What Is Medicaid -How, When, and Where Do I Apply?

by Jill Lorentz

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Processing Medicaid paperwork is cumbersome and a bit time consuming but you can do it on your own if you have the time and energy. You can call the local medicaid office or go online to obtain it.

However, the paperwork must be filled out in the county you wish to have the resident reside. If you have urgency surrounding the issue, you can possibly have a company fill out and submit the paperwork for you, but the cost is approximately $800. The time for processing the paperwork with the US government is 60 -90 days.

I suggest you tour or call the places you are interested in which accept Medicaid.
IMPORTANT - The first question you need to ask at all of the communities which you visit is:
Do you accept Medicaid on Day 1, or do I need a spend down to qualify?

Again - Do Not Apply for Medicaid benefits until you know which county the person will be living in.
When you call a community…

1. Be sure to ask if they will accept Medicaid from the time of the move-in.
2. Ask if there is availability.
3. Find out if there is a wait list and if so about how long.
4. Arrange a tour of the community.

This is a cumbersome process, so I have researched information form Medicaid.gov which will hopefully answer your questions.

Best of luck,
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Eligibility

Medicaid is a joint federal and state program that, together with the Children's Health Insurance Program, provides health coverage to over 72.5 million Americans, including children, pregnant women, parents, seniors and individuals with disabilities. Medicaid is the single largest source of health coverage in the United States.

In order to participate in Medicaid, federal law requires states to cover certain groups of individuals. Low income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups (PDF 177.87 KB). States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community based services and children in foster care who are not otherwise eligible.

The Affordable Care Act of 2010 created the opportunity for states to expand Medicaid to cover nearly all low-income Americans under age 65. Eligibility for children was extended to at least 133 percent of the federal poverty level (FPL) in every state (most states cover children to higher income levels) and states were given the option to extend eligibility to adults with income at or below 133 percent of the FPL. The majority of states have chosen to expand coverage to adults, and those that have not yet expanded may choose to do so at any time. Click here to see if your state has expanded Medicaid coverage to low-income adults.

Determining Eligibility for Medicaid

Financial Eligibility

The Affordable Care Act established a new methodology for determining income eligibility for Medicaid, which is based on Modified Adjusted Gross Income (MAGI). MAGI is used to determine financial eligibility for Medicaid, CHIP, and premium tax credits and cost sharing reductions available through the health insurance marketplace. By using one set of

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income counting rules and a single application across programs, the Affordable Care Act made it easier for people to apply and enroll in the appropriate program.

MAGI is the basis for determining Medicaid income eligibility for most children, pregnant women, parents and adults. The MAGI-based methodology considers taxable income and tax filing relationships to determine financial eligibility for Medicaid. MAGI replaced the former process for calculating Medicaid eligibility, which was based on the methodologies of the Aid to Families with Dependent Children (AFDC) program that ended in 1996. The MAGI-based methodology does not allow for income disregards that vary by state or by eligibility group, and does not allow for an asset or resource test.

Some individuals are exempt from the MAGI-based income counting rules, including those whose eligibility is based on blindness, disability or age (65 and older). Medicaid eligibility for individuals 65 and older or who have blindness or a disability is generally determined using the income methodologies of the supplemental security income (SSI) program administered by the Social Security Administration (some states, known as 209(b) states, use certain more restrictive eligibility criteria than SSI's, but still largely apply SSI's methodologies). Eligibility for the Medicare Savings Programs, through which Medicaid pays Medicare premiums, deductibles and/or coinsurance costs for beneficiaries eligible for both programs (often referred to as dual eligibles) is determined using SSI methodologies.

Certain Medicaid eligibility groups do not require a determination of income by the Medicaid agency. This coverage may be based on enrollment in another program, such as SSI or the breast and cervical cancer treatment and prevention program. Children for whom an adoption assistance agreement is in effect under title IV-E of the Social Security Act are automatically eligible. Young adults, who meet the requirements for eligibility as a former foster care recipient, are also eligible at any income level.

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Non-Financial Eligibility

To be eligible for Medicaid, individuals must also meet certain non-financial eligibility criteria. Medicaid beneficiaries must generally be residents of the state in which they are receiving Medicaid. They must either be citizens of the United States or certain qualified non-citizens, such as lawful permanent residents. In addition, some eligibility groups are limited by age, or by pregnancy or parenting status.

