



Advocate

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MEDICAID, MEDICARE AND WORK

*Using the Medicaid and Medicare Work Incentives to Retain
a Funding Source for Assistive Technology and Other Key Services*

The Ticket to Work and Work Incentives Improvement Act of 1999, in its “findings” section, recognizes the importance of assistive technology (AT) in helping individuals with disabilities to work:

Coverage ... for [personal assistance services], as well as for prescription drugs, durable medical equipment, and basic health care are powerful and proven tools for individuals with significant disabilities to obtain and retain employment. 42 U.S.C. § 1320b-19(a)(4)(emphasis added).

Individuals with disabilities have greater opportunities than ever before, aided by innovations in assistive technology, medical treatment and rehabilitation. 42 U.S.C. § 1320b-19(a)(7).

The availability of AT can make a tremendous difference in the ability of an individual to work, even when that individual has a severe disability. In the work context, AT may make it possible to: participate in an education or training program; prepare to leave the home for work or training; and travel to and from work. In some cases, the work itself could not be done without the AT.

In both the Medicaid and Medicare programs, what we might refer to as AT is most often categorized as durable medical equipment (DME). Although DME often makes it possible for individuals to work, DME typically serves much more basic functions, allowing individuals to achieve, for example: functional mobility (wheelchairs, powered scooters, walkers);

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functional communication (augmentative and alternative communication devices, also known as speech generating devices); and functional hearing (hearing aids, other hearing devices). Other items of DME allow individuals to either avoid or recover from a range of health problems, such as decubitus ulcers (a major justification for specialized beds, tilt and space features on wheelchairs, standing frames, and therapeutic whirlpool equipment). The reality is that all of these items of DME and many others make it much more likely that individuals will be able to obtain or retain employment, by allowing them to either overcome the limitations caused by their disabilities or maintain basic health.

Congress, the Social Security Administration (SSA), and the Centers for Medicare and Medicaid Services (CMS) recognize that the fear of losing Medicaid or Medicare because of work activity is a significant barrier to employment for beneficiaries of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Recognizing that, Congress, SSA, and CMS have, at various times over the past 25 years, introduced new laws and regulations or amended existing laws and regulations to make it easier to obtain or retain Medicaid and Medicare as individuals with severe disabilities enter or re-enter the workplace. These initiatives include Medicaid's 1619(b) and buy-in programs, and the extended Medicare provisions.

This article will describe how these work incentives fit into the SSI and SSDI programs and how an individual establishes eligibility for them. Additionally, we describe how some of the other SSI or SSDI work incentives coincidentally allow for continuation of Medicaid or Medicare, by enabling the beneficiary to retain cash benefits while working. We will also explain how the SSI work incentives will apply to the calculation of income and resources in many of the optional state medically needy programs, allowing individuals to either limit or avoid Medicaid spend downs as their earned income increases.

Ironically, at a time when Congress, SSA, and CMS are actively promoting the work incentives for individuals with disabilities, restrictive policies at the state and federal levels often make it difficult to obtain Medicaid or Medicare-funded DME if a purpose of the DME will be to function independently outside of a home or apartment. Although we recognize this

and will continue to devote resources to help attorneys and advocates overcome these restrictive policies, those issues will not be discussed within this article.

This article will use 2007 figures whenever they are available and note when figures from 2006 or other years are being used.

Medicaid: SSI and the Section 1619(b) Program

What is Medicaid?

Medicaid, also known as Medical Assistance, is a cooperative federal-state program authorized by Title XIX of the Social Security Act. 42 U.S.C. §§ 1396 et seq. It is a health insurance program, designed to serve persons with limited income and resources. Although every state has the option of whether or not to have a Medicaid program, every state has exercised that option. Administration will occur at the state level, with the state Medicaid agency often delegating decision making to other state agencies, to county or local Medicaid units, or to managed care organizations. Medicaid often pays for very expensive items or services, such as DME, home health care, prescription drugs, psychiatric counseling, and a range of other services that will depend, in part, on whether your state has included various optional services in its Medicaid Plan.

Medicaid is typically the only or most important health insurance plan for persons with disabilities who have limited income. Additionally, an increasing number of individuals with disabilities are looking to Medicaid as an important, long-term health insurance plan,

“Bridges to Better Advocacy”

Conference:

***Join Us in Austin, Texas,
March 28-30, 2007***

Our 11th annual “Bridges” conference will take place again at the Hilton Garden Inn (formerly the Capitol Place Hotel) in Austin, Texas. Our traditional two-day event will take place on March 29th and 30th (Thursday-Friday). An optional pre-conference is scheduled for Wednesday, March 28th and will focus on special education.

A flyer and registration form is available as an insert to this newsletter or is available on the National AT Advocacy Project's website, www.nls.org/natmain.htm.

