these states, you will need to find out how SSI recipients qualify for Medicaid in your state.

**Working with SSI’s income and resource rules will often ensure Medicaid eligibility.** The SSI income and resource rules are discussed in Chapter XX. Individuals, spouses and parents can often organize their finances to ensure SSI and Medicaid eligibility. For example, in a state that pays the 2006 SSI federal benefit rate (FBR) of $603, with no state supplement, a single parent living with two children including one with a disability would be able to maintain SSI eligibility for the child with a disability until the parent’s gross monthly income reaches $2,838 ($34,056 per year). If Medicaid is critical to the child, the parent may wish to work with his or her employer to keep their income below $2,838 per month. This could be done by accepting extra health benefits in lieu of cash; putting money into a cafeteria plan or flexible spending account (approved under section 125 of the Internal Revenue Code), if available; or by going to a part-time schedule.

If Medicaid is important to the child, the parent must be careful to keep the parents’ and child’s resources within SSI limits. For example, retaining exempt resources, such as the residential home or a vehicle for family travel, will not affect SSI eligibility. On the other hand, accumulating more than $2,000 in a child’s savings account would result in a termination of SSI eligibility and, with it, the right to automatic Medicaid in most states. The considerations for adult SSI recipients will be the same or very similar.
The following provisions each allow a former SSI recipient to be treated as an SSI recipient for Medicaid purposes, allowing that person to continue eligibility for Medicaid.

**Recipients of Social Security Widow’s/Widower’s Benefits:** If a person loses SSI when he or she becomes entitled to Social Security widows or widowers’ benefits, the person remains automatically eligible for Medicaid if SSI eligibility would continue in the absence of the widow’s or widowers’ benefits. Eligibility continues only for so long as the person remains ineligible for Medicare, a period of 24 months following the first month of Social Security eligibility.

*Example:* Mary was receiving SSI benefits of $603 per month and was automatically eligible for Medicaid in her state. Upon the death of her husband, she qualifies for Social Security Widows’ Benefits of $700 per month, which makes her ineligible for continuing SSI benefits. She will continue to be eligible for Medicaid, as if she was still an SSI recipient, for the two-year waiting period for Medicare.

**Recipients of Social Security DAC Benefits:** A recipient of Social Security Child’s Insurance Benefits, often referred to as Disabled Adult Child’s (DAC) Benefits or Childhood Disability Benefits, can continue eligibility for automatic Medicaid if, after July 1, 1987, the person lost SSI due to entitlement to or an increase in DAC benefits.

*Example:* Paul, age 33, was receiving SSI benefits in early 2006 at the FBR of $603. He was also automatically eligible for Medicaid in his state. During the spring of 2006, Paul’s father dies and Paul becomes eligible for Social Security DAC benefits of $750 per month and loses his SSI benefits because of excess income. Since Paul lost his benefits due to receipt of DAC benefits he will remain eligible for Medicaid so long as his resources and income other than DAC benefits remain within SSI limits.

**The Pickle Amendment:** This protects certain persons who, after April 1977, were eligible for both SSI and SSDI and later lost eligibility for SSI because the receipt of SSDI, along with any other income, made the person ineligible for SSI. Automatic eligibility for Medicaid continues if the person would be presently eligible for SSI if SSDI cost of living increases since the person last received SSI are disregarded.

*Example:* In 2002, John was receiving $488 in monthly SSDI benefits and $77 in SSI benefits (the 2002 FBR was $545). That same year he started receiving a private pension of $125 per month, making his combined SSDI and private pension income more than allowed by SSI [i.e., his countable income of $593 (i.e., $613 - 20 general income exclusion) was now more than the SSI rate of $545]. Having lost SSI, John also lost his right to automatic Medicaid. Assume John’s pension will remain a constant $125 per month.
Because the Pickle Amendment allows John to disregard SSDI cost-of-living increases since 2002 (i.e., since he was last dually entitled to SSI and SSDI), his countable income for Pickle Amendment purposes will remain a constant $593 in future years. This was more than the FBR of $552 in 2003, more than the FBR of $564 in 2004 and more than the FBR of $579 in 2005, meaning that he remained ineligible for Medicaid under Pickle. In 2005, with the FBR now up to $603, John’s countable income of $593 (after ignoring SSDI cost-of-living increases) is now less than the SSI rate for his state. Since John would now be eligible for a small SSI check ($10) if the post-2002 SSDI increases are ignored, John is now eligible for Medicaid under Pickle.

