

Part I Chapter 5 – Understanding Medicaid

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Chapter 5 – Understanding Medicaid

Learning Objectives

After you have read this chapter and completed the associated lectures and activities during WIPA Initial Training, you should be able to:

1. Describe the three mandatory Medicaid eligibility groups for people with disabilities: SSI eligible, 1619(b) eligible and Special Medicaid Beneficiaries.
2. Describe four optional Medicaid eligibility groups for people with disabilities: State Supplement Payment (SSP), Medically Needy, Medicaid Buy-in (MBI), and Home and Community Based Services (HCBS).
3. Describe how individuals apply for Medicaid, how states make Medicaid eligibility determinations, the Medicaid redetermination process, and how to appeal Medicaid determinations.
4. Describe how Medicaid interacts with Medicare and employer sponsored health insurance.
5. Describe the benefits of 1619(b) Medicaid while Working, the eligibility requirements for 1619(b) and the process Social Security uses to make 1619(b) determinations.
6. Describe the effect of work on Special Medicaid Beneficiary status.
7. Describe the effect of work on the optional Medicaid eligibility groups: State Supplement Payment (SSP), Medically Needy, Medicaid Buy-in (MBI), and Home and Community Based Services (HCBS).
8. Describe the conditions under which individuals lose eligibility for Medicaid.

List of Acronyms

- BBA – Balanced Budget Act
- BEP – Break-even Point
- BWE – Blind Work Expenses
- CDR – Continuing Disability Review
- COLA – Cost of Living Adjustment
- CMS – Centers for Medicare and Medicaid Services
- DHHS - U.S. Department of Health and Human Services
- EIE – Earned Income Disregard
- FBR – Federal Benefit Rate
- GIE – General Income Disregard
- HCBS – Home and Community Based Services
- HIPP - Health Insurance Premium Payment
- ICF – Intermediate Care Facilities
- IRWE – Impairment Related Work Expense
- LTC – Long Term Care
- MA – Medical Assistance
- MBI – Medicaid Buy-in
- MSP – Medicare Savings Program
- PASS – Plan to Achieve Self-Support
- SDX – State Data Exchange
- SEIE – Student Earned Income Exclusion
- SSP – State Supplement Payment

Medicaid Basics

Medicaid, also known as Medical Assistance (MA), is a cooperative federal-state healthcare program authorized by Title 19 of the Social Security Act. Congress created Medicaid in 1965 as an optional program for states to provide healthcare coverage to certain categories of people with low income. Since the early 1980s, all states have chosen to implement a Medicaid program. Currently, Medicaid provides healthcare coverage to more than 78 million Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities.

Medicaid is a jointly funded and administered federal and state program. At the federal level, the Centers for Medicare and Medicaid Services

(CMS) within the U.S. Department of Health and Human Services (DHHS) administers Medicaid. CMS establishes Medicaid regulations and provides guidance about how states must operate their program. For a state to receive federal funding, it must abide by the federal regulations. The purpose of these federal guidelines is to ensure each Medicaid program provides a basic level of coverage to certain groups of people.

States may request a waiver from one or more of the federal regulations. However, to get a waiver, CMS must approve it, and the changes must improve the quality or efficiency of the Medicaid program. Federal regulations provide states with considerable flexibility in designing their Medicaid program. As a result, Medicaid programs vary significantly from state to state and no two states are the same when it comes to the design of their Medicaid program. Within broad federal guidelines and state options available from the federal government, states use a great deal of discretion in setting the eligibility standards for their Medicaid program, determining the types, amounts, and duration of services available to Medicaid recipients, and in setting the rates of payments for services. Some states have even given their Medicaid program a unique name, such as Medi-Cal in California or TennCare in Tennessee.

At the state level, overall responsibility for Medicaid must rest with one state agency. That agency is responsible for developing the Medicaid State Plan, which is the written contract between CMS and the state outlining the details of the Medicaid program. The State Plan describes how the state will meet the federal Medicaid requirements and defines the way that the state will implement specific options where states have flexibility. While the Medicaid state agency is also responsible for administering the program, it often delegates day-to-day Medicaid program operations to other entities, including one or more other state agencies, county-run agencies, or health maintenance organizations (if the state uses a managed care model for any part of its Medicaid delivery system).

In creating their State Plan, the state must outline the medical services and items that the state will cover in the Medicaid program. CMS requires states to provide certain medical items or services to individuals who are “categorically eligible” for Medicaid – this means in a group that CMS requires states to serve. In many states, most if not all Medicaid eligibility groups have access to the same set of services listed in the State Plan. You can find a list of **mandatory and optional Medicaid**

services on the Medicaid website

(<https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html>).

Eligibility for Medicaid

To be eligible for Medicaid, someone must first be a member of a category. There are six categories:

1. People with disabilities;
2. People age 65 or older;
3. Children;
4. Pregnant women;
5. Parents or caretaker relatives; and
6. Adults.