Effective Date of Coverage

Once an individual is determined eligible for Medicaid, coverage is effective either on the date of application or the first day of the month of application. Benefits may also be covered retroactively for up to 3 months prior to the month of application, if the individual would have been eligible during that period had he or she applied. Coverage generally stops at the end of the month in which a person no longer meets the requirements for eligibility.

Medically Needy

States have the option to establish a "medically needy program" for individuals with significant health needs whose income is too high to otherwise qualify for Medicaid under other eligibility groups. Medically needy individuals can still become eligible by "spending down" the amount of income that is above a particular state's medically needy income standard. Individuals spend down by incurring expenses for medical and remedial care for which they do not have health insurance. Once an individual's incurred expenses exceed the difference between the individual's income and the state's medically needy income level (the "spenddown" amount), the person can be eligible for Medicaid. The Medicaid program then pays the cost of services that exceed what the individual had to incur in the way of expenses in order to become eligible.

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In addition to states with medically needy programs, 209(b) states must also allow a spenddown to the income eligibility levels eligibility groups based on blindness, disability or age (65 and older), even if the state also has a medically needy program. Thirty-six states and the District of Columbia use spenddown programs, either as medically needy programs or as 209(b) states.

Spousal Impoverishment

The expense of nursing home care — which ranges from $5,000 to $8,000 a month or more — can rapidly deplete the lifetime savings of elderly couples. In 1988, Congress enacted provisions to prevent what has come to be called "spousal impoverishment," leaving the spouse who is still living at home in the community with little or no income or resources. These provisions help ensure that this situation will not occur and that community spouses are able to live out their lives with independence and dignity.

Under the Medicaid spousal impoverishment provisions, a certain amount of the couple's combined resources is protected for the spouse living in the community. Depending on how much of his or her own income the community spouse actually has, a certain amount of income belonging to the spouse in the institution can also be set aside for the community spouse's use.

Following is the minimum and maximum amount of resources and income that can be protected for a spouse in the community in 2017:

- 2017 Spousal Impoverishment Standard (PDF 18.69 KB)

Post-Eligibility Treatment of Income

The post eligibility calculation is made to determine how much an individual in an institution (usually a nursing home) is able to contribute to cost of his/her own care. It applies only to individuals who are institutionalized (most commonly to those in nursing

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facilities) and to certain individuals receiving home and community-based waiver services. The process only applies to those with income and only after their Medicaid eligibility has been established.

The contribution is determined by first calculating the individual's total income and **then** deducting certain amounts from that income. Specifically, the individual's contribution is his or her total income less the following deductions (often referred to as "protected amounts"):

- A personal needs allowance of at least $30;
- If there is a community spouse and the spousal impoverishment rules discussed above apply, a community spouse's monthly income allowance (at least $2,002.50 but not exceeding $2,980 for 2016), as long as the income is actually made available to the community spouse;
- A family monthly income allowance, if there are other family members living in the household;
- An amount for medical expenses incurred by the spouse who is in the medical facility.

Once the above items are deducted from the institutionalized individual's income, any remaining income is contributed toward the cost of his or her care in the institution. Treatment of Trusts: When an individual, their spouse, or anyone acting on the individual's behalf establishes a trust using at least some of the individual's funds, that trust can be considered available to the individual for purposes of determining eligibility for Medicaid. Transfers of Assets for Less Than Fair Market Value: Medicaid beneficiaries who need LTSS will be denied LTSS coverage if they have transferred assets for less than fair market value during the five-year period preceding their Medicaid application. This rule applies when assets are transferred, sold, or gifted for less than they are worth by individuals (or their spouses) who need LTSS in a long-term care facility or wish to receive home and community-based waiver services.

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Estate Recovery and Liens

State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States have the option to recover payments for all other Medicaid services provided to these individuals, except Medicare cost-sharing paid on behalf of Medicare Savings Program beneficiaries. Under certain conditions, money remaining in a trust after a Medicaid enrollee has passed away may be used to reimburse Medicaid. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age. States are also required to establish procedures for waiving estate recovery when recovery would cause an undue hardship.

States may impose liens for Medicaid benefits incorrectly paid pursuant to a court judgment. States may also impose liens on real property during the lifetime of a Medicaid enrollee who is permanently institutionalized, except when one of the following individuals resides in the home: the spouse, child under age 21, blind or disabled child of any age, or sibling who has an equity interest in the home. The states must remove the lien when the Medicaid enrollee is discharged from the facility and returns home.