Medicaid Waivers Can Support Work Activity

A Centers for Medicare and Medicaid Services (CMS) approved waiver allows a state to operate outside the confines of specified federal mandates for the Medicaid program, often to test innovative approaches to delivery of services or to extend or expand coverage for a targeted population. For example, the “home and community-based services” (HCBS) waiver allows Medicaid agencies to serve individuals who would be eligible for Medicaid if institutionalized. These are often called 1915(c) waivers, 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(VI), 1396n(b)-(e), and can be used to offer a broader range of services than are offered to Medicaid recipients under the general state plan. Although states are not required to implement waiver programs, all states have one or more CMS-approved HCBS waivers.

HCBS waivers can be used to provide an array of services for targeted populations that either are not available as mandated or optional services under the federal Medicaid Act, or are not available because the state does not cover all optional services. PAAT attorneys and advocates may be very familiar with one or more waiver programs in their state that cover AT that would not otherwise be covered by the regular Medicaid program. For example, in Iowa's brain injury waiver program (www.ime.ia.state.us/docs/BIPacket.doc), home modifications, blind/visual disability aids, telecommunication devices for the deaf (TDDs), environmental controls, computer software, educational/vocational aids, and vehicle modifications can be funded.

In 1997, the HCBS regulations were amended to allow for “expanded habilitation services,” which include “prevocational services” and “educational services.” 42 C.F.R. § 440.180(c)(2)(I) & (ii). Under the prevocational and educational services categories, CMS would allow an approved waiver to provide a wide range of services that would prepare an individual with a very severe disability to eventually move to either competitive employment, long term supported employment, or a more traditional vocational rehabilitation program. Services available through the expanded habilitation services category include:

- Teaching an individual such concepts as compliance, attendance, task completion, problem solving, and safety;
- Supported employment services (which presumably includes job coaching) that are provided in integrated work settings with an assumption that the individual is not receiving a competitive wage (at or above minimum wage) during the period they receive services;
- Any combination of special supervisory services, training, transportation, and adaptive equipment that the state demonstrates are essential for engaging in paid employment.

notwithstanding higher levels of income. Medicaid may be available to those individuals through the section 1619(b) provisions, through optional Medicaid buy-in programs, or through state-specific Medicaid waivers.

SSI Recipients are Automatically Eligible for Medicaid in Most States

Medicaid eligibility criteria will vary somewhat from state to state. Generally, persons with severe disabilities will become Medicaid-eligible in one of two ways: through the SSI program or through the medically needy program. In 39 states, the District of Columbia, and the Northern Mariana Islands, an individual eligible for SSI is automatically eligible for Medicaid. 42 U.S.C. § 1396a(a)(10)(A)(i). If the SSI check is as little as \$1, eligibility is guaranteed. In most of these states, an SSI application is also a Medicaid application and no additional action is needed to ensure Medicaid eligibility. However, the following states require a separate Medicaid application: Alaska, Idaho, Kansas, Nebraska, Nevada, Oregon, Utah, and

the Northern Mariana Islands.

In 11 states, known as section 209(b) states, Medicaid eligibility is not automatic for SSI recipients. These states use their own Medicaid eligibility criteria which differs from SSI eligibility criteria. The states which exercise the 209(b) option are: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. SSA Program Operations Manual System (POMS) SI 01715.020.

Section 1619(b): Continued Medicaid for Beneficiaries Who Lose SSI Through Earnings

Continued Medicaid coverage, through section 1619(b), is one of the most important work incentives that exists within the SSDI and SSI programs. 42 U.S.C. § 1382h(b). Section 1619(b) provides Medicaid to persons who lose cash SSI because countable earnings equal or exceed the SSI payment rate. For example, in states which pay the 2007 federal benefit rate of \$623, with no state supplement, gross monthly

wages of \$1,331 will result in \$623 in countable income, reducing the SSI check to \$0.

Under 1619(b) criteria, a person must:

- 1) continue to be blind or disabled (a person age 65 or older may qualify if also blind or disabled);
- 2) have unearned income less than the SSI limit;
- 3) have resources within SSI limits;
- 4) meet a prior month requirement;
- 5) meet a Medicaid use test; and
- 6) meet an income “threshold” test. POMS SI 02302.010 B.

Items (2) through (6) require some discussion. A person who would be ineligible for SSI, based on unearned income alone, cannot be eligible for 1619(b). For example, in a state which does not supplement the 2007 federal benefit rate of \$623, an SSDI payment of \$700 per month would make a person ineligible for SSI, without regard to any additional earnings. This would make the person ineligible for 1619(b), even if he or she met the rest of the 1619(b) criteria. Similarly, an individual whose resources, after exclusions, exceed \$2,000 would be ineligible for 1619(b) Medicaid. 20 C.F.R. § 416.1205(c). (Note: If your state has established a Medicaid buy-in program, that individual might separately qualify for Medicaid through the buy-in even though unearned income or resources are above 1619(b) limits.)

