

Center for Medicaid and State Operations 7500 Security Boulevard Baltimore, MD 21244-1850

August 29, 2000

Dear State Medicaid Director:

This is the second in a series of letters that provide guidance on the implementation of the "Ticket to Work and Work Incentives Improvement Act of 1999" (TWWIIA). This legislation improves access to employment training and placement services for people with disabilities who want to work. It also offers States unprecedented opportunities to eliminate barriers to employment for people with disabilities by improving access to health care. Our first letter, dated March 29, 2000, provided (a) general information about the legislation, (b) an overview of our plans for implementing the two new Medicaid eligibility groups created by the legislation, and (c) a description of our plans for issuing grants to assist States with the infrastructure and for demonstration projects.

This letter provides more detailed information about the two new Medicaid eligibility groups. Those groups are briefly described below, with particular emphasis (as discussed in the enclosure to this letter) on how eligibility is determined for those applying for coverage under these groups.

New Eligibility Groups Related to Employment (Section 201 of the legislation). TWWIIA created two new optional categorically needy Medicaid eligibility groups.

Under what we are calling the "**Basic Coverage Group**" (otherwise known as the subsection (XV) eligibility group), States can cover individuals who are age 16 or over, but under age 65, and who, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits, regardless of whether they have ever received SSI cash benefits. This group is similar to the group created by section 4733 of the Balanced Budget Act (BBA), except that eligibility is not limited to people with family income below 250 percent of the Federal poverty level family income limit, AND under this new group States are free to establish their own income and resource standards

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(including the option to have no income or resource standards at all).

Under what we are calling the "**Medical Improvement Group**," States can cover employed individuals with a medically improved disability who lose Medicaid eligibility under the Basic Coverage Group described above because their medical conditions have improved to the point where they are no longer disabled under the SSI definition of disability. If a State wants to cover this group, it must cover the Basic Coverage Group described above.

As with the original BBA group, States may impose premiums or other cost-sharing charges on a sliding scale based on income for individuals eligible under both of the new eligibility groups. For individuals with annual adjusted gross income (as defined by the IRS) that exceeds \$75,000, States are required to charge 100 percent of the premiums they may impose. However, States can subsidize the premium cost for these individuals, using State funds.

Both of these new eligibility groups become effective on October 1, 2000.

I enclose a detailed explanation of how eligibility is determined under the two new groups. We have also developed draft State plan preprint pages which States can use, if they wish, when submitting Medicaid State plan amendments to implement either or both of these groups. The draft preprint pages are available from your HCFA regional office eligibility contact or State Representative, from the HCFA Central Office contact shown below, or they can be downloaded from HCFA's Work Incentives website at www.hcfa.gov/medicaid/twwiia/twwiiahp.htm.

If you have questions about the new eligibility groups created by the Ticket to Work and Work Incentives Improvement Act of 1999, please contact Roy Trudel of my staff at 410-786-3417 ([e-mail rtrudel@hcfa.gov](mailto:rtrudel@hcfa.gov)).

We look forward to working with you as you consider the options available to your State under this legislation, which has the remarkable potential to assist people with disabilities to work in competitive employment.

Sincerely,

/s/

Timothy M. Westmoreland
Director

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Enclosure

cc:

Richard Riley Secretary Department of Education

Alexis Herman Secretary Department of
Labor

Page 3 – State Medicaid Director

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All HCFA Regional Administrators

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Bryon R. MacDonald Social Security Subcommittee Co-Chair National Council on Independent Living

Matt Salo Director of Health Legislation National Governors' Association

Becky Ogle Executive Director President's Task Force on the Employment of People with Disabilities

State Options for Medicaid Coverage

to Enable People with Disabilities

to Work

**Health Care Financing Administration
Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group**

August 2000

ENCLOSURE

EXPLANATION OF ELIGIBILITY GROUPS

I.	Basic	Coverage	Group
A.	Key Elements.....	1	
B.	Defining Work	3	
II. Medical Improvement Group			
A.	Key Elements	4	
B.	Defining "Employed Individual" and Work.....	5	
C.	Defining "Medically Improved Disability"	6	
III. Premiums and Cost-Sharing			
A.	Key Elements.....	7	
B.	Sliding Scale Based on Income.....	8	
C.	Private Health Insurance.....	9	
<small>file:///F:/New%20Website%20Content/PCPG%20Files/2000/2000/smd082900.asp (4 of 14)4/12/2006 12:58:48 PM</small>			
IV.	Maintenance of Effort	10	

The "Ticket to Work and Work Incentives Improvement Act of 1999" (TWWIIA) created two new Medicaid eligibility groups to allow States to provide Medicaid to certain individuals with disabilities who want to work, or who are already working but want to increase their earnings. Both groups are optional categorically needy groups. Following is detailed information about these groups, including how eligibility is determined and your options for charging premiums and other cost-sharing expenses.

