

MEDICAID

What is it?

Medicaid is a governmental health insurance program that pays for medical services for certain low- and moderate-income people. In North Carolina, Medicaid is financed jointly between the federal, state and county governments.

Who is it for?

Only certain “categories” of people can qualify for Medicaid: families with dependent children, children under the age of 21, pregnant women, older adults (65 and older), and persons with disabilities or certain visual impairments (blindness). A potential recipient must first fit into one of the “categories” to qualify, and then must meet certain income and resource qualifications.

Where are applications taken?

All county Departments of Social Services (DSS) take Medicaid applications. You may also apply at some public health departments, hospitals, and community, migrant, and rural health centers.

INTRODUCTION

Medicaid is a governmental health insurance program that provides assistance with medical costs to certain low- and moderate-income individuals and families. The federal government sets the broad guidelines for the program. A state is then given considerable latitude to establish eligibility criteria and to determine what services will be covered for that state’s Medicaid recipients.

In North Carolina, you may be eligible for Medicaid if you fit into one of the categories listed above. People within the categories must then meet certain criteria regarding their income and resources (assets). These criteria are different for each category. The medical services covered may also differ.

This chapter begins with general information about Medicaid. Each “category” is then discussed separately. You can find information on the different programs as follows:

- **Families receiving Work First or Transitional Medicaid benefits**
- **Families with dependent children**
- **Pregnant women**
- **Infants and children under Age 19**
- **Breast and cervical cancer**

- **Aged, blind, or disabled persons**
- **Medicare savings programs**
- **Medically needy**

GENERAL INFORMATION ABOUT MEDICAID

Introduction

Several general rules apply to all types of Medicaid programs, regardless of the category a person qualifies under. The following information applies to all Medicaid programs (unless noted otherwise). Requirements that are unique to a program are outlined in each program section.

Benefits

Medicaid will pay for the following services:

- ◆ *Inpatient and outpatient hospital care*, including specialty hospitals
- ◆ *Physician services and other professional services*, such as podiatrists, osteopaths, chiropractors, and optometrists (limited to 24 visits per year unless life-threatening circumstances exist)
- ◆ *Clinic services* (including services at rural health centers, migrant health clinics, county health departments, and other services which are furnished by or under the direction of a physician or dentist — limited to 24 visits per year)
- ◆ *Prescription drugs and insulin* (limited to six prescriptions per month for certain individuals unless life-threatening circumstances exist)
- ◆ *“Health Check,”* a program of early and periodic screening, diagnosis, and treatment for children under the age of 21 (includes periodic physicals; hearing, dental and vision screenings; immunizations; and all the follow-up treatment identified by the provider)
- ◆ *Family planning services*
- ◆ *Laboratory and X-ray services*
- ◆ *Nurse midwife services*
- ◆ *Case management services* (available only for pregnant women, children under age five with special needs, people with mental illness, chronic substance abusers, and people with HIV)
- ◆ *Dental care* (there are a number of service limitations on dental services, except for children)
- ◆ *Mental health care* is limited to 24 visits per year for adults unless care is provided through an area mental health program (also referred to as a Local Management Entity) or authorized by Value Options. Children are not limited to the 24 visits per year limit. Medicaid will cover individualized treatment plans authorized by

psychiatrists. Treatment in a state psychiatric hospital or a freestanding psychiatric hospital is not covered for persons between the ages of 22 and 64.

- ◆ *Eyeglasses* and related services
- ◆ *Medically necessary Medicaid transportation* services and ambulance services (ambulance services are only available if other means of transportation would endanger the patient's health)
- ◆ *Adult screening* for early detection of physical and mental health problems and certain preventive health services such as mammograms or Pap smears (limited to 24 visits per year)
- ◆ *Home- and community-based services*, including: home health services and personal care services such as assistance with dressing, feeding, household tasks, transportation, and monitoring self-administered medication. Medicaid will also pay for private duty nursing in limited situations. Note: more extensive services, called Community Alternatives Programs (CAP), are available for people who would otherwise need to be placed in an institution (see below).
- ◆ *Nursing home care* (including intermediate care facilities for the mentally retarded)
- ◆ *Hospice care*
- ◆ *Durable medical equipment*
- ◆ *Hearing aids* (for children under age 21 only)
- ◆ *Home infusion therapy services*
- ◆ *Nurse practitioners*
- ◆ *Prepaid health plan services* (HMO coverage is an available option in certain parts of the state)
- ◆ *Prosthetics and orthotics* (for children under age 21 only)
- ◆ *Audiologists, occupational therapists, physical therapists, and respiratory therapists*
- ◆ *Speech and language pathologists* (for children under age 21 only)

Community Alternatives Programs (CAP)

The state offers several different CAP programs, which are designed to provide additional assistance to individuals who would otherwise need to be institutionalized. Different eligibility requirements apply to these programs. If eligible, the person is entitled to the full range of Medicaid benefits, and may receive additional services not otherwise offered to Medicaid-eligible individuals.

- ◆ *Community Alternatives Program for Children (CAP/C)*, which provides medically fragile children with a cost-effective home care alternative to institutional care.

To be eligible, the child must have a medical condition that places them at risk of needing nursing facility or long-term hospital care. The child must reside in a private residence. Children who are eligible for CAP/C may receive case management, home mobility aids, certain supplies, personal care services, respite care, and hourly nursing services. The total cost of home care must be within a monthly cost limit. There is a limit on the total number of children who may participate each year. For more information about CAP/C services, contact the Home Care Initiatives Unit in the Division of Medical Assistance at: (919) 857-4021 or the CARELINE at (800) 662-7030.