Under the “prior month” analysis, to be initially eligible for 1619(b) a person must have been eligible to receive an SSI check during the past 12 months. A person would lose prior month status for 1619(b) only if he or she went through a period of 12 consecutive months without any entitlement to an SSI check or 1619(b) benefits. POMS SI 02302.010 D.

The “Medicaid use test” should be easy to meet in most cases. This test is met if the person (1) used Medicaid within the past 12 months; (2) expects to use Medicaid in the next 12 months; or (3) would be unable to pay unexpected medical bills in the next 12 months without Medicaid. POMS SI 02302.040 A.1. The criteria in (1) and (2) are straightforward. Most people who really need Medicaid will fit into one of the categories. Furthermore, only the rare individual with superior medical insurance and great job security will be outside the scope of criterion (3).

The final 1619(b) criterion is the “income threshold” test. To meet this test, one must have annual gross earnings below a certain “threshold.” The purpose is to measure whether

an individual has sufficient earnings to provide the equivalent of SSI benefits, Medicaid, and publicly funded attendant care. POMS SI 02302.045 A. The 1619(b) eligibility thresholds vary greatly from state to state, with 2007 thresholds ranging from a low of \$22,174 in Tennessee to a high of \$52,407 in Connecticut, as the threshold is based on a combination of the state’s SSI rate and its annual per capita Medicaid expenditures.

There is both a “general threshold,” which applies to all individuals in a state, and an “individualized threshold,” which will be specific to an individual. A person who meets the other 1619(b) criteria will be eligible for Medicaid if annual earnings are below the general threshold. If the person’s income is above that threshold, he or she may still be eligible if individual expenses are high enough.

The general threshold is calculated by adding together a base amount and a Title XIX (Medicaid) amount. POMS SI 02302.045 B.1. In New Mexico, for example, the 2007 threshold is \$32,016 (base of \$15,972 + Title XIX of \$16,044). In other states, the threshold may be higher or lower. (The thresholds for each state are published in POMS SI 02302.200.)

Example, general 1619(b) threshold.

Mary was getting SSI benefits of \$623 and Medicaid until March 2007 when she started working a job that pays \$18,000 per year (\$1,500 per month). She will lose her cash benefits, but should be able to keep Medicaid in New Mexico (and all states) under the 1619(b) program so long as other criteria are met. All states have eligibility thresholds that are higher than \$18,000 per year.

If the general threshold is exceeded, 1619(b) eligibility is determined under an “individualized threshold” by totaling the following: Medicaid amount from the threshold chart, or actual Medicaid expenses if higher; blind work expenses; impairment related work expenses; expenditures under an approved Plan for Achieving Self-Support (PASS)(In most states, an SSI beneficiary with an approved PASS will be eligible for Medicaid automatically and have no need for 1619(b)); and publicly funded personal/attendant care that would be lost if the individual lost SSI. These expenses are then added to the base amount. The sum is the individualized threshold. POMS SI 02302.050 C. (An individualized threshold

calculation worksheet can be found at POMS SI 02302.300.)

Example, individualized 1619(b) threshold. Assume that Mary in the preceding example resides in Utah where the 2007 general threshold is \$26,524 in gross annual wages. Mary gets a promotion and will now be earning \$28,000 in gross annual wages, just above Utah's general 1619(b) threshold. Mary has \$15,000 per year in Medicaid-funded expenses.

Mary's individualized threshold is determined by taking the base amount from the 1619(b) chart in SSA's POMS manual (\$15,972 for Utah) and adding the annual amount that would be paid by Medicaid (\$15,000). Adding those two figures provides you with her individualized eligibility threshold, \$30,972 per year. Since Mary's new annual wage, \$28,000, is less than her individualized threshold of \$30,972 she remains eligible for Medicaid

under 1619(b).

Some individuals will access 1619(b) eligibility at very low levels of earnings.

Some individuals get very small SSI checks because their SSI payment supplements another source of income, such as SSDI payments. Such an individual would lose SSI with a very modest level of earnings.

Example, accessing 1619(b) with low wages.

Cynthia receives \$520 in SSDI benefits and \$123 in SSI benefits. She goes to work part time and earns \$365 per month in gross wages.

Cynthia now has \$500 of countable unearned income ($\$520 - 20 = \500) and \$150 in countable earned income ($\$365 - 65 - 150 = 150$), making her total countable income \$650. Since that is more than the \$623 federal benefit rate paid in her state, she will lose SSI. Under these facts, Cynthia should be able to continue Medicaid through 1619(b) because she lost SSI due to wages.

***Outreach to Promote the Medicaid and Medicare Work Incentives:
An Area for Collaboration Between PAAT and PABSS Programs***

The Protection and Advocacy for Assistive Technology (PAAT) and Protection and Advocacy for Beneficiaries of Social Security (PABSS) programs work under two different mandates. For PAAT, the advocacy and related activities are to be directed toward helping individuals with disabilities obtain AT devices and services. For PABSS, those activities are to be directed toward helping SSI and SSDI beneficiaries overcome barriers to work. For users of Medicaid or Medicare-funded durable medical equipment (DME), both of those mandates are met when a beneficiary is able to utilize the work incentives to retain Medicaid or Medicare following a loss of cash benefits due to earnings.