For a more detailed explanation, see Bonnyman, G., *Medicaid Eligibility in a Time Warp*, 22 Clearinghouse Rev. 120 (June 1988) and Bonnyman, G., *A Quick and Easy Method of Screening for Medicaid Eligibility under the Pickle Amendment* (updated and published annually in the Clearinghouse Review).

**Section 1619(b): Continued Medicaid for Persons Who Lose SSI Due to Wages:** This special work incentive is fully discussed in Chapter XX. It provides Medicaid for individuals who lose SSI benefits when earnings are too high. Under 1619(b), automatic Medicaid continues if the person would continue to be eligible for SSI if the wages were ignored and if annual income is less than a specified income threshold. In section 209(b) states, Medicaid continues, pursuant to the 1619(b) criteria, if the individual was eligible for Medicaid in the month prior to losing SSI and the other 1619(b) criteria is met.

The income threshold changes every calendar year and will be different in each state, based on the state’s unique SSI rate and Medicaid expenditures. These thresholds range from $22,000 to $49,000 per year. A higher, “individualized threshold” can be established if medical or other expenses are high enough.

**The Medically Needy Program, as Available to Persons with Disabilities, is an Option Exercised by Two-Thirds of the States:** Medically needy individuals are those who would qualify for Medicaid, including individuals who are disabled, but have income or resources above limits set by their state. Since Medicaid agencies often do not explain the spend down (or “share of cost”) program to applicants or recipients, you should find out if your state offers this option and take steps to educate yourself and your clients/consumers on how it works.

**How the Spend Down Works:** Each state sets its medically needy income levels based on family size. For example, New York set its 2005 level at $667 per month for a household of one. All individuals meeting the federal (i.e., SSI) definition of disability, who have income and resources below the medically needy level, automatically qualify for Medicaid. A state must establish a
uniform set of income and resource rules for determining income for the medically needy. The state’s methodology employed in determining income and resource eligibility “shall be no more restrictive than the methodology which would be employed under the [SSI] program in the case of ... blind, or disabled individuals ....”

Individuals with income above the medically needy level do not automatically qualify for Medicaid. They must first meet a “spend down” or “share of cost” test. The spend down is the amount by which income exceeds the medically needy level after subtracting allowable deductions.

For example, in New York, a single adult with a disability receives a monthly SSDI check of $787, which exceeds the state’s 2005 medically needy level of $667. The Medicaid agency will disregard the first $20 as an unearned income exclusion and the individual will face a $100 spend down (i.e., countable income exceeds the medically needy level by $100). The spend down acts like a deductible or insurance premium that must be paid or incurred before coverage begins.

Nearly any medical expense that is paid or incurred can be used to meet a spend down requirement, even if it is for goods or services not covered by your state plan. The following is a list of typical expenses that may be used: health insurance premiums and co-payments; doctor bills; mental health bills (including a psychiatrist’s services and mental health counseling services); dental bills; home health care; prescriptions drugs; eyeglasses and optometry bills; and over-the-counter drugs or purchases related to health care.

These provisions allow states, with approval of the federal Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, to waive (or not follow) specific requirements of the Medicaid Act. These are often referred to as “section 1915(c) waivers.” All states participate in these optional waivers to varying degrees.

**Waiver of “Statewidedness:”** Ordinarily, the state’s Medicaid plan must offer comparable coverage in all regions of a state. It would be illegal, under regular Medicaid rules, to offer a Medicaid-funded service to some individuals that are not offered to Medicaid recipients statewide. A waiver can be approved to offer a level of Medicaid coverage in one or more sections of the state, or to a limited number of recipients, that is not available to all recipients statewide.

**Waiver of Comparability:** Ordinarily, the state’s Medicaid plan must treat all similarly situated recipients equally. It would be illegal, under regular Medicaid rules, to offer a Medicaid-funded service to one individual with a disability and not offer it to others with a different disability. A waiver could select a targeted group of recipients (such as persons with traumatic brain injury or persons with AIDS) and offer them a scope of services not available to persons who have different disabilities but similar needs.
**Waiver of Certain Income and Resource Rules:** A waiver can be implemented which exempts certain populations from the general income and resource requirements. For example, a waiver may allow a Medicaid program to disregard parental income and resources for certain children.

These waiver programs are structured to provide an alternative to institutional care and often provide greater access to a range of services and equipment (often referred to as durable medical equipment or assistive technology) than available under other covered services within the state plan. A number of other services may be available under your state’s unique waiver program or programs, such as case management, job coaching, homemaker services, home health aide services, adult day health, habilitation, respite, home modifications, partial hospitalization and psycho-social rehabilitation for persons with psychiatric diagnoses. Some of these are optional services that a state may not cover in its regular state plan. Others are services that are not otherwise available as either required or optional services.

