Chapter 4

Medicaid

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SYNOPSIS

The purpose of this chapter is to clarify important information you need to know about Medicaid. It will answer your questions about eligibility requirements and enrollment processes.

4-1. Medicaid

Medicaid is a federal-state medical assistance program for low-income recipients of public benefit programs. Medicaid provides more complete coverage than does Medicare, without significant payments from the beneficiaries. Only low-income persons with limited resources who are elderly, blind, disabled, or are low-income families can receive Medicaid.

Who Receives Medicaid?

Medicaid was created as an add-on health benefit to two welfare programs: Supplemental Security Income (SSI) and Aid to Families with Dependent Children (AFDC). AFDC was replaced by the Temporary Assistance for Needy Families (TANF) program. Recipients of either SSI or TANF, or those who would qualify for AFDC if it still existed, are eligible for Medicaid, as are Old Age Pension (OAP) recipients who are disabled or more than 64 years of age. People who would continue to receive those benefits except for earned

income or cost of living increases often continue to receive Medicaid. Women with breast or cervical cancer may also qualify if they lack health insurance.

The eligibility rules for elderly or disabled people generally use the SSI income and resource rules. Total resources (bank accounts, property, etc.) may not exceed $2,000 for an individual, or $3,000 for a married couple. Some property does not count as a resource, like your residence, your car, some funeral items or plans, wedding jewelry, and life insurance with a cash value of $1,500 or less. For long-term care (see section 4-2, below), the income cap is three times the SSI payment standard for one, or $2,206 per month for 2017. For additional income and resource rules for couples, see "Spousal Protection" in section 4-2, below.

There are many additional eligibility rules, including citizenship requirements, special requirements for long-term care, and severe transfer restrictions (see "Estate Planning" in section 4-2, below).

What Services Are Covered?

In Colorado, Medicaid covers most necessary services, including hospital, nursing home, physician, prescriptions, medical supplies and equipment, skilled home care (nurse or Certified Nursing Assistant required), and assistance with transportation. In addition, non-skilled or personal in-home services are provided by Home and Community Based Services (HCBS) programs for specific groups such as the elderly and people with developmental disabilities, mental illnesses, AIDS, or other chronic disabilities.

While there is a co-payment for some services ($.50 to $10 or more in Colorado), Medicaid generally pays the entire charge approved by the Medicaid program. Additionally, most nursing home residents must pay all but $81.95 per month of their income toward their care. Medicaid is the payor of last resort, so other insurance, including Medicare, must pay first.

How to Apply for Medicaid

Apply for Medicaid at your county Department of Social or Human Services. If you are receiving SSI, bring your SSI award letter. If you are eligible for SSI but are not receiving it, first go to your local Social Security office to apply for SSI. You can apply for OAP and Medicaid at the county Department of Social Services at the same time. Nursing home residents apply in the county in which the nursing home is located.

You will need to be able to verify income, resources, age, and disability, if any. You should bring the following documents with you:

- ▶ Proof of all income, including investment income, if any;
- ▶ Bank statements for all accounts;
- ▶ Copies of title or other proof of ownership of any real estate or other assets;
- ▶ Copies of life and health insurance policies;
- ▶ Proof of age, such as a birth certificate; and
- ▶ Medicare and Social Security cards.

While you may be asked to come back for another appointment with any documentation that is lacking, you have a right to sign the first page of the application when you first come in. This serves as your application date. If you cannot travel to the office, a responsible person can apply on your behalf.

Nursing home residents should tell the nursing home staff that they are applying for Medicaid. The law prohibits a nursing facility from requiring a third-party guarantee of payment.

4-2. Long-Term Care

Nursing home and Home and Community Based Services (HCBS) are available only when there is a medical need for nursing home-level care. HCBS may be available to help a recipient stay in his or her home, but only when the cost to the program is less than the cost of a nursing home. Twenty-four-hour care is not available in the home, since it would cost more than nursing home care. Because of the cost of long-term care, the income limit for eligibility is three times the SSI payment level (approximately $2,206), but see the "Estate Planning" subsection below for exceptions. There was a recent change to require proof of disability for long-term care.