- ◆ *Community Alternatives Program for Disabled Adults (CAP/DA)*. CAP/DA is available to older adults or people with disabilities who would otherwise need nursing facility level of care. The individual must reside in a private residence. The program covers the cost of case management, adult day health care, in-home aide services, home mobility aids, respite care, telephone alert, home-delivered meals, and medical supplies. The total cost of home care must be within a monthly cost limit. There is a limit on the total number of people who may participate each year. For more information about this program, contact the CAP Unit in the Division of Medical Assistance at: (919) 857-4021 or the CARELINE at: (800) 662-7030.
- ◆ *Community Alternatives Program for Children and Adults with Mental Retardation or Developmental Disabilities (CAP-MR/DD)*. This program is available for children and adults who need the care of an Intermediate Care Facility for the Mentally Retarded or Developmentally Disabled (ICF-MR/DD). CAP-MR/DD clients are entitled to a full range of Medicaid-covered medical services. In addition, Medicaid can also be used to pay for augmentative communication devices, case management services, crisis stabilization, developmental day care, environmental accessibility adaptation, family training, personal care services, personal emergency response systems, respite care, vehicle adaptation, and other services, supplies, and equipment, up to a maximum monthly amount. The state currently limits the number of people it serves through CAP-MR/DD. Children and adults may apply for this program at local area mental health, developmental disability and substance abuse agencies. For more information about CAP/MR-DD services, contact the Division of Mental Health, Developmental Disabilities and Substance Abuse Services at: (919) 571-4980.
- ◆ *Community Alternative Program for Persons with AIDS (CAP/AIDS)*. This program is an alternative to nursing facility care for persons with AIDS as well as children who are HIV-positive and meet other criteria. The person must live in a private residence. The program covers the cost of case management, adult day health care, in-home aide services, home mobility aids, respite care, personal emergency response systems, home-delivered meals, and certain medical supplies. The total cost of home care must be within a monthly cost limit. There is a limit on the total number of individuals who may participate each year. CAP/AIDS is a cooperative effort with the AIDS Care Unit in the Division of Public Health. For more information about CAP/AIDS, contact the AIDS Care Unit at: (919) 715-3122, the Department of Medical Assistance Community Care Section at: (919) 857-4021 or the CARELINE at: (800) 662-7030.

Cost Sharing

Some Medicaid recipients are required to make a small payment — called a copayment — for some of their health services. These include chiropractic visits (\$1 per visit), prescription drugs (\$1 per prescription for generic drugs, and \$3 for brand-name drugs), optometrist visits (\$2 per visit), physician visits (\$3 per visit), and hospital outpatient visits (\$3 per visit).

The following services do not require any copayment from the patient:

- ◆ Family planning services
- ◆ Pregnancy-related services
- ◆ Services to residents in nursing facilities, mental hospitals, and intermediate care facilities for the mentally retarded (ICF-MR)
- ◆ Hospital emergency room services
- ◆ Community Alternatives Program (CAP) services
- ◆ Services provided at rural health clinics
- ◆ Non-hospital dialysis
- ◆ Services covered by both Medicaid and Medicare
- ◆ Any services provided to children under the age of 21

Eligibility

To qualify, individuals and families must be in one of the categories of individuals/families covered. In addition, the individuals or families must also meet personal and financial eligibility restrictions.

Personal eligibility

To qualify for Medicaid, an applicant must:

- ◆ Be a US citizen or eligible immigrant (see below)
- ◆ Be a resident of North Carolina
- ◆ Have a Social Security number, or have applied for one
- ◆ Provide verification of any health insurance
- ◆ Assign to the state the right to payment for health care from any third parties
- ◆ Not be in a public institution. (In other words, Medicaid will not pay for someone in prison or a non-elderly adult in a state psychiatric hospital. Medicaid will, however, pay for children under age 21 or adults age 65 or older who are receiving in-patient psychiatric service, or people age 21–65 who are in the medical/surgical unit of a state mental hospital.)

- ◆ Not be receiving Medicaid through any other source (for example, in another county or state)

Citizenship/Immigration Status

Citizens are eligible for assistance under the Medicaid program if they meet other programmatic rules. Most immigrants are ineligible for Medicaid, although they can receive Medicaid for emergency services. However, legal permanent residents (LPR) are eligible for assistance if admitted on or before August 22, 1996. If the person was admitted after August 22, 1996, he or she is ineligible for five years from the date of entry (unless he or she meets one of the exceptions listed below).

The five-year ban on receiving assistance does not apply to certain lawful permanent residents, including:

- ◆ Refugees, asylum-seekers, persons granted withholding of deportation, Cuban and Haitian entrants, and Amerasians can obtain benefits immediately but can only receive assistance during their first seven years. (Note: they can continue to receive assistance after seven years if they change their immigration status to another permanent status.)
- ◆ Veterans and active duty service members and their spouses and unmarried children under 21 can obtain benefits immediately, and continue to receive these benefits as long as they meet the programmatic rules.
- ◆ Immigrants who are receiving SSI can continue to receive Medicaid for as long as they continue to receive SSI.

Children born in the United States are US citizens, even if born to undocumented immigrants. The children are eligible for benefits, as long as they meet other programmatic rules. Parents who apply on behalf of their citizen child are not required to produce their own Social Security number or to provide information about their own immigration status. Applying for Medicaid will not normally affect their ability to later qualify for permanent residence.