In the case of PAAT programs, outreach and training activity to educate individuals with disabilities about these work incentives should result in more of those individuals being able to access Medicaid or Medicare as a funding source for DME. A secondary result of that outreach effort should be to inform individuals about the availability of PAAT services to challenge a denial of DME (i.e., AT) through Medicaid, Medicare, or another funding source.

In the case of PABSS programs, the goal of the outreach is much broader – i.e., it should result in beneficiaries being able to access Medicaid or Medicare for the full range of services (including DME) covered by those programs. A secondary goal, of course, is to make the beneficiaries and others attending the outreach sessions aware of the availability of PABSS services to assist with any case that seeks to remove a barrier to work. Such a case could involve enforcement of the 1619(b), Medicaid buy-in, or extended Medicare provisions. It could even involve representing the beneficiary at a Medicaid or Medicare hearing to challenge a denial of funding for DME if winning the hearing would help overcome a barrier to work.

Given the common ground of the PAAT and PABSS programs in this area, a joint outreach effort would be in order. In fact, it would also make sense to involve the Social Security-funded Work Incentives Planning and Assistance (WIPA) project for your state or region of the state. By involving additional partners in the outreach effort, your PAAT or PABSS project minimizes the commitment of its modest resources. Of course, depending on the scope of the outreach/training event, additional SSI and SSDI work incentives could be discussed including those like the Plan for Achieving Self Support, Impairment Related Work Expenses, and Blind Work Expenses which are potential funding sources for AT.

Section 1619(b) eligibility in 209(b) states.

In what are commonly referred to as section 209(b) states, the state determines Medicaid eligibility for persons who are aged, blind, or disabled using state criteria rather than SSI's criteria. 42 U.S.C. § 1396a(f).

The law governing section 1619(b) mandates Medicaid coverage in 209(b) states to those who were eligible for Medicaid under a state's criteria, "provided they were eligible for Medicaid in the month prior to becoming eligible for 1619." 42 U.S.C. § 1382h(b)(3); POMS SI 02302.010 C. So long as a person was eligible for both SSI and Medicaid in the month prior to losing SSI, 1619(b)'s prior month requirement would be met. Otherwise, the remainder of the 1619(b) criteria, as discussed above, will apply in 209(b) states.

Medicaid: The Medically Needy Program and the Medicaid Buy-In Program

The "Medically Needy" or "Spend Down" Program

An Option Exercised by 32 States.

Medically needy individuals include individuals with disabilities or blindness, who would qualify for SSI, but have income or resources above the SSI limits set by their state. 42 U.S.C. § 1396a(a)(10)(C). Since disability and blindness are two optional coverage groups under the medically needy program, not all states will cover them. CMS State Medicaid Manual § 3612. Thirty-two states, the District of Columbia, and Puerto Rico have established a medically needy program for individuals with disabilities or blindness, including Arkansas, California, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin. See CMS's *Medicaid At-a-Glance 2005: A Medicaid Information Source*, www.cms.hhs.gov/MLNProducts/downloads/MedGlance05.pdf.

How the Spend Down Works. Each state sets its medically needy income levels based on family size. For example, New York set its 2007 level at \$700 per month for a household of one. All individuals meeting the federal SSI definition of disability or blindness, who have income and resources below the medically needy level, automatically qualify for Medicaid. Individuals with income above the medically

needy level must first meet a "spend down" or "share of cost" test. The spend down is the amount by which income exceeds the state's medically needy level after subtracting allowable deductions.

Requirement to follow SSI's income and resource rules. In states where Medicaid is automatic for SSI recipients, the Medicaid agency must follow SSI's rules (or rules that are more liberal than the SSI rules) for counting of income and resources. See 42 U.S.C. § 1396(a)(10)(C)(I); 42 C.F.R. §§ 435.831 (income)(requiring, at § 435.831(b)(2) that "the agency must deduct amounts that would be deducted in determining eligibility under SSI"), 435.601 and 435.845 (resources); CMS State Medicaid Manual § 3620 C. In those states, the rules (or "methodologies") used in determining eligibility for persons who are blind or disabled can be no more restrictive than those employed by the SSI program. See *Addis v. Whitburn*, 153 F.2d 836 (7th Cir. 1998); *Camacho v. Perales*, 786 F.2d 32 (2d Cir. 1986). In states using more restrictive income and resource rules than those of SSI (i.e., section 209(b) states), those rules can be no more restrictive than those used under the state's Medicaid plan in effect on January 1, 1972. See, e.g., 42 C.F.R. § 435.831(b)(3)(regarding income determinations).

