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.

**Eligibility for Medicaid: In General**
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.
Medicaid Resources on the Internet

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

Introduction to State Child Health Insurance Program

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.
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. 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.”
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.