Within each category, there are Medicaid eligibility groups. Each Medicaid eligibility group has specific eligibility criteria, including income, and, in many cases, resource limits. To be eligible for Medicaid, a person must first fit into a category and then meet the requirements of a specific Medicaid eligibility group within that category.

There are more than 60 different Medicaid eligibility groups. Some are mandatory, which means states must provide Medicaid to those who meet the eligibility criteria. Other groups are optional, which means the state may choose to include them in the State Plan. If a person meets the eligibility criteria of a mandatory and an optional eligibility group, their eligibility should default to the mandatory group. We will not cover the details of every Medicaid eligibility group in this chapter. Instead, we will provide detailed information about the mandatory eligibility groups for people with disabilities plus some general information about the more common optional eligibility groups for people with disabilities.

Mandatory Medicaid Eligibility Groups for Individuals with Disabilities

There are a number of mandatory eligibility groups for individuals who are blind or disabled. This chapter will focus on the eligibility groups that

people with disabilities living in the community (not in an institution, such as a nursing facility) can use. The most common mandatory eligibility groups are tied to receipt of SSI benefits. The other mandatory eligibility groups covered in this chapter are for people who had SSI at one time, but lost it due to very specific reasons.

Mandatory Group #1: SSI Eligible Individuals

In most states, Medicaid eligibility is automatic once Social Security determines that an individual is eligible for SSI. When Congress created SSI in 1972, it wanted states to provide Medicaid coverage to those who were SSI eligible. Some states supported this idea while other states did not. As a result, Congress decided to give states three options:

- **1634 States:** These states use Social Security’s approval of SSI as an automatic approval of Medicaid. In other words, if Social Security finds a person entitled to SSI, they automatically receive Medicaid. Thirty-four states and the District of Columbia use this option and are called “1634 states.” This title refers to the part of the Social Security Act that authorizes the states to enter into agreements with Social Security to make Medicaid eligibility decisions.
- **SSI Criteria or SSI Eligibility States:** These states use the same income and resource rules as SSI to determine Medicaid eligibility, but a beneficiary must file an application specifically for Medicaid with the state Medicaid agency (or its designee). Eight states (Alaska, Idaho, Kansas, Nebraska, Nevada, Oklahoma, Oregon, and Utah) and the Northern Mariana Islands use this option and are called “SSI Criteria States” or “SSI Eligibility States.” In these states, Social Security does not make any Medicaid eligibility decisions – the state makes all of them.
- **209(b) States:** These states use most, but not all, of the SSI income and resource rules to determine Medicaid eligibility. The 209(b) states use at least one more restrictive eligibility criterion than the SSI program. The beneficiary must apply for Medicaid at the state Medicaid agency (or its designee) and the state makes all Medicaid eligibility decisions. The Medicaid eligibility standards 209(b) states employ vary widely from state to state. These requirements may be more restrictive or

more liberal than the SSI program criteria for different parts of the decision. Eight states have chosen this option: Connecticut, Illinois, Minnesota, New Hampshire, Virginia, Hawaii, Missouri, and North Dakota. Every 209(b) state is different in terms of how it defines Medicaid eligibility.

- **The important thing to remember** is that in most cases, as long as a beneficiary is eligible for SSI, they will be eligible for Medicaid benefits through the SSI eligible group. However, if you serve beneficiaries who reside in 209(b) states, there may be exceptions to this general rule.

Mandatory Group #2: 1619(b) Eligible Individuals

Section 1619(b) of the Social Security Act provides continued Medicaid eligibility for SSI recipients whose earned income is too high to qualify for SSI cash payments, but not high enough to offset the loss of Medicaid. Individuals who are eligible for Section 1619(b) do not receive SSI payments because their countable earned income is high enough to eliminate an SSI payment after Social Security applies all income exclusions and deductions. Social Security considers individuals in 1619(b) status to be SSI eligible, simply not in cash payment status. Due to this important distinction, in most cases, states are required to provide Medicaid coverage to individuals who meet the eligibility requirements for 1619(b). We will cover 1619(b) in detail further on in this chapter in the section on how work affects Medicaid eligibility.

Mandatory Group #3: Special Medicaid Beneficiaries

In most states, categorical Medicaid eligibility for people who are aged, blind, and disabled is directly tied to eligibility for SSI. For this reason, loss of SSI eligibility often results in loss of Medicaid coverage. Over the years, Congress has enacted special Medicaid continuation provisions to preserve critical Medicaid coverage for certain special groups of former SSI recipients who continue to meet Social Security's definition of disability. A "Special Medicaid Beneficiary" is someone who lost SSI eligibility due to establishing eligibility for or receiving increases in Title II disability benefits, and who meets specific criteria that allows Medicaid coverage to continue. States are required to afford Special Medicaid Beneficiary status to individuals who lost SSI eligibility because of:

1. Any reason, but who are not currently entitled to SSI because of Cost-of-Living Adjustments (COLAs) in Social Security Disability Insurance benefits (SSDI);
2. Entitlement to or increase in Childhood Disability Benefits (CDB); or
3. Entitlement to Disabled Widow(er) Benefit (DWB) Special Medicaid Beneficiary status only applies to DWB beneficiaries until Medicare starts.