Application of SSI work incentives to medically needy programs. In states that are required to follow SSI's rules for determining countable income and resources, the implications are very significant for those Medicaid applicants and beneficiaries who are working or have vocational plans. This is because all of the SSI work incentives, as part of the SSI framework for determining countable income and resources, must be available to reduce what would otherwise be countable income and resources. For example, the following monthly income disregards must be allowed when determining income eligibility or the amount of an individual's spend down:

- The \$1,510 student earned income exclusion for students under age 22 (2007 figure);
- The \$20 general income exclusion;
- The \$65 earned income exclusion;
- Impairment related work expenses;
- One-half of remaining earned income;
- Blind work expenses; and
- Amounts set aside in a Plan for Achieving Self Support (PASS).

For a comprehensive discussion of the various

work incentive rules, *see* BENEFITS MANAGEMENT FOR WORKING PEOPLE WITH DISABILITIES: AN ADVOCATE'S MANUAL (Edwin J. Lopez-Soto & James R. Sheldon, Jr. eds)(Empire Justice Center 2007), ch. 3.

Work disincentives with a medically needy program. Even in states required to apply the SSI work incentives in calculating countable income and resources, there remain disincentives to work or increased work activity:

- As earnings increase, the spend down increases (typically the first \$65 or \$85 is excluded, with the spend down increasing by \$1 for every additional \$2 earned). Thus, after taxes, the Medicaid recipient has a net gain of less than 50 cents for every dollar earned in most cases.
- If gross monthly earnings exceed the substantial gainful activity amount (\$900 for the non-blind in 2007), the individual will cease to be eligible for the medically needy program as he or she no longer meets the SSI definition of disability.

Faced with these disincentives, but with a need for continued Medicaid, many individuals with disabilities have not pursued work goals. In states that have implemented a Medicaid buy-in program, these barriers to work will largely disappear.

The Optional Medicaid Buy-In

The optional Medicaid buy-in program allows individuals with disabilities to obtain or retain Medicaid coverage when they are working. It is designed to provide health insurance to working people with disabilities who, because of relatively high earnings, cannot qualify for Medicaid under other eligibility categories. The buy-in was originally made available through the Balanced Budget Act of 1997. The enhancements to this program have been touted as some of the most important provisions of the Ticket to Work and Work Incentives Improvement Act of 1999. 42 U.S.C. §§ 1396a(a)(10)(A)(ii) and 1396o.

At the time of publication, 33 states had adopted and were implementing a buy-in

Using the SSI Work Incentives Can Ensure SSI and Medicaid Eligibility

Our lead article does not attempt to summarize the many work incentives that are available to SSI recipients, as these are summarized in many other materials. *See, e.g.,* BENEFITS MANAGEMENT FOR WORKING PEOPLE WITH DISABILITIES: AN ADVOCATE'S MANUAL (Edwin J. Lopez-Soto & James R. Sheldon, Jr. eds)(Empire Justice Center 2007), ch. 3; SSA's *Redbook on Work Incentives*. We will, instead, provide a few examples of how work incentives could be used to establish or retain SSI and, presumably, Medicaid in most states.

SSI's PASS can be used in any case in which the individual is disabled, needs money to pay for items or services to support a vocational goal, and has excess income or resources that would affect eligibility for SSI or the benefit amount. A very comprehensive discussion of the PASS appears in a policy and practice brief co-authored by Jim Sheldon of the National AT Advocacy Project and Ed Lopez of Cornell University's Program on Employment and Disability. *See PASS: SSI'S Plan for Achieving Self-Support*, available at www.ilr.cornell.edu/edi/s-PPBriefs.cfm (then scroll down to article on PASS); *see also*, our Spring-Summer 2006 issue of *AT Advocate*, available at www.nls.org/av/summer06.htm or www.nls.org/av/spring-summer06.pdf.

PASS Example. An individual with a monthly SSDI check of \$820, who lives in a state that pays the 2007 SSI federal benefit rate of \$623, could put \$400 per month into an approved PASS to save for modified computer equipment and software and qualify for an SSI check of \$223 per month and Medicaid in most states. With the \$20 general income exclusion and a \$400 PASS exclusion, countable income is reduced to \$400 ($\$820 - 20 - 400 = \400). The SSI check is then calculated by subtracting \$400 from the \$623 SSI rate ($\$623 - 400 = \223).