I. BASIC COVERAGE GROUP

A. Key Elements Under Section 1902(a)(10)(A)(ii)(XV) of the Act

To be eligible under this group, an individual must:

- Be at least 16 but less than 65 years old;
- Be disabled as defined under the SSI program (except for earnings);

Have income and resources that do not exceed a standard established by the State.

You have sole discretion to establish income and/or resource standards for this group, including the choice not to have any income and/or resource standard at all if you wish.

The following rules and requirements apply to this group:

- If you choose to establish an income and/or resource standard, SSI methodologies apply in determining eligibility, including the SSI earned income disregard of \$65 plus one-half of the remainder. Unlike the BBA Group, all earned income is not automatically disregarded in determining eligibility under this group. However, you can use section 1902(r)(2) of the Act (described below) to disregard additional earned income beyond the SSI earned income disregard, including a total disregard of earned income.

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Section 1902(r)(2) of the Act (optional use of more liberal income and resource methodologies than are used by the SSI program) applies to this group.

The limitations on Federal Financial Participation (FFP) at section 1903(f) of the Act do not apply to this group. This means that States can use more liberal income methodologies under section 1902(r)(2) without the usual FFP restrictions.

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file:///F:/New%20Website%20Content/PCPG%20Files/2000/2000/smd082900.asp (5 of 14)4/12/2006 12:58:48 PM

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- If a State exercises its option not to establish an income and resource standard for this group, the above requirements are not applicable.

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- Section 1902(f) (209(b) States) applies to this group. 209(b) States may (but are not required to) apply their more restrictive eligibility criteria in determining eligibility for this group.

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- There is no requirement that an individual must at one time have been an SSI recipient to be eligible under this group. However, if the individual is not currently an SSI or SSDI recipient, you must do a disability determination to ensure that the individual would meet the definition of disability under the SSI program. NOTE: The disability test must be identical to the SSI/SSDI disability test except that employment activity, earnings, and substantial gainful activity (SGA) must not be considered in determining whether the individual meets the definition of disability.

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- Because this is an optional categorically needy eligibility group, the benefits and services available to individuals eligible under the group are the same as are available to the categorically needy under your State plan.

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- You may provide services under a home and community-based services (HCBS) waiver to individuals eligible under this group. To do so, you must amend an existing waiver (or apply to

HCFA for a new waiver) to cover the group. Individuals receiving services under an HCBS waiver must meet the level of care requirement (i.e., would require the level of care provided in a medical institution if not for receipt of waiver services). NOTE: Individuals eligible for Medicaid under the Basic Coverage Group are eligible under community, not institutional rules. Therefore, institutional rules under HCBS waivers (including spousal impoverishment, institutional deeming of income and resources, and post-eligibility treatment of income) do NOT apply to this group.

B. Limitations on Defining Employment Under the BBA and Basic Coverage (Subsection (XV)) Groups

We are aware that many States, concerned about the potential costs of covering one or more of the eligibility groups created by TWWIIA and the BBA, would like to define "employment" or "work" in a manner similar to the definition of employment discussed later for the Medical Improvement Group. We appreciate States' concerns, but must make it clear that under the statute, defining employment for the Medical Improvement Group applies only to the Medical Improvement Group. There is no authority under the statute to apply that definition (or any similar definition) to the Basic Coverage Group

file:///F:/New%20Website%20Content/PCPG%20Files/2000/2000/smd082900.asp (6 of 14)4/12/2006 12:58:48 PM

(subsection (XV)) described previously, nor can it be applied to the existing eligibility group created by section 4733 of the BBA (section 1902(a)(10)(A)(ii)(XIII) of the Act).

For both the BBA group and the Basic Coverage Group, you:

- Must require that an individual have earned income; i.e., that the individual be working;

- May require that the individual provide evidence of employment or work; for example, pay stubs, evidence of FICA taxes paid, or other evidence of employment that the State finds appropriate and necessary.

- May use your options under the premium and cost-sharing process (described in more detail below) to encourage substantive work efforts while discouraging participation by individuals with high levels of unearned income (e.g., SSDI or other benefits) who do not intend to engage in a substantive work effort. For example, you can establish a two-tiered cost-sharing structure that charges a low amount on earned income, but a high amount on unearned income above a personal maintenance level.