Note: undocumented immigrants will not qualify for regular Medicaid coverage regardless of their length of time in the United States. However, all immigrants (including undocumented immigrants) can qualify for emergency Medicaid if they meet other program rules (e.g., categorical eligibility, residency, income and assets). Emergency Medicaid is available to help pay for medical conditions (including labor and delivery) with acute symptoms that could place the person's health in serious jeopardy, result in serious impairment to bodily functions, or cause serious dysfunction in any bodily organ or part. Emergency Medicaid will only pay for services necessary to stabilize the patient, not for ongoing care.

Financial eligibility

The income and, for most Medicaid programs, the resources of the person applying for Medicaid will always be counted in determining Medicaid eligibility. In addition, federal law makes certain people financially responsible for other people. In these instances the income and, when applicable, the resources of both the person seeking assistance *and* the financially responsible person will be considered in determining eligibility. For example, under federal law, spouses are considered to have financial responsibility for each other as long as they are living in the same home. In most instances, the joint income and resources of both spouses are counted in determining eligibility for Medicaid. Similarly, parents are generally responsible for their children, so the income and resources of both the parents and children are usually counted in determining Medicaid eligibility.

Income eligibility

The income of the person applying for Medicaid will always be counted in determining Medicaid eligibility, but not all income is “countable.” Income that is not counted by Medicaid includes but is not limited to:

- ◆ Supplemental Security Income (SSI)
- ◆ Earned Income Tax Credit payments
- ◆ Income that is unpredictable, such as occasional yard work or baby-sitting
- ◆ Foster care payments equal to or below the maximum state rate for foster care
- ◆ Loans, if there is an agreed-upon plan for repayment
- ◆ HUD Section 8 benefits

In addition, Medicaid applicants are allowed certain income exemptions, disregards, and deductions. Each Medicaid category has slightly different rules about income exemptions, disregards, and deductions. Please see sections on specific Medicaid programs for information unique to each program.

Income must be verified by bringing in a copy of a source document, such as a paycheck stub or statement from the employer.

Resource eligibility

In most of the Medicaid program categories, most of a person’s assets or resources are counted in determining Medicaid eligibility. An applicant may have only a certain limited amount of resources in order to be found eligible for Medicaid. However, some resources are not “countable.” Assets that do not count towards the resource limit include, but are not limited to:

- ◆ Personal effects and household goods
- ◆ One essential motor vehicle (used to retain employment or to get to the doctor at least four times a year, or one that is specially equipped for the disabled)
- ◆ Partial interests in real property, such as life estates, remainder interests that cannot be sold, and interests held with others as tenants-in-common
- ◆ Income-producing real property, such as rental property, or land that is rented out for farming (the Medicaid program has special rules to determine if the property is producing enough income to be exempt from the resource consideration)
- ◆ Income-producing personal property, such as farm or business equipment
- ◆ Retirement accounts, unless they can be withdrawn as a lump sum

Most people applying for Medicaid are limited in the amount of resources (assets) they can own. In the past, some people who needed medical services but could not afford them — such as an older person who needed nursing home care — got rid of excess resources in order to become eligible for Medicaid.

PLEASE NOTE: people who attempt to qualify for Medicaid by getting rid of their excess resources may be disqualified from receiving Medicaid. If you are in a nursing home, receiving home- or community-based services through the Community Alternatives Program (CAP), or receiving personal care services while living at home and you transfer certain assets to another person for less than fair market value in the 36 months immediately before applying for Medicaid, you may be disqualified from Medicaid for a certain number of months, depending on the value of the assets transferred. Of course, you are free to sell off any assets, if you receive fair market value for them. You may also be subject to a disqualification period if you set up a trust with excess assets within 60 months of applying for Medicaid.

The rules about transferring assets are notoriously tricky. Many people who innocently transferred assets have later found themselves being temporarily disqualified for Medicaid. It is worth consulting with a lawyer or your local Department of Social Services before transferring any resources. Free legal advice may also be available. See Appendix B to locate a Legal Services office near you.

Applications

An individual or family can apply for Medicaid at their county's Department of Social Services office. (See Appendix B for the DSS office in your county). Some hospitals, public health departments, and community, rural, and migrant health centers also have DSS workers available to take applications.

You have a right to apply for Medicaid on the same day you seek assistance. DSS must determine your eligibility within 45 days of the date of your application. If you are applying for Medicaid on the basis of being disabled, DSS must determine your

eligibility within 90 days of the date of your application.

People can apply for all of the Medicaid programs for which they are eligible. For instance, a woman with a child may be eligible for Medicaid for Families with Dependent Children, and her child may be eligible for Medicaid for Children. DSS workers are supposed to determine eligibility for all of the programs for which an individual or family may be eligible.

You can apply for ongoing Medicaid coverage for the next six months (prospective coverage). You may also apply to have Medicaid cover your medical expenses for one, two, or three months prior to the date of application (retroactive coverage). You may also apply for both prospective and retroactive coverage.

Much of the information needed for a Medicaid application must be verified by documents or in some other way. You should not wait to apply, though, if you don't have these papers at hand. They can be produced later in the application process. In addition, you can ask DSS to help you obtain whatever documents are required. As a general rule, the following documents should be brought when applying for Medicaid:

- ◆ Proof of income, such as wage stubs or award letters from government agencies
- ◆ Proof of assets, such as bank books, financial statements, deeds, property tax statements, or insurance policies
- ◆ Social Security cards for all applicants. (Note: Parents applying on behalf of their child need not provide their own Social Security number, just that of the child.)
- ◆ Immigration papers for all non-citizen applicants
- ◆ Proof of disability for those applying on that basis, such as medical reports from physicians
- ◆ Birth certificates or other proof of age for all applicants

Appeals

Medicaid applicants or recipients have a right to appeal any decision by the county DSS that involves the granting, denying, terminating, or modifying of assistance, or the failure of the county DSS to act within a reasonable time. Generally, the person has 60 days to request a hearing on an adverse decision. The 60-day deadline is calculated from the date the notice of the decision is mailed. If the person is already receiving Medicaid, he or she can request that benefits be continued until the first appeal is completed. Coverage will continue in these instances only if the person requests continued benefits within 10 days of the date of the notice.

