Chapter 6 Medicaid Program

Medicaid is a federally aided, state-operated program of health care assistance for the poor, or those who are aged, blind, disabled, or have families with dependent children and are within certain poverty guidelines. Eligibility for Medicaid assistance is based primarily on financial need.

Established in 1965 by Title XIX of the Social Security Act, Medicaid is jointly funded by the federal and state governments but administered by the states. Federal regulations mandate minimum standards for eligibility and coverage of benefits but grant considerable discretion to states in a number of program areas, including:

-Expanding eligibility to groups above the minimum required by the federal government
-Expanding health care services above the minimum
-Establishing provisions for reimbursement to providers

Under current law, federal funds pay for at least 50 percent of allowable Medicaid costs in every state. However, the federal government assumes a larger share of the cost in states that have a low per capita income. Currently the federal share ranges from 50 percent to 80 percent of Medicaid expenditures in a state.

Medicaid spending covers a variety of mandated services, including:

-Inpatient and outpatient acute care services
-Long-term care for the elderly and mentally ill
-Medicare Part B premiums for elderly persons in poverty
-Disproportionate share hospital payments

Medicaid and Medicare should not be confused. Medicare is not a welfare program; it is an "entitlement" program in that recipients pay into the system via payroll taxes, and thus are "entitled" to take out of the program. The income and assets of a Medicare beneficiary are not a consideration in determining eligibility or benefit payments. Medicaid is different. A Medicaid recipient must be able to prove eligibility for benefits due to limited assets or limited income. Unlike procedures for Medicare, which do not vary significantly from state to state, those associated with Medicaid are different from state to state.

The services and medical care provided under a state's Medicaid program can be delivered separately from Medicare or, in some instances, in conjunction with Medicare. In this case, the recipient of both Medicare and Medicaid programs becomes known as a "dual eligible." The largest portion of Medicaid funds is spent on the elderly, but Medicaid also covers numerous people, including children, who are not eligible for Medicare.

Medicaid programs are run by the states, with the benefits provided and the requirements for eligibility determined on a state-by-state basis. Each state gets a portion of the funding for its Medicaid program from the federal government, so the coverage provided is based on guidelines issued at the federal level. Each state works out its own program within the guidelines. With the continuing push in Washington to lower the cost of Medicaid, the states are being given ever more flexibility in deciding how to spend the money and in determining eligibility qualification standards for recipients.

PPACA

To some extent, the Patient Protection and Affordability Care Act of 2010 changed this picture. A provision of the law, as originally passed, set forth a minimum Medicaid income eligibility level for all states, and stipulated that each state was to expand its Medicaid programs to include those individuals whose incomes were at or below 133 percent of the federal poverty level; failure to do so would result in loss of federal funds for the state's Medicaid program. The requirement that all

states had to expand their programs was eventually overturned by the U.S. Supreme Court; however, many states did, in fact, follow this provision. As of late 2019, 37 states (including Washington, D.C.) had opted to expand Medicaid. Much of the cost of the expanded programs was borne by the federal government for the first three years.

For many elderly Medicare recipients, Medicaid assistance becomes a necessity. This occurs because of the financial problems caused by payments for long-term nursing home care or for high medical bills from a catastrophic illness. Because Medicare does not cover custodial care, many elderly individuals exhaust their financial resources long before their need for care ends. The costs associated with an extended nursing home stay or the expenses associated with catastrophic illnesses can overwhelm personal savings very quickly.

Assistance for medical care under the Medicaid program can also be provided for people who receive supplementary security income benefits from Social Security.

Basic Medicaid Coverage

Most states provide certain types of coverage to Medicaid recipients, but each state is flexible in the services that are covered. For Medicare beneficiaries who are eligible for their state's Medicaid program, Medicaid functions as the secondary insurer, with Medicare as the primary insurer.

