Screening for Medicaid and State Children's Health Insurance Program (SCHIP) Eligibility

Introduction

Under federal law and regulations, states are required to provide Medicaid to some groups of people, and they have the option to provide coverage to other groups of people. Generally, coverage is available to low-income seniors, adults with disabilities, children, and parents of dependent children. Each person or family must meet income and resource (also called asset) tests, which vary from state to state. The income and resource tests also differ for each group of people: In most states, for example, income guidelines for children are more generous than income guidelines for their parents. States also have options about the coverage they offer children under the federally created State Children's Health Insurance Program (SCHIP).

States submit Medicaid plans and SCHIP plans to the Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. These plans show what options they have taken under federal rules regarding eligibility and benefits. Some states have received "waivers" from the federal government, allowing them to depart from federal eligibility rules in order to extend coverage to some people, such as non-disabled adults without children. Waiver documents show the agreements that CMS and a state have reached regarding coverage rules for the population under a waiver. The screening questions listed below are intended as a reference to help you determine whether someone may qualify for Medicaid or SCHIP coverage. Information about where to find federal and state-specific information is included in each question. You can also use the screening questions and the reference material about your state to create a state-specific screening tool.

The Health Assistance Partnership provides support to the approximately 1,300 consumer health assistance programs across the country. The Health Assistance Partnership's mission is to help these programs to serve and educate health care consumers and to advocate for consumers' health care rights. These programs provide services to individuals and families whether they are privately insured, publicly insured, or uninsured.

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Background

Where to get state-by-state information and federal documents about Medicaid and SCHIP eligibility

You can get a very rough idea of whether a person is eligible for Medicaid or SCHIP by comparing the person's income to the state thresholds listed on Kaiser Family Foundation's State Health Facts Online (http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi) (click on Medicaid and SCHIP). If the person's income is below the threshold listed, the person is probably eligible for Medicaid and/or SCHIP. Even some people whose incomes are above the thresholds will be eligible because federal rules require states to disregard certain types of income (as discussed further throughout this paper). States also have wide latitude to further liberalize their methods for counting income and resources for many groups of people, effectively raising the Medicaid income and resource guidelines. The links to sources in the box on page 3 provide further information about Medicaid and SCHIP eligibility.

Medicaid's relationship to other federal public benefit programs

A few historical notes may help newcomers to Medicaid policy better understand eligibility rules.

At one time, Medicaid eligibility for families with children was linked to families' eligibility for welfare benefits under the AFDC program (Aid to Families with Dependent Children.) The AFDC program no longer exists—Temporary Assistance to Needy Families (TANF) replaced it in 1996. Since 1996, Medicaid has not been linked to welfare, but many states still base their Medicaid eligibility guidelines for parents on the AFDC guidelines that existed in 1996.

For seniors (that is, people age 65 and over) and for people with disabilities, Medicaid eligibility is related to eligibility for Supplemental Security Income (SSI), a federal

program. Most states determine whether a person meets the criteria for disability with the Medicaid program according to the standards used by the SSI program, and most states adopt the income and resource disregards used by the SSI program. This paper briefly describes those standards and disregards, but for more information about what is considered a disability or how income and resources are counted for seniors and people with disabilities, you should consult an SSI expert in a legal services program or in the Social Security Administration.

Links for information about Medicaid and SCHIP eligibility

- Kaiser Family Foundation, *State Health Facts Online*, available online at (http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi).

- State Medicaid Plans – Contact your state Medicaid agency or the regional office of CMS for the most up-to-date copy of your state's Medical Assistance Plan. Contact information for Medicaid agencies is on http://www.nasmd.org/about/NASMD_Member_List.rtf and on http://www.cms.hhs.gov/apps/contacts/ (select "contacts whose organization is state medical assistance office"). Contact information for CMS regional offices is on http://www.cms.hhs.gov/RegionalOffices/01_Overview.asp

- State SCHIP Plans –The State Children's Health Insurance Program (SCHIP) provides block grants to states to provide health insurance for children. States may use the grants to expand Medicaid eligibility for children (and in some cases, their parents), to establish separate children's health plans to cover children with incomes over the Medicaid limits, or to create a combination of Medicaid and separate SCHIP plans. For more information see http://www.cms.hhs.gov/LowCostHealthInsFamChild/ and click on "SCHIP approved state plan information."

- The federal Medicaid law is Title XIX of the Social Security Act. It is online at http://www.ssa.gov/OP_Home/ssact/title19/1900.htm.

- Federal Medicaid regulations are in the Code of Federal Regulations, 42 CFR § 430 et seq. They can be retrieved from (http://www.gpoaccess.gov/cfr/retrieve.html) or (http://www.law.cornell.edu/cfr/).

- Summaries of approved Medicaid waivers and copies of some waiver documents are at (http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp#TopOfPage).

- The National Health Law Program's *An Advocate's Guide to the Medicaid Program* (National Health Law Program, Los Angeles, CA, 2001) can be purchased by calling 310-204-6010 or visiting (http://www.healthlaw.org).

- The National Council on the Aging provides a computerized screening tool regarding seniors' eligibility for Medicaid and other benefits at (http://www.benefitscheckup.org/).

- The Social Security Administration's Web site (http://www.ssa.gov) includes information to help consumers determine whether they qualify for SSI benefits as well as information for attorneys and other representatives about program rules. In most states, all SSI beneficiaries are eligible for Medicaid.

Medicaid/SCHIP Screening Questions: Children and Families

1. Is the person pregnant?

States must offer Medicaid coverage for pregnancy-related services, including prenatal care and delivery and postpartum care, to women with incomes up to 133 percent of the poverty level (Social Security Act § 1902(a)(10) and 1902 (l)). States can set the income limit for pregnant women at up to 185 percent of the poverty level under their state Medicaid plans, and many states do this. In some states, waivers or greater income disregards allow women to be eligible at even higher income levels. Once she establishes Medicaid eligibility, a pregnant woman remains eligible for pregnancy-related services under Medicaid for 60 days postpartum, even if her income increases (42 CFR § 435.170). The Kaiser Family Foundation's State Health Facts Online at (http://www.statehealthfacts.org) provides some information about the income guidelines used by each state. To get more detail for a particular state, check with the state's Medicaid agency. The information will be in the state's medical assistance plan in Attachment 2.6A, Supplements 1 and 8a. Though states can establish more generous income deductions in determining a pregnant woman's eligibility, at a minimum, states must use the income deductions that were used by the AFDC program.

Even though the coverage that pregnant women receive when they qualify for Medicaid under the method described above is limited to "pregnancy-related services" (42 CFR 440.210 (a)(3)), states can consider most health care for a pregnant woman as "pregnancy-related" and thus provide pregnant women the Medicaid coverage that they need. States are required to provide *full* Medicaid coverage—not just coverage of pregnancy-related services—to pregnant women who meet a lower income standard based on the state's 1996 AFDC cash assistance levels (see question 9). For the purposes of determining the family size of a pregnant woman, the fetus counts as a family member—that is, a single pregnant woman with no children would qualify for Medicaid if her income was below her state's 1996 AFDC standard for a two-person family (42 CFR § 435.116 and Social Security Act §1905(n)).

At a minimum, states must allow pregnant women to keep the amount of resources allowed in the SSI program ($2,000 for an individual and $3,000 for a couple in 2007; some resources, such as the person's residence, are not counted).. States can establish a more

liberal resource test or elect not to use a resource test at all. For precise information on income and resource limits in each state, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf

Note: The Social Security Administration published a final rule in the February 7, 2005 Federal Register which changes the way resources are counted for determining Social Security Income (SSI) eligibility. Under the new rules, clothing, household goods, personal effects, and one automobile are no longer counted as resources-no matter what their dollar value-in determining SSI eligibility. (Previously, an automobile was excluded from resources only if it was used to get to employment or medical appointments or was specially equipped for a person with disabilities. Now one automobile is excluded if it is used for transportation for the individual or a member of the individual's household.)

In some states, a pregnant woman can be presumptively eligible for Medicaid, getting immediate coverage for ambulatory care when "qualified" health care providers (usually providers in hospital or community clinics) determine that she meets Medicaid income levels. She must complete a Medicaid application by the next month in order to retain coverage (Social Security Act §1902(a)(47)). Some women are not eligible for full Medicaid coverage or coverage of all pregnancy-related services due to immigration status or less than five years' U.S. residency. If an immigrant woman meets other Medicaid requirements, she is still eligible for Medicaid coverage of labor and delivery. (See question 14 for more information about immigrants.)

States can also use SCHIP funds to cover prenatal services for some women. Some states use their SCHIP funds to expand Medicaid programs, some have established separate SCHIP programs, and some have established a combination. See the state SCHIP plan (http://www.cms.gov/schip/chpa-map.asp) to determine how SCHIP funds are used in a particular state.

A pregnant woman may receive SCHIP coverage of prenatal services in two ways: (1) the woman qualifies for SCHIP because she is under age 19 and meets the SCHIP eligibility guidelines in her state, or (2) the fetus qualifies for SCHIP (even if the mother does not) because the state has elected to consider fetuses as "children" in the SCHIP program and the "unborn child" meets SCHIP eligibility requirements. (See 42 CFR §457.10).

If a pregnant woman does not meet any of these eligibility categories, check questions 9-18 and 22-26.

2. Is the person under age one?

Infants born to mothers with Medicaid coverage remain eligible for Medicaid for one year as long as they remain in the mother's household and the mother's income and resources stay below the limits for pregnant women (see question 1 and 42 CFR § 435.117 and Social Security Act §1902(e)(4)). See the Kaiser Family Foundation State Health Facts Online (http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi) or visit the state Medicaid agency's Web site for a general idea of income limits applying to infants, and see each state's Medicaid plans, Attachment 2.6A, Supplement 1 (available through the state's Medicaid agency). Supplement 2 lists resource limits.

Infants not eligible for Medicaid may be eligible for separate SCHIP programs. See the state SCHIP approved state plan, available from the state or on CMS's website at (http://www.cms.hhs.gov/LowCostHealthInsFamChild/) to determine how SCHIP funds are used in a particular state and the Kaiser Family Foundation State Health Facts Online at (http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi).

If the infant is not qualified under this method, check questions 6-9,11-15, and 26.

3. Is the person under age six?

Children in this age group are eligible in every state if their family income does not exceed 133 percent of the poverty level and they meet state resource requirements (Social Security Act §1902(a)(10) A and §1902(l)(1)). States can set higher income limits and/or liberally disregard income, effectively raising the income guidelines for children. The Kaiser Family Foundation *State Health Facts Online* at (http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi) provides a general idea of income limits applying to children in this age group. For more precise information on income and resource limits in each state, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf. States can decide whether to use a family resource test for children under age six, but that test can be no more restrictive than that used by the AFDC program in 1996 ($1,000 in countable resources per family (42 CFR § 435.116(c)). As of this writing, only Alabama, New York, Tennessee, and Utah use resource tests for children in Medicaid.

States can use their SCHIP funds to expand Medicaid for uninsured children at higher incomes or to establish separate health programs that may provide limited benefits to somewhat higher-income children or for a combination of Medicaid and separate health plans (Social Security Act § 2101 et seq.). (The federal government matches state SCHIP expenditures at a higher rate than regular Medicaid expenditures.) The states' SCHIP plans, available from the state or on CMS's website at (http://www.cms.hhs.gov/LowCostHealthInsFamChild/) and the Kaiser Family Foundation State Health Facts Online at (http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi) provide information about income and resource requirements.

