HEALTH COVERAGE FOR WORKERS WITH DISABILITIES

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I. Introduction to Health Coverage for Workers with Disabilities

The federal Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999 offers states the option to protect Medicaid coverage for workers with disabilities. People with disabilities are often discouraged from working for fear that their earnings would make them ineligible for Medicaid. TWWIIA offers state Medicaid programs options to expand Medicaid eligibility criteria for workers with disabilities.

II. Background

North Carolina is authorized to provide Medicaid for disabled/blind workers under the Health Coverage for Workers with Disabilities Act (G.S. 108A-54.1). Health Coverage for Workers with Disabilities (HCWD) provides an incentive for persons with disabilities to go to work or to increase their hours of work while protecting their Medicaid eligibility.

HCWD covers blind or disabled workers age 16 through 64 regardless of total countable income or CAP status. However, there is a limit on unearned income of 150% of the federal poverty level. The resource limit is the minimum community spouse resource allowance (See MA-2231, Community Spouse Resource Protection). HCWD recipients are entitled to full Medicaid coverage under MAB or MAD. Recipients age 16 through 20 are also entitled to additional services provided under EPSDT (See MA-2905, Medicaid Covered Services, XXXVIII.). HCWD consists of two groups, the Basic Coverage Group and the Medically Improved Coverage Group.

III. COVERAGE GROUPS

A. Basic Coverage Group

The Basic Coverage Group consists of individuals aged 16 through 64 who, except for engaging in substantial gainful activity, would meet the Social Security/SSI disability criteria, or who do not engage in substantial gainful activity but are over income and/or reserve for regular MAD. See MA-2525, Disability.

B. Medically Improved Coverage Group

1. The Medically Improved Group consists of individual(s) age 16 through 64 who previously received HCWD in the Basic Coverage Group but lost

eligibility in this group because their medical conditions improved to the point where they no longer meet the Social Security/SSI definition of disability.

2. Although no longer considered disabled by Social Security due to medical improvement, the individual must continue to have a severe medically determinable impairment. The individual continues to have a severe medically determinable impairment if he:

   a. Still has the underlying condition or conditions which made him disabled;

   b. Is under treatment for the condition or conditions; and

   c. Has a strong likelihood of again meeting the Social Security definition of disabled if he were to cease treatment.

3. If the answer to any of the questions in 2. is no, refer to IV.C. below.

4. Eligibility in the Basic Group for any period of time qualifies an individual for eligibility in the Medically Improved Group if he meets all other eligibility requirements.

5. Eligibility in the Medically Improved Group can begin no earlier than the month after coverage ends in the Basic Group.

IV. Eligibility Requirements

A. Generally

To be eligible to receive HCWD, an individual must:

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

2. Meet the Social Security Administration definition of disability except for earnings or be eligible under the Medically Improved Group;

3. Be employed;

4. Have countable resources equal to or less than the minimum community spouse resource allowance (See MA-2231, Community Spouse Resource Protection II.B), whether budgeted as an HCWD individual or HCWD couple;

5. Meet the income requirements for his coverage group (See IV.D. below);

6. Meet all the other eligibility requirements applicable to Adult Medicaid coverage groups. (See MA-2000, Non-SSI Eligibility Regulations.)

B. Disability

To be eligible in the Basic Coverage Group, the individual must meet the Social Security/SSI definition of disability other than the requirement that the individual not be engaging in a substantial gainful activity. Disability can be proven by 1, 2 or 3 below.

1. Receipt of Social Security Disability or SSI.

2. A determination by Disability Determination Services (DDS).

   a. If an HCWD applicant is not receiving RSDI/SSI and has not been determined disabled by DDS or a Hearing Officer, he must be referred to DDS for a determination to ensure that he meets the definition of disability. Use the DDS referral form, DHB-4037 (See MA-2525, Disability, for instructions).

      (1) Refer the applicant to the local SSA office to apply for RSDI and suggest that the applicant also apply for SSI.

      (2) If the applicant is found to be disabled by DDS but is later denied SSI/RSDI, the DDS disability approval remains valid for HCWD eligibility purposes. Do not terminate an HCWD recipient for having been denied SSI/RSDI.