Medicaid covers a variety of services with benefits designed to meet the complex needs of the diverse population it serves. State Medicaid programs are required to cover the following:

- -Doctor and surgeon fees, inpatient or outpatient
- -Inpatient and outpatient hospital services
- -Physician, midwife, and certified nurse practitioner services
- -Prescription drugs—MMA 2003 states that people with Medicare who are also fully eligible for Medicaid will receive their prescriptions through Medicare Part D. Medicaid eligibility will automatically qualify individuals for:
    - -full premium subsidy
    - -full subsidy of deductible
    - -minimal co-pays
- -Rural health clinics and federally qualified health center services
- -Early and periodic screening, diagnosis, and treatment (EPSDT) for children under 21
- -Laboratory and X-ray services
- -Family planning services and supplies
- -Nursing home and home health care for individuals aged 21 and older

Basic Medicaid Eligibility

Eligibility for Medicaid is determined by state requirements in three classifications:

- -Proof of disability or age
- -Income limitations
- -Asset limitations

A person has to show financial need based on his or her state's formula for calculating the maximum allowable income and assets. This calculation excludes certain asset items, and it varies depending on the need for living expenses of a spouse, if any. It does not allow a person to keep much in the way of a financial cushion.

To apply for Medicaid assistance, the applicant must disclose all assets and sources of income. The formulas used and the types of assets that are counted are complicated and vary by state. If a person is poor, Medicaid is the place he or she will most likely look for assistance with medical bills. It is important that applicants learn about their states' requirements before needing assistance. This is especially important for married couples.

Spending Down
If an applicant is over 65, has an income below the state limitation, and does not have qualifying assets that exceed the state's requirements, he or she can qualify for Medicaid assistance. If the applicant's assets are above the allowable limits, he or she will have to nearly exhaust them before becoming eligible. This process is referred to as spending down one's assets to pay for nursing home or home health care or to become "dually eligible" for Medicaid benefits in addition to Medicare benefits. The limits and the types of income and assets counted also vary depending on whether the applicant has a spouse who requires support.

MIPPA 2008 included a number of specific statutory changes that allow low-income Medicare recipients to have greater and easier access to the various Medicare and Medicaid programs available to them. This includes making it easier to qualify for the "low-income subsidy" (Extra Help program) in the Part D Prescription Drug benefit and ease the assets test for Medicare Savings Programs.

In addition to Extra Help, a program called The Limited Income Newly Eligible Transition Program became effective in January 2010. This program provides Part D coverage for all low-income subsidy (LIS) beneficiaries with an immediate need who are not already enrolled in a Part D plan, and for full-benefit dual eligibles (those eligible for both Medicare and Medicaid) with uncovered months in the past. The plan can be accessed by auto-enrolling through CMS; by filling a prescription at the point-of-sale; or by submitting a receipt for prescriptions already paid for out-of-pocket during eligible periods. The enrollment is for the current month and the next month and an automatic enrollment in a standard Part D plan two months into the future.

MIPPA 2008 included provisions relating to the low-income subsidy and the Medicare Savings Program. More specifically, the act allowed for lowering or eliminating barriers to enrollment in such programs, provided money for training government employees to educate possible LIS beneficiaries about where and how to apply for these programs, and made such information and applications available at local Social Security offices. It also instructed Social Security employees to help applicants complete their applications and provided money for state SHIP employees to help with the education of those employees.

In keeping with the intent to make qualification for low-income subsidy easier, beginning on January 1, 2010, states were no longer allowed to recover the amount of Medicare cost sharing paid under a Medicare Saving Program from the estate of a deceased Medicaid recipient. Also beginning January 2010, income and eligibility determinations for low-income subsidy program benefits could not include non-financial support (i.e., help from family or friends), nor can cash surrender values of a life insurance policy be considered as a detriment to eligibility for LIS support.

A conscientious Medicare Advantage or Medicare Supplement producer who believes a client might qualify for Medicaid assistance should advise the client to call the state or county Department of Health and Human Services to see if he or she would be eligible for Medicaid benefits.

Supplemental Security Income
If a person is receiving supplemental security income (SSI) payments from Social Security, he or she may be eligible for Medicaid. SSI is a program run by Social Security. It pays monthly checks to the elderly, the blind, and people with disabilities who do not own many resources or have much income. If a person gets SSI, he or she usually qualifies for food stamps and Medicaid, too. For such individuals, Medicaid helps pay doctor and hospital bills.