If a child under age six is not eligible by this method, check questions 6-9, 11-15, and 26.

4. Is the person at least age 6 but under age 19?

States must cover children in this age group whose family income is up to 100 percent of the federal poverty level (Social Security Act § 1902(l)). States can set higher income limits or use liberal methods for disregarding income to extend eligibility. (See the Kaiser Family Foundation State Health Facts Online at (http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi) for a general idea of income limits applying to children in this age group. For specific information about state plans, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf. States can decide whether to use a family resource test for children ages 6 to 19, but the test can be no more restrictive than the test used by the AFDC program in 1996 ($1,000 in countable resources per family). As of this writing, only Alabama, New York, Tennessee, and Utah use resource tests for children in Medicaid.

States can use their SCHIP funds either to expand Medicaid for uninsured children at higher income or establish separate health programs that may provide fewer benefits to these somewhat higher-income children (Social Security Act § 2101 et seq.). The states' SCHIP plans, available from the state or on CMS's website at (http://www.cms.hhs.gov/LowCostHealthInsFamChild/) and the Kaiser Family Foundation State Health Facts Online at (http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi) provide information about income and resource requirements.

If the person is not qualified under this method, check questions 6-9, 11-15, and 26.

5. Is the person age 19 or 20?

States can decide whether to offer coverage to 19- and 20-year-olds (Social Security Act § 1905(a)(9); 42 CFR § 435.201(a)(4) and 42 CFR § 435.222). They can also opt to limit coverage of 19- and 20-year-olds to those who are fulltime students in secondary school or in vocational or technical training programs. Similarly, they can limit coverage of 19- and 20-year-olds to those who live in foster care, who have been adopted, or who are in nursing facilities or psychiatric institutions. For specific information about state plans, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf.

Children who are not eligible for full Medicaid may be eligible for separate SCHIP programs. The states' SCHIP plans, available from the state or on CMS's website at (http://www.cms.hhs.gov/LowCostHealthInsFamChild/) and the Kaiser Family Foundation State Health Facts Online at (http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi) provide information about income and resource requirements.

If the person is not qualified under this method, check questions 9-10, 17, and 23-26.

6. Is the person a child in foster care or an adopted child?

Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act are eligible for Medicaid. Children under state adoption agreements, rather than federal adoption agreements, may be eligible for Medicaid at state option and under some conditions. States must cover foster children under age 18, and states can opt to cover foster children until their 21st birthday (42 CFR § 435.145 and 42 CFR § 435.227 and Social Security Act § 473(b)(3)).

7. Is the person a child with a disability?

In most states, children who receive SSI due to a disability are automatically eligible for Medicaid (42 CFR § 435.120). Eleven states, known as 209(b) states, are permitted to use more restrictive definitions of disability for their Medicaid program than are used in the SSI program (42 CFR § 435.121). The 209(b) states are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. For specific information about state plans, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available online at http://www.nasmd.org/about/NASMD_Member_List.rtf.

When children who once received SSI lose their SSI benefits because the Social Security Administration no longer considers them disabled, states must determine whether the children are still eligible for Medicaid under a different category of coverage. Children who lost SSI benefits in 1996 or 1997 due to a change in the SSI disability definition retain Medicaid eligibility as long as they continue to meet other program requirements.

Beginning in 2007, states can expand Medicaid coverage to children who meet the Social Security Administration's disability standards and whose families earn up to 300 percent of poverty ($61, 950 for a for a family of four in 2007). The state may require these families to pay sliding-scale premiums. However, families with incomes below 200 percent of poverty will not have to pay more than 5 percent of their incomes for premiums and cost-sharing. Families with incomes between 200 and 300 percent of poverty will not have to pay more than 7.5 percent of their incomes for premiums and cost-sharing. The law notes that states can also cover children whose families earn more than 300 percent of poverty using state funds, but federal matching funds are not available. States can phase-in children by age group and cover children up to age 6 in 2007, children up to age 12 in 2008, and children through age 19 in 2009. (The Family Opportunity Act and the Deficit Reduction Act established this option by amending Social Security Act §§1902 (a) (10) (A) (ii) (XIX) and sub-section (cc)). For more information about the Family Opportunity Act, please see the Kaiser Commission's report on changes to long-term care under the Deficit Reduction Act, available online at (http://www.kff.org/medicaid/upload/7486.pdf).

If the child is not qualified under this method, check questions 2-6, 8, 11-15, and 26.

8. Is the person a child with a disability so severe that he or she could be admitted to a medical institution?

When a child resides in an institution for more than 30 days, the income and resources of the child's parents are no longer counted in determining the Medicaid eligibility of the child. Therefore, children who are institutionalized for more than a month will generally qualify for Medicaid.

States can opt to cover children age 18 or younger at home if those children have disabilities that require the level of care provided in hospitals, nursing facilities, or facilities for people with mental retardation provided the child would otherwise qualify for care in an institution (42 CFR § 435.225 and Social Security Act § 1902 (e)(3)). Called the TEFRA (Tax Equity and Fiscal Responsibility Act) or "Katie Beckett" option, children with significant medical expenses get Medicaid coverage for home and community-based care, regardless of their family's income. A child must meet the disability definitions of either the SSI or Social Security Disability Income (SSDI) programs and be cared for at home. The cost of care in the community must not be more than the estimated cost of the institutional care, and the child must not have income or resources in his or her own name that exceed the state's financial eligibility standard for a child living in an institution. In 2002, the following states used the TEFRA option:

Alaska, Arkansas, Connecticut, Delaware, Georgia, Idaho, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New, Hampshire, Rhode Island, South Carolina, South Dakota, Vermont, West Virginia, and Wisconsin. (For more information, see *Avoiding Cruel Choices*, Bazelon Center for Mental Health Law, Washington, DC, November 2002, at (http://www.bazelon.org/issues/children/publications/TEFRA/index.htm).)

States can also use home and community-based care waivers to provide coverage for care at home for children who would otherwise need institutionalization. Under waivers established under either Sections 1115 or 1915c of the Social Security Act, states can provide coverage for a wide array of home and community-based services, not just those normally covered by the Medicaid program. States can limit the number of children they serve under the waivers or set other eligibility limits. States must show that the aggregate

cost of home and community-based care for children served under the waiver will not exceed the cost of institutional care that would otherwise be paid by Medicaid. See the "Medicaid waivers and demonstrations list" on http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/ for listings of states that have applied for or been granted 1915c home and community based care waivers or broader waivers.

9. Is the person a parent of a dependent child or a child not eligible under any of the previous questions?

States, at a minimum, provide Medicaid coverage to parents who meet the income and resource standards used for AFDC cash assistance in 1996.[1] (These standards are sometimes called the "pre-welfare reform criteria.") The AFDC-related Medicaid income guidelines, which are now the floor for Medicaid coverage for parents, vary by state but are generally stingy. States can establish more generous guidelines for parents as a result of a law that went into effect in 1996 (the Personal Responsibility and Work Opportunity Reconciliation Act), which "de-linked" Medicaid and welfare eligibility. This law established a new category of Medicaid eligibility for low-income families, Section 1931 of the Social Security Act. (In practice, Section 1931 guidelines mostly affect parents. Usually, the poverty-related income guidelines for children, discussed in questions 2-4, will be more generous than family income guidelines in a state under Section 1931, but children *can* qualify for Medicaid under the Section 1931 category.)

In 1996, the AFDC program was replaced by TANF, a block-grant program that allows states to provide time-limited cash assistance to families. *TANF and Medicaid are not linked, and Medicaid is not a time-limited benefit*. TANF recipients will generally qualify for Medicaid, and families can often file a single application for TANF and Medicaid. When TANF eligibility ends, however, Medicaid eligibility does not necessarily end.

Some of the ways that TANF and Medicaid rules differ are in their treatment of working two-parent families, time limits on benefits, and the consequences of failure to meet a work requirement or help the state to establish paternity. The Medicaid rules are as follows:

- For two-parent working families, states *must* allow Medicaid coverage if parents work less than 100 hours or work temporarily or only intermittently. States can decide whether to cover adults in two-parent families if both parents work more than 100 hours per month. Children cannot be excluded from Medicaid coverage due to their parents' employment status.

- People can continue to receive Medicaid benefits as long as they continue to meet eligibility requirements and "re-certify" their eligibility for benefits. Medicaid is not a time-limited benefit.

- If a person loses TANF for failure to meet a work requirement, states can deny *that individual* Medicaid (unless that individual is pregnant) but cannot deny Medicaid to minors who are not the head of the household or to infants.
- If a parent refuses to help the state establish paternity, the parent can be denied Medicaid, but the child or children remain eligible for Medicaid.

Federal rules or less restrictive state rules govern what family income to count and what family income to disregard in establishing Medicaid eligibility (see box on page 20). The income and resources of spouses living together and the incomes of parents living with children under age 21 are counted together in establishing Medicaid eligibility.

Incomes of other relatives living in the house are not counted (42 CFR §§ 435.113 and 435.602).

Under Section 1931, by disregarding certain amounts or types of income and resources, states can liberalize their income and resource limits for parents and children. For example, a state might disregard all income below a certain threshold in order to make families with incomes up to 200 percent of the poverty level eligible for Medicaid. For more information on this option, see http://www.familiesusa.org/resources/tools-for-advocates/kits/health-action-2007-tool-kit-2.html.

For a rough idea of the income guidelines applying to parents in each state, see http://www.familiesusa.org/assets/pdfs/disparities_in_eligibilitye4a1.pdf. For specific information about state plans, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf.

If the person is not qualified under this method, check questions 1, 11-18, and 22-26. When a family's income increases above the Medicaid income limits, the family may be entitled to Transitional Medical Assistance, which is described in question 11.

[1] Federal law allows states to keep the 1996 guidelines as the basis for family Medicaid eligibility; to raise the 1996 guidelines by the cost of living, instead using more liberal guidelines; or to roll back the 1996 guidelines to those they used for AFDC in 1988. Fortunately, as of this writing, no state has rolled back the guidelines below 1996 levels.

10. Is the person a relative caring for a dependent child?

When relatives assume the responsibility for a dependent child, they can elect to apply for Medicaid as part of the child's family. They can qualify for Medicaid by meeting the same income and resource standards that would apply to a parent (see question 9 and 42 CFR § 435.113 and Social Security Act § 1902(a)(17)). If such a caretaker is also aged, blind, or disabled, he or she might qualify for Medicaid under higher income standards. In this case, the caretaker can elect to have his or her Medicaid eligibility determined independently of the child's eligibility. See questions 17-26.

11. Has the person's family income recently increased?

Families with dependent children may be eligible for Transitional Medical Assistance (TMA) when their earnings increase (Social Security Act § 1925(a) and (b)). If they received Medicaid for three of the six months previous to their increased earnings, they are eligible for Medicaid for another six months, regardless of their new incomes. They are entitled to an additional six months of Medicaid if their income (with child care expenses deducted) is less than 185 percent of the poverty level. Some states have extended TMA benefits beyond 12 months.