An individual might also use blind work expenses to qualify for SSI despite earnings that would ordinarily be too high to qualify for a monthly check. For example, an individual who earns \$18,000 gross per year (\$1,500 per month) and lives in a state that pays the 2007 SSI federal benefit rate (\$623) would not ordinarily qualify for SSI because their countable income, \$707.50, is more than the monthly SSI rate. If we assume that the individual has \$500 in monthly blind work expenses, covering expenses such as income tax withholding, Social Security and Medicare taxes, union dues, transportation, guide dog expenses, lunches, readers, braille paper, cassette tapes, and computer discs, POMS SI 00820.535 -.565, then countable income is reduced to \$207.50 and the individual will qualify for an SSI check of \$415.50 and automatic Medicaid in most states.

program. Additional states were in the process of developing buy-in programs that would need to be approved by CMS prior to implementation. The states currently implementing a buy-in program include: Alaska, Arizona, Arkansas, California, Connecticut, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oregon, Pennsylvania, South Carolina, Texas, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming. Additionally, Massachusetts is implementing a Medicaid waiver program very similar to the buy-in program. See CMS's *Enrollment History for the Medicaid Buy-In Program for Workers with a Disability* (as of March 31, 2005)(Maryland and Texas, which do not appear on this 2005 list implemented buy-in programs more recently).

The buy-in program is most important to those individuals with disabilities who have significant health care needs that cannot be met through employer-sponsored health insurance plans and have no other means to obtain or retain Medicaid when working for significant wages. The group that will often benefit are recipients of SSDI who are not simultaneously eligible for SSI and, thus, cannot qualify for Medicaid under section 1619(b). Many of these individuals currently receive Medicaid through medically needy programs and could not afford to work if it meant giving up Medicaid as the payment source for expensive items like prescription drugs, personal care services, and durable medical equipment. In states that have implemented buy-in programs, eligibility for Medicaid can continue in many cases at annual wage levels exceeding \$50,000. In a few of the states, Medicaid eligibility can continue at annual wage levels exceeding \$70,000. Subject to federal criteria, a state can structure the buy-in as it sees fit. (A comprehensive discussion of buy-in criteria and buy-in experiences, in several states, is contained in *The Effectiveness of the Medicaid Buy-In Program in Promoting Employment of People with Disabilities: A Briefing Paper for the Ticket to Work and Work Incentives Advisory Panel* (Cornell University Institute for Policy Research, July 2004), available at www.socialsecurity.gov/work/panel (then follow links for "panel documents," then "briefing papers").)

Only five or six states had initiated buy-in programs when the Ticket to Work and Work Incentives Improvement Act (TWWIIA) was signed into law in December 1999. TWWIIA sought to make the program more attractive to states.

The key eligibility criteria for buy-in programs established since 1999 are:

- States can set income eligibility levels between 250 and 450 percent of the federal poverty level. (Since income is "net," i.e., after SSI-related disregards, including earned income disregards, individuals can earn well over \$50,000 per year and keep Medicaid even in states with the more modest 250 percent of poverty level guideline.)
- A person can perform substantial gainful activity (i.e., earn more than \$900 per month in 2007) and still qualify for the buy-in.
- Individuals need not ever have been eligible for SSI in the past.
- States can increase Medicaid resource limits to as high as \$14,000
- States can charge premiums or other cost-sharing charges, on a sliding scale, based on income
- States can require some individuals to pay the full premium as long as the premiums do not exceed 7.5 percent of the individual's total income.
- States must require a 100 percent premium payment for individuals with adjusted gross incomes greater than \$75,000 unless states choose to subsidize the premium using their own funds.

Example of individual using buy-in. Anna, age 46, is single, has multiple sclerosis and receives SSDI benefits of \$1,020 per month. She lives in a state that has the optional medically needy program, with a monthly income eligibility threshold of \$600 for a household of one. Since the Medicaid program will disregard the first \$20 of her unearned income, her countable income is \$1,000 per month and she pays a \$400 per month spend down to qualify for Medicaid. She uses Medicaid to pay for doctor's visits, medication, and her power wheelchair, among other things. (Note: If Anna is also eligible for Medicare because she has received SSDI payments for 24

months, she will be required to get her medications through the Medicare Part D program.)

Anna lives in a state that has implemented a buy-in program, with eligibility based on 250 percent of the federal poverty level. This means her countable monthly income, after all SSI-related exclusions, must be below \$2,042 in 2006. Her state's buy-in program allows her to have non-exempt resources of up to \$14,000. If approved for the buy-in, her state will require that she pay a premium based on 3 percent of her countable earned income and 7.5 percent of her countable unearned income. (States retain considerable flexibility on whether to charge premiums and premium payment rates.)

Anna goes to work in July 2007 at a part-time job paying \$865 gross per month. Using SSI-related earned income disregards, her gross earned income is reduced by \$65, then by one half of the remainder ($\$865 - 65 - 400 = \400). Since her gross wages are less than the 2007 substantial gainful activity (SGA) figure of \$900 per month, she will keep her SSDI checks of \$1,020 per month. Combining her countable earned and unearned income, Anna now has \$1,400 in countable income ($\$400 + \$1,000$), meaning her spend down would now increase to \$800 per month. However, Anna should now qualify for her state's Medicaid buy-in program as she:

- meets the disability test based on her receipt of SSDI;
- is engaged in paid work;
- we will assume has well below \$14,000 in non-exempt resources; and

- has countable income of \$1,400, well below the 2006 eligibility threshold of \$2,042 per month.

