

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 (<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 2008; 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 hospitals 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.hhs.gov/LowCostHealthInsFamChild/downloads/SCHIPStatePlanActivityMap.pdf>) 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 23-27.

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/>) 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.

Most states with separate SCHIP programs cover children up to 200 percent of poverty, and many cover children at higher income levels. Information on SCHIP plans for each state is available through the state or on CMS's website (<http://www.cms.hhs.gov/LowCostHealthInsFamChild>). Income requirement guidelines for state SCHIP programs are available from the Kaiser Family Foundation's State Health Facts Online (<http://www.statehealthfacts.org/>).

If the infant is not qualified under this method, check questions 6-9,12-16, and 27.

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* (<http://www.statehealthfacts.org/>) 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 Montana, South Carolina, Texas, 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.) Most states with separate SCHIP programs cover children up to 200 percent of poverty, and many cover children at higher income levels. Information on SCHIP plans for each state is available through the state or on CMS's website (<http://www.cms.hhs.gov/LowCostHealthInsFamChild>). Income requirement guidelines for state SCHIP programs are available from the Kaiser Family Foundation's State Health Facts Online (<http://www.statehealthfacts.org>).

If a child under age six is not eligible by this method, check questions 6-9, 12-16, and 27.

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/> 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.). Most states with separate SCHIP programs cover children up to 200 percent of poverty, and many cover children at higher income levels. Information on SCHIP plans for each state is available through the state or on CMS's website (<http://www.cms.hhs.gov/LowCostHealthInsFamChild>). Income requirement guidelines for state SCHIP programs are available from the Kaiser Family Foundation's State Health Facts Online (<http://www.statehealthfacts.org>).

If the person is not qualified under this method, check questions 6-9, 12-16, and 27.

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 full-time 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. Most states with separate SCHIP programs cover children up to 200 percent of poverty, and many cover children at higher income levels. Information on SCHIP plans for each state is available through the state or on CMS's website (<http://www.cms.hhs.gov/LowCostHealthInsFamChild>). Income requirement guidelines for state SCHIP programs are available from the Kaiser Family Foundation's State Health Facts Online (<http://www.statehealthfacts.org>).

If the person is not qualified under this method, check questions 9-10, 18, and 24-27.

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 (\$63,600 for a family of four in 2008). 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, 12-16, and 27.

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 per month 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 the last page of this chapter). 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>.

Updated guidelines for parent eligibility in state can be found at <http://www.statehealthfacts.org>. 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, 12-18, and 23-27. 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 17-27.

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.