Medicaid Third Party Liability & Coordination of Benefits

It is common for Medicaid beneficiaries to have one or more additional sources of coverage for health care services. Third Party Liability (TPL) refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan. By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid state plan. The Deficit

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Reduction Act of 2005 included several additional provisions related to TPL and coordination of benefits for Medicaid beneficiaries. For more information on Medicaid TPL and COB, see our Frequently Asked Questions (PDF 252.32 KB). For training presentations and detailed information about COB/TPL policies, see our Coordination of Benefits and Third Party Liability (COB/TPL) in Medicaid 2016 (PDF 950.83 KB).

Coordination of Benefits

Coordination of Benefits (COB) refers to the activities involved in determining Medicaid benefits when an enrollee has coverage through an individual, entity, insurance, or program that is liable to pay for health care services. Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid Agency.

Examples of third parties which may be liable to pay for services:

- Group health plans
- Self-insured plans
- Managed care organizations
- Pharmacy benefit managers
- Medicare
- Court-ordered health coverage
- Settlements from a liability insurer
- Workers' compensation
- Long-term care insurance
- Other state or Federal coverage programs (unless specifically excluded by law)

Identification of Third Parties

States gather information regarding potentially liable third parties, including information about other sources of health coverage, when individuals apply for medical assistance. This information is periodically updated whenever a Medicaid enrollee's eligibility is renewed.

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Data Matching
States conduct data matches to identify third party resources. States must have laws in place that require health insurers to provide their plan eligibility and coverage information to Medicaid programs. For example, states conduct data matches with public entities, such as the Department of Defense, to identify Medicaid enrollees and/or their dependents that have coverage through the Military Health Services system and the TRICARE program. States also match with workers' compensation and state motor vehicle accident files. These matches can identify Medicaid enrollees that have sustained injuries which may be covered through workers' compensation or through an automobile insurance policy. State child support agencies are required to notify the Medicaid agency whenever a parent has acquired health coverage for child as a result of a court order.

State Medicaid Programs and Use of Contractors for Data Matching
State Medicaid programs may enter into data matching agreements directly with third parties or may obtain the services of a contractor to complete the required matches. When the state Medicaid program chooses to use a contractor to complete data matches, the program delegates its authority to obtain information from third parties to the contractor. Third parties should treat a request from the contractor as a request from the state Medicaid agency. Third parties may request verification from the State Medicaid agency that the contractor is working on behalf of the agency and the scope of the delegated work.

Managed Care and Third Party Liability
The contract language between the State Medicaid agency and the Managed Care Organization (MCO) dictates the terms and conditions under which the MCO assumes Third Party Liability (TPL) responsibility. Generally, TPL administration and performance activities that are the responsibility of the MCO will be set by the state and should be accompanied by state oversight.

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There are four basic approaches to carrying out TPL functions in a managed care environment.

1. Enrollees with any other insurance coverage are excluded from enrollment in man aged care;
2. Enrollees with other insurance coverage are enrolled in managed care and the state retains TPL responsibilities;
3. Enrollees with other insurance coverage are enrolled in managed care and TPL re sponsibilities are delegated to the Managed Care Organization (MCO) with an appropriate adjustment of the MCO capitation payments; and
4. Enrollees and/or their dependents with commercial managed care coverage are excluded from enrollment in Medicaid MCOs, while TPL for other enrollees with private health insurance or Medicare coverage is delegated to the MCO with the state retaining responsibility only for tort and estate recoveries.

MCOs and Data Matching

State Medicaid programs may contract with MCOs to provide health care to Medicaid beneficiaries, and may delegate responsibility and authority to the MCOs to perform third party discovery and recovery activities. The Medicaid program may authorize the MCO to use a contractor to complete these activities.

When TPL responsibilities are delegated to an MCO, third parties are required to treat the MCO as if it were the State Medicaid agency, including:

- Providing access to third party eligibility and claims data to identify individuals with third party coverage;
- Adhering to the assignment of rights from the state to the MCO of a Medicaid beneficiary's right to payment by such insurers for health care items or services; and
- Refraining from denying payment of claims submitted by the MCO for procedural reasons.

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Third parties may request verification from the state Medicaid agency that the MCO or its contractor is working on behalf of the agency and the scope of the delegated work.
Resource:
https://www.medicaid.gov/medicaid/eligibility/index.html

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