When determining Medicaid eligibility for these special former SSI recipients, state Medicaid agencies must exclude a portion of the eligible individual's Title II disability benefit. Essentially, if the individual would otherwise be entitled to SSI or 1619(b) without counting that portion, that individual would be entitled to special Medicaid Beneficiary status. Eligibility for Special Medicaid Beneficiary status is complicated and beyond what CWICs are expected to understand at this stage. For now, you just need to know that this special Medicaid eligibility status exists and that it is a mandatory eligibility group. To learn more about **Special Medicaid Beneficiaries** you can refer to a resource document found on the NTDC website (<https://vcu-ntdc.org/resources/viewContent.cfm?contentID=136>).

Optional Medicaid Eligibility Groups for People with Disabilities

Over the years, Congress has created a number of optional Medicaid eligibility groups that states can choose to cover. Because the availability of these eligibility groups varies substantially from one state to another, we only describe the most commonly used groups by people with disabilities in this chapter. Many of the optional eligibility groups have flexibility, allowing states to set some of the eligibility criteria, such as income and resource limits. As a result, the explanation of each optional Medicaid eligibility group below is for background. You will need to learn the categories that exist in the states you serve.

Optional Group #1: State Supplemental Payment (SSP) Eligible

Some states provide a cash payment called a State Supplement Payment (SSP) to supplement the federal SSI benefit. The maximum SSP amount varies by state as well as by factors such as marital status, living

situation, and whether or not the person is blind. Income and resource limits also vary by state. If a person is eligible for State Supplement Payments, they may also be able to get Medicaid through this related Medicaid eligibility group.

In some states, **Social Security administers the SSPs**

(<https://www.ssa.gov/ssi/text-benefits-ussi.htm>) instead of the state Medicaid agency. When Social Security administers the SSP, it is treated as if it were a regular SSI benefit. As a result, a person who is eligible to receive a dollar of SSI, whether it is federal SSI, or the SSP, is eligible for full Medicaid coverage. In addition, an eligible individual who loses federal SSI or a Social Security administered SSP due to earned income can use 1619(b) to maintain Medicaid. With state administered SSPs, the state sets its own policies governing whether loss of SSP due to earned income will result in loss of the related Medicaid. Not all states provide this coverage, and those that do may determine their own eligibility requirements.

Optional Group #2: Medically Needy

The Medically Needy eligibility group (also known as “spend-down”) is an optional category of Medicaid coverage in 1634 and SSI criteria states. These states have the option of expanding Medicaid eligibility to blind or disabled persons who have high medical costs and too much income to qualify for Medicaid under any other group. Because 209(b) states have at least one more restrictive criterion than the SSI rules, CMS requires that these states offer a spend-down to meet eligibility standards.

With Medicaid Medically Needy, each state sets its medically needy income limit based on family size. Resource limits are typically the same as those in the SSI program. States must also establish rules governing what forms of income and resources count during Medically Needy eligibility determination. The federal government requires that the state’s method for deciding financial eligibility may not be more restrictive than the rules for the SSI program. This requirement does not apply to 209(b) states. These states have at least one more restrictive eligibility rule than the SSI program, and may offer different services under Medicaid.

When a person has too much income, the applicant must meet a “spend-down” before they can get Medicaid coverage. The spend-down is the amount of income that exceeds the Medically Needy income limit, after subtracting all allowable income deductions. The spend-down acts like a

deductible that the beneficiary must pay or incur before coverage begins. Most medical expenses that beneficiaries pay or incur can meet a spend-down requirement, even if it is for goods or services the Medicaid state plan does not cover.

Optional Group #3: Medicaid Buy-In (MBI)

Congress specifically created the Medicaid Buy-In (MBI) option, to provide Medicaid eligibility for workers with a disability. The Balanced Budget Act (BBA) of 1997 and the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket Act) authorized the MBI. MBI provides health coverage to working people with disabilities who, because of increased earnings, resources, or both, do not qualify for Medicaid under another category. When using MBI, people with disabilities who are working may pay monthly premiums for their Medicaid coverage.

CMS gives states lots of room to set their own rules for their MBI program. Some states have no cap on earned income or resources. Other states are very restrictive as to who is initially eligible, but have more liberal rules on earnings and resources once the person is enrolled in the MBI. Each state's MBI is unique in its mix of features within the federal rules with which it must operate.

CMS provides an **[overview of the Medicaid Buy-In option](https://www.medicaid.gov/medicaid/ltss/employment/index.html)** on the Medicaid website
(<https://www.medicaid.gov/medicaid/ltss/employment/index.html>).

