



Section 4

PATHWAYS TO COVERAGE

Any person has the right to apply for Medicaid or the Children's Health Insurance Program (CHIP) and to have eligibility decided promptly. A parent, caretaker relative, or guardian may apply for children in the household as well as for himself or herself. If a disability determination is involved, the state is required to take no longer than 90 days to decide (so long as the applicant has given the state all the necessary information); if disability is not being decided, the decision is required to take no more than 45 days. All applicants must receive written notice of the eligibility decision and the opportunity to appeal if he or she disagrees with the decision.

To receive Medicaid or CHIP coverage, the applicant must meet certain eligibility criteria. The two key factors in deciding who is eligible are 1) whether the person falls within a category of people who are covered by Medicaid or CHIP and 2) whether the person's household income meets the income eligibility threshold. Some states also look at whether the household's assets are below a certain level.

Medicaid Eligibility

Major Mandatory Eligibility Groups

Federal law has long required states to provide Medicaid coverage to people with household income below a certain level who are in specific eligibility groups (primarily children, their parents, people receiving SSI due to disability, and people over 65). States then have the option to extend eligibility to people who have higher income levels and to other groups of individuals.

Presently, states are required to provide Medicaid to children aged 0 through 18 in households with incomes under 133% of the federal poverty level (FPL). States have the option of extending Medicaid to children at higher income levels. With the exception of Arizona, all states also participate in the CHIP program (described below) to provide coverage for uninsured children at higher income levels. Using Medicaid or both Medicaid and CHIP, all but four states provide coverage to children in households with incomes up to at least 200% of the FPL.¹⁹ It is important to note that Medicaid also covers youth age 18 and older (as a "family of one"), but often at a lower FPL.

¹⁹In addition, thirty-six states and the District of Columbia cover pregnant women at or above 185% of the federal poverty level. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. (2016). *Where are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children, and Pregnant Women*. Retrieved April 7, 2016 from <http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/>

The two key factors in deciding who is eligible for Medicaid or CHIP coverage are:

1. Whether the person falls within a category of people who are covered by Medicaid or CHIP;
2. Whether the person's household income meets the income eligibility threshold.

Some states also look at whether the household's assets are below a certain level.

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Major Optional Coverage Groups

In addition, states may extend coverage to other optional groups, including:

- Children with severe disabilities who live at home, but qualify for an institutional level of care *without regard to the family's income*. This is often known as a TEFRA or Katie Beckett option and is provided in eighteen states.²⁰ For more about TEFRA, please refer to [Section 11](#) of this tutorial.
- Children who meet the SSI disability criteria with income under 300% of the FPL who pay a premium and “buy in” to Medicaid;
- Adults or children with disabilities and incomes less than 300% of the SSI Federal benefit level who require an institutional level of care;
- Parents with children 18 or under in households with income above the level for which Medicaid coverage is federally required;²¹
- “Medically needy” persons who would be eligible for Medicaid except their income is too high, but incur substantial medical costs in less than six months; they “spend down” until they reach a state-specified income eligibility level.

Waivers

States may cover other groups of individuals by requesting a waiver from the Centers for Medicare and Medicaid Services (CMS). The request to CMS asks for permission to “waive” certain requirements of the Social Security Act. Requests can be made to waive other federal rules such as statewide availability of services, freedom of choice of providers, and universal access to all benefits.

The three most common types of waivers are named after the section of the Social Security Act to which they refer, and include: 1) 1115 Research and Demonstration waivers to demonstrate innovations in service delivery (using a 1115 demonstration waiver, states can cover people who do not fit into a Medicaid category—for example, adults without dependent children at home); 2) 1915 (b) waivers that forgo freedom of choice of providers, most commonly used to implement mandatory managed care programs; and 3) 1915 (c) waivers to provide Home and Community-Based Services (HCBS) to people living at home who otherwise would be eligible only if they reside in an institution.

Many states operate HCBS waivers for adults and children with developmental disabilities. These waivers sometimes raise the income eligibility level for Medicaid coverage, and may provide coverage for additional benefits such as family support services, care coordination, specialized equipment, medical supplies, respite care, and home modifications. Other waivers that include certain groups of CSHCN include autism waivers, waivers for children who are medically fragile or technology dependent, and waivers for individuals with traumatic brain injuries (see <http://cahpp.org/project/the-catalyst-center/financing-strategy/medicaid-waivers/>).