The federal law that establishes TMA has been scheduled to sunset several times in the past few years, and then been extended by Congress. If you have questions concerning the current status of TMA and "continued" Medicaid coverage, please contact Families USA at info@familiesusa.org

Note: If a state rolls back its Medicaid income eligibility limits for working families, families who are then ineligible due to their earnings may receive TMA. A lawsuit in Missouri, White v. Martin, No. 02-4154-CV-C-NKL (W.D. Mo. Oct. 3, 2002), established the right to TMA when that state rolled back eligibility limits. Similar litigation is underway in other states.

Families are also eligible for four months of continued Medicaid coverage when an increase in child support or spousal support puts their income over the Medicaid income thresholds (42 CFR § 435.115).

States may allow people in Medicaid managed care plans or Primary Care Case Management (PCCM) plans to retain Medicaid coverage through those plans for six months, regardless of changes in income (42 CFR § 435.112 and Social Security Act § 1902(e)(2)).

Income not counted for families with children in determining Medicaid eligibility under Section 1931 of the Social Security Act

Do not count income that the state did not count in determining AFDC eligibility for families in July of 1996. This included:

- The first $90 of monthly earned income.
- Up to $200 for child care expenses for a child under age two or up to $175 for an older child; up to $175 for care of an incapacitated household member.
- $50 of child support per family.
- Earned income tax credits.
- The earned income of a dependent child who is a member of a family receiving Medicaid if the child is a student working only part-time.

In determining the family's continuing eligibility for Medicaid, $30 plus one-third of the remainder of their earned income not already disregarded is deducted for four months, and $30 is deducted for an additional eight months. In addition, families are entitled to additional months of Medicaid (called Transitional Medical Assistance) when their earnings increase above the state's Medicaid income guidelines. These provisions apply to families receiving Medicaid under Section 1931 of the Social Security Act (see question 9 in this paper). Children who receive Medicaid because their incomes are less than the poverty level or 133 percent of the poverty level do not necessarily use these deductions.

States can opt to deduct child care expenses actually paid by the state from a family's earned income and/or to adopt additional disregards or deductions.

For more information, see 42 CFR § 435.601 and 42 CFR § 233.20.

Medicaid/SCHIP Screening Questions: High Medical Expenses

12. Does the person or family have significant medical expenses?

Many states allow people to "spend down" their incomes to a state-established income level by paying or incurring medical and remedial expenses to offset income in excess of the state level (42 CFR § 435.301-42 CFR § 435.350 and Social Security Act § 1902(a)(10)(c)). The costs of prescription drugs and home care are among the expenses that can be applied to a spend-down. Once people document that they have reached the state's "medically needy income level," Medicaid will pay their remaining and continuing medical expenses (but not the expenses incurred to meet the spend-down) until the end of a certification period (42 CFR § 435.831).[1] At the end of the certification period, people must again show how much their income exceeds the state's threshold and again document that they have paid or incurred medical and remedial expenses to meet the spend-down. People who have unpaid bills larger than their spend-down amount but too old to be retroactively paid by the Medicaid program (that is, bills over three months old—see question 13) may apply parts of the bills to several successive spend-down periods.

States can take a different approach to assisting people with incomes slightly higher than the Medicaid income thresholds: They can allow people to pay monthly premiums to the state equaling the difference between the family's income and the medically needy income levels to qualify for Medicaid.

Medically needy levels in many states are very low—sometimes lower than SSI limits. Under rules that became effective in 2001, states can raise those medically needy levels. For more information, see Families USA, "Could Your State Do More to Expand Medicaid for Seniors and Adults with Disabilities," November 2001, (http://www.familiesusa.org/assets/pdfs/ExpandingMedicaid93a7.pdf) and 42 CFR § 435.1007.

States that do provide medically needy coverage must offer such coverage to pregnant women and children under age 18. They can choose whether to cover any or all of the following groups in their medically needy programs: children ages18 through 20; parents and caretaker relatives; people over age 65; adults who are blind or disabled; people in managed care. States specify their medically needy income levels in their state Medicaid plans. States specify their medically needy income levels in their state Medicaid plans. For specific information about state plans, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf. . They specify their certification period for the medically needy (sometimes referred to as a "budget period") in Attachment 2.6-A 4.

[1] Medical and remedial expenses outside the state's Medicaid benefit package can apply to spend-downs. For example, if a state Medicaid program does not cover personal care services, the person's out-of-pocket expenses for personal care can still be used to meet a spend-down. Though these expenses will still not be covered when the person establishes Medicaid eligibility, the person will receive other Medicaid benefits.

13. Does the person or family have unpaid medical bills for services or treatment received within the last three months?

An individual or family can get retroactive coverage for a medical service received three months prior to the date of their Medicaid application if they would have been eligible for Medicaid had they applied then. States can elect to make coverage retroactive to the first day of the third month prior to application (Social Security Act § 1902(a)(34) and 42 CFR § 435.914). For example, if a person applies for Medicaid on July 15 and is found eligible, the state must provide coverage retroactive to April 15 (three months prior to the date of application), and some states elect to make coverage retroactive to April 1 (the first day of the third month prior to application).

Medicaid/SCHIP Screening Questions: Special Situations

14. Is the person an immigrant?

Generally, immigrants are divided into two groups: A) "qualified aliens" and B) "nonqualified aliens."

A) Qualified aliens include lawful permanent residents, refugees, and asylees; some people who have had their deportation withheld; some people granted parole; some people granted conditional entry; and battered spouses. Among these qualified aliens, some are immediately eligible for full Medicaid benefits, provided they meet other program requirements; others are subject to a five-year waiting period after they enter the country before they can qualify for full Medicaid benefits (42 CFR §§ 435.406 and 435.408 and Social Security Act § 1903(v)):

- If they meet other program requirements, veterans or people on active duty in the U.S. Armed Services and their dependents; refugees; asylees; Cuban, Haitian, and Amerasian entrants; lawful permanent residents with 40 work quarters of Social Security coverage; and Canadian-born immigrants with at least 50 percent North American Native heritage are immediately eligible for Medicaid coverage.

§ Other qualified aliens who entered the country prior to August 1996 are eligible for full Medicaid if they meet the other eligibility standards for the Medicaid program. Those who entered after August 1996 are eligible for Medicaid coverage of emergency services (including labor and delivery) during their first five years in this country (42 CFR § 435.139 and Social Security Act § 1903(v)) but are banned from getting full Medicaid benefits for a period of five years. A number of states, however, use state-only funds to provide coverage for those banned from the federal program. See the National Immigration Law Center's "Resource Manual: Low-Income Immigrant Rights Conference" online at http://www.nilc.org/immspbs/special/pb_issues_ovrvw_042005.pdf) and table of immigrant eligibility guidelines at http://www.nilc.org/pubs/guideupdates/tbl1_ovrvw_fed_pgms_032505.pdf. These resources provide an overview of federal benefits available to immigrants. A list of state-funded programs (updated between 2005 and 2007) is available at http://www.nilc.org/pubs/Guide_update.htm.

B) Nonqualified aliens include those visiting the country for a temporary period, people who have been granted temporary protected status, people with pending applications for status, undocumented immigrants, and some people allowed to stay in the United States for humanitarian reasons. These aliens are eligible only for Medicaid coverage of emergency treatment if they meet other Medicaid guidelines.

Immigrants may be afraid to apply for Medicaid because they are under the impression that they will be considered "public charges" and that this will adversely affect their application for U.S. citizenship. This is not correct, and the U.S. Citizenship and Immigration Service has issued specific guidance about this. The U.S. Citizenship and Immigration Services has replaced the Immigration and Naturalization Service (INS). See: http://www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextoid=c215c9f3743ff010VgnVCM1000000ecd190aRCRD&vgnextchannel=4f719c7755cb9010VgnVCM10000045f3d6a1RCRD. Another problem that may concern immigrants is how their Medicaid application will affect their sponsors. While sponsors sign a legally binding document promising to be financially responsible for an immigrant, there is as yet no federal guidance about how or whether the cost of most Medicaid benefits will be collected from the sponsor. See National Immigration Law Center (http://www.nilc.org) for updates. Sponsors are *not* liable for emergency Medicaid services. In some situations, only some members of an immigrant family will be eligible for Medicaid. Immigrants applying for Medicaid are not required to list the social security numbers of family members who are not applying for Medicaid.

For more information, see Families USA, *Immigrants' Eligibility for Medicaid and CHIP*, February 2001, available online at http://www.familiesusa.org/assets/pdfs/immigrantsb676.pdf.

15. Is the person homeless, or has the person recently moved into the state?

States cannot exclude people from Medicaid based on their having a fixed address or the length of time they have lived in a state. State residency means that a person is physically present in the state and intends to remain indefinitely. Emancipated minors can declare their own state of residency. For other minor children and for people unable to form or express their intent (such as adults with diminished cognitive capacity), caretaker relatives or guardians or other substitute decision-makers described in the federal Medicaid regulations may establish the intent of the person to reside in the state. When one state arranges to place a person in an out-of-state institution, the state that arranged the placement is considered the state of residence and is responsible for Medicaid payments (42 CFR § 435.403).

16. Did the person leave a job that offered COBRA benefits?

People who have group health insurance through an employer with 20 or more workers may be eligible for continued health insurance through that employer when they leave the job. If the person's income is under the poverty level and his or her resources are less than twice the SSI resource thresholds, states can elect to pay for the continued cost of the COBRA premiums (Social Security Act §§ 1902(u)(1) and 1905(a)(x)).

Medicaid/SCHIP Screening Questions:
People over age 65 and people with disabilities

17. Is the person an adult with a disability, or is the person blind?

In most states, people who meet the disability and blindness definitions used in the SSI program are eligible for Medicaid if they meet the state's income and resource tests (42 CFR §§ 435.120 and 435.530-435.541 and Social Security Act § 1902(a)(10)). A few states that had more restrictive definitions of disability or blindness when the SSI program first began have been permitted to retain these restrictions.

Under the SSI disability rules, an adult must have a severe "medically determinable physical or mental impairment" that renders the person unable to engage in any "substantial gainful activity." In 2007, substantial gainful activity was defined as a job that pays more than $900 per month (after any impairment-related work expenses and employment subsidies) for a person with disabilities and $1500 for a statutorily blind individual (See http://www.ssa.gov/OACT/COLA/SGA.html). This substantial gainful activity test is lifted after the person initially qualifies for Medicaid. See question 18.

States generally accept the Social Security Administration's decisions about whether someone is disabled, but if Social Security fails to act within 90 days of receipt of an application or if a person is applying for Medicaid but not SSI, the state must make its own disability determination. The Social Security Administration's Web site (http://www.ssa.gov) includes program manuals and other information about disability determinations.

In 39 states, everyone receiving SSI (and a state supplemental payment in states that supplement SSI benefits) is eligible for full Medicaid coverage (Social Security Act § 1902(a)(10) and 42 CFR § 435.232). In many of these states, SSI beneficiaries automatically receive Medicaid and do not have to complete a separate Medicaid application. For specific information about state plans, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf

In 11 states (called 209(b) states), SSI eligibility does not guarantee Medicaid eligibility. These states use more restrictive eligibility criteria for Medicaid: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. For specific information about state eligibility guidelines and restrictions, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf.