Optional Group #4: Home and Community Based Services (HCBS) Group

Historically, Medicaid only funded long-term care services in an institutional setting. Long-term care (LTC) services include support with activities of daily living (ADLs), such as bathing, dressing, and eating. LTC services have also included support with instrumental activities of daily living, such as taking medications as prescribed, managing money, shopping for groceries, and transportation within the community. If an individual needed this type of support, in the past Medicaid would only provide those services in nursing facilities, intermediate care facilities (ICF), intermediate care facilities for those with intellectual disabilities (formerly called ICF/ID), or hospitals. Over the years, Congress has created several options for states to provide LTC services to support people to live in the community, rather than in a Medicaid funded

institution. The most common option is to develop a Home and Community Based Services (HCBS) program through a waiver with CMS.

HCBS waivers provide a set of special Medicaid services for targeted populations, thereby making it possible for the individuals to live with maximum independence in the community rather than in an institution (e.g., nursing facility). Under the HCBS waiver authority, a state may provide a wider range of long-term care services than is generally allowed under a state's Medicaid program, including residential, habilitation, leisure/recreational and vocational services. HCBS programs may also cover non-medical services such as minor home modifications like ramps or special safety devices. HCBS programs may also be designed to serve specific disability groups such as individuals with intellectual disabilities, individuals with traumatic brain injuries, or individuals with spinal cord injuries. Some states have several different HCBS waivers targeted to different populations. Enrollment in HCBS programs is often limited due to state Medicaid budget constraints and many programs have long waiting lists.

To use this group, a person must have income below a standard set by the state (not to exceed 300 percent of the SSI FBR), have resources below the SSI resource limits, and meet other eligibility requirements for the HCBS program set by the state. If a state chooses to use this optional Medicaid eligibility group, they may require "post eligibility treatment of income," which is often called a cost share, patient liability, offset, or cost of care. This cost share is a specific amount of the beneficiary's monthly income that he or she must pay to help cover some of the HCBS waiver services. States vary widely in terms of the types of HCBS waivers they provide and the eligibility requirements they establish for each waiver program.

You can read more about **HCBS waivers** on the CMS website (<https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html>).

How to Apply for Medicaid

The process people use to apply for Medicaid varies by state and by the category of Medicaid coverage. For example, if you live in a 1634 state,

Social Security automatically enrolls you in Medicaid when you become eligible for SSI. In 1634 states, Social Security also makes eligibility determinations for 1619(b) and notifies the Medicaid agency when an individual moves from SSI cash benefits into 1619(b) status. In SSI criteria or SSI eligibility states, individuals have to apply for Medicaid separately after Social Security determines that they are eligible for SSI. This means SSI recipients have to apply through the state agency that performs Medicaid eligibility determinations. In these states, when a person loses SSI cash payments due to earned income, they need to contact the Medicaid agency to apply for 1619(b) status to make sure that they keep their Medicaid coverage.

In all states, individuals who want to apply for Special Medicaid Beneficiary status or any of the optional Medicaid groups should contact their state Medicaid agency. In most states, the state Medicaid agency website will provide instructions for applying and information about the eligibility requirements and determination process. You will find a **state Medicaid program locator** on the CMS website (<https://www.medicaid.gov/about-us/beneficiary-resources/index.html#statemenu>).

Medicaid Redeterminations and Appealing Medicaid Decisions

CMS holds state Medicaid agencies responsible for ensuring that individuals who are eligible for Medicaid remain enrolled as long as they meet eligibility criteria. In addition, states are required to perform periodic redeterminations to make sure Medicaid enrollees continue to meet program eligibility requirements. Individuals who no longer meet the eligibility requirements for the group in which they are enrolled will either be terminated from the Medicaid program entirely or moved into another coverage category for which they are eligible. States vary widely in terms of how they conduct Medicaid redeterminations.

Under federal Medicaid law, a Medicaid applicant or recipient is entitled to an administrative hearing after any decision that affects their right to Medicaid or to any service for which they are seeking Medicaid funding. This is known as a “fair hearing” and is available in all states.

A person is entitled to a letter when the state denies or terminates Medicaid benefits or right to services funded by Medicaid. In most cases, the letter will read NOTICE OF ACTION. The notice must explain the action the state is taking, the reason for the action, the right to a hearing to appeal the decision, and the availability of free services from a legal services, legal aid, or similar program (such as a Protection and Advocacy program). States may establish their own time limits for requesting hearings. Typically, states will permit the Medicaid beneficiary a time limit (up to 60 days) for requesting the hearing. However, if the notice indicates that the state will terminate an ongoing benefit, such as funding for home health care services, on a certain date, the recipient will need to request the hearing before the termination date if they will request continued services pending the appeal. Federal Medicaid law requires states to continue benefits pending the appeal if the beneficiary requests a hearing before the effective termination date and requests the continuation of benefits.

Medicaid and Other Health Insurance

Many beneficiaries worry that when they become eligible for Medicare or an employer-sponsored health insurance plan, they will lose their Medicaid coverage. Fortunately, there are many options for individuals to maintain Medicaid if they enroll in other insurance programs.