Anna will also be required to pay a monthly premium of \$87, i.e., 3 percent of countable earned income ($.03 \times \$400 = \12) plus 7.5 percent of countable unearned income ($.075 \times \$1,000 = \75). If Anna's rate of pay increases to more than the \$900 per month SGA level and she loses her SSDI benefits, she can retain Medicaid through the buy-in as there is no SGA test for buy-in eligibility. Additionally, if Anna is receiving Medicare and must now obtain prescription drugs from the new Part D program, her "dual eligibility" for Medicare and Medicaid will make her automatically eligible for the full low-income subsidy program, allowing her to save as much as \$3,000 per year on prescription drug costs.

The Extended Medicare Provisions

What is Medicare?

Medicare is a federally-sponsored health insurance program most often associated with receipt of Social Security benefits. Medicare is divided into three parts. Medicare Part A, known as hospital insurance, covers services related to inpatient care. POMS HI 00601.001. For most Medicare beneficiaries, there is no premium required to obtain Part A coverage.

Medicare Part B, known as supplemental medical insurance, covers various outpatient services, including physician services, durable medical equipment, prosthetic and orthotic devices, and home health services. POMS HI 00610.001. To enroll in Part B, a Medicare

The Relationship Between Medicaid and Medicare Part D Benefits

Retaining Medicaid Through 1619(b) or the Buy-In Will Ensure Eligibility for Part D's Full Low-Income Subsidy Program

Many of the individuals who access the Medicaid work incentives – i.e., section 1619(b) and the Medicaid buy-in – will also be eligible for Medicare. This is because the individuals are either current SSDI beneficiaries or former SSDI beneficiaries, who lost benefits due to earnings above the substantial gainful activity level and now receive extended Medicare benefits. Since these individuals are now "dually eligible" for Medicaid and Medicare, their prescription drug coverage must now come from Medicare Part D rather than Medicaid.

For many individuals, a primary reason for obtaining or retaining Medicaid under 1619(b) or the buy-in is to ensure access to prescription medication. There are two reasons to keep Medicaid through 1619(b) or the buy-in even when Medicare Part D must now be used to pay for medication: first, Medicaid can still pay for every other service that the program covers, including many that are not covered through Medicare; and second, keeping Medicaid, even if the benefit may not be used, guarantees "dual eligibility" and automatic eligibility for the full low-income Part D subsidy, saving as much as \$3,000 per year in deductibles, co-payments, and premium payments.

beneficiary must pay a monthly premium (\$93.50 for most beneficiaries in 2007). State Medicaid programs may pay the Part B premiums under what are known as Medicare Savings Programs (i.e., the Qualified Medicare Beneficiaries, Selected Low-Income Beneficiaries, and QI-1 programs). The Part B benefit will pay for a range of DME, including custom and powered wheelchairs, powered scooters, and speech generating devices.

Effective January 2006, Medicare also includes an optional Part D, covering prescription drugs. Importantly, individuals who are dually eligible for Medicaid and Medicare must now obtain their prescription drugs through the Part D program.

The Connection Between SSDI and Medicare

Medicare covers three primary classes of persons:

- persons age 65 or older;
- persons receiving SSDI payments (including many adults with disabilities who receive SSDI on the earnings record of a parent, and many who receive SSDI as widows or widowers) or railroad retirement benefits based on disability;
- persons with end stage renal disease.

42 U.S.C. § 1395c.

An SSDI beneficiary will qualify for Medicare after 24 months of eligibility for cash benefits. Individuals with a diagnosis of ALS, sometimes referred to as Lou Gehrig's disease do not face the 24-month waiting period and qualify for Medicare as soon as they start receiving SSDI payments.

Medicare Will Continue During SSDI's Nine-Month Trial Work Period

SSDI beneficiaries are entitled to a nine-month trial work period (TWP). During the nine TWP months, which need not be consecutive, the individual is entitled to both the SSDI check and paycheck no matter how high their earnings are. During the entire TWP, Medicare eligibility continues under the same terms (Part A automatic and cost-free, Parts B and D optional and subject to premiums).

Extended Medicare: Continued Coverage for at Least 93 Months After the Trial Work Period

SSDI beneficiaries who have exhausted their nine-month trial work period move into what is known as the 36-month Extended Period of Eligibility (EPE). The 36 months of the EPE

run consecutively and start immediately after the ninth TWP month. The first time during the EPE that the individual earns at the substantial gainful activity level (\$900 per month for the non-blind during 2007), he or she will receive SSDI payments for that month and two more (a three-month grace period). Thereafter, and for the remainder of the EPE, the individual will receive an SSDI payment when earnings are below the SGA level and will not receive a payment in months that earnings are above the SGA level.

