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.

The Health Assistance Partnership thanks Meredith King,
Barbara Fisher, Yolonda Reeves, and Marc Steinberg
for all of their help in preparing these questions and answers.

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.