Program of All Inclusive Care for the Elderly (PACE)

Another option available to frail elders is known as the Program of All Inclusive Care for the Elderly (PACE). This program provides comprehensive health care and supportive services for people 65 years and older. In the Denver metro area, the PACE contract is currently managed by InnovAge (www.myinnovage.org or (720) 974-2411). In Colorado Springs, the PACE contract is managed by Rocky Mountain PACE (www.rmhcare.org or (719) 466-8777); in Pueblo, it is managed by InnovAge (www.myinnovage.org or (719) 553-0400); in Delta and Montrose, it is managed by Senior CommUnity Care (www.seniorcommunitycare.org or (970) 835-8500 in Delta and (970) 252-0522 in Montrose). For more information, contact your local PACE provider or your county Department of Social Services.

Estate Planning

Even with the higher income cap, many people who have income too high to qualify for Medicaid long-term care are still unable to pay for nursing home care (since nursing homes charge more than $2,206 per month). In those cases, a trust — sometimes known as an "income trust" or "Miller trust" — may set aside enough income to make an individual eligible. Other forms of estate planning may preserve some assets. However, transfers to create eligibility can result in severe penalties, particularly if made within five years before applying for Medicaid. Because of the possible penalties, any financial planning should be done by an attorney with Medicaid expertise.

Spousal Protection

The "Spousal Protection rule" allows a spouse who remains at home to avoid poverty by keeping between $2,002 and $3,023 of the couple's monthly income, while the institu-

tionalized spouse receives Medicaid. The community spouse generally may also keep his or her IRAs, pensions, other exempt property as described above under general Medicaid eligibility rules, and up to $120,900 in non-exempt resources. The spousal protection rules are indexed to the Consumer Price Index and change yearly.

Estate Recovery

Under a program known as the Colorado Estate Recovery Program, the state can recover Medicaid expenditures from the recipient's estate after he or she dies. The estate recovery program applies to people who were 55 years of age or older when they received such assistance, as well as to all institutionalized individuals. The program permits the state to file a claim against an individual Medicaid recipient's estate, including a lien on the home. After the person dies, the state can enforce the lien and recover the expenses paid by Medicaid from the proceeds of the sale of the property. No action is taken against the property while the Medicaid recipient is still living.

The home may be protected from recovery if a surviving spouse or dependent child is still living there. There are other exceptions to recovery. It is important to consult with an attorney knowledgeable about Medicaid eligibility concerning these provisions, since they are complex and subject to change.

4-3. New Medicaid Regulations Within the Deficit Reduction Act of 2005

On February 8, 2006, President Bush signed the Deficit Reduction Act (DRA) of 2005. This legislation contained several changes to the Medicaid regulations that will affect elderly individuals who apply for the program. Here are the major parts of the new rules.

Increases the Look-Back Period

All transfers made on or after February 8, 2006, whether to individuals or to trusts, are subject to a five-year look-back period rather than the prior three-year look-back period. This makes the application process more difficult and could result in more applicants being denied for lack of documentation, given that they will need to produce five years' worth of records instead of three years.

Postpones the Penalty Period Start Date

Under the old rules, if you made a transfer within the three years prior to a Medicaid application, you would incur a penalty period based on the amount of the gift. The penalty period would begin on the month that you made the transfer. The new law shifts the start of the period of ineligibility for a transfer of assets from the first day of the month of the transfer to the later of that date or "the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care." So, what does this mean? First, the penalty period does not begin until the individual moves to the nursing home or requires a level of care that is equal to nursing home

care. Second, the penalty period does not begin until the person would be eligible for Medicaid, meaning until he or she has spent down to $2,000 (or a different asset limit in some states).