All Medicaid appeals except those involving disability are first heard by a local DSS official. If you disagree with the decision of the local DSS official, you may appeal the decision to the North Carolina Department of Health and Human Services (DHHS). You have 15 days to appeal to DHHS. The 15-day deadline is counted from the date the local official's decision was mailed to you. The case will then be

heard before a state hearing officer, who will issue a decision. You can appeal an adverse DHHS decision to Superior Court by filing a petition for judicial review in Superior Court. The petition for judicial review has to be filed within 30 days of the time you get notice of DHHS's decision.

Free legal advice may be available to help you appeal an adverse Medicaid decision. Legal Services offices can provide more information about Medicaid appeals and the assistance that may be available. Legal Services offices are listed in Appendix B.

ADMINISTRATION

Medicaid is administered on the federal level by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (US DHHS). The program is administered on the state level by the Division of Medical Assistance (DMA) of the North Carolina Department of Health and Human Services (DHHS), and locally through the county Departments of Social Services (DSS).

SOURCES OF LAW

Federal law(s): 42 U.S.C § 1396 *et seq.*
Federal regulation(s): 42 C.F.R. §430 *et seq.*
State law(s): N.C.G.S. 108A-54 *et seq.*
State regulation(s): 10 N.C.A.C. Chapters 26 and 50

There are also state policy manuals on the different Medicaid programs. All manuals are available at county DSS offices or are available on-line at:

<http://info.dhhs.state.nc.us/olm/manuals/>

FOR MORE INFORMATION

Division of Medical Assistance
N.C. Department of Health and Human Services
1985 Umstead Dr.
2501 Mail Service Center
Raleigh, NC 27626-2501
(919) 857-4011

DHHS also has a toll-free number for Medicaid information and referral. Call CARELINE at (800) 662-7030.

There is a special toll-free number for information about the Medicaid for Pregnant Women program. Call (800) FOR-BABY (367-2229).

MEDICAID FOR FAMILIES RECEIVING WORK FIRST PAYMENTS OR TRANSITIONAL MEDICAID BENEFITS

Medicaid coverage for families is available automatically for families receiving Work First payments. In order to qualify, a family with dependent children must also meet strict work, income, and resource eligibility criteria. The major advantage to this program category is that both the children and the parents (or caretaker relatives) can receive assistance. Families do not need to apply for Medicaid separately, as all of the family members automatically receive Medicaid when they are part of a family receiving Work First payments.

Up to 24 months of transitional Medicaid benefits are available to families who lose Work First cash payments due to the earnings of a parent or caretaker relative. To qualify, families must have received cash assistance during at least three of the six months prior to having their cash assistance terminated due to earnings.

MEDICAID FOR FAMILIES WHO WOULD HAVE QUALIFIED UNDER NORTH CAROLINA'S FORMER AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) PROGRAM

Introduction

Medicaid coverage for families with dependent children is available to families with children under age 21 who have been deprived of the support of one or both parents because of death, absence from the home, physical or mental incapacity, or the unemployment or underemployment of the parent who is the principal wage earner. Families who do not qualify for Work First payments, for example, because the family fails to participate in the work programs, or after the two-year or five-year time limits expire, may nonetheless still qualify for Medicaid under the old AFDC program requirements. If a family applies for Work First and is not eligible, they will not be required to make a separate Medicaid application. The local DSS office will evaluate whether the family is eligible for other Medicaid programs, such as Medicaid for families that would have qualified under the state's former AFDC program. The chief advantage of this program category is that both the children and parents or caretaker relatives can receive assistance, in contrast to the program for Children under Age 19 where only the children can receive assistance.

Eligibility

Personal Eligibility

The general personal eligibility rules set out in the General Information section are applicable both to a child and to caretaker relatives. However, additional personal eligibility rules are also applicable to each.

To be eligible as a caretaker, the person must:

- ◆ Be living with and caring for a child under age 19 (including unborn children) who is deprived of the support of at least one parent because of death, absence from the home, incapacity, or unemployment
- ◆ Be either the child's parent or a specified relative (such as a grandparent, aunt, or uncle who is related by blood, marriage, or adoption)
- ◆ Cooperate with the local Child Support Enforcement Agency in establishing paternity and medical support for all dependent children in the family
- ◆ Meet financial need requirements

To be eligible as a child, a person must:

- ◆ Be under age 21
- ◆ Meet financial need requirements

Income Eligibility

Certain deductions from gross income are allowed in determining a family's countable income. These include:

- ◆ Any Earned Income Tax Credit included in wages
- ◆ 27.5% of earned income. This deduction covers work-related expenses and expenses for childcare or adult day care. (Note: if a family is unable to qualify for Work First because they make too much income, then DSS will evaluate their earnings using income deductions that used to be in effect under the old AFDC program. These include a \$90 deduction per wage earner for work-related expenses, and child care or adult care expenses of \$200 for each child under age two and \$175 for others).
- ◆ Court-ordered alimony or child support payments to someone outside the household
- ◆ Needs of any minor children who are not in the family (up to certain maximums)
- ◆ \$50 per month child support or military allotment
- ◆ The earned income of a child who is a student may be excluded. The earnings of full-time students are excluded regardless of whether they work full- or part-time, but the earnings of a part-time student are excluded only if he or she works part-time.
- ◆ In-kind shelter and utility contributions paid to the supplier

To be eligible for Medicaid under this program category, the family's countable *monthly* income minus allowable deductions may not exceed the following amounts:

<u>Family Size</u>	<u>Monthly Income Limit</u>
1	\$362
2	\$472
3	\$544
4	\$594
5	\$648
6	\$698
7	\$746
8	\$772

If the family's countable income exceeds the amounts listed above, the family is not eligible for this program (although it may still be eligible under the medically needy program category). In addition, the children may be eligible under the Medicaid for Infants and Children (MIC) program category, which has higher income eligibility requirements.