States have additional options for extending Medicaid to people over age 65 and to people with disabilities whose incomes are above SSI levels. Many states provide coverage to people 65 or older or to people with disabilities whose incomes are up to 100 percent of the poverty level or a higher income cap. Federal rules allow states to offer coverage up to 100 percent of the poverty level and then to disregard some income so that people with a higher income level will qualify. Both states that provide Medicaid to all SSI beneficiaries and 209(b) states can offer this coverage option. States can also liberalize resource limits for seniors and people with disabilities. (Except in 209(b) states, under federal law, the minimum resource limits for seniors and people with disabilities are $2,000 for an individual and $3,000 for a couple, but states can raise these resource limits. The Social Security Administration published a final rule in the February 7, 2005 Federal Register which changes the way resources are counted for determining Social Security Income (SSI) eligibility. Under the new rules, clothing, household goods, personal effects, and one automobile are no longer counted as resources-no matter what their dollar value-in determining SSI eligibility. (Previously, an automobile was excluded from resources only if it was used to get to employment or medical appointments or was specially equipped for a person with disabilities. Now one automobile is excluded if it is used for transportation for the individual or a member of the individual's household.) Some states have more liberal ways of counting income and resources. For specific information about state plans, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf.

If the person is not qualified under these methods, check questions 12-13, 18, and 20-26.

18. Is the person working despite disability or blindness?

People with disabilities who have significant medical expenses may also qualify for Medicaid as medically needy (see questions 12-13.) As mentioned in question 17, usually, to be considered disabled, adults must be unable to engage in any substantial gainful activity. In 2007, to initially qualify for Medicaid, their jobs must pay less than $900 per month (after any impairment-related work expenses and employment subsidies) for a person with disabilities and less than $1450 for a statutorily blind individual (http://www.ssa.gov/OACT/COLA/SGA.html).

However, this substantial gainful activity test is lifted once a person begins working. If the person's earnings rise above the limit, the state must continue to provide Medicaid coverage until the person has sufficient earnings to provide a "reasonable equivalent" of the combination of SSI benefits, Medicaid benefits, and publicly funded attendant care services.

States have options under two different laws, the Balanced Budget Act and the Ticket to Work and Work Incentive Improvements Act (TWWIIA), to expand Medicaid coverage for working people with disabilities. Under the Balanced Budget Act of 1997, states can provide coverage to people who are working despite a significant disability and whose family incomes are up to 250 percent of the poverty level (Social Security Act § 1902(a)(10)(A) (XIII)). States can charge premiums to this group of people on a sliding-fee scale and can require them to make copayments. States can liberally disregard income and resources to raise the income limit beyond 250 percent of the poverty level and the resource limits beyond SSI resource limits. Under TWWIIA, states can set Medicaid income and resource standards as high as they wish for working people with disabilities and charge premiums based on income. States providing coverage under TWWIIA can also elect to continue Medicaid coverage for working people whose medical condition improves to the extent that they are no longer eligible for SSI or Social Security Disability Income (SSDI) (Social Security Act §§ 1902(a)(10)(XVI) and 1905(v)(1)). This provision is especially important, for example, for people with HIV whose conditions improve through the use of medications.

Some state-by-state information on these two options is available on the Center for Workers with Disabilities pages of the American Public Human Services Association website at http://cwd.aphsa.org/Home/home_news.asp. The Centers for Medicare and Medicaid

Services provides information at (http://www.cms.hhs.gov/TWWIA/). For more information about whether a state has taken these options, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf

Note: The Social Security Administration published a final rule in the February 7, 2005 Federal Register which changes the way resources are counted for determining Social Security Income (SSI) eligibility. Under the new rules, clothing, household goods, personal effects, and one automobile are no longer counted as resources-no matter what their dollar value-in determining SSI eligibility. (Previously, an automobile was excluded from resources only if it was used to get to employment or medical appointments or was specially equipped for a person with disabilities. Now one automobile is excluded if it is used for transportation for the individual or a member of the individual's household.)

19. Is the person at least age 65 and living in the community rather than in an institution?

To determine eligibility for Medicaid for seniors, states must look at the income and resources of spouses living in the same household. The finances of other relatives living in the home have no impact on Medicaid determination of these seniors.

In most states, everyone receiving SSI (and a state supplement in states that supplement SSI) is eligible for full Medicaid coverage. In many states, SSI beneficiaries automatically receive Medicaid and do not have to complete a separate Medicaid application. (See the states' Medicaid plans, Attachment 2.6A, Supplement 6, available online at http://www.cms.gov/medicaid/stateplans/.

In 11 states (called 209(b) states), SSI eligibility does not guarantee Medicaid eligibility. These states use more restrictive eligibility criteria for Medicaid: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. For specific information about state eligibility guidelines and restrictions, please visit the state Medicaid agency's Web site. You can find a list of state Medicaid agencies and their Web sites at http://www.nasmd.org/about/NASMD_Member_List.rtf.

States have options for extending Medicaid to elderly people whose incomes are above SSI levels. Many states provide coverage to people who are elderly or who have disabilities and whose incomes are up to 100 percent of the poverty level (or higher income caps). Federal rules allow states to offer coverage up to 100 percent of the poverty level and then to disregard some income so that people with a higher income level will qualify (Social Security Act §§1902(a)(10)(A)(ii)(X),1902(m), and 1902(r)(2); 42 CFR §§ 435.601 and 435.1007). States can also liberalize resource limits for seniors and people with disabilities. They must, at a minimum, cover individuals with resources up to $2,000 and couples with resources up to $3,000, assuming they meet income limits. Some states have more liberal ways of counting income and resources. For specific information about state plans, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available online at http://www.nasmd.org/about/NASMD_Member_List.rtf.

Note: The Social Security Administration published a final rule in the February 7, 2005, Federal Register that changes the way resources are counted for determining Supplemental Security Income (SSI) eligibility. Under the new rules, clothing, household goods, personal effects, and one automobile are no

longer counted as resources, no matter what their dollar value, in determining SSI eligibility. (Previously, an automobile was excluded from resources only if it was used to get to employment or medical appointments or was specially equipped for a person with disabilities. Now, one automobile is excluded if it is used for transportation for the individual or a member of the individual's household.)

Following the passage of the Deficit Reduction Act of 2005, some states have implemented long-term care partnership programs, which may allow seniors with higher incomes to take advantage of Medicaid. When seniors purchase an approved long-term care partnership insurance policy, they may become eligible for Medicaid once their private long-term care insurance benefits run out. This enables seniors to qualify for Medicaid without spending down all of their assets. The extent of asset protection depends on the value of the private insurance policy ((Social Security Act § 1917 (b) (C)). As of 2005, California, Connecticut, Indiana, and New York offered partnership policies. More information on long-term care partnership policies is available online at http://www.brookings.edu/views/papers/200412retirement.pdf, http://www.cms.hhs.gov/NewFreedomInitiative/downloads/LTC%20Roadmap%20to%20Reform.pdf, and http://www.aarp.org/research/longtermcare/insurance/fs124_ltc_06.html.

Seniors with significant medical expenses, including prescription drug expenses, may qualify as medically needy (see questions 12-13). If the person is not qualified under these methods, check questions 20-23 and 26.

20. Does the person receive Medicare?

Provided the federal resource requirements of less than $4,000 for an individual or $6,000 for a couple or the state's more liberal resource requirements are met:

- Medicare beneficiaries with incomes at or below the federal poverty level, known as Qualified Medicare Beneficiaries (QMBs), are entitled to have Medicaid pay their Medicare premiums, deductibles, and copayments.
- Medicare beneficiaries with incomes between 100 and 120 percent of the poverty level, known as Specified Low-Income Medicare Beneficiaries (SLMBs), are entitled to have Medicaid pay their Medicare Part B premiums only.
- Medicare beneficiaries with incomes between 120 percent and 135 percent of the federal poverty level, known as Qualified Individuals (QIs), are eligible through a federal block grant program to apply for payment of their Medicare Part B premiums.
- Working people with disabilities who receive Medicare and whose incomes after disregards are less than 200 percent of poverty level, known as Qualified Disabled Working Individuals (QDWIs), are entitled to full or partial payment of their Medicare Part A premiums. States can opt either to cover premiums in full or to charge QDWIs on a sliding-fee scale. (See Social Security Act §§ 1902(a)(10)(E),1905(p), 1905(s), and 1916(d).) Medicare beneficiaries with full Medicaid, QMB, SLMB, or QI benefits are also deemed eligible for "extra help" with the costs of Medicare Part D prescription drug coverage (technically called the "low-income subsidy"). They can enroll in Part D plans that do not charge them premiums, and should pay only nominal cost-sharing for covered drugs (in 2007, up to $3.10 for Medicaid beneficiaries with incomes below poverty and up to $5.35 for beneficiaries with incomes above poverty). See http://www.hapnetwork.org/assets/pdfs/Low-Income-Cost-Sharing-Chart-Non-LTC-2007.pdf for more information. This benefit is part of the Medicare program, but state Medicaid agencies exchange information with the federal government to automatically process the above groups for "extra help." State Medicaid agencies also process applications for "extra help" for people who do not qualify for Medicaid but have incomes below 150 percent of poverty. The Medicare Modernization Act of 2003 and pursuant regulations provide details. (See summaries of the rules and act at www.hapnetwork.org.)

For each of the above programs, states must, at a minimum, use the income disregards of the SSI program. They must deduct $20 of unearned income, $65 of earned income and half of remaining earnings, and impairment-related work expenses (detailed in 20 CFR § 404.1576). At a minimum, states must use resource limits that are twice those used by the SSI program. Thus, the federal resource limits for the above programs are currently $4,000 for an individual and $6,000 for a couple. State can liberalize income and resource disregards. For specific information about state plans, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf.

21. Is the person's health condition severe enough to qualify for nursing home coverage?

States can use any combination of the following methods to determine Medicaid eligibility for people in nursing homes or other institutions. States may:

- Provide coverage for people who would be eligible for SSI or state supplements if they were not in institutions (42 CFR§ 435.211).
- Provide coverage for people with incomes below a state-established threshold that does not exceed 300 percent of federal SSI benefit levels (42 CFR §§ 435.236 and 435.1005). In these states, people can qualify for Medicaid by putting income that exceeds 300 percent of SSI benefits into what are known as "Miller Trusts," which can be used only to pay nursing home expenses (Social Security Act § 1917). Establishing a Miller Trust requires the help of an attorney.
- Provide coverage to medically needy nursing home residents whose income after paying the cost of nursing home care is below a state established medically needy threshold. Generally, people with incomes less than the monthly cost of nursing home care qualify under this method.
- Provide coverage to seniors who purchased and used all the benefits of a qualifying long-term care partnership policy without forcing them to spend down all of their assets first. Individuals can qualify for Medicaid while retaining assets. The value of assets they can retain depends on the value of their long-term care partnership policy (Social Security Act § 1917 (b) (C)). More information on long-term care partnerships is avlailable online at http://www.cms.hhs.gov/NewFreedomInitiative/downloads/LTC%20Roadmap%20to%20Reform.pdf, http://www.aarp.org/research/longtermcare/insurance/fs124_ltc_06.html, and http://www.brookings.edu/views/papers/200412retirement.pdf.

In each case, people must also meet the state's resource requirements. Special rules are designed to protect spouses of nursing home residents from impoverishment. Under these rules, certain income and resources are set aside for the spouse remaining at home, who is known as the community spouse.