Since it is a financial needs-based program, Medicaid is a payer of last resort. As a result, Medicaid programs encourage beneficiaries to pursue other health insurance options. When Medicaid enrollees access additional health insurance, the Medicaid program saves money, because the other insurance becomes the primary payer. Some states require Medicaid beneficiaries to enroll in Medicare if they are eligible. If a Medicaid beneficiary's employer or a family member's employer offers the beneficiary "cost-effective" employer-sponsored health insurance, the state may require the beneficiary to take the coverage, and in return, the state will pay the premium. When beneficiaries become eligible for new health care coverage, they must report this to the state Medicaid agency. Timely reporting ensures that the forms of insurance correctly coordinate.

Medicaid and Medicare

A number of the beneficiaries you work with will receive both SSI and Title II disability benefits. Social Security calls these individuals “concurrent beneficiaries”. In most states, these beneficiaries will eventually be eligible for both Medicare and Medicaid. When a person is eligible for both Medicare and Medicaid, CMS considers them to be “dually eligible” with regard to their health insurance. It is also possible that a Title II disability beneficiary can have too much income for SSI but could be eligible for Medicaid through a Medicaid eligibility group that has a higher unearned income limit (e.g., Medicaid Buy-In, HCBS waiver, Medically Needy). When this happens, the person will be dually eligible for both Medicare and Medicaid. When a Medicaid beneficiary has or can get Medicare, most state Medicaid agencies will require the beneficiary to enroll in the Medicare program. When a beneficiary has both Medicare and Medicaid coverage, Medicare always pays first, and Medicaid pays second. Dually eligible individuals often receive assistance with Medicare expenses including premiums, cost sharing, and deductibles through Medicaid or by enrolling in Medicare Savings Programs (MSPs). We discussed MSPs in Chapter 2.

Medicaid and Employer-Sponsored Health Insurance

In some states, if a beneficiary can get health insurance through their own employer, their spouse’s employer, or their parents’ employer, the state requires the beneficiary to take it. When a Medicaid beneficiary becomes eligible to apply for another form of health insurance, the state Medicaid agency usually will require that the beneficiary report this new option to the Medicaid eligibility worker. The Medicaid staff will ask the beneficiary for details about the health insurance policy including monthly premium amount, deductible, coverage amount, services covered, etc.). With that information, the Medicaid staff will determine if the plan is “cost effective.” If it is cost effective, in order to maintain Medicaid, the state may require the beneficiary to enroll in the new health insurance option. Generally, if state Medicaid rules require beneficiaries to take the new option, the state will pay the monthly premium. This is called a Health Insurance Premium Payment (HIPP). In many cases, Medicaid will also pay for cost sharing associated with the health insurance, including co-payments and deductibles. If Medicaid doesn’t consider the plan cost effective, generally the state will not require the beneficiary to take the

new health insurance option. The beneficiary could still choose to take it, but the state generally will not pay the premium.

Medicaid and Work

Medicaid provides critical healthcare coverage for some of the most vulnerable Americans – those with disabilities who have low incomes. Disability beneficiaries often fear that going to work will cause ineligibility for Medicaid while their earnings are not sufficient to purchase other forms of insurance that will cover essential medical services. Fortunately, under the current regulations, Medicaid continues uninterrupted for most eligible individuals who work but retain some SSI cash payment. Even after SSI cash payments stop due to earned income, individuals who meet the eligibility requirements for 1619(b) may continue to receive Medicaid indefinitely.

Understanding 1619(b) Medicaid While Working

To benefit from the 1619(b) provisions, an individual must meet all five of the eligibility criteria described below. Medicaid may continue indefinitely under the 1619(b) provision. **If, however, at any point a beneficiary fails to meet one or more of these criteria, the individual will not be eligible for Medicaid coverage under 1619(b).**

1. **Eligible individuals must continue to meet the Social Security disability definition.** Individuals in 1619(b) status continue to be subject to medical continuing disability reviews (CDRs). If the person is found to no longer meet the disability requirements, 1619(b) Medicaid stops.
2. **Individuals must have been eligible for a regular SSI cash payment based on disability for a previous month within the current period of eligibility.** This “prerequisite month” requirement simply means that 1619(b) is not available to someone who wasn’t previously eligible for SSI due to disability. Additionally, for those in 209(b) states, the SSI beneficiary must have been eligible for Medicaid in the month immediately prior to becoming 1619(b) eligible.
3. **Eligible individuals must continue to meet all other non-disability SSI requirements.** Countable resources must

remain under the allowable SSI limits of \$2,000 for an individual and \$3,000 for an eligible couple. In addition, countable unearned income must remain under the current Federal Benefit Rate (FBR). Finally, individuals must also meet all SSI citizenship and living arrangement requirements. All of these non-disability SSI requirements apply when Social Security initially establishes 1619(b) eligibility and remain in effect forever onward.

