

MEDICAID

This section covers:

- Medicaid Overview
- Medicaid Eligibility
 - Eligibility in General
 - Categorical Eligibility Test
 - Financial Need Test – Assets
 - Financial Need Test – Income
 - General Procedures
- Medicaid Programs
 - Full Medicaid Benefits
 - Medically Needy Programs
 - Nursing Home Medicaid
- Medicare Savings Programs (MSPs)
 - Qualified Medicare Beneficiary Program (QMB)
 - Specified Low-Income Medicare Beneficiary Program (SLMB)
 - Qualified Individual (QI-1) Program
 - Other MSP Notes
- Home and Community-Based Services Program
- Medicaid and MSP Problem-Solving
- Where to Learn More

MEDICAID OVERVIEW

Medicaid is a health insurance program that is available to low-income people, many of whom have Medicare. Those who receive benefits from both Medicare and Medicaid are often called “dually-eligible” beneficiaries or “duals.” According to a Kaiser Family Foundation report, there were 8.8 million duals in 2005. About 5.6 million of them were age 65 and older, and 3.2 million were younger than 65 and received Medicare benefits due to a disability. (See Kaiser Family Foundation, *Dual Eligibles: Medicaid’s Role for Low Income Medicare Beneficiaries*, 2009, available online at <http://www.kff.org/medicaid/4091.cfm>.)

Medicaid is designed as a federal-state partnership established under Title XIX of the Social Security Act. Depending on a state’s per capita income level, the federal government pays from 50 percent to 76 percent of a Medicaid program’s costs. The state pays the balance. The federal government also sets minimum standards and broad guidelines that give the states flexibility to design their Medicaid programs. The Centers for Medicare and Medicaid Services (CMS) oversees the state programs to ensure compliance with federal standards. Note that Medicaid goes by different names in some states. Some know it as

Medical Assistance or MA. People in several states call it Title XIX, and a few states have their own names for the program, including Medi-Cal in California, MaineCare in Maine, and TennCare in Tennessee.

Since Medicaid began in 1965, the program has had close ties to the Supplemental Security Income (SSI) program, the federal income assistance program administered by the Social Security Administration (SSA). SSI and the state Medicaid programs use many of the same rules and procedures to determine eligibility. The connection between the two programs, however, is closer in some states than others.

- In 32 states and the District of Columbia (DC), the SSA makes Medicaid eligibility determinations, and a person who qualifies for the federal SSI program is automatically enrolled in the state Medicaid program.
- In 6 other states and the Northern Mariana Islands (NMI), a person who qualifies for SSI is eligible for Medicaid, but because the state makes its own Medicaid eligibility determinations a person must apply at a local Medicaid office not at an SSA office.
- In the 11 remaining states, a person who is eligible for SSI is not automatically eligible for Medicaid. These states use eligibility criteria for Medicaid that are more restrictive than those for SSI.

Typically, these states' income eligibility levels are lower than SSI's income levels (currently, \$674 per month for one person and \$1,011 per month for a couple). See the SSA's List of State Medicaid Programs for the Aged, Blind, and Disabled at <https://secure.ssa.gov/apps10/poms.nsf/lrx/0501715020!opendocument>.

In general, there are four programs under Medicaid's administrative umbrella that involve Medicare beneficiaries. They are the full-benefit Medicaid program, nursing home Medicaid, the Medicare Savings Programs (MSPs), and the Home and Community-Based Waiver (HCBW) program. In addition, 34 states, DC, and the NMI have "Medically Needy" programs for people whose income is too high to qualify for Medicaid under the state programs' income limits. They must "spend-down" their excess income using incurred medical expenses to reach the Medicaid income eligibility level.

- The three Medicare Savings Programs (MSPs) all pay the Medicare Part B premium for qualifying beneficiaries. The result is that people see \$96.40 (in 2010) added to their monthly Social Security checks. The three MSPs are the Qualified Medicare Beneficiary (QMB) program, the Specified Low-income Medicare Beneficiary (SLMB) program, and the Qualified Individual (QI) program.
- For contact information and Web sites for the state Medicaid agencies, go to <http://www.medicare.gov> and click on the "Find Helpful Phone Numbers and Websites" link. On the "Helpful Contacts" page, select "find a specific organization" and then, from the drop-down menu select "State Medical Assistance Office." Several state Medicaid Web sites have links to local or county offices.