However, under the law a State cannot establish a definition of work or employment for the Basic Coverage Group (or the BBA Group) that sets a minimum standard for number of hours worked during a period of time, or a minimum level of earnings. Any such definition is inherently more restrictive than permitted under the applicable provisions of the Medicaid statute, and as such would be out of compliance with the statute.

NOTE: See section III. below for information concerning State options for requiring payment of premium or other cost-sharing charges. See section IV. below for information on maintenance of effort

requirements.

II. MEDICAL IMPROVEMENT GROUP SECTION 1902(a)(10)(A)(ii)(XVI) OF THE ACT

NOTE: TO COVER THIS GROUP, YOU MUST ALSO COVER THE BASIC COVERAGE GROUP DISCUSSED ABOVE.

A. Key Elements

To be eligible under this group, an individual must:

Be at least 16 but less than 65 years of age;

Be employed and have a medically improved disability (see below for further explanation); •

Have been eligible under the Basic Coverage Group discussed above, but lost that eligibility because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer meet the definition of disability under the SSI or SSDI programs;

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- Have income and resources that do not exceed a standard established by the State.

You have sole discretion to establish income and/or resource standards for this group, including the choice to not have any income and/or resource standard at all if you wish.

The following rules and requirements apply to this group:

- If you choose to establish an income and/or resource standard, SSI methodologies apply in determining eligibility, including the SSI earned income disregard of \$65 plus one-half of the remainder. Unlike the BBA Group, all earned income is not automatically disregarded in determining eligibility under this group. However, you can use section 1902(r)(2) of the Act (described below) to disregard additional earned income beyond the SSI earned income disregard, including a total disregard of earned income.
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- Section 1902(r)(2) of the Act (optional use of more liberal income and resource methodologies than are used by the SSI program) applies to this group.
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- The limitations on Federal Financial Participation (FFP) at section 1903(f) of the Act do not apply to this group. This means that States can use more liberal income methodologies under section 1902(r)(2) without the usual FFP restrictions.
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- If a State exercises its option not to establish an income and resource standard for this group, the above requirements are not applicable.
-
- Section 1902(f) (209(b) States) applies to this group. 209(b) States may (but are not required to) apply their more restrictive eligibility criteria in determining eligibility for this group.
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- There is no requirement that an individual must at one time have been an SSI recipient to be eligible under this group. A disability test, different from the SSI/SSDI disability test, will apply

file:///F:/New%20Website%20Content/PCPG%20Files/2000/2000/smd082900.asp (8 of 14)4/12/2006 12:58:48 PM

and is discussed below in Part II.C. below.

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- Because this is an optional categorically needy eligibility group, the benefits and services available to individuals eligible under the group are the same as are available to the categorically needy under your State plan.
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- You may provide services under a home and community-based services (HCBS) waiver to individuals eligible under this group. To do so, you must amend an existing waiver (or apply to HCFA for a new waiver) to cover the group. Individuals receiving services under an HCBS waiver must meet the level of care requirement (i.e., would require the level of care provided in a medical institution if not for receipt of waiver services). NOTE: Individuals eligible for Medicaid under the Medical Improvement Group are eligible under community, not institutional rules. Therefore, institutional rules under HCBS waivers (including spousal impoverishment, institutional deeming of income and resources, and post-eligibility treatment of income) do NOT apply to this group.

Employed Individual with a Medically Improved Disability

To be eligible under the Medical Improvement Group, an individual must be employed, and have a medically improved disability. In the interest of clarity, the following addresses the definitions of "employed individual" and "medically improved disability" as separate topics.

B. Employed Individual

For purposes of determining eligibility under the Medical Improvement Group, an employed individual is one who:

- Is at least age 16 but less than 65 years of age; and

- Is earning at least the Federally required minimum wage AND is working at least 40 hours per month; OR is engaged in a work effort that meets an alternate definition of substantial and reasonable threshold criteria for hours of work, wages, or other measures as defined by the State and approved by the Secretary.

State-Defined Work Effort

As noted above, a State may establish its own definition of employment that differs from the minimum level of earnings and hours worked per month set forth in the statute. A State's alternative definition of work effort must be approved by HCFA. If a State wishes to establish an alternative definition of work effort, it should do so as part of an amendment to its Medicaid plan to cover the Medical Improvement

file:///F:/New%20Website%20Content/PCPG%20Files/2000/2000/smd082900.asp (9 of 14)4/12/2006 12:58:48 PM

Group.

