Medicare Minute Teaching Materials – June 2020
Medicare and Medicaid

1. What is Medicaid?

Medicaid is a federal and state program that provides health coverage for certain people with limited income and assets. Medicaid may be called something different in your state, for example, in some states it is called Medical Assistance. Each state runs various Medicaid-funded programs for different groups of people (see number 3), including:

- Older adults
- People with disabilities
- Children
- Pregnant people
- Parents and/or caretakers of children

All states also have Medicaid programs for people with limited incomes and assets who need nursing home care, long-term care services, and home health care services. Some states also have programs for individual adults who don't fit any of these categories.

Each state uses financial eligibility guidelines to determine whether you are eligible for Medicaid coverage. Generally, your income and assets must be below a certain amount to qualify, but this amount varies from state to state and from program to program. You are eligible for Medicaid if you are in an eligible group and meet that group's financial eligibility requirements.

If you are eligible for both Medicare and Medicaid (dually eligible), you can enroll in both. Medicaid can cover services that Medicare does not, like long-term services and supports. It can also pick up Medicare's out-of-pocket costs (deductibles, coinsurances, copayments).

Some states offer a Medicaid spend-down program or medically needy program for individuals with incomes over their state's eligibility requirements. A spend-down program allows you to deduct your medical expenses from your income so that you can qualify for Medicaid. Contact your local Medicaid office to learn if a spend down is available in your state.

2. How does Medicaid work with Medicare?

All states offer a variety of Medicaid programs, with eligibility and coverage specifics varying by state. If you qualify for a Medicaid program, it may help pay for costs and services that Medicare does not cover. Here are a few examples of how Medicaid can work with Medicare:

- **Medicaid can provide secondary insurance:** For services covered by Medicare and Medicaid (such as doctors' visits, hospital care, home health care, and skilled nursing facility care), Medicare is the primary payer. Medicaid is the payer of last resort, meaning it always pays last. When you visit a provider or facility that takes both forms of insurance, Medicare will pay first and Medicaid may cover your Medicare cost-sharing, including coinsurance charges and copays.

- **Medicaid can provide premium assistance:** In many cases, if you have Medicare and Medicaid, you will automatically be enrolled in a Medicare Savings Program (MSP). In other cases, you can apply for an MSP even if you are not automatically enrolled. MSPs pay your Medicare Part B premium and may offer additional assistance.
- **Medicaid can provide additional cost-sharing assistance:** Depending on your income, you may also qualify for the Qualified Medicare Beneficiary (QMB) MSP. If you are enrolled in QMB, you do not pay Medicare cost-sharing, which includes deductibles, coinsurances, and copays, when you see a provider who accepts Medicare.
- **If you are eligible for Medicaid, you are eligible for prescription drug assistance:** Dually eligible individuals are automatically enrolled in the Extra Help program (see number 10) to help with their prescription drug costs.
- **Medicaid can offer care coordination:** Some states require certain Medicaid beneficiaries to enroll in Medicaid private health plans, also known as Medicaid Managed Care (MMC) plans. These plans may offer optional enrollment into a Medicare Advantage Plan designed to better coordinate Medicare and Medicaid benefits. Note: You cannot be required to enroll in a Medicare Advantage Plan.

Make sure to call 1-800-MEDICARE or contact your local Medicaid office to learn more about Medicare and Medicaid costs and coverage, especially if you are dually eligible. State Health Insurance Assistance Programs (SHIPs) also helps beneficiaries and caregivers understand how Medicare and Medicaid work together in their state. See the last page for SHIP contact information.

3. What types of Medicaid are there for people who have Medicare?
If you are eligible for Medicare and have sufficiently low income, you may qualify for help from certain Medicaid programs in your state. Whether you qualify will depend on

- Your earned and unearned income, including wages and Social Security payments;
- Your assets, including checking accounts, stocks, and some property; and
- Your nursing care and long-term needs.
    - You must meet your state's functional eligibility criteria (standards for assessing your need for help with activities of daily living, such as toileting, bathing, and dressing). Each state sets its own standards.

Medicaid programs vary by state, but below are three Medicaid programs available to Medicare beneficiaries in most states. Note that in all of these cases, if you have both Medicare and Medicaid, Medicare will pay first for covered services and Medicaid will pay second for qualifying costs. If you meet income, asset, and other guidelines in your state, you may qualify for one of the following Medicaid programs:

1. **Aged, blind, and disabled (ABD) Medicaid:** Beneficiaries with ABD Medicaid have coverage for a broad range of health services, including doctors' visits, hospital care, and medical equipment. ABD Medicaid may also pay for your Medicare cost-sharing. However, ABD Medicaid may not provide adequate coverage if you have long-term care needs.
2. **Medicaid home- and community-based services (HCBS) waiver programs:** HCBS waiver programs provide general health coverage and coverage for certain services to help you stay at home or in a

community-based setting (for example, in an assisted living facility). Covered services may include personal care, homemaker services, case management, adult day care, skilled nursing care, and therapy services. To qualify, you must meet state-specific functional eligibility criteria.