**The Medicaid Buy-in Program**

This optional program, created by the Balanced Budget Act amendments of 1997, is designed to provide health insurance to working people with disabilities who, because of relatively high earnings, cannot qualify for Medicaid under another provision. These provisions were specifically targeted to those SSDI recipients who, because they were not also eligible for SSI, could not qualify for Medicaid under the 1619(b) provisions. Subject to federal criteria, a state can structure the buy-in as it sees fit.

The original 1997 buy-in included several key eligibility components:

- Individuals are not required to have been on SSI.
- Eligibility was set at net income of less than 250 percent of the federal poverty level, with all SSI exclusions applied. For a household of one, this meant a state could provide Medicaid to an individual who has $40,000 or more in annual wages.
- Except for their earnings, the person with a disability would be eligible for SSI.
- Substantial gainful activity (i.e., earnings in excess of $860 monthly in 2006 and adjusted in later years) is not an eligibility consideration. A person could be eligible for the buy-in despite earning in excess of the substantial gainful activity amount.
- States could increase the Medicaid resource limits to as high as $14,000.
- States could charge premiums or other cost-sharing charges.
Section 201 of the Ticket to Work and Work Incentives Improvement Act of 1999 included several key provisions to make the Buy-in program more attractive:

- It allows states to offer a buy-in to persons with earnings up to 450 percent of the poverty level. For a household of one, this means a state could provide Medicaid to an individual who has $70,000 or more in annual wages.

- States are now allowed to set income limits and require cost sharing and premiums, based on income, on a sliding scale. A state could require some individuals to pay the full premium as long as the premiums do not exceed 7.5 percent of the individual’s total income.

- States must require a 100 percent premium payment for individuals with adjusted gross incomes greater than $75,000 unless states choose to subsidize the premium using their own funds.

At the time this document was written, 30 states had adopted and were implementing buy-in programs, with many additional states at various stages of pre-implementation (including several that had been adopted and were awaiting federal approval, and several pending in state legislatures). You should check the status of the buy-in program in your state as it may offer the only means of accessing continuing Medicaid for those SSDI recipients who are unable to access continuing Medicaid through the 1619(b) program.

Under federal Medicaid law, a Medicaid applicant or recipient is entitled to an administrative hearing any time a decision is made which affects his or her right to Medicaid or to any service for which Medicaid funding is sought. This is known as a “fair hearing” and will be available in all states.

A person whose Medicaid benefits or right to services funded by Medicaid are either denied or terminated is entitled to a written notice of that decision. The notice must explain: the action that is being taken, the reason for the action, the right to a hearing to appeal the decision, and the availability of free services from a Legal Services, Legal Aid or similar program (such as a Protection and Advocacy program). States are permitted to establish their own time limits for requesting hearings. Typically, the Medicaid recipient will be permitted a time limit (30 - 60 days) for requesting the hearing. However, if the notice indicates that an ongoing benefit, such as funding for home health care services, is to be terminated on a certain date, the recipient will need to request the hearing before the termination date if continued services are going to be requested pending the appeal. Federal Medicaid law provides that benefits are to be continued pending the appeal (a concept often referred to as “aid continuing”) if the hearing is requested before the effective termination date and the recipient (or advocate working on his or her behalf) specifically requests the continuation of benefits.
A growing number of Medicaid-related resources are available on a wide variety of web sites. The web sites listed below include those of the federal Centers for Medicare and Medicaid Services and several private agencies that are national in scope. Benefits Specialists will also want to identify government and not-for-profit agency web sites that are unique to their states.

**Federal Agency Web Sites**

Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration’s Web Site - www.cms.gov

**Not-for-Profit Agency Web Sites**

National Health Law Project - www.healthlaw.org

National Senior Citizens Law Center - www.nsclc.org

National Assistive Technology Advocacy Project - www.nls.org/natmain.htm

Kaiser Family Foundation – www.kff.org

Families USA – www.familiesusa.org

For many individuals with disabilities contemplating a return to work, the question of continued medical coverage is a pressing issue. While SSI recipients returning to work are able to continue receiving Medicaid coverage for themselves in most states, what about their children? What if they find a job, which pays too much for their children to continue on Medicaid, but which does not itself provide health insurance? For these individuals, the State Child Health Insurance Program (SCHIP) may provide health care coverage.