Resource Eligibility

Under this program category, families cannot have more than \$3,000 in countable resources, regardless of the size of the family. Certain resources are excluded in determining eligibility:

- ◆ All real property and life insurance are excluded

Benefits

Those receiving Medicaid under the Families with Dependent Children program are entitled to the full range of Medicaid services listed in the General Information section. Children are entitled to the services without the copayments. In addition, children are eligible for "Health Check," which includes routine screenings, immunizations, and any follow-up treatment identified in the screenings. Health Check visits and follow-up treatment are exempt from any coverage limitations (such as the limit of 24 physician visits per year, or the limit on prescription drugs).

MEDICAID FOR INFANTS AND CHILDREN UNDER AGE 19 (MIC)

Introduction

Children under 19 may be eligible for Medicaid if they meet certain income requirements. Under this program, only the children—not their parents or caretaker relatives—are eligible for Medicaid coverage. Children need not reside with their parents or with caretaker relatives in order to qualify for this program. Children who are between the ages of 19-21 can qualify on their own, but must meet the income and resource requirements listed in the Medicaid program for families who would have qualified under the former AFDC program.

Eligibility

Income Eligibility

Income eligibility is determined by the family's countable income, family size, and the child's age. Even though parents are not covered under this program, the income of the parent(s) is considered in determining the child's eligibility, if the parent lives in the same household as the child seeking coverage.

Certain deductions from gross income are allowed in determining the family's countable income. These include:

- ◆ Any Earned Income Tax Credit (EITC) included in wages
- ◆ Work-related expenses of \$90 per wage earner per month
- ◆ Child care or adult day care expenses, limited to \$200 for each child under age two and \$175 for others per month
- ◆ Court ordered alimony or child support paid to someone outside the household
- ◆ Needs of any minor children who are not in the family (up to certain maximums)
- ◆ \$50 per month child support or military allotment
- ◆ The earned income of a child who is a student may be excluded. The earnings of full-time students are excluded regardless of whether they work full or part-time, but the earnings of a part-time student are excluded only if he or she works part-time.
- ◆ In-kind shelter and utility contributions paid to the supplier

If the family's countable income exceeds the amounts listed below, the child is not eligible for this program (although he or she may still be eligible under the medically needy program category). These income guidelines are effective April 1, 2003, and are revised annually.

<u>Family Size</u>	<u>Children <1 (185% FPG)</u>	<u>Children 1-5 (133% FPG)</u>	<u>Children 6-18 (100% FPG)</u>
1	\$1,385	\$996	\$749
2	\$1,869	\$1,344	\$1,010
3	\$2,353	\$1,692	\$1,272
4	\$2,837	\$2,040	\$1,534
5	\$3,321	\$2,388	\$1,795
6	\$3,805	\$2,736	\$2,057
7	\$4,289	\$3,084	\$2,319
8	\$4,773	\$3,432	\$2,580
Each Additional Person	+ \$485	+ \$349	+ \$262

Resource Eligibility

There are no resource limits for children under age 19 if applying under the MIC program.

Benefits

Children are entitled to the full range of Medicaid covered services, which are listed in the General Information section, but limits on services available to other Medicaid recipients are not applied to children. For instance, to get some Medicaid services, recipients have to pay a small fee when they use the service (called a “copayment”). Children are entitled to services without copayments. As another example, an adult’s use of some Medicaid services is limited. In general Medicaid will pay for only 24 visits to a physician each year. But “Health Check” for children and any necessary follow-up treatment are excluded from the 24-visit limit.

MEDICAID FOR WOMEN DIAGNOSED WITH BREAST OR CERVICAL CANCER (BCCM)

In 2001, the NC General Assembly approved new Medicaid coverage for women who have been enrolled in and screened for breast or cervical cancer under the NC Breast and Cervical Cancer Control Program (See Chapter 15, State Health Programs). In order to qualify for this new coverage, the woman must:

- ◆ Have been enrolled in and screened for breast or cervical cancer under the North Carolina Breast and Cervical Cancer program (BCCCP)
- ◆ Need treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer
- ◆ Be uninsured (have no major health insurance coverage including Medicaid or Medicare)
- ◆ Be age 18 through age 64
- ◆ Meet other Medicaid eligibility requirements (such as citizenship requirements, residency, etc.)

A BCCCP screening provider must complete the Medicaid application form. The application must include a medical form, completed by a physician, that gives the diagnosis and estimated length of treatment. There are no income or resource limits in this Medicaid program; however, only women with incomes equal to or less than 200% of the federal poverty guidelines are eligible for the NC Breast and Cervical Cancer Control program. So effectively, only women with incomes less than 200% of the federal poverty guidelines will qualify for this Breast and Cervical Cancer Medicaid coverage.