      (3) If prior to receiving a disability determination from DDS the county determines that the applicant is ineligible for MAD or HCWD, immediately contact DDS and tell them of this determination and that a disability determination is no longer necessary. Denying the application which updates the DDS data screen is not sufficient. See MA-2525 Disability, IV.B.10 for DDS contact numbers.

   b. If an HCWD applicant is not receiving RSDI/SSI but was previously determined to be disabled by SSA, DDS or a Hearing Officer he still may be considered disabled for HCWD purposes. The IMC must consider the reason for the termination as well as the length of time between termination of RSDI or SSI benefits, the DDS decision, or the Hearing Officer's decision and application for HCWD.

      (1) If the termination of RSDI or SSI benefits, or the DDS decision or the Hearing Officer's decision occurred 12 months or less prior to the date of application and the termination was for non-medical reasons, a DDS determination of disability is not necessary.

      (2) Example: The month of application for HCWD is November 2015. SSI was terminated for non-medical reasons in November

2014. This is 12 months prior to the month of application and therefore the requirement is met (November 1, 2014 – October 31, 2015).

(3) If the termination of RSDI or SSI benefits occurred more than 12 months prior to the date of application or the termination was for medical reasons, a DDS determination of disability is required.

3. A determination of blindness by DSB

An HCWD applicant who alleges blindness and does not receive RSDI due to blindness must have his blindness determined by DSB unless a previous determination of blindness has been made. Follow procedures in MA-2531, Blindness M-AB for submitting materials to DSB if a determination is needed.

C. Medically Improved Cases

1. MAD Cases

a. If DDS determines during a Continuing Disability Review that an HCWD recipient in the Basic Group is no longer disabled, if the individual is still working assume that the individual is Medically Improved until the next redetermination.

b. At redetermination do not refer a recipient in the Medically Improved Group to DDS for a determination of whether he still meets Medically Improved Criteria. To determine if the individual continues to meet the Medically Improved eligibility criteria, contact the recipient's treating physician using the DMA-5151, Health Coverage for Workers with Disabilities (HCWD) Medical Release Authorization, and a DMA-5028, Authorization to Disclose Information, asking the following three questions:

(1) Does the recipient still have the underlying condition or conditions which made him disabled?

(2) Is the recipient still under treatment for the condition or conditions which made him disabled?

(3) Is there a strong likelihood that the recipient would again be disabled if he were to cease treatment?

If the answers to all three questions are yes, the recipient continues to meet the Medically Improved criteria. Be sure to document the treating physician's responses in the case record.

If the answer to one or more of the questions is no, the individual no longer meets the Medically Improved criteria. Evaluate for eligibility in all other programs including the HCWD Basic Coverage Group. If the individual would only be eligible as MAD/MAB/HCWD, a referral to DDS is required (remember to use the DDS referral form, DHB-4037, for HCWD referrals).

2. MAB Cases

When the county learns that the individual is no longer considered blind, refer to instructions in C.1. above.

D. Employment

1. Basic Coverage Group

Employment means being engaged in a substantial and reasonable work effort which is defined to require both a. and b. below.

a. Working in a competitive and inclusive work setting for a wage or salary, or being self-employed,

(1) Competitive means that the job was held open to the general public.

For example, a handyman who is hired by a neighbor to do a chore is not engaged in competitive employment. He may be self-employed if he meets that criteria.

(2) Inclusive means that the job is not in a sheltered workshop setting. Generally, those who work as staff in a sheltered workshop are not working in a "sheltered workshop setting." Evaluate the individual's responsibilities to determine if his position is "sheltered."

(3) Self-Employed has the same meaning as it is defined in MA-2250, Income, VII.D.

b. Being able to provide proof of payment of payroll taxes through FICA, or the equivalent.

For example, self-employed individuals who have not filed tax forms may submit alternative proof such as a business ledger, or similar documentation that shows that the business is operational.