An example should help explain how this will work. Let's assume that a senior transfers $70,000 to her son on July 1, 2011, but keeps $100,000 in her name. Let's further assume that our senior falls and breaks her hip on July 1, 2013, and subsequently moves to a nursing home. The senior spends down her savings over the following year, leaving her eligible for Medicaid on July 1, 2014, but for the transfer penalty. Under the new law, because the penalty does not start until she is at a nursing home level of care and is down to the $2,000 asset limit (minus the normal exemptions such as the residence, a vehicle, personal property items, and a burial plot or plan), she would not be eligible until April 27, 2015. Unless the son can give back the $70,000 transfer, there will be no funds to pay for care unless a family member helps or the senior appeals and receives a waiver of the ineligibility period.

The Effective Date

The new transfer rules apply to all transfers occurring on or after the date of enactment of the DRA (February 8, 2006). Transfers made before February 8, 2006, are outside the look-back period, so they do not result in a transfer penalty.

Hardship Waivers

Each state will institute a process for seeking a hardship waiver where the application of the transfer penalty would result in deprivation of medical care that would endanger the applicant's health or life, or of "food, clothing, shelter, or other necessities of life." The process must include notice to applicants, a timely process for ruling on the application, and an appeal process.

The new law also permits the nursing home to apply on behalf of the individual for such a waiver upon receipt of consent from the resident or his or her personal representative. However, the waiver is only for hardship to the resident, not to the facility. If a facility cannot evict a nonpaying resident without providing alternative care and no alternative care exists, there is really no hardship to the resident, only the nursing home.

Annuities

The new rules require that the state be "named the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant." The provision also provides that the state be the secondary beneficiary where a community spouse or minor or disabled child is the primary beneficiary.

The Valuable House Rule

Under the DRA, homes of nursing home residents in which the residents own more than $560,000 in equity shall be countable unless the nursing home resident's spouse, child under age 21, or blind or disabled child is living in the house. The effective date of this provision was January 1, 2006.

Deposits or Buy-Ins at Continuing Care Retirement Communities (CCRCs)

Any amount required for a deposit in a CCRC, or that is used for a buy-in at a CCRC, will now be counted as an asset. In the past, CCRCs would require, say, a $50,000 buy-in for residence but would provide for these funds to be held and returned to the person, or their beneficiaries, when the individual moved out or passed away. Under the new rule, these deposits will be seen as countable assets that will need to be recouped and spent down before Medicaid eligibility.

4-4. Medicaid Payment for Medicare Premiums, Deductibles, and Co-Payments

People whose income makes them ineligible for Medicaid may still qualify for one of three Medicaid programs that pay Medicare-related costs.

A Qualified Medicare Beneficiary (QMB) receives payment by Medicaid of all Medicare premiums, deductibles, and co-pays. The QMB income maximum is $1,010 for one person, and $1,355 for a couple.

Similarly, a Special Low-Income Medicare Beneficiary (SLMB) receives only payment of Medicare premiums. The SLMB income maximum is higher: $1,208 for one person or $1,622 for two.

Finally, a similar program called QI-1 can provide assistance with Medicaid premiums with income up to $1,357 for one person and $1,823 for two, but any assistance is subject to the availability of state funding.

Note that some earned income may be excluded for all three of these income caps, and that the income caps change annually as poverty figures are changed.

4-5. New Medicaid Category Under the Affordable Care Act of 2010

In 2010, President Obama signed the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), which, together, make up the Affordable Care Act (ACA). This legislation provides for a significant expansion of the Medicaid program in participating states, like Colorado.

The ACA provisions dealing with Medicaid expansion went into effect on January 1, 2014. These provisions create a new eligibility group: adults under age 65 who do not currently qualify for Medicare or Medicaid as a result of disability and whose annual income is less than 138 percent of the federal poverty level (FPL). There is an income disregard of 5 percent of annual income, meaning that annual income will be under 133 percent of the FPL after the disregard. The financial eligibility requirement for this new group of Medicaid beneficiaries is based solely on income; resources are not counted.

Those with income greater than 133 percent of the FPL but less than 400 percent of the FPL after the disregard will be able to purchase health insurance through Connect for

Health Colorado and receive a discounted premium. Colorado has created its own exchange without federal participation. Colorado's exchange is of the "clearinghouse" variety, meaning that all health insurance providers licensed in Colorado will have the opportunity to participate and compete. There is grant funding from the federal government to assist Colorado to set up and operate its exchange.