MEDICAID FOR PREGNANT WOMEN (MPW) OR BABY LOVE

Introduction

A pregnant woman or pregnant minor whose countable income is not more than 185% of federal poverty guidelines is eligible for Medicaid for Pregnant Women as soon as her pregnancy is medically verifiable. This program is also known as the “Baby Love” program. For pregnant minors, the income of the minor and her parents will be counted in determining eligibility. There is no resource test in this program. Medicaid coverage will continue throughout the pregnancy and for a certain length of time after the pregnancy ends. In general, pregnant women and minors receive Medicaid coverage until the end of the month containing the 60th day after the pregnancy ends. Coverage will continue for the full eligibility period, even if her personal finances improve and she no longer meets the income guidelines.

Financial Eligibility

Income eligibility

Pregnant women and minors must have family incomes of not more than 185% of the federal poverty guidelines to qualify for assistance. For adults, only the income of the pregnant woman and her spouse, if any, will be counted. For minors, DSS will also count the income of the pregnant teen’s parent(s) if the minor is living with her parents.

Eligibility is determined based on the number of people in the family. The family includes the pregnant woman, her unborn child(ren), the spouse, and parents (for a minor), and any other children residing with the family. However, if eligible, only the pregnant woman receives coverage.

Families are allowed certain deductions from gross income. These include:

- ◆ Any Earned Income Tax Credit included in wages
- ◆ Work-related expenses of \$90 per wage earner
- ◆ Child care or adult day care expenses, limited to \$200 for each child under age two and \$175 for others
- ◆ Court ordered alimony or child support paid to someone outside the household
- ◆ Needs of any minor children who are not in the family (up to certain maximums)
- ◆ \$50 per month child support or military allotment
- ◆ The earned income of a child who is a student may be excluded. The earnings of full-time students are excluded regardless of whether they work full or part-time, but the earnings of a part-time student are excluded only if he or she works part-time.
- ◆ In-kind shelter and utility contributions paid to the supplier

After subtracting the allowable deductions, the countable income of the family must be no more than 185% of the federal poverty guidelines. The following are the *monthly* income guidelines in effect from April 1, 2003 to March 31, 2004. These income guidelines are revised each April.

<u>Family Size</u>	<u>Pregnant Women (185% FPG)</u>
1	\$1,385
2	\$1,869
3	\$2,353
4	\$2,837
5	\$3,321
6	\$3,805
7	\$4,289
8	\$4,773
Each Additional Person	+ \$485

Resource Eligibility

There are no resource limits in this program.

Benefits

Pregnant women who qualify for Medicaid under the Medicaid for Pregnant Women program are eligible for *pregnancy-related services only*. Treatment of other conditions, such as pregnancy-induced diabetes, which might complicate the pregnancy is also covered. (Pregnant women may also qualify under the TANF-related or Families with Dependent Children coverage programs. If they qualify under these latter programs, they are eligible for the full range of Medicaid benefits).

Applications

Eligibility for Medicaid under this program can be determined “presumptively” — that is, staff at health departments, hospitals, or clinics can “presume” that a woman will be eligible for this coverage and begin providing care immediately, based on medical verification of the pregnancy and a verbal declaration by the applicant of her family income. If it appears that she will be eligible, coverage will begin immediately. Coverage while a woman is “presumptively eligible” is limited to ambulatory prenatal care.

In order to continue coverage, the applicant must file a formal application with the Department of Social Services by the last working day of the month following the “presumptive eligibility” determination. The final determination of eligibility will be made within 45 days of application.

MEDICAID FOR THE AGED, BLIND, AND DISABLED (ABD)

Introduction

Medicaid is also available to certain older adults, people with disabilities or visual impairments (blind). In order to qualify, an individual or couple must be:

- ◆ Age 65 or older
- ◆ Blind (corrected visual acuity of 20/200 or worse in the better eye, or tunnel vision)
- ◆ Disabled meeting the Social Security disability definition. (Note: There are two separate definitions of disability, one for children and one for adults. For adults, disability is defined as a physical or mental impairment that keeps a person from performing any "substantial" work and is expected to last 12 months or result in death. A child's impairment must result in "marked and severe functional limitations" and must be expected to last 12 months or result in death.)

In order for a couple to qualify under this program, both members of the couple must be 65 or older, blind, or disabled. So, for instance, a couple composed of a man aged 66 and a blind woman of 64 would qualify. A couple composed of a man aged 66 and a woman of 64 who is not blind or disabled would not qualify as a couple, although the husband could still qualify for Medicaid coverage for himself. Children who are blind or disabled may also qualify if they meet the income and resource requirements.

Benefits

People who are eligible for Medicaid under this program are entitled to all the medical services listed in the General Information section at the beginning of this chapter. Additional benefits are available to people with disabilities or older adults participating in one of the state's Community Alternatives Programs (CAP).

Financial Eligibility

Income eligibility

The following general information about income eligibility under this program applies to people who are living at home or in a private living arrangement (for instance, with a sibling or other family member). Different income eligibility rules apply to people who are living in a nursing home or who are in a CAP program. Information on these exceptions appears at the end of this section on income eligibility.

Income rules for people living at home or in a private living arrangement:

Individuals who receive Supplemental Security Income (SSI) payments will automatically receive Medicaid. Others may also qualify, if their income is not more than 100% of the federal poverty guidelines. Generally, the income of the individual

and his or her spouse will be counted. Children applying on the basis of disability or blindness may also have some of their parents' income counted.