Residents of nursing homes and other institutions are required to turn most of their

incomes over to the institution to pay for the cost of their care. They can keep only the following (42 CFR §§ 435.725 and 435.733):

- A personal needs allowance. The minimum personal needs allowance is $30 for an institutionalized individual and $60 for an institutionalized couple. States can set a higher personal needs allowance.
- Certain veterans' benefits.
- A maintenance amount for family members remaining at home. A community spouse must be allowed to keep a portion of the couple's income that is at least 150 percent of the federal poverty level for a two-person family. If the community spouse's shelter costs exceed 30 percent of the amount of income retained, the community spouse keeps an extra shelter allowance. States can set a higher amount for the spousal allowance. If a dependent other than a spouse is living at home, federal law also allows the nursing home resident to contribute a maintenance allowance for this person, based on an assessment of that person's financial needs against state-set standards (Social Security Act § 1924).
- Money to pay for medical or remedial care that is not covered by another source, up to "reasonable limits" set by the state. (Most states have not set limits as of this writing.)
- If an individual or an institutionalized couple is expected to return home within six months, states can allow the person or couple to retain an amount to maintain the primary residence (42 CFR 435.725). However, if an individual has equity interest in a home of more than $500,000 and that individual does not have a spouse or dependent living in the home, the individual does not qualify for Medicaid nursing home care. (At state option, this amount can be raised to equity interest of $750,000.) (This provision was added by the Deficit Reduction Act of 2005 and amends Social Security Act § 1917.)

At the time one member of a couple is institutionalized, states take a "snapshot" of the couple's resources. The spouses' countable resources are pooled, and the value of these resources is computed.

- The house in which the community spouse resides and certain other resources are not counted.
- The community spouse is allowed to keep an amount of resources established by the state. Usually, this amount is at least half of the couple's resources. Federal rules set outside limits for states' resource thresholds – between a minimum of $20,328 and a cap of $101, 640 under federal rules in 2007. See http://www.cms.hhs.gov/MedicaidEligibility/downloads/1998-2007SSIFBR102406.pdf.

States' income and resource thresholds and methodology for dividing resources are

discussed in the states' Medicaid plans.For specific information about state plans, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf. in Attachment 2.6A and Supplements 5, 9,10, and 13. In some cases, a spouse can get the income and/or resource allowances increased by showing at a Medicaid fair hearing or through a court proceeding that the allowance is inadequate. If there is no spouse at home, resource limits are the same as those that apply to non-institutionalized Medicaid beneficiaries in the state.

If people transfer assets or resources for less than fair market value during the 60 months prior to the date they apply for Medicaid, they will be disqualified from Medicaid coverage of their nursing home care for a period of time. The penalty period during which the person is disqualified for Medicaid is calculated as the amount of the transfer that was below fair market value divided by the average monthly nursing home cost in the state. The result is the number of months that the person is ineligible for Medicaid coverage of nursing home care. This penalty period begins on the date on which the individual applies for and would otherwise qualify Medicaid coverage of their nursing home care, or on the date the individual transfers assets, whichever is later. States can grant "hardship waivers" from transfer of asset penalties if a person's health or life would be endangered or if the person would be deprived of "food, clothing, shelter or other necessities of life." If people establish trusts to qualify for Medicaid (except for Miller trusts and certain trusts to care for people with disabilities) during the 60 months prior to the date they apply for Medicaid, they may similarly be disqualified for a period of time.

For more information, see the federal law and regulations and consult an attorney with expertise in elder law. The National Senior Citizens Law Center at (http://www.nsclc.org) has links to various directories of attorneys.

22. Does the person want care at home or in the community even though his or her condition is serious enough to qualify for nursing home care?

States can provide a wide array of home and community-based services under Section 1915(c) or Section 1115 waivers for people who need a level of care equivalent to that provided in a nursing home or other institution and who would meet Medicaid eligibility standards if in a nursing home or other institution (42 CFR § 435.217). In addition to medical care, states can provide supportive services, such as adult day care and chore and housekeeping services. States can limit the number of people served through a home and community-based care waiver, but under the Americans with Disabilities Act and the Rehabilitation Act, any waiting lists for these services must move at a reasonable pace.

Waivers permit states to extend eligibility for home and community-based services up to the same income thresholds that states use for institutional care, and they permit states to cover a broad range of services. Even without a waiver, states can still provide some home services, including home health care, personal care, and case management, to people who meet the states' regular Medicaid income and resource standards. States can provide a broader range of home and community-based services to people 65 and over who are "functionally disabled" and eligible for SSI (and for state supplements in states that supplement SSI). The functionally disabled are people who cannot perform certain activities of daily living, have Alzheimer's disease, or are otherwise cognitively impaired (see Social Security Act § 1929). Following the passage of the Deficit Reduction Act of 2005, federal rules also permit states to provide home and community based services without a waiver for seniors or other disabled individuals living in the community who have an income up to 150 percent of poverty (Social Security Act § 1915 (i) (1)). Seniors who require an institutional level of care are eligible, but there is no requirement that the individual need an institutional level of care.

More information on eligibility for home and community-based care waivers and the services covered in each state is available online at http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/) and (http://www.hcbs.org/.

Under their state plans, states can also provide coverage to people receiving hospice care who would qualify for Medicaid if they were in an institution. For specific information about state plans, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available online at http://www.nasmd.org/about/NASMD_Member_List.rtf.

23. Did the person at one time receive SSI benefits?

States must provide Medicaid coverage to the following groups of people who once had and then lost SSI benefits:

- Adults over 18 who began receiving SSI due to disability or blindness before they reached age 22 but lost SSI when they received other Social Security benefits;
- Widows and widowers who lost SSI or state supplements due to Social Security benefit increases in 1984 and who applied for continued Medicaid coverage before 1988;
- Widows and widowers age 50 and over who lost SSI or state supplements because they received early Social Security retirement or disability benefits;
- People who lost SSI; state supplements; or assistance from the predecessor cash assistance programs for the aged, blind, and disabled due to a Social Security increase in 1972; and
- People who once received both SSI and Old-Age, Survivors, and Disability Insurance (OASDI) Social Security benefits but lost SSI due to Social Security cost-of-living increases. (See 42 CFR §§ 435.131- 435.138.)

Children who lost SSI in 1996 or 1996 due to changes in disability criteria should have retained Medicaid benefits. See question 7.

Income not counted for Medicaid beneficiaries with disabilities or age 65 or older

Incme not counted:

- $20 of unearned income.
- $65 of earned income and half remaining earnings.
- Earned income of a student.
- One-third of child support from an absent parent.
- Some needs-based assistance such as housing assistance and home energy assistance.
- Other deductions that may be allowed by the state.

People with disabilities who are working under an approved plan for self-support can deduct reasonable work-related expenses from their home.

For more information and additional income disregards, see 42 CFR § 435.601 and 20 CFR §§ 416.1100-416.112.

In 209(b) states (described under questions 17 and 19), the following are disregarded:

- SSI payments.
- State supplemental payments.
- Incurred medical expenses not paid by another source.
- Other deductions that may be allowed by the state.

Medicaid/SCHIP Screening Questions: Diseases

24. Does the person need breast or cervical cancer treatment?

States have the option to cover people who are not otherwise eligible for Medicaid and who are not yet age 65 if they 1) have been screened by a Centers for Disease Control Breast and Cervical Cancer Early Detection Program and 2) have been found to need treatment, 3) have low incomes, and 4) are uninsured (Social Security Act § 1920(B)). Nearly all states have taken this option. In this context, a woman using the Indian Health Services is deemed uninsured. See the "National Breast and Cervical Cancer Early Detection Program" section of the CDC website for more information and a map of state activity (http://apps.nccd.cdc.gov/cancercontacts/nbccedp/contacts.asp).

States can elect to enroll women in Medicaid for a limited period of time before the women have completed the Medicaid application and approval process if health care providers determine that the women are likely to qualify for coverage of breast or cervical cancer treatment. This is called "presumptive eligibility."

25. Does the person have sickle cell anemia?

States have the option to use Medicaid funds to identify and educate individuals "who are likely to be eligible" for Medicaid and who have Sickle Cell disease or carry the sickle cell gene. When people with Sickle Cell disease do qualify for Medicaid under any of the criteria listed in this screening guide, states have the option to cover additional services for them related to their disease (chronic blood transfusion, genetic counseling and testing, and other treatment and services to prevent SCD individuals who have had a stroke from having another stroke (Social Security Act §§ 1903(a)(3)(d), 1905 (a) (27) and 1905(x)).

26. Does the person have tuberculosis?

States have the option to provide limited coverage for people not otherwise eligible for Medicaid who have tuberculosis provided they meet the income and resource standards that apply to beneficiaries with disabilities (Social Security Act § 1902(z). People with tuberculosis can get coverage for prescription drugs, physician services, lab and x-ray services, care in clinics, case management, and services designed to encourage completion of a drug regimen. To find out whether a state provides this coverage, please contact your state Medicaid agency. Contact information for state Medicaid agencies is available at http://www.nasmd.org/about/NASMD_Member_List.rtf.

Medicaid/SCHIP Screening Questions: Other

27. If the person is not qualified under any of the above categories, does he or she live in a state that uses a Section 1115 waiver to expand eligibility? (For example, is this person an adult who is neither disabled nor elderly and does not have dependent children?)

Some states use Section 1115 waivers to provide Medicaid eligibility to nondisabled adults or to other groups of people who are not normally eligible for Medicaid under federal rules. If the person is not qualified, see the CMS Web site (http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp#TopOfPage) for a list of states that have been granted 1115 waivers or have waivers pending and for links to waiver documents.

Screening for Medicaid and State Children's Health Insurance Program (SCHIP) Eligibility

State Adaptation Instructions

You can create your own state-specific guide to help determine if someone is eligible for Medicaid or SCHIP by researching the answers to the questions below for your state. Our national guide explains how you can find answers to these questions in your state Medicaid plan. You may also be able to get answers by interviewing an eligibility expert in your state Medicaid agency. Remember to check annually with your state for updates.

1. Is the person pregnant?

- What is (state's) income limit for pregnant women?
- What health care services are considered "pregnancy-related" in (state)?
- What resource limits, if any, apply to pregnant women in (state)?
- In (state), can a pregnant woman be presumptively eligible for Medicaid?
- Does (state) offer SCHIP coverage for prenatal services?

2. Is the person under age one?

- What is (state's) income and resource limit for pregnant women? (See answer under 1 above.)
- Does (state's) SCHIP plan cover infants ineligible for Medicaid? If so, what are the income guidelines?

3. Is the person under age 6?

- What are the family income guidelines in (state) in order to cover children under age six? Does (state) disregard any income for children beyond the federal requirements? (Federally required disregards are listed at the back of the "Children and Families" tab.)
- Does (state) apply a family resource test for children under age six? If so, what are its guidelines?
- Does (state), through its SCHIP funds, expand Medicaid coverage for or establish separate children's health insurance programs for or a combination of the two for uninsured children at higher incomes? What are the guidelines for these children?

4. Is the person at least age 6 but under age 19?

- What is (state's) family income limit for children between six and nineteen? Does (state) disregard any income for children beyond the federal requirements? (Federally required disregards are listed at the back of the Children and Families tab.)
- Does (state) apply a family resource test for children between six and nineteen? If so, what are its guidelines?
- Does (state), through its SCHIP funds, expand Medicaid coverage for or establish separate children's health insurance programs for or a combination of the two for uninsured children at higher incomes? What are the guidelines for these children?