MEDICAID ELIGIBILITY

Eligibility in General

To be eligible for Medicaid, a person must meet the requirements of three “tests” to qualify for benefits. They are:

- The categorical eligibility test. The state determines if the applicant fits within a group or category of people who are eligible for Medicaid. One example of an eligible category is persons aged 65 and older.
- The non-financial eligibility tests. The state determines, for example, if a Medicaid applicant is a state resident.
- The financial need test. The state determines if an applicant’s countable assets and income are low enough to qualify for Medicaid.

Medicaid recipients also must comply with certain rules and procedures such as informing the Medicaid program of any changes in assets, income, or other factors that would affect Medicaid eligibility.

Categorical Eligibility Test

The Medicaid program covers many groups of low-income people, including some children. Where Medicare beneficiaries are concerned, both the SSI and Medicaid programs take applications from those who are:

- aged (65 and older),
- blind, or
- disabled.

As noted above, SSI recipients, and some former SSI recipients, are automatically enrolled in Medicaid in 32 states and in DC. This arrangement relieves the state of some local administration costs because the Social Security Administration (SSA) administers the SSI program and processes applications. SSA then shares its files with the state’s Medicaid agency, which enrolls eligible people in Medicaid. Those who prefer to receive Medicaid benefits without SSI can apply separately for Medicaid at a local Medicaid office.

Financial Need Test—Assets

Medicaid’s financial needs test focuses on assets and income. An applicant must show that her resources, or “assets” (such as savings accounts), and income are low enough to qualify. The Social Security Administration and the state Medicaid programs use the same methods for calculating “countable resources” and “countable income.” In determining SSI and Medicaid eligibility, certain financial resources and income do not count against the applicant. They are excluded for purposes of Medicaid eligibility. States have some flexibility in setting the income and resource eligibility standards.

For SSI and Medicaid eligibility in most states, the countable resources test allows \$2,000 for one person and \$3,000 for a married couple. If a single person's countable resources exceed \$2,000, he is not eligible. Note that a few states use higher resource limits than those for SSI. North Dakota's Medicaid asset limits, for example, are \$3,000 for one person and \$6,000 for a couple.

The law generally allows applicants to exclude certain assets from the countable resource determination:

- The homestead, including the home and adjoining land, as long as the Medicaid applicant or a qualified dependent lives there (Note: if a person's equity in the homestead is more than \$500,000, Medicaid does not pay for home health services, home and community-based (waiver) services, or nursing home care).
- One vehicle
- Household goods and personal belongings
- A wedding ring and engagement ring
- Life insurance with a face value of \$1,500 or less. Any accumulated cash value in the policy is excluded.
- Certified irrevocable funeral contracts
- Some burial funds and burial spaces

For SSI and Medicaid eligibility, certain assets generally are counted:

- Savings accounts
- Checking accounts
- Certificates of Deposit (CD)
- Savings bonds
- Real property (e.g., vacation homes)
- Stocks
- Bonds
- Mutual funds
- More

Financial Need Test—Income


In determining SSI and Medicaid eligibility, an applicant's income must be low enough to qualify. In many states, a single person whose countable income is \$674 per month (\$1,011 for a married couple) or less (in 2010) qualifies for SSI payments and Medicaid benefits. Countable income includes Social Security retirement and disability benefits (the gross amount before subtracting the Part B premium), railroad retirement, veterans benefits, retirement income from pensions, and unemployment insurance. Note that some states

supplement the federal monthly SSI payment. This effectively raises the income level for Medicaid eligibility above \$674 per month. The monthly SSI income levels (for 2010) in New York, for example, are \$761 for one person and \$1,115 for a married couple.

Some income does not count against the applicant. For SSI and Medicaid eligibility, some examples of income that are excluded:

- Work expenses for the blind
- Allocation to dependent children
- Unearned income disregard (\$20 monthly)
- Earned income disregard (\$65 monthly) plus one-half of the applicant's remaining earned income
- SSI payments
- Stipends paid to Senior Companions program participants

EXAMPLE *Marion asked a SHIP counselor if she should apply for Medicaid. She reported that she is 72 years old and that her only assets are the home she has lived in for 25 years, a ten-year old Chevy Malibu, and \$1,200 in a credit union savings account. Her only income is a \$684 monthly Social Security check. Marion may very well be eligible for Medicaid. The state Medicaid office – or Social Security office if she applies for SSI – does not count her home and car because they are excluded assets. Her Social Security income is \$10 above the income limit, but both the state Medicaid program and Social Security (for SSI eligibility) would apply a \$20 income disregard to bring her countable income down to \$664 per month. With countable income below the \$674 income level, Marion would qualify for a \$10 monthly SSI payment and Medicaid.*



SHIP counselors are not expected to know all the rules concerning countable assets and income. When clients bring questions about the legal status of an asset that you cannot answer or don't feel comfortable answering, refer them to a legal services attorney or Medicaid case worker.