2. Medically Improved Coverage Group

a. Employment

For an individual to be considered "employed" for purposes of Medically Improved Group eligibility he must meet the requirements of (1) or (2):

(1) Have gross earnings at least equivalent to those of an individual who is working 40 hours per month at minimum wage; or

(2) Be actively engaged in a self-employment activity, and have earnings after operational expenses at least equivalent to those of an individual who is working 40 hours per month at minimum wage.

b. Voluntary Loss of Employment

If a recipient in the Medically Improved Group voluntarily stops his employment evaluate for eligibility in all other programs. If MAD is the only program in which he may be eligible, a disability determination by DDS is necessary (for involuntary loss of employment see IV.K. below).

E. Income

HCWD has varying income limits that will determine eligibility and/or cost sharing. These limits are:

- Those who have unearned incomes greater than 150% of FPL are not eligible for HCWD.
- Those whose total countable income is equal to or less than 150% of FPL have no cost sharing (other than applicable co-payments).
- Those whose total countable income is greater than 150% of FPL must pay a $50 annual enrollment fee (see IV. G.).
- Those whose total countable monthly income exceeds 200% of FPL must pay a monthly premium in addition to the enrollment fee. The monthly premium increases as income increases until countable income exceeds 450% of FPL, at which point these individuals must pay a full premium (see IV.H. below). Because countable income determines whether the individual is subject to cost-sharing and the amount thereof, countable income must be determined and all applicable exclusions applied.

Note: These individuals are likely to have work expense exclusions for the blind and impairment-related work expense exclusions for the disabled.

F. Financial Responsibility

Apply financial responsibility and budgeting rules as outlined in MA-2260, Financial Eligibility Regulations – PLA.

G. Enrollment Fee

All individuals with total monthly countable income above 150% of the federal poverty level must pay a $50 enrollment fee for each twelve month certification period. The enrollment fee is collected by the county and retained to offset administrative expenses. Do not charge an enrollment fee for the retroactive month(s) when an a/b receives retroactive coverage. If a premium is due (see II.C. below), the county must mail the enrollment fee notice with the premium invoice.

Note: Members of federally recognized Native American tribes and Alaska natives are exempt from cost sharing, including enrollment fees and premiums.

1. Determine if an Enrollment Fee is due

   a. Calculate the amount of total countable net income for the individual.

   b. If this amount exceeds 150% of FPL, an enrollment fee is due (Those in this income range must have unearned income at or below 150% of FPL).

2. Notification of Enrollment Fee

   Upon determination that an a/b is eligible for HCWD and that his income exceeds 150% of FPL, notify the applicant in writing that an enrollment fee of $50 is due. (See **DMA-5149**)

   a. Give the a/b at least 12 calendar days to pay the fee.

   b. If 12 calendar days exceeds the 45/90 day processing standard, pend until you receive notice of payment, or until the first workday after the due date for payment.

      Allow for the exclusion of days when necessary verifications are received and the only remaining item necessary to process the application is the enrollment fee (and premium when applicable). The exclusion of days begins on the day of the request for the fee and ends on the day the fee is received or on the 13th calendar day, whichever occurs first. Use HCW code for this purpose. Refer to MA-2304, Processing the Application.

c. Inform the office or individual responsible for collecting the fee of the date by which the fee must be paid and the date when the IMC must be informed of payment or nonpayment (see 3. below).

3. Payment/Collection/Notification

a. Each county is responsible for establishing procedures for collection of enrollment fees.

(1) Determine which methods of payment (i.e. cash, money order, certified check) are acceptable. Do not accept a non-certified check in payment.

(2) Partial payment is not allowed. The entire fee must be paid prior to approval of the application.

b. Determine what office and/or person(s) are responsible for collection of enrollment fees for HCWD. This decision must be communicated in writing to all eligibility staff responsible for HCWD determinations.

c. Establish procedures for communication between the IMC staff and the fee collector for:

(1) Identification of case/individuals who must pay an enrollment fee, and

(2) The amount of the fee due, and

(3) The date by which the fee must be paid, and

(4) The time frame and method for notification to the IMC that the fee has been paid, or

(5) Notification that the a/b refused to pay, or failed to pay the fee by the date due.

d. The enrollment fee may be paid with funds provided by individuals or organizations other than the applicant, including county funds.

