Module IV. Eligibility

Title XIX (Medicaid) of the federal Social Security Act is a public assistance medical care program administered by states and financed jointly through federal and state funds. The purpose of the program is to help states meet the costs of necessary health care for low-income and medically needy populations. States qualify to receive federal matching funds to help finance these costs by filing a state Medicaid plan with the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. States have substantial flexibility in designing their own programs as long as they stay within the parameters of federal requirements related to eligibility, services, program administration, and provider compensation. Therefore, Medicaid services differ from state to state.

To find out if a person is eligible for Medicaid services, they must apply at their local SRS office. An Economic and Employment Support (EES) Specialist will review their information and determine whether or not the person is Medicaid eligible. If the individual is found to be eligible, they are then referred to area organizations that can assess their needs and ascertain if they qualify for HCBS/HI waiver services.

To be eligible for the HCBS/HI waiver, a person must meet the following requirements:

1) Have acquired a non-degenerative traumatic brain injury (TBI) that resulted in residual deficits and disabilities
2) Be between the ages of 16 and 55
3) Be found financially eligible for Medicaid by SRS
4) Meets the criteria for placement in a Head Injury Rehabilitation Facility

Client Obligation

Some individuals may only qualify financially for HCBS/HI services if they pay a portion of the cost of service each month. The amount that must be paid is determined by the EES Specialist. This amount can vary from month to month, based on the person's medical expenses and income.

The case manager reviews the plan of care with the person and identifies which service provider the client obligation is to be applied to. Whenever possible, the entire client obligation is applied to a single service provider.

Medicaid

Medicaid is a jointly-funded, federal-state health insurance program for certain low-income and needy people. It covers approximately 36 million individuals including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. To be eligible for federal funds, states are required to provide Medicaid coverage for most individuals who receive federally assisted income maintenance payments (such as SSI), as well as

for related groups not receiving cash payments. To be eligible for the HCBS/HI waiver, you must be eligible for Medicaid.

Working Healthy

The Balanced Budget Act of 1997 allowed states to provide Medicaid coverage to working individuals with disabilities who, because of their earnings, could not qualify for Medicaid under other statutory provisions. The Ticket to Work and Work Incentive Improvement Act (TWWIIA) of 1999 expanded upon the Balanced Budget Act by creating two additional optional categorically needy Medicaid "buy-in" eligibility groups. In Kansas, these relatively new Medicaid options are administered through the Working Healthy Program, which began on July 1, 2002.

The Working Healthy Program offers people with disabilities who are working or interested in working the opportunity to keep their Medicaid coverage while on the job. Some people may be required to pay a monthly premium to receive coverage. The premium, however, is never more than 7.5% of your total monthly income and is calculated on a sliding fee scale based on an person's income. In addition, some income may be disregarded in calculating this premium. SRS personnel are able to calculate the monthly premium. To be eligible for the program an individual must be a Kansas resident and have assets of less than $15,000 and net family income below the Working Healthy Program limits, meet the SSI or SSDI disability standard, and have verified earned income from competitive employment.

Title II of TWWIIA also extends the period of premium free Medicare Part A eligibility and requires consumer protection for certain individuals with Medigap coverage. A Medigap policy is sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. When an individual buys a Medigap* policy, they pay a premium to the insurance company.

TWWIIA requires, at a policyholder's request, suspension of Medigap coverage and premiums for those entitled to Medicare Part A if the worker with a disability is covered under an employer group health plan. The law also requires automatic reinstatement of a Medigap policy if group coverage is lost and the employee makes the request within ninety days of losing employer coverage.

See the Medicaid web site at http://www.cms.hhs.gov/medicaid for further information.

**The term Medigap and Medicare Supplement are used interchangeably. A Medicare supplemental policy means a group or individual insurance policy of accident and sickness insurance or a subscriber of hospital and medical service associations or health maintenance organizations, other than a policy issued under Section 1876 of the Social Security Act.*