General Procedures

People can apply for Medicaid at any time by contacting a Medicaid office (for Medicaid only) or a local Social Security office (for SSI and Medicaid). There are no enrollment periods as with Medicare. Some states require an in-person interview to apply for Medicaid benefits while others conduct interviews by phone. Some accept written applications and follow up by phone to verify the information. Contact your state Medicaid office to find out more about its application procedures. The state Medicaid office must notify an applicant in writing of its eligibility determination. If the application is approved, the beneficiary typically receives an award letter and a Medicaid ID card from the state.

MEDICAID PROGRAMS

Full Medicaid Benefits

Federal rules require state Medicaid programs to provide certain mandatory benefits for Medicaid recipients, and allow states to cover other optional benefits. Those who qualify for full Medicaid benefits have coverage for most of the same services that the Original Medicare program does, and more. Thus, full Medicaid benefits serve as supplemental coverage for those Medicare beneficiaries, called “full duals,” who have both programs.

The mandatory benefits include coverage for inpatient and outpatient hospital care, laboratory and x-ray services, nursing facility care for people 21 and older, home health care, physician services, and more. To receive federal funding, states must provide these services. People who qualify for Medicaid also are deemed eligible for the Medicare Part D low-income subsidy (LIS).

State Medicaid programs also may cover several optional benefits that are important for dually eligible beneficiaries. These include dental care, hearing aids, chiropractic care, and some vision care. Nominal copayments apply to these services.

To learn about the optional services your state covers, contact your state Medicaid office or refer to the coverage charts in CMS’s *Medicaid At-a-Glance 2005* booklet, available online at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/02_MAAG2005.asp.

For Medicare-covered services, such as physician visits, Medicare pays first. Medicaid is a payer of last resort, meaning that it pays for a service or item only after all other insurers with responsibility for the claim have paid. Federal law permits states to avoid paying the Medicare cost-sharing amounts like the Part B 20 percent coinsurance charge, if the Medicaid program’s payment rate for the same service is less than the Medicare payment.

Medically Needy Program

People who meet the categorical eligibility and countable resource tests may qualify for Medicaid even if their income is above the monthly income standard. They must incur medical expenses that enable them to “spend down” their income to a state-established “medically needy income level.” This income level varies among the states, and in some cases is lower than the standard income eligibility level. Some states refer to this spend-down amount as a “deductible.”

Medical costs that count toward the spend-down amount include health insurance premiums and unreimbursed expenses (such as copayments) for medical care. The many rules governing the process for calculating the spend-down amount and for protecting certain income are beyond the scope of this manual. For more information on Medically Needy

programs, contact your state Medicaid program or visit CMS's Medically Needy program web page at http://www.cms.hhs.gov/MedicaidEligibility/06_Medically_Needed.asp#TopOfPage.

After a person qualifies as a medically needy Medicaid recipient, he receives coverage for a range of services that complements Medicare coverage but which varies from state to state, and which also may differ from the scope of services that full Medicaid recipients receive. Medically Needy Medicaid recipients also are deemed eligible for the Medicare Part D low-income subsidy (LIS).

Nursing Home Medicaid

Nursing home residents whose assets are below a state's Medicaid resource level (\$2,000 for one person in most states) may qualify for Medicaid payments toward their nursing home care. Often, people in nursing homes qualify for Medicaid after they have paid the home's private pay rate for a few months and in the process depleted their savings and other resources to meet the low asset requirements for Medicaid's financial need test.

A nursing home resident whose combined income (e.g., Social Security, pensions, annuities) is more than the nursing home's private pay rate, or above a separate state-established income limit, is not eligible for Medicaid. If the resident qualifies for Medicaid, the program pays toward the cost of nursing home care after the resident gives most of her income to the nursing home.