4. Decision Following Payment or Non-Payment

a. Upon receipt of notification from the fee collector that the enrollment fee has been paid, authorize eligibility.

b. Upon receipt of notification from the fee collector that the a/b refused to pay the fee, or failed to pay the fee, deny the application. If it is a

redetermination, terminate after timely notice. (See IV.G.2. above for notice time frame requirements.).

c. If no communication has been received from the fee collector on the first workday following the date on which the fee was due, contact the collection office/individual to verify payment status. If payment has not been made, document the contact and deny the application for non-payment of the fee. If it is a redetermination, terminate after timely notice. (See IV.G.2. above for notice time frame requirements.).

Note: If the redetermination is late, provide coverage without enrollment fee payment until timely notice is effective.

5. Individuals Currently Receiving in Other Programs

Other than at application, review or recertification, an enrollment fee is not due.

H. Premiums

Individuals with countable income above 200% of FPL must pay a monthly premium in addition to an enrollment fee of $50 per year. The premiums increase with income range until income exceeds 450% of FPL, at which point a 100% premium is due. The 100% premium is based upon the average claims paid for an individual receiving Medicaid and may change yearly.

1. The income ranges and associated premiums are found in the following chart:

Federal Poverty Level	Income Range - HCWD Individual	**Monthly Premium**	Income Range - HCWD Couple	**Monthly Premium**
0-150%	0 - $1,562	**0**	0 - $2,114	**0**
151-200%	$1,562.01 - $2,082	**0**	$2,114.01 - $2,819	**0**
201-250%	$2,082.01 - $2,603	**196**	$2,819.01 - $3,523	**265**
251-300%	$2,603.01 - $3,123	**235**	$3,523.01 - $4,228	**318**
301-350%	$3,123.01 - $3,643	**274**	$4,228.01 - $4,933	**370**
351-400%	$3,643.01 - $4,164	**313**	$4,933.01 - $5,637	**423**
401-450%	$4,164.01 - $4,684	**352**	$5,637.01 - $6,342	**476**
451 and above	$4,684.01 and up	**875**	$6,342.01 and up	**875**

NOTE: Refer to Job Aid: Forced Eligibility to process HCWD premium.

2. Determine if a Premium is due

   a. Calculate the amount of total countable net earned and unearned income for the individual. Those with **unearned income** above 150% FPL are not eligible for HCWD.

   b. If total countable monthly income exceeds 200% of FPL, a premium is due. Use chart above to determine premium amount.

   Note: Members of federally recognized Native American tribes and Alaska natives are exempt from cost sharing, including premiums and enrollment fees.

3. Notification of Premium due

   Notify the applicant in writing that a premium is due. (See DMA-5146 for premium invoice).

   a. Date the premium invoice the date it will be mailed.

   b. The invoice must identify the premium amount due for each month separately.

   c. The caseworker must provide his name, direct phone number and email address on the invoice.

   d. If an enrollment fee is due, mail the premium invoice with the enrollment fee notice (see IV.G. above).

   e. Give the A/B 12 business days to pay the premium. Day one is the day after the invoice is mailed.

   f. Payment must be by certified check or money order payable to: "NC DHHS" **and** "HCWD Premium" must be written on the memo line of the check.

   g. Have payment mailed to: "DHHS Controller; 2022 Mail Service Center; Raleigh, NC 27699."

   h. When the premium payment is made, DMA will notify the county worker designated on the invoice by telephone and email a copy of the invoice and check to the worker.

4. Premium Invoices for Applications

a. The applicant must be billed for all premiums due from the first month authorized through one month after the current calendar month.

b. If 12 calendar days exceeds the 45/90 day processing standard, pend until you receive notice of payment, or until the first workday after the due date for payment.

(1) Allow for the exclusion of days when necessary verifications are received and the only remaining item necessary to process the application is the premium (and enrollment fee when applicable).

(2) The exclusion of days begins on the day of the request for premium payment and ends on the day the premium is received or on the 13th calendar day, whichever occurs first.