As in the other program categories, there are certain allowable deductions from gross income. Countable income is determined by subtracting the following deductions from gross income:

- ◆ The first \$65 of earned income plus half the remaining earned income
- ◆ Work-related expenses for individuals who are visually impaired (At the time of this writing, the state was also considering adding a work-related expense deduction for other people with disabilities.)
- ◆ Child care or adult day care expenses
- ◆ The needs of minor children in the household not in the family (certain maximums apply)
- ◆ A \$20 standard deduction
- ◆ One third of child support is excluded for people who qualify under the Medicaid program for the aged, blind, and disabled

After subtracting the allowable deductions, the countable income of the individual, couple or family must be no more than 100% of the federal poverty guidelines.

The following are the *monthly* income guidelines in effect from April 1, 2003 to March 31, 2004. These income guidelines are revised each April.

<u>Family Size</u>	<u>Aged, Blind, and Disabled (100% FPG)</u>
1	\$749
2	\$1,010
3	\$1,272
4	\$1,534
5	\$1,795
6	\$2,057
7	\$2,319
8	\$2,580
Each Additional Person	+ \$262

Individuals who live with and are supported by others (not their parents or spouses) are subject to different income limits. For example, if someone is living rent-free in a sibling's home, then they will have reduced monthly income limits. The reduced monthly income limits are \$493 for an individual, or \$664 for a couple. These limits are changed January 1st of each year.

Some people who used to receive SSI but became ineligible because of Social Security cost of living increases, qualifying for Social Security widows or widowers benefits, or qualifying for Social Security Disabled Adult Children coverage, may still qualify for automatic Medicaid eligibility. If you have received SSI any time since 1977, it is worth contacting your local Department of Social Services to determine if you are eligible for automatic Medicaid eligibility.

Income rules for people in long-term care:

People in long-term care (nursing homes or the CAP/DA program) have different income rules. As a general rule, a person in long-term care is eligible for Medicaid if his or her countable monthly income is less than the monthly costs of the nursing home.

People in long-term care must usually use any income to pay the costs of nursing home care. A person in long-term care may keep a certain amount of his or her monthly income: \$30 a month for a “personal needs allowance” and enough to pay for any medical needs not covered by Medicaid (such as over-the-counter drugs, or prescription drugs that exceed the Medicaid limit). The remainder of his or her income must be used to pay as much of the nursing home bill as possible, and Medicaid will pay any balance.

Special rules apply to people in long-term care who have a spouse at home (called the “community spouse”). These rules are intended to ensure that the community spouse has sufficient income to meet his or her subsistence needs. The spouse in the nursing home can give some of his or her income to supplement the community spouse’s income so that the combined income reaches \$1,493 per month. (This amount became effective July 1, 2002 and is updated annually).

The income of the community spouse determines whether and how much income the institutionalized spouse may contribute. If the at-home spouse has a monthly income of more than \$1,493, nothing can be contributed. If the at-home spouse has a monthly income of \$1,000, the institutionalized spouse may contribute \$493 per month (the difference between the contribution limit and the at-home spouse’s income).

In addition to the contribution that the institutional spouse can make to the community spouse, the institutional spouse can make additional contributions for excess shelter costs and/or dependents:

- ◆ *Excess shelter expenses:* “Shelter expenses” are housing expenses (for instance, rent or mortgage) plus utilities. The institutionalized spouse may make an additional contribution for shelter expenses over \$448 (effective July 1, 2002). So, for instance, if the at-home spouse’s shelter expenses were \$748, the institutionalized spouse could contribute \$300. The total amount that an institutional spouse can contribute towards the community spouse for both the regular contribution and excess shelter expense is \$2,267. (This amount became effective Jan. 1, 2003 and is updated annually).

- ◆ *Dependent expenses:* The institutional spouse can contribute up to an additional \$498 per month for each dependent depending on the dependent's income. (This amount became effective July 1, 2002 and is updated annually).

Exceptions to these amounts may be authorized through an appeals process. These figures are revised annually. Check with your local DSS to determine current limits.

Resource Eligibility

The following general information on resource eligibility applies to people living at home or in another private living arrangement. People in long-term care have special resource rules that are described below.

Resource rules for people living at home or in private living arrangements:

The countable resource limit is \$2,000 for an individual and \$3,000 for a couple. Certain resources are excluded in determining eligibility:

- ◆ One vehicle used for any purpose
- ◆ The homesite plus all contiguous property
- ◆ Income-producing property is excluded only if there is \$6,000 or less in equity and it produces at least 6% of its equity annually
- ◆ \$1,500 in revocable burial funds for both the applicant and his or her spouse. (For example, this would include money in the bank that the person intended to use for burial funds.)
- ◆ Life insurance policies when the total face value of all policies that accrue cash value does not exceed \$10,000
- ◆ Irrevocable pre-need burial contracts

Resource rules for people in long-term care:

Usually, DSS examines the resources of both the applicant and his or her spouse in determining eligibility. However, if a Medicaid applicant is in a nursing home, certain exceptions are made to protect some of the couple's joint assets for the spouse at home. Typically, the community spouse is entitled to half of the couple's joint assets, but not less than \$18,132 or more than \$90,660 (these amounts are effective January 1, 2003 and updated annually). Thus, if the couple only has \$13,000 in countable assets, the community spouse can keep all of their joint resources. However, if the couple jointly owns \$200,000 of countable assets; the community spouse can only keep \$89,280.

Applications

People who receive a Supplemental Security Income (SSI) check do not need to file a separate application for Medicaid. They will receive Medicaid automatically upon being approved for SSI. SSI applications are taken at local Social Security offices.

If you are ineligible for SSI, you can make a separate application for Medicaid. The procedures are essentially the same as outlined above in the General Information section. Decisions on applications should be made within 45 days for aged and blind individuals and within 90 days when applying on the basis of a disability.