At this time HCFA does not plan to approve alternative definitions of work effort that involve an across-the-board change in the statutory number of hours worked per month or level of earnings described above. We believe that Congress intended those levels to serve as the reasonable baseline for work effort for the Medical Improvement Group as a whole, and thus should serve as the standard most individuals eligible under the group should be expected to meet.

However, we recognize that there is considerable diversity among people with disabilities, including relative degrees of disability, the employment opportunities available to them, and many other considerations that can affect types and amounts of work people with disabilities do, and consequently how work effort can be measured. Therefore, we will consider alternative definitions of work effort involving different levels of earnings and/or hours worked for identifiable groups of individuals with disabilities provided the State can clearly define the group involved and explain why the proposed alternative definition is in fact reasonable and necessary for members of that group.

We will also consider alternative definitions of work effort using threshold criteria (and ways of determining if those criteria are met) that do not necessarily rely on measuring earnings levels and/or hours worked. It is quite possible that people with disabilities have access to employment and work opportunities where the number of hours worked or level of earnings is not the best or most valid measurement of the quality of the work effort. An example might be people who are self-employed. We believe States are in the best position to identify such situations and address them through alternative definitions and measurements of work effort. Therefore, we will definitely consider such alternative definitions, where appropriate, as part of an amendment to your Medicaid plan to cover the Medical Improvement Group.

C. Defining "Medically Improved Disability"

For purposes of determining eligibility under the Medical Improvement Group, an individual with a medically improved disability is one who:

- Was eligible for Medicaid under the Basic Coverage (subsection (XV)) Group discussed above;
- Continues to have a medically determinable severe impairment, but

- Whose disability, impairment, or condition has, by reason of medical improvement, improved to

the point where the individual has lost eligibility under the Basic Coverage (subsection (XV)) Group because it was determined, at the time of a regularly scheduled continuing disability review, that he or she no longer met the definition of disability under the SSI and SSDI programs.

It is important to emphasize that the loss of eligibility under the Basic Coverage Group must be the

file:///F:/New%20Website%20Content/PCPG%20Files/2000/2000/smd082900.asp (10 of 14)4/12/2006 12:58:48 PM

direct and specific result of loss of disability status because of medical improvement. Loss of disability status for a reason unrelated to medical improvement would not qualify as loss because of medical improvement.

Under the statute, the Secretary is required to define the term "medically determinable severe impairment." Information concerning how that term is defined, as well as information on other related disability issues in the context of the work incentives legislation, will be forthcoming in a separate letter to State Medicaid Directors.

NOTE: See section III below for information concerning State options for requiring payment of premiums or other cost-sharing charges. See section IV below for information on maintenance of effort requirements.

III. PREMIUMS AND COST-SHARING CHARGES

Under the existing eligibility group created by section 4733 of the BBA (section 1902(a)(10)(A)(ii) (XIII) of the Act), States may (but are not required to) require eligible individuals to pay premiums or other cost-sharing charges. If States require such payments, the amount must be set on a sliding scale based on income.

TWWIIA also permits States to require payment of premiums or other cost-sharing charges by individuals eligible under both the Basic Coverage Group and the Medical Improvement Group. While some aspects of the premium and cost-sharing requirements under TWWIIA are similar to those under the BBA, many are different.

A. Key Elements of TWWIIA Premiums and Cost-Sharing

The rules applicable to payment of premiums or other cost-sharing charges under TWWIIA are discussed below. The same basic rules apply to both the Basic Coverage (subsection (XV)) Group and the Medical Improvement Group, and your requirements for payment of premiums or other cost-sharing charges must apply equally to all individuals eligible under either of the two groups.

It should also be emphasized that while you have the option to require payment of premiums or other cost-sharing charges, you are not required to do so. A State can elect to impose no premium or cost-sharing charges at all on individuals eligible under either or both of these groups.

For individuals eligible under the Basic Coverage (subsection (XV)) Group and the Medical Improvement Group you may, in a uniform manner for all individuals eligible under those groups:

a. Require individuals to pay such premiums or other cost-sharing charges, set on a sliding scale based

file:///F:/New%20Website%20Content/PCPG%20Files/2000/2000/smd082900.asp (11 of 14)4/12/2006 12:58:48 PM

on income, as the State may determine;

b. For any individual whose annual family income is less than 450 percent of the Federal poverty level, you can require payment of premiums only to the extent that the amount of the premiums does not exceed 7.5 percent of the individual's income.

c. For any individual whose (IRS) adjusted gross income exceeds \$75,000 annually, you must charge 100% of premiums.