The Balanced Budget Act of 1997 created SCHIP, by adding a new Title 21 to the Social Security Act. Initially, many had referred to it as the Child Health Insurance Program, or CHIP. However, pursuant to Section 704 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999, the Federal government is prohibited from using the terms Child Health Insurance Program or CHIP. Therefore, we will use the term SCHIP. Final regulations implementing SCHIP became effective on June 23, 2000. The regulations add very little to the Title 21 requirements and are designed primarily to guide the States in obtaining reimbursement under the program.

The Centers for Medicare and Medicaid services (CMS), formerly the Health Care Financing Administration (HCFA), which administers SCHIP, has a very helpful SCHIP web site. The site is located at www.cms.hhs.gov/schip. It contains a summary of the program developed by CMS which provides interpretive guidance about the program, copies of informational letters sent to the States about the program, information about State implementation of SCHIP, and links to other helpful web sites.
The purpose of SCHIP is “to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.” The statute authorizes $40 billion over 10 years to be distributed to all 50 states and all U.S. territories. It commenced with the 1998 fiscal year, which began on October 1, 1997. Like Medicaid, the program is optional for each state, but as of the 2000 fiscal year (October 1, 1999), every state and territory is participating. Funds are allocated to each state based on a ratio, which includes the number of uninsured low-income children and the total number of low-income children in the state.

To receive funding, a state must have an approved plan, describing how the state will implement the program. However, “to provide states with the flexibility and time needed to develop their programs and to submit their child health plans,” HCFA (now CMS) published “reserved” rates for the 1998 and 1999 fiscal years, which became final once each state’s plan was approved.

The statute gives states an incredible amount of flexibility in implementing their program. States may simply extend Medicaid coverage to children who are eligible for SCHIP, create a separate program, or use a combination of both. Therefore, to fully understand how SCHIP is being implemented, it is critical to obtain your state’s plan to determine the basic program structure, who is eligible and what services are covered. A link is provided to each state’s SCHIP program from the federal governments SCHIP website at www.insurekidsnow.gov.

Despite SCHIP’s flexibility, the law provides some basic guidelines that will apply to all states. Each state’s plan must include a description of the following:

1. The actual child health assistance to be provided under the plan;
2. Eligibility standards, including those relating to the geographic areas to be served, age, income and resources (including any standards relating to spend downs and disposition of resources), residency, disability status (so long as any standard relating to such status does not restrict eligibility), access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis;
3. Eligibility screening to ensure that only eligible children receive services under the program, that children found to be eligible for Medicaid are referred to the Medicaid program, and that eligible American Indians are provided services;
4. Outreach to families of children likely to be eligible under the program or under other public or private insurance programs to inform them of available coverage and to assist them in enrolling their children in programs for which they are eligible; and
5. Procedures for coordinating SCHIP with other public and private health insurance programs.
In an effort to improve outreach to children who may be eligible but who have not yet enrolled in the program, the Agricultural Risk Protection Act of 2000 “established a critical link between the National School Lunch Program, Medicaid and [SCHIP].” States may now share information with SCHIP and Medicaid “agencies about families who participate in the school lunch program in an effort to help identify eligible children.” Almost every state has taken advantage of this opportunity to “enlist the support of schools in its outreach and enrollment strategies.” Sign Them Up: A Quarterly Newsletter about the Children’s Health Insurance Program (CHIP), p. 5 (Fall 2001, Children’s Defense Fund).

As noted above, states are given a wide degree of latitude in establishing eligibility criteria, including ages, geographic areas, income and resource rules, and duration of eligibility. Again, however, there are certain mandatory guidelines. Generally, coverage must be limited to children who are under 19 years of age, who are not eligible for Medicaid or other health insurance, and whose family income is below 200 percent of the federal poverty level for their size of family (which in 2005 is up to $38,700 per year for a family of four). See www.nccp.org/faq.html. However, children enrolled in a state-created insurance program, which was in place prior to July 1, 1997, and did not utilize any federal funds, will still be eligible for SCHIP. Effective November 1, 2002, the definition of child has been amended to include “the period from conception to birth.” This will allow a state, if it chooses, to cover prenatal care and delivery.

If a state has raised its Medicaid eligibility level above 150 percent of the poverty level before June 1, 1997, the state may raise the eligibility standards for SCHIP to 50 percent above the current Medicaid income level. However, the State cannot lower its Medicaid income and resource limits in an effort to make children ineligible for Medicaid and thereby eligible for SCHIP.

Any financial eligibility criteria must not operate to cover children in families with higher incomes without covering children in families with lower incomes. Nor can the eligibility criteria deny coverage to children with pre-existing medical conditions. Finally, children who are inmates in a public institution or who are patients in an institution for “mental diseases” are not eligible for coverage.