5. Is the person age 19 or 20?

- Does (state) cover 19- and 20-year-olds? If so, does it cover all 19- and 20-year-olds who meet income guidelines or only fulltime students?
- Are there service limitations to 19- and 20-year-olds who are fulltime students in secondary school or in vocational or technical training programs in (state)?
- Are there service limitations to 19- and 20-year-olds who live in foster care, who have been adopted, or who are in nursing facilities or psychiatric institutions in (state)?
- If not covered through Medicaid, is this population covered through (state's) SCHIP plan?

6. Is the person a child in foster care or an adopted child?

- Does (state) opt to cover foster children until their 21st birthday? (States must cover foster children at least until age 18.)

7. Is the person a child with a disability?

- Is (state) a 209(b) state? If so, what is the definition of disability for the state Medicaid program?

8. Is the person a child with a disability so severe that he or she could be admitted to a medical institution?

- Does (state) follow the Tax Equity and Fiscal Responsibility Act (TEFRA) or the "Katie Beckett" option to cover children with severe disabilities at home that can otherwise be admitted to a medical institution?
- Does (state) utilize a home and community-based care waiver to provide coverage for care at home of this population? If so, what is the eligibility criteria and what services are provided?

9. Is the person a parent of a dependent child or a child not eligible under any of the previous questions?

- What are the Section 1931 income guidelines for (state) that apply to parents?

- In (state), are adults in two-parent families covered if both parents work more than 100 hours per month?
- Does (state) deny the individual parent Medicaid if that person loses TANF for failure to meet work requirements?
- Does (state) deny Medicaid if a parent refuses to help the state establish paternity?
- Does (state) disregard any income for parents beyond the federal requirements? (Federally required disregards are listed at the back of the Families and Children tab.)

10. Is the person a relative caring for a dependent child? (See questions 17-20.)

11. Has the person's family income recently increased?

- Does (state) allow people in Medicaid managed care or primary care case management to retain Medicaid coverage for six months regardless of changes in income?

12. Does the person or family have significant medical expenses?

- Does (state) allow people to "spend down" their incomes to a state-established income level? If so, what is this state-established level?
- Does (state) allow people to pay monthly premiums if their incomes are slightly higher than the Medicaid income threshold?
- What groups are covered under (state's) medically needy program: children only or also 18 to 20 year olds; parents and caretakers; aged, blind, and disabled; people in managed care?

13. Does the person or family have unpaid medical bills for services or treatment received within the last three months?

- Does (state) provide retroactive coverage back to the first day of the third month prior to application?

14. Is the person an immigrant?

- Does (state) provide coverage through state-only funds for qualified aliens banned from receiving full Medicaid benefits for a period of five years?

15. Is the person homeless, or has the person recently moved into the state? (There are no state variations for this category.)

16. Did the person leave a job that offered COBRA benefits?

- Does (state) opt to pay for the continued cost of the COBRA premiums?

17. Is the person an adult with a disability, or is the person blind?

- Is (state) a 209(b) state? If so, what is its definition of "disability" and "blindness"?
- Do SSI beneficiaries automatically receive Medicaid in (state)? Do they have to complete a separate application? If Medicaid is not automatic, what are the eligibility criteria for Medicaid of this population?
- Does (state) opt to provide Medicaid coverage to individuals whose incomes are above SSI levels? If so, what is this income level?
- Does (state) disregard any income for those with incomes above the poverty guidelines?
- Has (state) liberalized resource limits beyond federal requirements?

18. Is the person working despite disability or blindness?

- Does (state) opt to expand Medicaid coverage for working people with disabilities through the Balanced Budget Act of 1997? If so, what is the family income level guideline in (state)?
- Does (state) opt to expand Medicaid coverage for working people with disabilities through the Ticket to Work and Work Incentive Improvements Act (TWWIIA)? If so, what is the family income level guideline in (state)?

19. Is the person at least age 65 and living in the community rather than in an institution?

- Do SSI beneficiaries automatically receive Medicaid in (state)? Do they have to complete a separate application? If it is not automatic, what are the eligibility criteria for Medicaid of this population?
- Does (state) opt to provide Medicaid coverage to individuals whose incomes are above SSI levels? If so, what is this income level?
- Has the (state) liberalized income or resource disregards for this population beyond federal requirements? If so, what income and resources are disregarded? (Federally required disregards are listed at the back of the "People over 65 and Disabilities" tab.)

20. Does the person receive Medicare?

- What are the income disregards for QMBs, SLMBs, QIs, and QDWIs in (state)?

21. Is the person's health condition severe enough to qualify for nursing home coverage?

- Which of the following methods does the state use to determine Medicaid eligibility in nursing homes: (a) SSI guidelines, (b) 300% of SSI, or (c) medically needy?
- What is (state's) resource requirement? What is (state's) methodology for dividing resources between spouses?

- What is (state's) personal need allowance?
- Has (state) set a higher spousal allowance than is federally required? If so, what is the allowance?
- Does (state) allow an institutionalized person who is expected to return home to retain some income to maintain his/her residence?

22. Does the person want care at home or in the community even though his or her condition is serious enough to qualify for nursing home care?

- Does (state) provide home and community-based services through a waiver? If so, what are the guidelines to be eligible for coverage and what services are provided in (state)?

23. Did the person at one time receive SSI benefits? (There are no state variations for this category.)

24. Does the person need breast or cervical cancer treatment?

- What are (state's) guidelines for women under 65 who are otherwise ineligible for Medicaid and who have cervical or breast cancer?
- Does (state) enroll individuals in Medicaid before completing the application process if it appears that they will likely be approved (called "presumptive eligibility")?

25. Does the person have sickle cell anemia?

- Does (state) cover individuals with tuberculosis who are not otherwise eligible for Medicaid? (If so, income and resource guidelines will be the same as for question 17.)

25. Does the person have tuberculosis?

- Does (state) cover individuals with tuberculosis who are not otherwise eligible for Medicaid? (If so, income and resource guidelines will be the same as for question 17.)

26. If the person is not qualified under any of the above categories, does he or she live in a state that uses as Section 1115 waiver to expand eligibility?

- What are the eligibility requirements and services provided under any section 1115 waivers used in (state)?

Screening for Medicaid and SCHIP Eligibility Hypothetical Scenarios: Questions and Answers

Please adapt these questions and answers for use in your own training sessions. The answers are based on minimum federal standards for state Medicaid and SCHIP programs, but many states have established more liberal requirements. If, in your use, you notice errors or places where additional notes should be inserted about possible state variations, please contact us at info@familiesusa.org.

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Scenario: Pregnant Women and Infants

Questions:

(Eligibility Questions 1 & 2)

Beth is 21 years old and is six months pregnant. She currently lives alone in an apartment and has no savings. She has a monthly income of $810. (If in Alaska, change amount to $1003 and if in Hawaii, change amount to $926.)

1. Will Medicaid cover Beth's pregnancy-related services?
2. If Beth suffers from a non-pregnancy-related illness during her pregnancy, will Medicaid or SCHIP cover those medical expenses?

   What is the appropriate family size to use to determine eligibility?

Four weeks have passed since childbirth, and the baby is due for a check-up.

4. With no disposable income (Beth's total pay check goes to rent and other basic needs), what is a possible method of paying for her baby's doctor visit?

Answers:

1. In every state, Medicaid is mandated to cover all pregnancy-related services, including prenatal and delivery and postpartum care, to women with incomes up to 133 percent of the poverty level, so Beth will be able to receive some care no matter where she lives. (Some states set higher income limits for pregnant women, but 133 percent is the federal limit. Some states also use resource limits in determining eligibility, but Beth does not have resources, this is not a problem for her.) [Note: Her income is between 100 percent and 133 percent of poverty.]

   If Beth had been under age 19 and had income exceeding Medicaid guidelines, it would be worth checking to see if she were eligible for services under SCHIP. In some states, SCHIP funds expand Medicaid eligibility while in other states, SCHIP is a separate health coverage program.

2. First, an advocate helping Beth may question whether the illness really is "non-pregnancy related" and see if it will in fact affect her pregnancy. If it truly will not impact her pregnancy, find out if Beth qualifies for full Medicaid benefits. States must provide full Medicaid coverage—not just for pregnancy-related services—to Beth if she meets a lower income-eligibility standard based on the state's 1996 AFDC cash assistance levels.

   In this situation, the fetus counts as a family member; therefore, the income guideline to follow would be for a two-person family.

3. Because Beth was Medicaid eligible at the time of her child's birth, the child remains Medicaid eligible during infancy (first 12 months) as long as Beth remains eligible and the child is living in the mother's household.

Note: If Beth needed any medical assistance relating to her pregnancy, she remains Medicaid eligible for pregnancy-related services for 60 days after childbirth regardless of her additional income. (In some states, Medicaid disenrollments are actually processed effective the first day of the following month, so in those states she will retain eligibility for two full months after the month of birth, which may be more than 60 days).

Scenario: Children

Questions:

(Eligibility Questions 3, 4, 5, & 6)

Janet has three children, Emily (age 4), Kim (age 12), and Seth (age 19). She also has adopted a former foster child, Jen, who is age 10. (Janet receives federal adoption assistance for this child.) They all reside together and the family income also includes the salary from her retail job. Seth is in a full-time technical training program but does not receive income from it. In total, the family's countable income is 120 percent of the federal poverty guideline. (Note: The federal poverty guideline is different in Alaska and Hawaii.)

Under federal minimum standards, answer the following questions about whether these family members qualify for Medicaid in every state. Then turn to your own state's standards to see if your state covers children and families with higher incomes than the minimum.

1. Does Emily qualify for Medicaid?
2. Does Kim qualify for Medicaid?
3. Does Seth qualify for Medicaid?
4. Does Jen qualify for Medicaid?
5. What about the mother, Janet?

Answers:

1. Because Emily is under age 6 and her family income is below 133 percent of the poverty level, she is eligible for Medicaid. [Note: Make sure to check your state's resource requirements.]
2. Medicaid covers children between the ages of 6 and 19 whose family income is less than 100 percent of the poverty level under federal rule in every state; therefore, Medicaid does not necessarily cover Kim (family income is 120 percent of poverty). However, some states set higher income limits for children's Medicaid or use liberal methods of disregarding income to extend eligibility [check the rules in your state]. Also, the state may use SCHIP funds to cover this uninsured population.
3. States have the option of offering coverage to 19- and 20-year olds but are not required to do so. Check your state's Medicaid eligibility rules. Also, a state may opt to cover Seth only while he remains a full-time student in a technical training program. If your state does not opt to cover 19-year-olds under Medicaid, check your state's SCHIP program rules.

4. Jen is eligible for Medicaid because she meets the requirements under Title IV-E of the Social Security Act as a former foster child.
5. Janet is not automatically covered. She is covered only if your state has elected to use the same standards for parents as for kids, which is an option sometimes called "Section 1931," or the "Low-Income Family" category of Medicaid. States that do not use this option could provide Medicaid only to parents who were eligible under 1996 AFDC levels which are much lower.