4. **Eligible individuals must need Medicaid benefits in order to continue working.** Social Security determines this by applying something called the “Medicaid Use Test.” This “test” has three parts, but a person only needs to meet one of the parts to pass. An individual needs Medicaid coverage if they:
 - a. Used Medicaid coverage within the past 12 months; or
 - b. Expect to use Medicaid coverage in the next 12 months; or
 - c. Would be unable to pay unexpected medical bills in the next 12 months without Medicaid coverage.

For more information about the Medicaid use test, refer to **POMS SI 02302.040 The Medicaid Use Test for Section 1619(b) Eligibility** (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302040>).

5. **Eligible individuals cannot have earnings sufficient to replace SSI cash benefits, Medicaid benefits, and publicly funded personal or attendant care.** Social Security uses a “threshold” concept to measure whether an individual has sufficient earnings to replace these benefits. The threshold is a specific dollar amount of annual countable earned income an individual may have and still qualify for 1619(b) continued Medicaid. In most cases, if a person’s annual countable earned income is over the threshold figure, they will not be eligible for 1619(b) Medicaid. Due to the way Social Security calculates the threshold figure, different states have different threshold amounts. The threshold amounts also change on an annual basis. If Social Security determines the individual’s countable earned income for the 12-month period is equal to or less than

the current state threshold amount, they meet this threshold test.

For more information about the threshold test, refer to **POMS SI 02302.045 The Threshold Test for Section 1619(b) Eligibility**

(<https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302045>).

You will find a listing of the **current threshold amounts for each state** in the POMS

(<https://secure.ssa.gov/poms.nsf/lnx/0502302200>).

How Earnings are Evaluated during the Threshold Test

Social Security makes threshold determinations prospectively for a 12-month period beginning the first month an employed SSI recipient's countable earned income causes SSI cash payments to cease. When estimating future earnings, Social Security personnel generally use the amounts the beneficiary earned in the past few months, but the agency may consider any indication given by the individual that they expect a change in earnings. Social Security will also consider any Impairment Related Work Expenses (IRWE) or Blind Work Expenses (BWE) the person has, as well as income excluded under an approved Plan to Achieve Self-Support (PASS). Social Security will exclude these work incentive expenses from estimated gross earnings to determine estimated countable earnings. If the beneficiary has estimated countable annual earnings under the current state threshold amount and meets all other eligibility requirements, Social Security will find the person eligible for 1619(b).

If estimated countable annual earnings are over the standard state threshold amount, Social Security checks to see if the individual is eligible for an individualized threshold amount. A person may get a higher individualized threshold amount if they have above-average Medicaid costs. Social Security also considers the value of publicly funded personal or attendant care the individual receives when making a threshold determination. Social Security recognizes that some SSI recipients may require attendant care services to assist with essential work-related or personal care functions. The objective of the individualized threshold calculation is to determine if the individual has earnings sufficient to replace ALL the benefits that he or she would actually receive in the absence of those earnings.

For more information about individualized threshold determinations, refer to **POMS SI 02302.050 Individualized Threshold Calculation** (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302050>). You will also find an individualized threshold calculation worksheet Social Security personnel use to make these determinations at **POMS SI 02302.300 Individualized Threshold Calculation Worksheet – Exhibit** (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302300>).

Social Security reviews earnings during 1619(b) re-determinations, as it does all other forms of unearned income, resources and other relevant eligibility information. In addition to the periodic re-determination required for Section 1619(b) cases, Social Security must verify earned income and exclusions from earned income. If during these reviews the annual estimate for the upcoming 12-month period exceeds the current threshold amount and if there is no indication that an individualized threshold calculation is in order, eligibility for 1619(b) Medicaid may stop. If Social Security finds an individual ineligible for 1619(b) because of excess resources or earned or unearned income, Social Security does not terminate the person's SSI eligibility immediately. Rather, the individual goes into a 12-month suspension period. If the individual can re-establish eligibility again within this 12-consecutive-month period, Social Security may reinstate cash benefits or 1619 (b) Medicaid without the individual needing to file a new application. Individuals in 1619(b) status are considered to be SSI eligible, simply not getting a cash benefit. The protections of the 12-month suspension period apply to individuals in 1619(b) status in the same way they apply to someone getting SSI cash payments.

1619(b) in 209(b) States

As mentioned before, certain states have their own eligibility criteria for Medicaid. Called "209(b)" states, they have a more restrictive definition of disability than that of the SSI program. Individuals who are eligible for Medicaid under 1619(b) status and reside in a 209(b) state can retain their Medicaid eligibility (as long as they meet all 1619 requirements) provided they were eligible for Medicaid in the month prior to becoming eligible for 1619 Medicaid. The state must continue Medicaid coverage so long as the individual continues to be eligible under section 1619(b).