It is possible to receive SSI and not be eligible for Medicaid.

To qualify for SSI, a person must be elderly or blind or have a disability. For this purpose, the following definitions apply:

-Elderly means a person is 65 or older.
-Blind means a person is either totally blind or has very poor eyesight. Children as well as adults can get benefits because of blindness.
-A disability means a person has a physical or mental problem that is expected to last at least a year or result in death. Children as well as adults can get benefits because of disability.

The basic federal monthly SSI benefit for 2020 is the same in all states—$783 for one person and $1,175 for a couple. Not everyone receives this exact amount, however. A person may get more if he or she lives in a state that adds to the SSI check. Or, the person may get less if he or she (or his or her family) has other money coming in each month. In October 2019, approximately 8 million people received SSI benefits.

Basic Medicare and Medicaid Coordination—Dual Eligibles
A person may be eligible for both Medicare and Medicaid coverage. In this situation, the person is considered a dual eligible, and his or her Medicare coverage will be the primary coverage, with all available benefits being used before Medicaid begins. Medicaid may also pay for items that Medicare does not cover, but coverage is based on financial need. States are rigorous in conducting their searches for assets and income.

Basic Assistance for Low-Income Beneficiaries—Medicare Savings Programs

If a person has a low income and limited resources, the state may pay his or her Medicare costs, including premiums, deductibles, and coinsurance. Each state has several programs that are part of the Medicaid program that will pay some of the costs of Medicare. Combined, the programs function under the common name of Medicare Savings Programs. The programs have similar names but offer different benefits. They also have slightly different qualifications. A person's income and resources (if any) determine which program he or she can apply for.

The different plans that Medicare Savings Programs offer include the following:

-Qualified Medicare Beneficiary (QMB)
-Special Low-Income Medicare Beneficiary (SLMB)
-Qualifying Individual (QI)
-Qualified Disabled and Working Individual (QDWI)

Qualified Medicare Beneficiary Program
Individuals may be eligible for the Qualified Medicare Beneficiary (QMB) Program if:

-They are entitled to Medicare Part A. If they do not have Medicare Part A because they cannot afford it, then the QMB program may pay the Medicare Part A premium for them.
-They have an income of 100 percent of the federal poverty level or less and resources not exceeding twice the limit for SSI eligibility.

Expenses covered by the QMB program include:

-Medicare Part A deductible
-The Medicare Part A premium (in some cases)
-Medicare Part A coinsurance for extended hospital stays and skilled nursing
-Medicare Part B premium
-Medicare Part B deductible
-Medicare Part B coinsurance

-The cost of additional health services and prescriptions if the person also qualifies for full
-Medicaid services (QMB Plus)

Specified Low-Income Medicare Beneficiary Program
Individuals may be eligible for the Specified Low-Income Medicare Beneficiary (SLMB) Program if:

-They are entitled to Medicare Part A; and
-They have an income above 100 percent but less than 120 percent of the federal poverty level, and resources do not exceed twice the limit for SSI eligibility.

Expenses that the SLMB program covers include:

-The Medicare Part B premium
-The cost of additional health services and prescriptions if individuals qualify for full Medicaid services (SLMB Plus)

Qualifying Individual Program
Individuals may be eligible for the Qualifying Individual (QI) Program if:

-They are entitled to Medicare Part A.
-They have an income of at least 120 percent but less than 135 percent of the FPL and resources do not exceed twice the limit for SSI eligibility.
-They are not otherwise eligible for Medicaid benefits.

The QI program covers the Medicare Part B premium for those who qualify.

The QI Program differs from the SLMB Program in the following ways:

-Because the state has only a certain amount of money for this program each year, once the money runs out, no one else is enrolled.
-Eligible beneficiaries receive assistance on a first-come, first-served basis.
-Beneficiaries must re-apply for the program every year.