On July 1, 2000, HCFA (now CMS) announced criteria for special demonstration projects under SCHIP. States that have had at least one year of experience implementing SCHIP and have submitted all of their required reports are eligible. In addition, the state will have “to provide assurances that it has met the primary purpose of SCHIP by expanding eligibility to low-income children” and “demonstrate that it is successfully reaching and enrolling eligible children.” In such cases, one of the possible demonstration projects can be to extend coverage “to low-income parents of the children they are enrolling in Medicaid and SCHIP.”
As noted above, states may choose to deliver services in one of three basic ways. They may simply choose to extend basic Medicaid coverage to those children determined to be eligible for SCHIP. In those cases, the state must apply, to SCHIP-eligible children, the full range of Medicaid services available to all other Medicaid eligible children in the state. This would include all the services available under Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The EPSDT program mandates that states provide all medically necessary mandatory and optional Medicaid services. See English, Abigail and Madlyn Morreale, *The New Children’s Health Insurance Program: Major Provisions and Early Lessons, ABA Center on Children and the Law*, www.abanet.org/child/chipfinal.html.

If a state chooses to create its own separate SCHIP program, it has a large degree of flexibility in choosing the scope of services to cover. There are four basic options available to states: benchmark coverage, benchmark-equivalent coverage, the preexisting state-based program in New York, Florida or Pennsylvania, or any other coverage package which is approved by CMS (formerly HCFA) as “appropriate.” Benchmark coverage must be equivalent to the coverage available to federal employees, state employees, or members of the largest commercial, non-Medicaid health maintenance organization in the state.

Benchmark-equivalent coverage must be the “actuarial equivalent” of one of the benchmark packages. They must include, at a minimum, the following categories of services:

- Inpatient and outpatient hospital services
- Physicians' surgical and medical services
- Laboratory and x-ray services
- Well-baby and well-child care, including age-appropriate immunizations

The state must also include the following optional services, if the benchmark package used by the state to determine “actuarial equivalence” includes them:

- Coverage of prescription drugs
- Mental health services
- Vision services
- Hearing services

States are free to provide coverage for benefits that are not listed in either of these categories. In fact, the scope of permissive services is extremely comprehensive. Covered services may include the following:
• Inpatient hospital services
• Outpatient hospital services
• Physician services
• Surgical services
• Clinic services (including health center services) and other ambulatory health care services
• Prescription drugs and biologics and the administration of such drugs and biologics, only if such drugs and biologics are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person
• Over-the-counter medications
• Laboratory and radiological services
• Prenatal care and pre-pregnancy family planning services and supplies
• Inpatient mental health services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structured services
• Outpatient mental health services, including services furnished in a state-operated mental hospital and including community-based services
• Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)
• Disposable medical supplies
• Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home)
• Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting
• Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest
• Dental services
• Inpatient substance abuse treatment services and residential substance abuse treatment services
• Outpatient substance abuse treatment services
• Case management services
• Care coordination services
• Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
• Hospice care
• Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by state law and only if the service is:
a. prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by state law,
b. performed under the general supervision or at the direction of a physician, or
c. furnished by a health care facility that is operated by a state or local government or is licensed under state law and operating within the scope of the license.

- Premiums for private health care insurance coverage
- Medical transportation
- Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals
- Any other health care services or items specified by the Secretary of HHS and not otherwise excluded

**Cost Sharing**

States are permitted to impose cost sharing charges, including premiums, deductibles and coinsurance, but the schedule for any of these charges must be made public. Any cost-sharing income received by the state will reduce the state’s appropriation under the program. Furthermore, any cost-sharing requirements must not favor children of higher income families over lower income families. No cost-sharing may be imposed for the preventive services of well-baby and well-child care, and age-appropriate immunizations. Finally, if the state is operating a Medicaid expansion program, the Medicaid rules for any cost sharing will apply.

There are additional limitations on the use of cost sharing based on the income of the family. For families above 150 percent of the federal poverty level, cost-sharing requirements may be imposed on a sliding scale, based on income, but the total amount of cost sharing cannot exceed five percent of the family’s income per year. For families below 150 percent of the federal poverty level, cost-sharing charges are limited to the Medicaid levels for non-categorically eligible individuals.

**Conclusion**

Although states are given a broad degree of discretion in implementing SCHIP, its basic purpose and scope of coverage make it an important program to extend health insurance coverage to low-income children who are not otherwise eligible for Medicaid. For those parents with disabilities contemplating a return to work, the SCHIP in your state may ensure that health insurance will be available to those children.