EXAMPLE *Deborah has \$3,020 in combined monthly income from Social Security and two pension payments. Only \$1,950 in assets remains in her name. Deborah is a resident at Arbor View Nursing Home where the monthly private pay rate is \$4,000. She lives in a state that determines eligibility for nursing home Medicaid in reference to the facility's private pay rate. Medicaid will disregard \$20 of her income, leaving her with \$3,000 in countable income. She qualifies for Medicaid. The state allows Deborah to keep \$60 per month as a patient allowance. She must then pay \$2,940 to the nursing facility and Medicaid covers the balance.*

MEDICARE SAVINGS PROGRAMS (MSPs)

All states have at least these three Medicare Savings Programs: the Qualified Medicare Beneficiary (QMB), Specified Low-Income Beneficiary (SLMB), and Qualified Individual (QI-1) programs. The federal government covers 100 percent of the cost of the QI-1 program and pays the same Medicaid matching percentage rate (based on state per capita income) for the QMB and SLMB programs as it does for regular Medicaid benefits. The common denominators for the MSPs are that 1) they pay the monthly Medicare Part B premium, in


effect adding \$96.40 per month (in 2010) to a person's Social Security check and 2) those who receive MSP benefits are deemed eligible for the Medicare Part D low-income subsidy (LIS) program and a 100 percent subsidy for their drug plans' monthly premiums.

With the passage of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, effective January 1, 2010, all Medicare Savings Programs (QMB, SLMB, and QI) have increased asset tests to match the asset levels for the full low-income subsidy (LIS). The asset levels for all Medicare Savings Programs are \$8,100 per individual and \$12,910 per couple (in 2010). MIPPA also mandates that the MSP asset tests be indexed each year for inflation, something that has not happened before in the history of the Medicare Savings Program. Note the federally mandated increase in MSP asset levels sets a floor for state programs. States may raise the asset level or even eliminate the resource test entirely.

Qualified Medicare Beneficiary Program (QMB)

QMB covers the deductibles and coinsurance charges for Medicare Part A and Part B and pays the monthly Medicare Part B premium. These include the inpatient hospital and SNF daily coinsurance charges and the Part B 20 percent coinsurance charge. In effect, the program can work like a basic Medigap policy, and it adds \$96.40 per month (in 2010) to a person's Social Security check.

To meet the financial need test for QMB, countable income must be at or below 100 percent of the federal poverty level, i.e., \$902.50 per month or less for one person, and \$1,214.17 per month or less for a married couple in 2009 (these income levels are higher in Alaska and Hawaii). Countable resources for QMB—as with all MSPs—is up to \$8,100 for one person and up to \$12,910 for a married couple, with some states using higher resource limits, or eliminating the resource test entirely.



For more information on the transfer of LIS applications to states for MSP eligibility, see the Help for Low-Income Beneficiaries section of HAP's Part D SHIP Resource Guide available at <http://www.hapnetwork.org/medicare-drug-coverage/ship-resource-guide/low-income-help>.

Specified Low-Income Medicare Beneficiary Program (SLMB)

SLMB is a federally funded program that covers the Medicare Part B monthly premium for persons whose income is between 101 percent and 120 percent of the federal poverty level. The program adds \$96.40 per month (in 2008 and 2009) to a person's Social Security check. SLMB differs from QMB is that it does not cover Medicare's deductibles and coinsurance charges.

To meet the financial need test for SLMB, an individual's monthly income must be between \$902.51 and \$1,083, and \$1,214.17 and \$1,457 for a married couple, in 2009 (these income levels are higher in Alaska and Hawaii). Countable resources for SLMB—as with all MSPs—is up to \$8,100 for one person and up to \$12,910 for a married couple, with some states using higher resource limits, or eliminating the resource test entirely.

Qualifying Individual (QI-1) Program

QI-1 covers the Medicare Part B monthly premium for persons whose income is between 121 percent and 135 percent of the federal poverty level. The program adds \$96.40 (in 2010) per month to a person's Social Security check. It is like the SLMB program in that it does not cover the Medicare deductibles and coinsurance charges.

In 2009, to qualify for QI the monthly countable income for one person must be between \$1,083.01 and \$1,218.38 and between \$1,457.01 and \$1,639.13 for a married couple. Countable resources for QI-1 – as with all MSPs – is up to \$8,100 for one person and up to \$12,910 for a married couple, with some states using higher resource limits, or eliminating the resource test entirely.

Other MSP Notes

Each spring, the federal government updates the federal poverty levels. The income standards for the Medicaid Savings Programs rise accordingly and take effect on April 1. The federal poverty levels for Alaska and Hawaii are somewhat higher than those for the other 48 states. The Social Security Administration posts poverty level information for the states at <https://secure.ssa.gov/apps10/poms.nsf/lnx/0603001010!opendocument>.