All waiver programs must cost the federal government no more than the amount projected if the state did not have the waiver. This is called “cost-neutrality.” States estimate the cost of providing services to each eligible individual under the waiver, and use this estimate to project the number of people that can be served under the waiver. In order to guarantee cost-neutrality, states often cap the number of people served under a waiver. This is why states often have waiting lists for their HCBS waiver programs even though the general Medicaid program, as an entitlement, is not permitted to have a waiting list.²²

²⁰Musumeci, M. (2011). Modernizing Medicaid Eligibility Criteria for Children with Significant Disabilities: Moving from a Disabling to an Enabling Paradigm. *American Journal of Law and Medicine*, 37(2011):81-127. TEFRA stands for the Tax Equity and Fiscal Responsibility Act of 1982. In TEFRA, states were given the option to serve severely disabled children in Medicaid regardless of family income without having to formally apply for a “Katie Beckett” waiver.

²¹States are required to provide Medicaid to parents who would have met the 1996 AFDC eligibility requirements in their state. This income level varies by state, but is very low – the median is 28% of the federal poverty level. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. (2011). *Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues*, Figure 1. Retrieved Dec. 21, 2011 from <http://www.kff.org/medicaid/8174.cfm> States have the option to cover parents above that level. In 2014 states will be required to allow parents to enroll in Medicaid if their income is under 138% of the federal poverty level.

²²State waivers are listed on the Centers for Medicare and Medicaid (CMS) website: <http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>

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CHIP Eligibility

The CHIP program provides coverage for uninsured children under 19 whose income is over the Medicaid eligibility limits, up to a limit established by the state and capped by the federal government. CHIP eligibility limits range from 160% of the federal poverty level in North Dakota to 400% of the FPL in New York.²³

Medicaid Eligibility and the Affordable Care Act (ACA)

In 2014, state Medicaid programs will be required to cover most people with income below 138% of the federal poverty level.²⁴ In some states children who are enrolled in CHIP will be shifted to Medicaid, which could improve their benefits (see Section 5 on Covered Services). The ACA's "maintenance of effort" provision prohibits states from reducing Medicaid or CHIP eligibility limits below those in effect when the ACA was enacted on March 23, 2010.

Where Are the Opportunities for Title V

²³Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured. (2016). *Where are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children, and Pregnant Women*. Retrieved April 7, 2016 from <http://kff.org/medicaid/fact-sheet/where-are-states-today-medicand-and-chip/>

²⁴The language of the ACA sets the eligibility limit at 133% of the federal poverty level (FPL) in 2014, but then instructs states to disregard an amount of income that brings the household to 138% of the FPL. The Affordable Care Act (ACA), Section 2001(a); Health Care and Education Reconciliation Act, Pub. L. No. 111-152 Section 1004(e).

Programs?

As states revamp their eligibility and enrollment processes for Medicaid, as they are required to do under the ACA, Title V programs have the opportunity to partner with state agencies in charge of health care reform to assure that the needs of families with CSHCN are considered. Title V programs may want to partner with Medicaid and CHIP programs to:

- Provide input on new eligibility and enrollment systems to assure that CSHCN who are Medicaid eligible (particularly under categories like Katie Beckett, TEFRA or medically needy--see [Section 11](#) for more about TEFRA) are enrolled in Medicaid and therefore receive EPSDT;
- Write into their cooperative agreement with the Medicaid and CHIP programs the type of outreach to potentially eligible CSHCN families that each program will conduct and how subsequent enrollment will occur;
- Encourage Medicaid and CHIP programs to incorporate screening for special health care needs as part of the eligibility or health plan enrollment process in order to track eligibility and enrollment trends, create opportunities for cross referrals to Title V, and identify children who might benefit from care coordination or care planning;
- Coordinate outreach to parents of CSHCN who will be newly eligible for Medicaid in 2014 to help facilitate enrollment.

This document is part of *Public Insurance Programs and Children with Special Health Care Needs: A Tutorial on the Basics of Medicaid and the Children's Health Insurance Program (CHIP)*, available in its entirety at <http://cahpp.org/resources/Medicaid-CHIP-tutorial>

Is this tutorial helpful to you? Please take our survey at <http://bit.ly/catalyst-impact-survey>

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Test your knowledge

1. As of 2011, states must provide Medicaid to children age 6-18 in households with incomes less than:
 - a. 200% of the FPL
 - b. 138% of the FPL
 - c. 133% of the FPL
 - d. 100% of the FPL
2. 1915c waivers for Home and Community-Based Services may be implemented to provide special services for:
 - a. Children with developmental disabilities
 - b. Children who are dependent on medical technology
 - c. Children with autism
 - d. Any of the above
3. True or False: States may provide Medicaid coverage to certain children regardless of their parent's income.



Find Out in Your State

1. What is the income eligibility limit for children in your state for Medicaid? For CHIP? What is the eligibility limit for their parents?
2. What does your state cooperative agreement between Title V and Medicaid include?
3. What waivers does your state Medicaid program currently have in place that serve CSHCN? How many CSHCN are served under these waivers? Is there a waiting list to enroll in these waivers?

1. d 2. d 3. True. Children living at home with disabilities severe enough to qualify them for care in an institution are eligible at state option in twenty-five states.