MEDICARE SAVINGS PROGRAMS

Introduction

Aged, blind, and disabled individuals who cannot qualify for full Medicaid coverage may be able to qualify for more limited coverage under the Medicare Qualified Beneficiaries (MQB-Q) program, also known as the “Medicare Savings” program. The MQB-Q program was established to help low-income people with some of the costs of the Medicare program. There are four different MQB programs that will be outlined separately below. To qualify for Medicaid under the MQB program, you must meet certain income and resource tests, and must be eligible for Part A Medicare coverage.

Income eligibility

Income limits are different for each of the three programs. The income amounts listed below are current as of April 1, 2002 and are adjusted on April 1st of each year.

MQB-Q

The MQB-Q program pays Medicare premiums, deductibles, and copayments. To be eligible for MQB-Q, you must:

- ◆ Be eligible for Medicare Part A coverage
- ◆ Have a monthly income of less than \$749 for an individual and \$1,010 for a couple

An MQB-Q applicant who receives support and maintenance from someone else, such as a person living free in a sibling’s home, must have income lower than that listed above. In this case, a single MQB-Q applicant must have a monthly income of no more than \$499, and a couple no more than \$674.

MQB-B and MQB-E

The MQB-B and MQB-E programs pay only Medicare’s Part B premiums. To be eligible for this program you must:

- ◆ Be eligible for Medicare Part A coverage

- ◆ Have a monthly income of no more than 135% of the federal poverty guidelines, currently \$1,011 for an individual and \$1,364 for a couple

As noted in the MQB-Q section above, an MQB-B or MQB-E applicant who receives support and maintenance from someone else must meet lower income standards. A single MQB-B/E applicant in this circumstance may have a monthly income of no more than \$674, and a couple no more than \$910.

M-WD

The M-WD program pays only Medicare's Part A premiums. This program is available to certain disabled people who are working. To be eligible, you must:

- ◆ Be disabled and working
- ◆ Be eligible for Medicare Part A
- ◆ Have a monthly income of no more than \$1,497 for an individual and \$2,020 for a couple

As in the other MQB programs, an M-WD applicant receiving support and maintenance from someone else must have less income than mentioned above. A single M-WD applicant in this situation must have monthly income of \$998 or less, and a couple of less than \$1,347.

Resource eligibility

The resource exclusions are generally the same as those listed in the General Information section. Under MQB, the resource limits are higher than in most other Medicaid programs. To qualify for MQB, a single person may have no more than \$4,000 in resources, and a married couple may have no more than \$6,000 in resources. As with most other Medicaid programs, if your resources are over the limit, you are not eligible for MQB coverage.

MEDICALLY NEEDED

Introduction

North Carolina also provides Medicaid coverage to "medically needy" individuals and families. An individual or family who would otherwise qualify for Medicaid under another program category, but who has too much income, may still qualify for Medicaid under the medically needy program. In general, an individual or family qualifies as medically needy because of large medical expenses. To qualify as medically needy, the individual or family must incur and be responsible for paying medical bills equaling the difference between their countable income and the medically needy income limits (see below). This difference is called a deductible or "spend-down."

Eligibility

Personal Eligibility

To qualify under the medically needy Medicaid program, the individual or family must meet the same personal eligibility requirements of the other Medicaid programs. Thus, if a child applies separately, the child must meet the personal eligibility requirements of the Medicaid program for infants and children under age 21, or for disabled children. If the whole family is applying under the medically needy program, then the family must meet the personal eligibility requirements of the Work First or former AFDC program. If an older adult or person with a disability applies, they must meet the personal eligibility requirements of the Aged, Blind and Disabled program (see preceding sections).

Income Eligibility

Individuals or families who cannot qualify for other programs because of excess income may still be able to qualify for Medicaid under the medically needy program with a deductible. The individual's or family's countable income is compared to the medically needy income limits and the difference is the monthly deductible or "spend-down."

<u>Family Size</u>	<u>Medically Needy Monthly Income Limit</u>
1	\$242
2	\$317
3	\$367
4	\$400
5	\$433
6	\$467
7	\$500
8	\$525

These figures were last revised January 1, 1990, and are subject to change by the North Carolina General Assembly.

Example: A family of four who has \$800 in countable monthly income.
\$800 – countable monthly income
- 400 – medically needy income limits
\$400 – monthly deductible or "spend-down"

If the family wants ongoing Medicaid coverage, the amount of the deductible is calculated on a six-month prospective basis. In the example outline above, the family would have to incur \$2,400 in medical bills (\$400 deductible ► 6 months = \$2,400). After the family meets the deductible, Medicaid will pay medical bills for covered services for the remaining of the six-month period.

Alternatively, families can request that the Medicaid coverage be retroactive—that is, that Medicaid cover medical bills incurred in the one-, two-, or three-month period prior to applying. The amount of the deductible would be calculated accordingly.

Note: the family need not actually pay the medical bills in order to qualify. They must, however, be responsible for paying those medical bills. Medical bills that will be paid by a third party (such as an insurance company) cannot be applied to the deductible. Medical bills that a family incurs to cover the cost of health insurance, medical services, over the counter medications, or products can be used in meeting a deductible.

Resource Eligibility

For families who qualify under “medically needy” requirements, there is a \$3,000 resource limit (regardless of family size). All real property is excluded if someone is applying as medically needy under any of the families with children program categories. For older adults and people with disabilities, the person’s homesite plus all contiguous property is excluded from the resource calculation.

Note: as with other Medicaid programs, if you exceed the resource limits, you are not eligible for Medicaid. Applicants should be wary, however, of transferring assets in order to qualify for Medicaid. Please see the information on page 93 about transferring assets.