Both the SLMB and QI-1 programs cover the Part B premium. So what is the difference between the two, other than their income guidelines? The explanation is that SLMB is an entitlement and QI-1 is not. All states must cover people who qualify for SLMB. But the QI-1 program involves a block grant for the states and Congress must authorize funding for it regularly. If a state ever runs out of funding for the QI-1 program, it can turn away applicants who are otherwise eligible.

Note: One source of confusion in your work as a counselor may be duplicate abbreviations. Note that "MSP" abbreviates both the Medicare Secondary Payer program and the Medicare Savings Program. Also note that MA abbreviates the Medicare Advantage program and some states' Medical Assistance, or Medicaid, program.

HOME AND COMMUNITY-BASED SERVICES PROGRAM

Federal law allows CMS to waive some Medicaid program rules (e.g., the regular Medicaid income standards) so that states can design programs that help prevent or delay nursing home admissions for people 65 and older and people with disabilities. Waiver programs provide a wide range of home based services, including home health aides and respite care, to help those at risk of nursing home admission stay in their homes.

The income eligibility test for Home and Community Based Services (HCBS) program often is much higher than the qualifying income level for regular Medicaid benefits or the MSPs. But the same asset test typically applies to the HCBS program as to nursing home Medicaid; \$2,000 for one person in most states. The program ends when a beneficiary enters a long-term care nursing facility.

MEDICAID AND MSP PROBLEM-SOLVING

Common Advocacy Issues for Dual-Eligible Clients

SHIP counselors can expect to see one or more of the following problems arise from time to time in your work with low-income Medicare beneficiaries. The challenges include:

- Finding and gathering the documents a client needs to demonstrate financial need and establish eligibility for public assistance.
- Clients who are billed for Medicare's 20 percent coinsurance charge because they went to a provider who is not participating in Medicaid.
- Clients who are wary of public assistance programs and the people who run them.
- Eligibility denials for failure to prove financial need or due to an administrative error.
- Medicaid coverage denials for services and items due to lack of medical necessity.
- Pharmacy access and copayment problems for all Medicaid recipients, particularly those who are new to Medicare and in transition from state Medicaid drug coverage to coverage through a private Medicare Part D drug plan.

Problem Solving Strategies for Dual-Eligible Clients

SHIP counselors should be aware of both informal and formal steps that may help resolve coverage and payment problems for low-income clients.

- **Informal problem-solving strategies include:**
 - For Medicaid and MSP eligibility denials, contact the eligibility caseworker to identify the cause of the problem and resubmit an amended application.
 - For Medicaid and QMB recipients who are facing bills from providers who do not participate in Medicaid, call or write the provider to request an adjustment or write-off for the bill.
 - For billing mistakes, call the provider's billing office to explain that Medicaid and QMB recipients are not liable for deductibles and coinsurance after Medicare has made its payment.
 - For pharmacy access and over-billing problems for dually-eligible beneficiaries, contact the drug plan and inform the contact person that Medicare's Best Available Evidence (BAE) policy applies to your client (see *Medicare Prescription Drug Benefit Manual*, Chapter 13, Section 70.5, available online at http://www.cms.hhs.gov/manuals/downloads/Pub100_18.pdf).
- **A formal strategy is:**
 - Appeal procedures, including redetermination and fair hearings, to review eligibility and service coverage denials. Check the *Explanation of Benefits* statements for instructions. Refer clients to legal services programs for help.

WHERE TO LEARN MORE

For detailed information on the CMS's administrative rules and policies for the state Medicaid programs, see:

- The *State Medicaid Manual*, CMS Publication 100-12, available online at <http://www.cms.hhs.gov/Manuals/IOM/list.asp?listpage=2>.
- The *State Buy-In Manual*, CMS Publication 100-15, available online at <http://www.cms.hhs.gov/Manuals/IOM/list.asp?listpage=2>.

For general information on Medicaid see:

- *What is Medicare/Medicaid?*, a fact sheet, available online at <http://www.medicare.gov> through the “Find a Publication” link.
- *Medicaid: Getting Started*, a quick-guide handout, available online at <http://www.medicare.gov/Publications/Pubs/pdf/11409.pdf>.

For information on the Medicare Savings Programs (MSP) see:

- *If You Need Help Paying for Medicare Costs, There Are Programs That Can Help You*, a CMS brochure about the Medicare Savings Programs (QMB, SLMB, and QI-1).