1619(b) for Eligible Couples

There are some important details about 1619(b) and eligible couples. As a reminder, an eligible couple exists when two SSI recipients are married to each other or are holding themselves out as married to the local community. If both members of the eligible couple are working, both can get 1619(b) protection. For 1619(b) to apply to both members of the couple, it doesn't matter how much either person is earning. One person may even be earning less than the \$65 earned income exclusion. If both members have earned income at some level, both may be eligible for 1619(b). In addition, the threshold amount applies to each member of the couple individually. In other words, each member can earn up to the state charted or individualized threshold amount and remain in 1619(b) status. Unfortunately, if only one member is working, continued Medicaid under 1619(b) only applies to that person, and not the unemployed spouse. Because 1619(b) is a work incentive, it is only available to persons who are working. The non-working spouse will lose the SSI-related Medicaid, though they may be eligible under a different Medicaid group.

1619(b) Eligibility Determinations and Redeterminations

Social Security is responsible for determining whether a person meets the 1619(b) eligibility criteria. The process can and should occur when the beneficiary starts reporting earned income to Social Security. Once Social Security personnel make a determination, they must enter a special code on the SSI record to note the beginning of 1619(b). The steps that follow vary depending on whether the person is in a 1634 state, a SSI Criteria and Eligibility state, or a 209(b) state.

1. **1634 State:** Because Social Security's SSI eligibility determination serves as the Medicaid eligibility determination, Medicaid simply continues when Social Security finds the person eligible for 1619(b). If the agency finds the person ineligible for 1619(b), it will send a letter with appeal rights.
2. **SSI Criteria Eligibility and 209(b) States:** Because the state Medicaid agency or its designee determines Medicaid eligibility for SSI recipients in these states, the process differs from that of 1634 states. The state Medicaid agency and Social Security share data through a shared data system known as the State Data Exchange (SDX). When Social

Security enters the special code on the beneficiary's record noting 1619(b) status, the Medicaid eligibility worker will be able to see that code. When the beneficiary reports his or her earnings to the Medicaid agency, the Medicaid eligibility worker will need to look in the data system to see that Social Security has made a 1619(b) determination for that person. With that coding in place, the Medicaid eligibility worker can continue the person's eligibility.

Once Social Security determines a person is eligible for 1619(b), the agency will conduct periodic re-determinations. Social Security conducts these re-determinations to ensure that individual continues to meet the 1619(b) eligibility criteria.

You can read more about **1619(b) policies** (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302000>) by starting with POMS **SI 02302.000 Continuing Benefits and Recipient Status Under Sections 1619(A) and 1619(B) for Individuals Who Work - Subchapter Table of Contents** found online (<https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302000>). You can also refer to a detailed resource document entitled **Understanding 1619(b)** found on the NTDC website (<https://vcu-ntdc.org/resources/viewContent.cfm?contentID=140>).

Work and Special Medicaid Coverage

State Medicaid agencies are required to disregard certain Title II disability payments (or portions of payments) when determining eligibility for Medicaid under the Special Medicaid rules. This exclusion occurs strictly for establishing eligibility for this category of Medicaid. This is important for you to remember when counseling Special Medicaid beneficiaries who work. Only a portion or possibly none of their Title II benefit will count when the state Medicaid agency determines countable income.

Both 1634 and SSI eligibility states treat earned income for Special Medicaid Beneficiaries the same way as the SSI program. States apply the \$20 General Income Exclusion (GIE) to unearned income (the Title II benefit minus the amount disregarded due to Special Medicaid Beneficiary status). The regular SSI earned income exclusions included in the SSI Calculation Sheet also apply in the standard order:

- Student Earned Income Exclusion (SEIE)

- Earned Income Exclusion (EIE)
- Impairment Related Work Expenses (IRWE)
- One-for-Two Offset
- Blind Work Expenses (BWE)
- Plans to Achieve Self -Support (PASS)

Only what is left after these deductions will count in determining eligibility for Special Medicaid. Just like in the SSI program, as long as an individual's total countable income is below the current FBR, and they meet the resource limit, the individual will continue to be eligible for Special Medicaid coverage. Even if countable earnings exceed the current FBR, some states allow Special Medicaid status to continue as long as the countable earned income stays under the state's 1619(b) threshold amount.

Medicaid agencies in 209(b) states must provide Special Medicaid using the same eligibility criteria basis as Medicaid is provided to individuals who receive SSI benefits. These states have the option of disregarding part, all, or none of the Title II benefit or increases in that benefit that make the individual ineligible provided that the same amount is disregarded for all members of the group.

Work and Optional Medicaid Eligibility Groups

Remember that not all states choose to offer Medicaid coverage to every optional eligibility groups and when they do, CMS allows them to establish their own eligibility standards within broad federal parameters. That means we cannot provide you with specific information about how earned income might affect eligibility for these optional Medicaid groups in your state. You will need to conduct research into how each of your state's optional Medicaid programs treat earned income during eligibility determinations. We can give you a little direction

State Supplemental Payment (SSP) Eligible

When Social Security administers the SSP, it is treated as if it were part of the federal SSI benefit. As a result, a person who loses a Social Security administered SSP can use 1619(b) to maintain Medicaid. With state administered SSPs, CWICs must research the state's Medicaid policy

manual to clarify whether loss of SSP due to earned income will result in loss of the related Medicaid.