B. Sliding Scale Based on Income

The requirement under (a.) above that payments be on a sliding scale based on income applies to both premiums and other cost-sharing charges. While the degree to which such premiums and charges increase with increasing levels of income is up to the State, the underlying principle is that individuals with higher levels of income should contribute more toward the cost of services they receive than those with less income. A percentage premium or cost-sharing charge (e.g., 5 percent of income) is, by definition, on a sliding scale based on income because the actual amount paid increases as income increases.

For purposes of this provision, premiums are defined as fees (usually monthly) that are charged to secure coverage under one of the work incentives Medicaid eligibility groups. Premiums would normally be paid by the individual directly to the State Medicaid agency. By contrast, cost-sharing charges are defined as any other charges that the State may establish through which an individual eligible under one of the work incentives groups shares in the cost of the care and services provided to him or her under the Medicaid program. Cost-sharing charges can either be paid by the individual directly to the State Medicaid agency, or paid by the individual to providers of services in the form of co-pays, deductibles, or co-insurance payments.

A flat cost-sharing or co-payment charge (e.g., \$5.00 for each doctor's visit) does not, if applied alone, meet the requirement that charges be on a sliding scale based on income. However, you can use a flat cost-sharing charge system provided that premiums charged to eligible individuals rise with increasing income, either because the premium is a percentage of income or the specified dollar amount of the premium increases as the individual's income increases. A flat cost-sharing charge in conjunction with a sliding scale premium produces an aggregate premium/cost-sharing charge that would meet the requirement that such charges be on a sliding scale based on income.

This means, for example, that a State's normal cost-sharing requirements, when used in conjunction with a sliding scale premium structure, would meet the sliding scale based on the income requirement. So long as there is a sliding scale premium structure, there is no need for a State to incur the added administrative expense of establishing a cost-share system which is different from that used in the rest of its Medicaid program.

It is important to emphasize that while under (a.) above you may require payment of premiums and other cost-sharing charges, the limitation of 7.5 percent of annual income described in (b) above applies only to premiums. The restrictions and requirements outlined in items (b.) and (c.) do not apply to cost-sharing charges that are not premiums.

Regardless of whether or not you exercise your option to require payment of premiums and other cost-sharing charges for the individuals described above you are required, under the statute, to charge 100 percent of premiums for certain other individuals. Individuals subject to payment of 100 percent of premiums are those whose adjusted gross annual income (as determined under the IRS statute) exceeds \$75,000. This amount will increase each year after 2000 by the percentage of the annual Social Security cost-of-living increase.

If you exercise the option described above to require individuals eligible under these groups to pay premiums, "100 percent of premiums" would be the highest amount of premiums that an individual would be required to pay under your premium structure. For individuals with income below \$75,000, you can require payment of the same amount of premiums, or a lower amount, provided the total premium for individuals with income below 450 percent of the poverty level does not exceed 7.5 percent of the person's income.

You may, if you wish, subsidize payment of premiums for individuals whose income exceeds \$75,000. However, any such subsidy must be made solely with State funds. No Federal matching funds are available for such subsidies.

C. Private Health Insurance and TWWIA Premiums or Other Cost-Sharing Charges

In some instances an individual eligible under the Basic Coverage Group or the Medical Improvement Group may have access to private health insurance coverage; for example, through employment or membership in an organization. If the individual could be covered under such private health insurance at no cost to him or her you may require, under your premium and cost-sharing rules, that the individual take advantage of that insurance. Where private insurance in the form of a group health plan is available to the individual, although at some cost, section 1906 of the Act allows States to enroll individuals in such plans provided such enrollment is cost-effective AND the State pays the cost of enrollment in the plan, including premiums, deductibles and co-insurance

Unless the State pays the full cost of enrollment in the private health insurance plan (including all premiums, deductibles and co-insurance) you may not require individuals to take advantage of the availability of private health insurance. Section 1906 of the Act does not permit mandatory enrollment in private health insurance when that insurance involves a cost to the individual.

IV. MAINTENANCE OF EFFORT REQUIREMENT

Under the statute, States are not permitted to supplant State funds directed toward programs to enable working individuals with disabilities to work with Federal funds used to provide benefits under the Basic Coverage Group and the Medical Improvement Group. If a State covers either or both of the eligibility groups discussed above, Federal Financial Participation (FFP) will not be available for services provided to individuals eligible under those groups for any fiscal year unless the State establishes, to the satisfaction of the Secretary, that its expenditures for those programs are not less than its expenditures for such programs for the fiscal year ending before December 17, 1999.

We will provide additional information concerning this requirement, including procedures to follow to establish and submit to HCFA baseline expenditure levels and annual reports on State expenditures, as well as HCFA's review and determination process, in a separate letter to State Medicaid Directors.

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