Note: If pending for enrollment fee and premium(s), the end date is the later of the dates the enrollment fee or premium(s) is received. Continue to exclude days until both payments are received.

(3) Use "HCW" code to indicate that the case is pending for the HCWD enrollment fee or premium or both. Refer to MA-2304, Processing the Application, for case pending instructions.

c. Premium Invoices for Retroactive Months

An applicant who requests retroactive coverage must pay a premium for each retroactive month authorized. An a/b cannot choose the month to which the premium is to be applied.

Note: No enrollment fee is due for retroactive months.

d. If no communication has been received from DMA on the first business day following the twelfth business day (date on which the fee was due), contact DMA Policy at 919-855-4000 to verify status. If payment has not been made, document the contact and deny the application or terminate the case for non-payment of the premium(s).

e. Decision Following Payment or Non-Payment

(1) Upon receipt of notification from DMA that the premium has been paid, authorize eligibility for the month or months covered by the premium using the "P" screen.

For applications:

(a) If the applicant has identified the premium payment as an ongoing payment, apply the payment to the earliest unpaid ongoing month.

(b) If the applicant has identified the premium payment as a retroactive payment, apply the payment to the earliest unpaid retroactive month.

(c) If the payment is not identified as retroactive or ongoing, apply the payment to the earliest unpaid month.

(2) Upon receipt of notification from DMA that the a/b refused to pay the premium or failed to pay the premium, deny the application using a G9 code and send the HCWD denial for non-payment of premium letter (See DMA-5147 for non-payment denial notice).

(a) Provide the coverage period and amount due for each month owed in the appropriate section of the denial notice.

(b) Provide caseworker name and contact information in the appropriate section of the denial notice.

(c) If the enrollment fee has been paid, refund it.

5. Premium Invoices for Ongoing Cases and Redeterminations

a. Send the monthly premium invoice on the first business day of the month prior to the next month of eligibility (See DMA-5146 for premium invoice).

b. Give the a/b 12 business days to pay the premium; day one is the day after the invoice is mailed.

c. Do not send a termination notice prior until the day after the payment is due.

d. If no communication has been received from DMA on the first business day following the twelfth business day (date on which the fee was due), contact DMA Policy at 919-855-4000 to verify status. If payment has not been made, document the contact and purpose termination of the case for non-payment of the fee (See 5.e.(2) below).

e. Decision Following Payment or Non-Payment:

(1) Upon receipt of notification from DMA that the premium has been paid, authorize eligibility for the

month or months covered by the premium. For on-going cases, apply premium payments to the oldest unpaid month in the current certification period.

(2) Upon receipt of notification from DMA that the A/B refused to pay the premium, or failed to pay the premium, terminate the case after timely notice (See DMA-5148 for non-payment termination notice).

(a) Provide the coverage period and amount due for each month owed in the appropriate section of the termination notice.

(b) Provide caseworker name and contact information in the appropriate section of the termination notice.

(c) For redeterminations, if the enrollment fee has been paid, refund it (do not refund enrollment fees in ongoing cases).

(3) If it is a redetermination, terminate after timely notice (See DMA-5148 for non-payment termination notice).

(a) Provide the coverage period and amount due for each month owed in the appropriate section of the termination notice.

(b) Provide caseworker name and contact information in the appropriate section of the termination notice.

(4) See IV.H.3. above for notice time frame requirements.

Note: If the redetermination is late, provide coverage without premium payment until timely notice is effective.

6. Individuals Currently Receiving in Other Programs

a. Send the monthly premium invoice for the next month of eligibility (See DMA-5146 for premium invoice).

b. Give the A/B 12 business days to pay the premium; day one is the day after the invoice is mailed.

c. Do not send a termination notice prior to the day after the payment is due.

d. If no communication has been received from DMA on the first business day following the twelfth business day (date on which the fee was due), contact DMA Policy at 919-855-4000 to verify status. If payment has not been made, document the contact and propose termination of the case for non-payment of the fee (See 6.e.(2) below).

e. Decision Following Payment or Non-Payment:

(1) Upon receipt of notification from DMA that the premium has been paid, authorize eligibility for the month or months covered by the premium(s).