Since the ACA provisions regarding guaranteed issue of insurance without preexisting condition exclusions also became effective on January 1, 2014, Colorado's exchange provides a means for many Coloradoans to obtain health insurance at an affordable rate. The ACA also gives Colorado the ability to monitor and prevent inappropriate health insurance rate increases of more than 10 percent.

The income level for purposes of eligibility for this new group will be based on projected Modified Adjusted Gross Income (MAGI) according to current income levels at the time of application. However, the income level for purposes of participation in the exchange will be based upon the MAGI as calculated from the individual's most recent federal tax return.

It is important to understand that the ACA is creating a new category of eligibility that will exist in addition to current eligibility categories. In other words, those currently qualifying for Medicaid due to SSI eligibility or for long-term care or HCBS benefits will continue to be governed by the same eligibility requirements that exist today. Beginning January 1, 2014, new applicants will first apply based upon MAGI. Those who do not qualify under the MAGI criteria can still apply for Medicaid long-term care, HCBS, or PACE benefits under the current eligibility criteria for those programs. Those who do not qualify under MAGI but need long-term care services will be able to apply for Medicaid long-term care, HCBS, or PACE benefits. The idea is that creating a new eligibility group should not cause anyone to lose eligibility for any existing group.

Those qualifying under the new MAGI standards will not necessarily receive the same benefits as current Medicaid beneficiaries. The ACA mandates states to adopt "benchmark" plans for many of the new MAGI beneficiaries. Colorado's benchmark is based upon an HMO plan issued by Kaiser Permanente. The plan will have to meet federal criteria for essential benefits and include all of the Colorado-specific coverage mandates.

Funding for the new MAGI category was entirely federal through 2016. After that, the federal government's contribution will gradually decrease to 90 percent by 2020.

Another result of the ACA Medicaid provisions is a change in the way that benefits will be coordinated between Medicare and Medicaid for dually elibigle persons. A new office has been created within the Centers for Medicare and Medicaid Services (CMS) called the "Medicare-Medicaid Coordination Office." According to the CMS,

> The office is charged with making the two programs work together more effectively to improve care and lower costs. The office is focused on improving quality and access to care for Medicare-Medicaid enrollees, simplifying processes, and eliminating regulatory conflicts and cost-shifting that occurs between the Medicare and Medicaid programs, states, and the federal government.

While there are no concrete financial projections, it seems that this initiative will likely result in significant cost savings to the federal government.

Finally, there are concerns that the new Medicaid expansion under the ACA will essentially eliminate the use of disability trusts and pooled trust accounts. The reasoning is that if an individual can obtain Medicaid coverage based solely on income, why place resources into the significantly stringent control of a disability trust or pooled trust account. For those currently receiving Medicaid through SSI eligibility, this may well be true.

An SSI recipient receiving a large personal injury settlement or inheritance may feel it a better choice to sacrifice the $735 per month SSI benefit in return for a large lump sum settlement, and then apply for MAGI Medicaid with eligibility based solely on income. If the individual does not qualify for MAGI Medicaid, he or she may still qualify for a discounted rate on health insurance through the exchange, and can then use his or her settlement proceeds to cover those premiums. In the meantime, the individual has access to a large lump sum of cash assets without having to face the prospect of forfeiting any assets remaining on death to the state or a pooled trust.

However, this is not true for those qualifying for Medicaid long-term care, HCBS, or PACE benefits. These individuals are receiving long-term care benefits in addition to what is normally covered as "health insurance," either under traditional Medicaid or under one of the new benchmark plans. Since the ACA deals only with health insurance and not long-term care insurance, the ACA Medicaid changes really will not help those needing long-term care services, whether in a nursing facility or through HCBS or PACE. These individuals will still need disability trusts and pooled trust accounts as much as they do today. The advent of Medicaid expansion under the ACA will not affect the ability of these individuals to qualify for Medicaid long-term care, HCBS, or PACE.

4-6. Resources

For more information about Medicare and Medicaid, call your nearest senior center.

See a list of county Departments of Social Services in section 5-6, "Resources."