All beneficiaries will continue to qualify for Medicare during the EPE, even during those months in which no SSDI payment is received. In fact, all beneficiaries who continue to have a medical disability will be eligible for continued Medicare during this period as part of the extended Medicare benefit. Extended Medicare benefits are available for a minimum of 93 months following the last TWP month. 42 U.S.C. § 426(b), as amended by the Ticket to Work and Work Incentives Improvement Act of 1999 (increasing the period from 39 to 93 months). An individual with a continuing disability who exhausts the TWP and extended period of Medicare coverage, and loses premium-free Medicare because of continued work activity, is able to separately purchase Medicare benefits under the "Premium HI for the Working Disabled" program. 42 U.S.C. § 1395i-2a; POMS HI 00801.170.

Conclusion

The set of work incentives discussed in this article – including 1619(b) Medicaid, the Medicaid buy-in, and extended Medicare coverage— are very important to the individuals with severe disabilities that our readers serve through Protection and Advocacy Programs, including the PAAT and PABSS programs. The ability to qualify for these work incentives will ensure that individuals with severe disabilities can work for significant wages and have access or continued access to a health insurance program that will pay for expensive health-related benefits, such as home health care, prescription drugs, and durable medical equipment. Those of us who work for P&A agencies and other programs serving SSI and SSDI beneficiaries should make sure that those beneficiaries are aware of these special work incentives.

***Texas Court Issues Important Due Process Decision
in a Medicaid Prior Authorization Case***

A recent case from Texas addresses an important due process question: Does a Medicaid beneficiary have a right to receive advance written notice and continued benefits when the service in question is subject to prior authorization and is approved only for a limited time? The case, *Jonathan C. v. Hawkins*, 2006 WL 3498494 (E.D. Tex. 12/5/06), holds that the beneficiary does have these rights, consistent with the due process protections of *Goldberg v. Kelly*, 397 U.S. 254 (1970), which is expressly applied to the states in the Medicaid regulations, 42 C.F.R. § 431.205(d), and the Medicaid fair hearing regulations, 42 C.F.R. Part 431.

Jonathan C. is a young boy with multiple disabilities and chronic health conditions who needs private duty nursing services (PDN). For four and a half years, the Texas Medicaid program approved his physician's prior authorization requests for the services without question or interruption. In 2004, however, the PDN services were abruptly reduced, even though there was no change in the child's underlying condition.

A cycle of denial and appeal ensued. The child requested repeated administrative hearings. According to the hearing officer, the sole issue for these hearings was whether the Medicaid agency had appropriately denied prior authorization for the requested period of time. By the time the hearing could be held and a decision issued, the prior authorization period in question had either expired or had only a few days remaining. Thus, even when the hearing officer ruled in favor of the child, the relief was essentially lost because the prior authorization would expire. In addition, the Texas Medicaid rules did not provide for advance written notice of the right to continued benefits or allow continued benefits pending the administrative appeal in cases involving a denial of a prior authorization request.

Jonathan was faced with a hearing system that offered no foreseeable relief as to his ongoing requests for PDN services. Because Texas does not allow for judicial review of a hearing officer's decision, his attorneys, Advocacy, Inc. of Texas (Peter Hofer, of Counsel), had no alternative but to file a case in federal court.

In his decision, Judge Thad Heartfield noted that "at the heart of Jonathan's motion is the fact that beneficiaries cannot practically receive relief under the fair hearing rules." However, the Court found the federal Medicaid fair hearing rules clear and unambiguous: "There is no exception in the federal regulations such as the exception for not providing prior authorized services pending a hearing decision"

The Medicaid agency contended that individuals requesting prior authorization of services – whether for the first time or subsequently – have no entitlement to any service beyond the authorized period and, thus, no protected property interest. The Court disagreed. It recognized Jonathan's cause of action under 42 U.S.C. § 1983 and concluded that the fair hearing system "clearly runs afoul" of *Goldberg v. Kelly's* procedural due process requirements because the benefits are reduced before the recipient is afforded an evidentiary hearing by agency authorities. (In so doing, the Court discussed and refused to defer to a 1994 letter from the Medicaid agency that supported the state's position, finding that there is nothing ambiguous about the relevant Medicaid regulations.) The Court noted that Texas certainly can use a prior authorization system for approving benefits, citing 42 C.F.R. § 440.230(d). However, the Court said it is "well-settled" that a hearing is required before an individual is deprived of those benefits ... as that denial may "deprive an eligible recipient of the very means by which to live while he waiting (citing *Goldberg*)." The Court held that in situations where the Medicaid recipient has been receiving the same amount of medically necessary, physician-directed benefits for years, "Defendant is erroneous in his contention that, for purposes of due process, Jonathan has no entitlement to procedural due process when requesting the continuation of PDN services that he has not been authorized to receive."

As a result of the decision, the state agency will need to provide advance written notice prior to the termination or reduction of prior authorized benefits, to include information about continued benefits in the notice, and to maintain benefits when authorized by the recipient.

A special thanks to Jane Perkins, Legal Director of the National Health Law Program, for allowing us to use her summary of this decision.

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