Scenario: Children with Disabilities

Questions:

(Eligibility Questions 7 & 8)

Alicia has a child Rick who is age 9. She works part-time, and her family income is above the Medicaid eligibility limits for a family of two in her state.

Rick is mentally retarded and has physical limitations. His mental and physical capacities are so severe that he requires around-the-clock care and supervision. Alicia has been trying to pay for the care that she cannot provide herself but realizes that she can no longer afford it. She has been told about the possibility of "spending down" to Medicaid eligibility but cannot meet her family's living expenses on the amount that would be left after she spends down. Alicia has heard that if Rick goes into an institution, he will eventually qualify for Medicaid.

1. If Rick goes into an institution, will all or most of Alicia's income be required for institutional care?
2. Under what conditions could a state's Medicaid program pay for Rick's care at home?

Answers:

1. Generally, a child who resides in an institution for more than 30 days qualifies for Medicaid. At this time, the income and resources of the child's parents are no longer counted in determining the child's Medicaid eligibility.
2. If Rick resides in a state following the "Katie Beckett" or TEFRA option (states listed in question 8 of the eligibility manual) and he requires the level of care provided in hospitals, nursing facilities, or facilities for people with mental retardation, then Rick may receive his care at home as long as the estimated cost of the home care does not exceed that of institutional care and his parents' income does not count in determining his Medicaid eligibility.

   If Rick does not reside in a state following the "Katie Beckett" or TEFRA option but does have a home and community-based services waiver for children with disabilities, the state may use the waiver to provide coverage at home. If the state has neither the TEFRA option nor the home and community-based services waiver but does provide "medically needy coverage," Medicaid can pay for some services (such as personal care, home care, and durable medical equipment) once the family spent-down to Medicaid eligibility, but if this is not practical or if the state does not offer medically needy coverage, Rick may be forced into an institution.

Scenario: Parents and Relatives Caring for Dependents

Questions:

(Eligibility Question 9 & 10)

Janice and Bob are married and have a twelve-year-old son. They receive TANF, and each works 10 hours per week at the local supermarket as cashiers.

1. Are Janice and Bob eligible for Medicaid?

Her friend Rachel is a single parent and works at the supermarket with her. Rachel, too, is a TANF participant and receives Medicaid. Because she works the day shift and her lunch break is too short for her to travel to her local Medicaid agency across town, she misses her regular appointment with her case worker.

2. Can this be a problem for her Medicaid benefits?

Katie also works at the supermarket and earns the same amount of money as Rachel. She has no children of her own, but she is the caretaker for her niece who lives with her.

3. Is Katie or her niece eligible for Medicaid? Are both of them eligible for Medicaid?
4. If Katie were disabled and caring for her niece, what choices would she need to make in applying for Medicaid?

Answers:

1. Janice and Bob are covered if their incomes and resources are within Medicaid income guidelines. (Though minimum state income-eligibility guidelines are based on 1996 AFDC guidelines updated through cost-of-living adjustments rather than on TANF, generally people with TANF will fall below those guidelines. If the state is using more liberal Medicaid income-eligibility guidelines for parents under Section 1931, people who receive TANF will also likely qualify.) States must allow Medicaid coverage of parents if they work fewer than 100 hours per month and meet financial criteria.
2. If during this missed visit with her caseworker Rachel were supposed to re-certify for her Medicaid coverage, she could possibly have lost her benefits, depending on the budget period in her state. However, many states allow re-certification by mail instead of through face-to-face interviews. In fact, in some states, caseworkers cannot require a face-to-face interview unless there is some reason for the requirement. She or her advocate should find out what re-certification procedures are required. If she has missed re-certification, she should contact her caseworker immediately.
3. Relatives of children who assume the responsibilities of a caretaker are eligible for Medicaid under the same requirements that apply to parents and legal guardians.
4. She could apply either jointly with her niece as part of the same household or separately as a person with disabilities.

Scenario: Family-Income Changes

Questions:

(Eligibility Question 11)

Sally is a single mother with one child. Her income includes her salary from her housekeeping job (her job does not offer benefits) and child support from her ex-husband. She was receiving Medicaid for her daughter and herself for a consecutive six months; however, her wages from her housekeeping job increased a month ago, and her caseworker told her she is now over the income limits.

1. How can Sally continue to get Medicaid?
   How long will this source of health insurance last?

A year later, Sally's hours and housekeeping wages were cut, making her earned income about 30 percent of the federal poverty level. This decrease in countable income (wages and current child-support payments) again made her daughter and herself eligible for Medicaid under their state's family Medicaid guidelines. However, her ex-husband received a pay raise and therefore her child support payments increased. This increase pushed her over the income threshold for Medicaid.

2. Is Sally's only immediate option for health insurance the private market?

Answers:

1. Even if her income is over the limits generally applicable for parents in the state, because Sally received Medicaid for at least 3 months before her income increased, she should qualify for Transitional Medical Assistance (TMA). [Note to trainers: As of this writing (October 10, 2005), the federal legislation that authorizes Transitional Medical Assistance has expired and it has not yet been reauthorized. Check the status of the program before using this case example.]

   TMA will last six months after Sally's loss of traditional Medicaid regardless of income. If Sally's countable income is below 185% of the poverty level, she qualifies for an additional six months.

   (Note that some states use more generous rules for working families, so you should also explore whether earned-income disregards continue to make Sally eligible for Medicaid under the regular income limits that apply in the state. Some states also allow children "continuous eligibility" in Medicaid for up to 12 months, even if their family incomes change.)

2. No. Sally is eligible for four months of continued Medicaid coverage because an increase in child support pushed her income over the Medicaid threshold.

Scenario: High Medical Expenses

Questions:

(Eligibility Questions 12 & 13)

Lee has a permanent disability and his countable income is $600 above his state's Medicaid income level. (His caseworker correctly calculates all of the allowable deductions from Lee's income in order to arrive at the countable income figure.) Lee applies for Medicaid and gets a notice that he is $600 over income. However, he then incurs $750 of medical expenses, such as prescription drugs and home care expenses during his state's budget certification period. (Note: It is useful to notify the trainees of the certification/budget period in your state and the "medically needy level" before covering the High Medical Expenses section of the eligibility manual. Depending on your state's "medically needy" level, the amounts may need to be changed.) After incurring these expenses, he is considered "medically needy" in his state.

1. How long will Lee be eligible for Medicaid?

Lee's friend, Greg, applied for Medicaid in August as a low-income person with a disability and was found eligible. However, Greg has been eligible for Medicaid since March. He had received medical services in late June and has the receipt.

2. Will Medicaid cover the medical services Greg received in late June?

Answers:

1. Medicaid will pay Lee's medical expenses (but not the expenses incurred to meet the spend-down) until the end of a budget/certification period. Of the $750, Medicaid will pay $150 and Lee is responsible for $600. At the end of the certification period, Lee must again show how much his income exceeds that state's threshold and again document that he has paid or incurred medical expenses to meet the medically needy income level in the state.
2. Because Greg would have been eligible for Medicaid in June, he can get retroactive coverage for his medical services because Medicaid will cover an individual's medical services three months prior to the date [or month] of application as long as the individual would have been eligible. [Note: Check to see if your state allows retroactive coverage three months prior to the date of application or the first day of the third month prior to application. (A few states have received federal 1115 waivers that permit them *not* to provide retroactive coverage, so check to be sure this question is applicable in your state.)

Scenario: Special Situations - Immigrants

Questions:

(Eligibility Question 14)

Maria has been in the U.S. for fifteen years and is a permanent resident with a green card. She has worked full-time (40+ hours) in custodial services for the past twelve years. Maria has health insurance, and her children, both of whom are American citizens, receive Medicaid. Just recently, her employer cut her work hours to 24 per week. As a part-time employee, she loses her health insurance benefit.

1. Is Maria eligible for Medicaid? If so, how soon can she receive it?

Maria's brother came to the U.S. two years ago with his children. He is also here lawfully—he has a sponsor and has come because of his job. However, he also has very low earnings and, while uninsured, was in a car accident and had to receive emergency medical services.

2. Will the sponsor be liable for the costs of his medical services?

Answers:

1. Because Maria is a lawful permanent resident with dependent children, she is immediately eligible for Medicaid coverage as long as she meets the financial criteria. She has worked enough quarters that she has no concerns about sponsor deeming (that is, her sponsor's income and resources will not be considered in calculating Maria's eligibility for any federal benefits).
2. Both temporary resident aliens and permanent residents are eligible for emergency medical services if they meet financial criteria and are aged, blind, disabled, parents of dependent children, or dependent children, regardless of how long they have been in the U.S. The federal law, Personal Responsibility and Work Opportunity Act of 1996, specifies that, when an immigrant qualifies for Medicaid coverage of emergency medical services, the government may *not* seek reimbursement of the cost of the immigrant's emergency medical services from a sponsor.

Scenario: Special Situations - Homeless, New State, and COBRA

Questions:

(Eligibility Question 15 & 16)

Bob has recently hit hard financial times and lost his part-time job and home. Before this time, he was eligible for Medicaid. For the past month, Bob has stayed with friends, lived in shelters, and slept in the streets. When he goes to re-certify for Medicaid, he tells his caseworker that he no longer has a permanent address.

1. Can Bob remain eligible and receive Medicaid with his new living situation?

Jack has a mental disability and currently resides in an institute in his home state where he receives Medicaid. A new facility that focuses on Jack's disability currently opened in a neighboring state. Jack's home state feels that he will be better served by receiving services in this out-of-state institution and arranges the transfer.

2. Which state is Jack's state of residence? Which state is responsible for the Medicaid payment?

Anita, mother of a 12-year-old, recently lost her job where she received group health insurance when her company down-sized. She is offered COBRA but cannot afford the premiums. (Her company was not involved in trade and she is not entitled to a health care tax credit.) Her unemployment benefits, her only source of income, are below the federal poverty level, but she still has $3,500 of savings, which she is hoping to use for family living expenses until she finds a job.

3. Can Anita get any help with her insurance premiums?

Answers:

1. Bob can still receive Medicaid even though he is homeless because states cannot exclude people from Medicaid based on their not having a fixed address.
2. Jack's home state remains his state of residence, and his home state is responsible for Medicaid payments because it arranged the transfer.
3. Because Anita's resources are less than twice the SSI resource threshold and her income is below poverty, Anita may be able to get Medicaid to pay for her COBRA premiums. Check with the state Medicaid agency to find out if the state has elected to pay COBRA premiums as part of its Medicaid program.

Scenario: People Over 65 and Disabilities - Disabled and "Gainful Activity"

Questions:

(Eligibility Questions 17 & 18)

Kevin is under 65 years of age and has a disability. He applied for SSI at Social Security's local office more than three months ago and has not heard anything on his eligibility status. He applied for Medicaid recently because he is unable to work as a result of his disability.

1. Is Kevin eligible for Medicaid if he meets his state's income and resource test?

Allen receives both SSDI and Medicaid. He has also been able to work a part-time job, despite his disability, that pays him $635 per month. His medical condition has been responding well to a new drug, and he is hoping to be able to increase his hours eventually; however, he doesn't think he'll be able to work full-time.

2. Does Allen's current work income prevent him from receiving Medicaid?
3. If Allen's hours increase, could he lose Medicaid?