Qualified Disabled and Working Individual Program
The Qualified Disabled and Working Individual (QDWI) program covers:

-Individuals with disabilities who lost their Medicare Part A because they returned to work and are eligible to purchase Medicare Part A benefits
-Individuals whose incomes are 200 percent or less of the FPL and whose resources do not exceed twice the limit for SSI eligibility
-Medicare Part A premiums

These individuals must not otherwise be eligible for Medicaid benefits.

Medicare Part D and Low-Income Subsidy—"Extra Help"
Once an individual is dual eligible (eligible for both Medicare and Medicaid), prescription drug benefits are covered under the Medicare Part D program or a Medicare Advantage plan that includes prescription drug coverage. Medicare automatically enrolls dual eligible individuals in a Medicare Part D Plan.

Dual eligible individuals automatically qualify for the Medicare Part D low-income subsidy, also called Extra Help. The low-income subsidy pays all or part of the individual's monthly premium for the Medicare Part D Plan. Plans are available that the enrollee can join and pay no premium. Other plans are available where enrollees have to pay a portion of the premium. If individuals are enrolled in a Part D Plan with a monthly premium less than the regional benchmark set by

Medicare, their monthly premium is paid in full by Extra Help. Medicare Advantage or Medicare Part D producers will find a question relating to Extra Help on their enrollment forms.

A dual eligible individual has no annual deductible, and he or she is covered for prescription drugs, even through the Medicare Part D coverage gap. In 2020, co-pays on prescription drugs were $3.60 for generic drugs and $8.95 for preferred drugs in the catastrophic phase, depending on the dual-eligible individual's income. If an individual has been in long-term care, such as a nursing home, for at least one month, no co-pay applies.

Medicaid Payments to Providers

The federal government pays for Medicare, so its rules are uniform nationally. But because individual states also pay a share of Medicaid bills, many rules vary from state to state. Generally, Medicare and private insurance are more generous than Medicaid when it comes to paying health care providers. That means many providers who are happy to treat Medicare and private insurance patients will not treat a Medicaid patient. It also means that Medicaid patients have trouble getting proper care even though the program pays for it. However, in the fall of 2012, CMS determined that it would pay primary care doctors who take Medicaid patients the same scale it pays general practitioners and primary care doctors for Medicare services.

Beginning in 1989 and continuing today, all state Medicaid programs were required to pay Medicare's Part B premiums and deductibles for Medicaid enrollees.

Medicaid and Nursing Homes

In 1995, the Department of Health and Human Services issued the toughest nursing home regulations in the history of the Medicare and Medicaid programs. Those reforms led to measurable improvements in quality of care for nursing home residents.

After implementing those reforms and monitoring their results, the government developed additional steps in July 1998 to further ensure that all nursing home residents receive quality care. As part of this ongoing commitment, the Centers for Medicare and Medicaid Services now require states to strictly regulate nursing homes that repeatedly violate health and safety requirements. CMS also has given consumers ready access to comparative information about nursing home quality and is changing the inspection process to increase its focus on preventing bedsores, malnutrition, and resident abuse. CMS also conducts ongoing studies of nursing home staffing levels and supports the Administration on Aging's Long-Term Care Ombudsman programs.

About 1.6 million elderly and disabled Americans receive care in nearly 11,000 nursing homes across the United States. Under the Medicare and Medicaid programs, states have the primary responsibility for conducting on-site inspections and recommending sanctions against nursing homes that violate health and safety requirements. The federal government helps fund these activities.

Nursing homes now may face fines of up to $10,000 for each serious incident that threatens residents' health and safety. In the past, fines could only be linked to the number of days that nursing homes failed to comply with federal requirements. This option permits penalty amounts to be more quickly determined and imposed.

On the other hand, nursing homes that have become dependent on Medicaid for the majority of their residents and funding for payment of their care are in a tight spot. The truth is that Medicaid is obviously a "bare-bones" proposition. For their Medicaid patients, nursing homes receive approximately 75 to 80 percent of the "street rate" (that is, the rate the nursing home would charge for private pay or insurance-paid care).

How, then, can government regulators and inspectors expect nursing homes to adhere to strict standards, such as staffing, when the amount of revenue generated by the Medicaid patient is less

than is needed to keep the establishment viable? This is a serious dilemma, and is only exacerbated by the budgetary problems facing both federal and state governments. What appear to be credible and sensible requirements for quality care become hardships for nursing homes that cannot receive adequate compensation to provide that care.