For on-going cases, apply premium payments to the oldest unpaid month in the current certification period.

(2) Upon receipt of notification from DMA that the A/B refused to pay the premium, or failed to pay the premium, terminate the case after timely notice (See DMA-5148 for non-payment termination notice).

(a) Provide the coverage period and amount due for each month owed in the appropriate section of the termination notice.

(b) Provide caseworker name and contact information in the appropriate section of the termination notice.

(c) If the enrollment fee has been paid, refund it.

(3) If it is a redetermination, terminate after timely notice (See DMA-5148 for non-payment termination notice).

(a) Provide the coverage period and amount due for each month owed in the appropriate section of the termination notice.

(b) Provide caseworker name and contact information in the appropriate section of the termination notice.

(4) See II.B.3. above for notice time frame requirements.

Note: If the redetermination is late, provide coverage without premium payment until timely notice is effective.

I. Resources

Countable resources must not exceed the minimum community spouse resource allowance (See MA-2231, Community Spouse Resource Protection II.B), whether budgeted as an HCWD individual or HCWD couple.

J. Retroactive Coverage

1. The HCWD applicant must meet all eligibility requirements, including the employment requirement, for retroactive eligibility.

   Example: John Blutarsky requests HCWD retroactive coverage for the months of June, July and August. He worked during the months of June and August, but not in July. If Mr. Blutarsky meets all other eligibility criteria, he can be authorized for June and August, but not for July. Evaluate for HCWD Continued Eligibility (See IV.O.) for the month of July (see IV.K. below). If Blutarsky is not eligible for HCWD Continued Eligibility, evaluate for all other programs. Accept the HCWD disability determination for MAD purposes.

2. Individuals who are eligible in the Basic Group only during a month in the retroactive period may be eligible in the Medically Improved group for subsequent months.

K. Program Classification

1. The classification code in EIS will be N, G, B or Q. Individuals will be MAB/MAD-N, MAB/MAD-G, MAB/MAD-B or MAB/MAD-Q.

2. As for any Medicaid case, classification for HCWD is determined by income and resources. The HCWD individual must be evaluated for dual eligibility (MQB-Q/MQB-B) if he is enrolled in Medicare. Refer to MA-2525, Non-MAGI MEDICAID INCOME/RESERVE LIMITS

L. Sub-Program Codes

1. For the Basic Coverage Group, enter B1.

2. For the Medically Improved Coverage Group, enter M5.

M. Federal Poverty Level Indicator

Enter the appropriate federal poverty level in the Federal Poverty Level Indicator. For poverty level indicator codes, see the EIS Manual.

Note: The sub-program codes and the FPL indicator are both located in the field labeled "sub-program." See EIS Manual Section 2600.

N. Certification.

1. Certification is for a twelve month period.

2. HCWD applicants currently in other programs:

   Where an HCWD applicant has less than twelve months left on an existing certification period, use the existing certification period for HCWD eligibility.

O. 12 Month Continued Eligibility After Involuntary Loss of Employment

An HCWD recipient, who becomes unemployed for reasons beyond his control, including health reasons, continues to have eligibility in HCWD as if still employed for up to 12 months beginning the month following involuntary unemployment provided he:

1. Has received HCWD for at least one ongoing or retroactive month, and

2. Maintains a connection with the workforce,

   Maintaining a connection to the workforce means:

   a. Registered with the Employment Security Commission for employment services, or

   c. Registered with a temporary employment agency, or

   d. His employer considers the individual on short-term disability even if he is not receiving a benefit, or

   e. On sick leave.

3. Continues to meet all other eligibility criteria for HCWD.

P. Break in Eligibility

A recipient who has lost eligibility in either the Basic or Medically Improved Coverage Group may reapply in the Medically Improved Group.

V. Redeterminations

A. Complete a redetermination every twelve months following procedures in MA-2320, Redeterminations.

B. The eligibility requirements in IV. above continue to apply.

VI. Terminations/Deletions

Follow procedures in MA-2352, Terminations/Deletions when an individual is ineligible for HCWD.