Answers:

1. Because it has been more than 90 days since Kevin applied for SSI, the state will need to make its own disability determination. Federal guidelines are as follows:

   3270.1 *When States Make Disability Determinations:* States must determine whether an applicant meets the definition of disability for Medicaid purposes in any of the following situations: …There is an application pending but SSA does not make a disability determination in sufficient time for the state to comply with the time limit in 42 CFR 435.911.

   42 CFR 435.911 requires states to establish time standards for determining Medicaid eligibility that "may not exceed … ninety days for applicants who apply for Medicaid on the basis of disability."

   Knowing that Kevin's income and resources are below the state's levels, he will be eligible for Medicaid if the state determines that he is disabled.

   Also note that if Kevin were approved for SSI benefits within 90 days, in most states, he would automatically get Medicaid. Only a few states require SSI beneficiaries to submit separate applications for Medicaid.

2. Usually to be considered disabled, adults must be unable to engage in any "substantial gainful activity." However, because Allen's income is below the limit ($830 in 2005) he will still be considered disabled. If his total income from SSDI and work, after deductions, remains within the state's Medicaid thresholds, he can still receive Medicaid and SSI. Among the deductions Allen can take from his income in calculating Medicaid eligibility are $20 of unearned income; $65 of earned income and half of the remaining earnings; and reasonable work-related expenses, such as the cost of any special accommodations that enable him to work.
3. The "substantial gainful activity" test is lifted once a person begins working. If Allen's income from work rises above $830, the state must continue to provide Medicaid coverage until Allen has sufficient earnings to provide a "reasonable equivalent" of the combination of SSI benefits, Medicaid benefits, and publicly funded attendant-care services. At that point, you will need to check to see if his state furnishes Medicaid to working people with disabilities under higher income guidelines. If the state provides a "Ticket to Work" or coverage pursuant to the Balanced Budget Act, he may be able to get Medicaid by paying monthly premiums.

Scenario: People Over 65 and Disabilities: Community Living

Questions:

(Eligibility Question 19)

Tim and Cindy are 75 and 76 years of age respectively. They have Medicare but still find themselves unable to afford Medicare's premiums, deductibles, and co-payments, plus they need some medical supplies that are not covered by Medicare. Their daughter Susan lives with them. Tim and Cindy have a combined income below the federal poverty level and their total resources are below $3000. Susan has a yearly salary of $75,000, and the deed to the house has been in Susan's name for the past ten years. Tim and Cindy pay a share of the household expenses.

1. Are Tim and Cindy eligible for Medicaid?
2. If Tim and Cindy had income over the federal poverty level, could they still be eligible for Medicaid?

Answers:

1. Tim and Cindy are eligible for Medicaid and are therefore "dual-eligibles" because they meet the income and resource limits for Medicaid as well as having Medicare. Under Medicaid rules, in determining an applicant's financial eligibility, only the income of a spouse (or in the case of a dependent, the income of a parent who is caring for a child who is under age 21 or blind or disabled) can be counted as available to the applicant. Finances of other relatives living in the home, like Susan, have no impact on Medicaid determination.
2. Depending on the state they live in, it is possible that even though Tim and Cindy have a combined income over the federal poverty level, they may qualify for Medicaid. In all states, if their income is below 135% of poverty and their resources are limited, they may qualify for a "Medicare Savings Program" in which Medicaid pays their Medicare premiums and sometimes the deductibles and co-pays. In some states, they may be eligible as "medically needy" if their out-of-pocket medical expenses are high, or they may be eligible if they need significant home-and community-based care. In a few states, people with incomes slightly above poverty may be eligible for full Medicaid benefits because of income disregards used in those states.

Scenario: People Over 65 and Disabilities - Medicare

Questions:

(Eligibility Question 20)

Denise is 68 years old and receives Medicare. She does not qualify for Medicaid because her total income is above the state's income limit for the aged and disabled. Her income is just above the federal poverty level, and her medical expenses are not quite high enough to qualify her for medically needy coverage under a Medicaid spend-down. However, she has no resources other than the house in which she lives, and she could really use some additional aid for her medical expenses.

1. Can Denise qualify for one of the Medicare Savings Programs (MSPs)? What income disregards apply? What help may she get from a Medicare Savings Program?

Answer:

1. For each MSP, states must, at a minimum, use the income disregards of the SSI program. They must deduct $20 of unearned income, $65 of earned income, and half of remaining earnings. [Check to see if your state uses more liberal disregards or disregards additional types of income. For example, some states do not count in-kind support, Census Bureau wages, or income from other specific sources.] If after taking allowable disregards, Denise's countable income is below the poverty line, she qualifies as a Qualified Medicare Beneficiary (QMB). She is entitled to have Medicaid pay her Medicare premiums, deductibles, and co-payments. If her countable income is between 100 and 120 percent of poverty, she qualifies for Specified Low-Income Medicare Benefits (SLMB) and is entitled to payment of Medicare Part B premiums. If her countable income is between 120 and 135 percent of poverty, she may be entitled to payment of her Medicare Part B premium as a Qualified Individual (QI) though as of this writing (October 10, 2005), the federal legislation that authorizes the QI program has expired, and the program has not yet been reauthorized. If she is working despite a disability and her countable income is below 200 percent of poverty, she may be entitled to full or partial payment of her Medicare Part A premium as a Qualified Working Disabled Individual. [Note: QMBs, SLMBs, and QIs are also automatically eligible for the low-income subsidy under Medicare Part D, called "extra help with prescription drug costs." That subsidy is paid by the Medicare program.]

Scenario: People Over 65 and Disabilities: Nursing Home and Home Care

Questions:

(Eligibility Questions 21 & 22)

Ellen and Eric have been married for the past 55 years. Eric's health has deteriorated, and he now needs nursing home care. Ellen, however, does not need that level of care and wants to remain in their home that is paid for. Their combined monthly income (160% of poverty) is less than the monthly price of Eric's nursing home care. Their combined resources are $18,000, not including their house.

1. Will Eric qualify for Medicaid coverage of nursing home care?
2. Will Eric receive a personal needs allowance?
3. Will Ellen be able to keep their home or will it go towards nursing home expenses?
4. Will Ellen be able to retain any of their income for personal use?

Margo has Alzheimer's disease and requires a level of care equivalent to that provided in a nursing home or other institution. If she resided in an institution, she would qualify for Medicaid; however, she would like to remain home if possible.

5. Can Margo remain at home and receive care? If so, what services can she receive?

Answers:

1. It is likely that Eric qualifies for Medicaid coverage of his nursing home care. His income is below 300 percent of the SSI level and below the cost of nursing home care, so he would meet the income test in states using either 300 percent of SSI or a medically needy threshhold to determine nursing home eligibility. The couple's combined resources are below the minimum amount to which Ellen, the spouse who remains in the community, is entitled under federal law.
2. At a minimum, Eric's personal needs allowance is $30. Some states set a higher personal needs allowance.
3. Their home is not counted in the resource limits to be eligible for Medicaid; therefore, Ellen may continue to reside there. (However, the state may impose a lien on the house for medical expenses, to be recovered from Eric's estate after Ellen is also deceased or no longer lives in the house. Check your state's lien and estate recovery practices.)
4. Ellen is considered a community spouse and therefore may keep a portion of the couple's income that is at least 150% of the federal poverty level for a two-person family. Check to see if your state allows a higher maintenance allowance to be retained by a community spouse. Furthermore, if Ellen spent more than 30% of her income on shelter (mortgage or rent, taxes, insurance, and utilities), she may be entitled to an additional shelter allowance.

5. This depends on the state. Margo may qualify for home health care, which is a mandatory Medicaid service, or personal care, an optional Medicaid service, under the state's Medicaid plan. In addition, states may provide a wide array of home- and community-based services under Section 1915(c) or Section 1115 waivers for people who need a level of care equivalent to that provided in a nursing home or other institution and meet whatever financial eligibility requirements are set forth under the state's waiver. Also, because Margo has Alzheimer's disease, she is considered functionally disabled and may be eligible for a broader array of services than is normally covered under the Medicaid state plan. Check your state's plan and home- and community-based care waivers for details.

Scenario: People Over 65 and Disabilities - Loss of SSI benefits

Question:

(Eligibility Question 23)

Meghan and Stephen both used to receive SSI benefits. Meghan received SSI and Old-Age, Survivors, and Disability Insurance (OASDI) Social Security benefits. She lost her SSI benefits solely because of Social Security cost-of-living increases. Stephen lost his SSI benefit when he married a wealthy woman.

1. Does either lose his / her Medicaid coverage or do both lose it? or neither?

Answer:

1. Only Stephen loses his Medicaid coverage. The incomes that he and his wealthy wife receive, as well as their resources, are above the limits. Meghan keeps her coverage because she had OASDI and lost her SSI benefit because of Social Security cost-of-living increases.

Scenario: Diseases - Breast Cancer, Cervical Cancer, and Tuberculosis

Questions:

(Eligibility Questions 24 & 25)

Nancy has not quite reached her 50th birthday. She recently felt a lump on her breast and her doctors suggest that she receive further testing and, if needed, treatment as soon as possible. Her income is below 100% of poverty and she is uninsured. The fact that she is not aged, disabled, or a parent of a dependent child has prevented her from being eligible for Medicaid.

1. What will Nancy need to do to ensure that if she is found to have breast cancer, Medicaid will cover her breast cancer treatment?
2. If she is diagnosed with cancer, as her counselor, what can you do to ensure she receives treatment immediately?

Danny is not categorically eligible for Medicaid. However, his income and assets are below the income and asset standards that apply to beneficiaries with disabilities. He recently found out that he has tuberculosis, and his doctor put him on a drug regimen.

3. Will Medicaid in your state cover Danny's tuberculosis drug regimen?

Answers:

1. Nancy will need to be screened by a Center for Disease Control Breast and Cervical Cancer Early Detection Program. If Nancy had cervical cancer, the same eligibility requirements would have applied. [Note: Most states have taken this option to cover women with cervical and breast cancer. Check your state plan to be sure.]
2. As her counselor, you can check to see if your state will allow Nancy to enroll immediately into Medicaid (for a limited time) before she completes the Medicaid application and approval process. This is known as "presumptive eligibility."
3. As Danny's counselor, you should find out if Medicaid in your state covers individuals with tuberculosis. You can do this by asking the Medicaid agency or checking the state Medicaid plan. Also, check to see if his prescription drugs and regimen are services provided to individuals with this diagnosis.

Scenario: Other - Not Qualified Under Any Previous Category

Question:

(Eligibility Question 26)

Tammy recently moved across country. In her home state she received Medicaid. However, in her new state her eligibility counselor tells her that she is not qualified. Tammy then explains that she qualified in her home state under a Medicaid expansion program.

1. What should you do to double-check her eligibility?

Answer:

1. Some states use Section 1115 waivers to provide Medicaid to those individuals, like Tammy, who do not qualify under Medicaid-eligibility federal rules. To find if your state has one, check out the CMS website at www.cms.gov/medicaid/waivers/waivermap.asp for a map of states that have been granted 1115 waivers and a brief description of the people and services covered under the waiver programs. You may also want to check with her former state to make sure you understand how she was covered previously and if that same type of coverage is available in her new state. More detailed information about waivers can be found in CMS's approval letters and terms and conditions. These are available on CMS's website at www.cms.hhs.gov/medicaid/waivers/ as well as from states.