Protective Legislation
In March 1999, bipartisan legislation was enacted to protect residents who are on Medicaid from being evicted inappropriately by nursing homes. Additional legislation provided assurances that nursing-home residents will receive the quality care that they deserve and expect by:

-Requiring nursing homes to conduct criminal background checks of employees
-Establishing a National registry of workers who have been convicted of abusing residents
-Allowing more types of nursing home workers with proper training to help residents eat and drink during busy mealtimes

Deficit Reduction Act of 2005

On February 8, 2006, the Deficit Reduction Act of 2005 (DRA) was signed into law. This sweeping legislation affects many aspects of domestic entitlement programs, including Medicare and Medicaid.

The DRA provided states with much of the flexibility they had been seeking over the years to make significant reforms to their Medicaid programs. Combined with other options in Medicaid, states are able to reconnect their healthy populations to the larger health insurance system, transform long-term care from an institutionally based, provider-driven system to a person-centered and consumer-controlled model. It included great opportunities for covering more people at a lower cost and with greater continuity of coverage.

Long-Term Care Partnership Programs
From an insurance producer's standpoint, DRA presents a great opportunity for those in the long-term care insurance arena. DRA expanded what are known as long-term care partnership programs from four states to all states that want to participate. A state LTC partnership program coordinates private LTC insurance plans and policies with its Medicaid eligibility standards. An insurance company and its producers can sell a LTCI policy with a certain dollar amount, whose benefits would be the first applied to cover the insured's long-term care needs. If and when the benefits under the private insurance policy are exhausted, the insured would be able to retain an amount equal to the benefits paid by the policy and have those assets "disregarded" for purposes of determining his or her eligibility for Medicaid.

For example, if a qualified long-term care partnership policy paid its full benefit of $250,000 and the insured continued to need long-term care, he or she would be able to have $250,000 of his or her assets not counted as "eligible assets" if he or she were to apply for Medicaid nursing home assistance. This would eliminate the need to "spend down" assets to qualify for Medicaid, up to the dollar amount of the policy's payments.

Nursing Homes and DRA
The cost of long-term care continues to increase, making such services difficult to afford for most individuals, and inaccessible for many. The Medicaid program provides coverage for long-term care services for individuals who are unable to afford this care.

Some individuals, with assistance from financial planners and attorneys, had developed methods of arranging assets in such a way that they were preserved for the individual and/or family members but were not countable as eligible assets when Medicaid eligibility is determined. This had the effect of transferring the risk of the cost of long-term care from the individual to the taxpayers. Various techniques were used to artificially impoverish Medicaid applicants, including gifting assets to family members, investing assets in financial instruments that are inaccessible,

and executing financial transactions for which fair market value was not actually received.

The DRA included several provisions designed to discourage the use of such "Medicaid planning" techniques and to impose penalties on transactions that are intended to protect wealth while enabling access to public benefits. In addition, the partnership policy availability, once approved by a state, reduces the temptations of "Medicaid planning," because an LTCI policy can be built to absorb initial dollar amounts of long-term care—say $200,000—and the patient/policyholder can then apply for a like amount of benefits from Medicaid without having to spend down, hide or transfer assets in a questionable manner.

The Patient Protection and Affordability Act of 2010

The Patient Protection and Affordability Act of 2010 (ACA) also had a significant impact on Medicaid. As noted, when the Act went into effect, it required all states to expand their Medicaid eligibility standards to include individuals under age 65 with incomes up to 138 percent of the federal poverty level, with the federal government covering the full cost of the expansion for the first three years. This provision of the ACA was challenged and in 2012, the U.S. Supreme Court ruled that this required Medicaid expansion was unconstitutionally coercive to the states, but with mitigating factors. As a result, Medicaid expansion remained intact, but the ruling left to the states the decision as to whether or not to implement it. As noted earlier in the course, 37 states (including Washington, D.C.) have expanded their Medicaid eligibility requirements to include low income earners younger than age 65.