Medically Needy Group

When a person using Medically Needy Medicaid begins working, it generally means they will have an increase in the amount of their spend-down. The spend-down acts like a deductible that the beneficiary must pay or incur before coverage begins. The higher a person's spend-down is, the more difficult it may be to retain eligibility for Medically Needy Medicaid. States vary significantly in how they count income when determining how much an individual's spend down is. You will need to conduct research to find your state's income and resource limits associated with this eligibility group, as well as the basics for how to calculate the spend-down.

Medicaid Buy-In Group

Congress specifically created the Medicaid Buy-In (MBI) option to provide Medicaid eligibility for workers with a disability. CMS gives states a wide berth to set their own income and resource rules for the MBI. Some states have no cap on earned income and/or resources. Other states are very restrictive as to who gets in, but have more liberal rules on earnings and resources once the person is eligible for and enrolled in the MBI. Each state's MBI is unique in its mix of features within the federal rules with which it must operate. You will need to conduct research to find out if your state offers an MBI, and if so, what the earned income limits are (if any).

Home and Community Based Services (HCBS) Group

To maintain the HCBS waiver services, a beneficiary must continue to meet the three eligibility criteria. The first two are generally not affected when a person begins working; generally, the person continues to have an institutional-level of care need and they continue to meet the criteria for the target disability group. The third criterion is the waiver's financial requirements - the person must continue to meet the income and resource limits applicable for the waiver from which they are receiving services. HCBS waiver participants who work will have increased income. Depending on the income rules for the waiver, an individual could lose entitlement to HCBS Medicaid. You will need to conduct research to find

out which HCBS waivers your state offers and what the eligibility criteria are for each waiver program.

When Medicaid for Individuals with Disabilities Stops

Medicaid coverage stops when an individual no longer meets the eligibility requirements for the group in which they are enrolled. For people enrolled in disability-related categories of Medicaid, this includes:

1. When an individual no longer meets Social Security's definition of disability; or
2. When an individual no longer meets the applicable income and resource requirements.

When eligibility for one group ends, it might be possible to establish eligibility under another group. This may be a different group for people with disabilities, or a Medicaid category of eligibility unrelated to disability. Remember, we have only covered the most common disability-related eligibility categories in this chapter, but there are other Medicaid eligibility categories that do not have a disability requirement. In most cases, if a Medicaid beneficiary loses entitlement to one group, state Medicaid eligibility workers will check all other eligibility categories available in the state to make sure an individual does not needlessly lose access to critical health insurance.

Finally, an important thing to remember is that Medicaid eligibility established in one state is not portable across state lines. Even for those who are in mandatory eligibility groups, if a beneficiary moves to a different state, they need to contact the state Medicaid agency in their new state to make sure coverage continues. Since eligibility requirements for various Medicaid groups can vary from state-to-state, individuals may need to re-apply for Medicaid in order to continue coverage.

Next Steps

As you can see from the discussion in this chapter, the Medicaid program is complex. The fact that states vary so widely in terms of which groups

they cover and how they define eligibility adds to this complexity. Once you achieve provisional CWIC certification, you will need to conduct research into how the Medicaid program operates in each state your WIPA program serves. Your NTDC Technical Assistance Liaison can help you get started, but this is not an area in which they have specific expertise. Social Security requires that WIPA programs access training on how state specific benefit programs are affected by work and Medicaid is the most important one of all. As you work to understand your state's Medicaid policies, you can build competency in the federal policies by taking the following steps:

1. The NTDC website has an entire section of resource documents focused on Medicaid. You will find **the Medicaid resources** on the NTDC website (https://vcu-ntdc.org/resources/resourceDetail_search.cfm?id=5). In particular, these documents provide you with more detail about 1619(b) and how work affects Special Medicaid Beneficiaries. These are two very important areas for CWICs to understand as they provide work incentives counseling to beneficiaries.
2. VCU's NTDC offers a comprehensive web course on Medicaid several times each year. We recommend that you complete this training after you achieve provisional certification to enhance your understanding of this complex healthcare program. Once you achieve provisional certification, you will start receiving email notices of upcoming web courses and other supplemental training through the National WIPA Listserv. You may visit the **calendar of upcoming supplemental training** on the VCU NTDC website (<https://vcu-ntdc.org/training/supplemental/upcoming.cfm>).
3. The NTDC also offers recorded teleconference and webinar supplemental trainings each year and these **archived trainings** can be found on the NTDC website (<https://vcu-ntdc.org/training/supplemental/archives.cfm>). These training sessions may be completed at any time and there are several that cover important aspects of the Medicaid program.