3. **Institutional or Nursing Home Medicaid:** Beneficiaries enrolled in Medicaid for residents in nursing homes—also called Institutional Medicaid or Nursing Home Medicaid—have coverage for nursing home services, including room and board, nursing care, personal care, and therapy services. To qualify, you must require a nursing home level of care or meet state-specific functional eligibility criteria.

4. What is aged, blind, and disabled (ABD) Medicaid?
ABD Medicaid provides coverage for a broad range of health services, including doctors' visits, hospital care, and medical equipment if:

- You are 65+, blind, or have a disability
- And, you meet the financial eligibility requirements

In many cases, Medicare and Medicaid will work together to cover your health care costs. Medicaid also pays for some services that Medicare does not cover, such as transportation to medical appointments and additional home care.

Even if your income and assets appear to be higher than your state's ABD Medicaid guideline, you should still apply if you need Medicaid. This is because:

- Certain kinds of income may not be counted (such as the value of your SNAP benefits or energy assistance payments), and all states exclude at least $20 of income
- Income limits may be higher if there are more than two people in your household
- The first $65 of your monthly earned income will not be counted
- One half of your monthly earned income (after the first $65 is deducted) will not be counted

In addition, some states offer a Medicaid spend-down program (see number 7) or medically needy program for individuals with incomes over their state's eligibility requirements. This program allows you to deduct your medical expenses and some other health care costs from your income so that you can qualify for Medicaid. Contact your local Medicaid office to learn if a spend-down is available in your state.

5. What is Institutional Medicaid?
All states have a Medicaid program for individuals who need nursing home or long-term care—also called Institutional Medicaid—that provides general health coverage and coverage for nursing home services. These services include room and board, nursing care, personal care, and therapy services. Remember that Medicare covers some skilled nursing facility (SNF) care: up to 100 days per benefit period. If you do not meet Medicare's requirements for the SNF benefit or you reached Medicare's limit for covered SNF care, Medicaid may pay for this care.

Institutional Medicaid may pay for a stay in a nursing home if:

- You need a nursing home level of care or meet nursing home functional eligibility criteria

- And, you have income and assets below certain guidelines (remember, your state may have higher Medicaid income guidelines if you need nursing home care, or a spend-down program to help you qualify).

States have different standards for determining whether you need a nursing home level of care. Generally, states assess your ability to function, as measured by your need for help with activities of daily living (such as toileting, bathing, and dressing).

When you have Institutional Medicaid, Medicare still covers medical services you may need beyond your nursing care. For example, if you need to go to a doctor or specialist's office, Medicare will pay for most of these services, and Medicaid will pay second by covering your remaining costs, such as coinsurances, copayments, and deductibles.

There are a few things you should keep in mind before applying for Institutional Medicaid:

- The program will consider you and your spouse together when counting your income and assets, but you typically will be able to set aside a certain amount of your income and assets for your spouse to keep. This amount will not be counted when you apply for Medicaid.
- If you qualify, you will be able to keep a small amount of your income for a personal allowance. This amount varies by state, so contact your local Medicaid office to learn more. You will have to pay the remainder of your income to the nursing home. For example, if your state's personal allowance is $75 and your income is $900, you will need to pay $825 to the nursing home, while keeping $75.
- In most states, Institutional Medicaid has a look-back period of up to five years. This means that your state will count most assets you transferred in the past few years when determining your eligibility. If Medicaid determines that you transferred assets in violation of the Medicaid rules, it can penalize you by not paying for part or all of your nursing home stay.
- If you own your home, be sure to talk to an elder law attorney about how it will affect your Medicaid eligibility and coverage. Depending on your circumstances, the equity from your home may count as an asset. When you no longer need long-term care, or when you are deceased, such assets may be used to repay Medicaid for the care that it covered for you.

6. What is the Medicaid home- and community-based services (HCBS) waiver?

Most states have at least one Medicaid home- and community-based services (HCBS) waiver program that provides general health coverage and coverage for certain services to help you stay at home or in a community-based setting (for example, in an assisted living facility). Remember that Medicare only covers home health care if you meet certain criteria, such as being homebound and needing skilled care.

Even if you qualify for Medicare-covered home health care, you may need additional services. Medicaid HCBS waiver programs can be used to supplement the amount and kind of services you get. If you do not meet Medicare's requirements for home care, you still may be eligible for a Medicaid HCBS waiver program.

Services covered through an HCBS waiver program may include:

- Personal care
- Homemaker services
- Case management
- Adult day care
- Skilled nursing care
- Therapy services
- Home modifications
- Respite care
- Help with chores

The amount and type of services that Medicaid may cover varies by state. You may qualify for help from a Medicaid HCBS waiver program if:

- You meet your state's functional eligibility requirements for home and community-based services
- And, you have income and assets below certain guidelines (remember, your state may have higher Medicaid income guidelines if you need long-term care, or a spend-down program to help you qualify).

States have different functional eligibility standards for determining whether you are eligible for HCBS waiver programs. Most states require you need a nursing home level of care to qualify, but you may also need less care and still qualify for Medicaid coverage. States will also usually assess your need for help with activities of daily living (such as toileting, bathing, and dressing).

When you qualify for a Medicaid HCBS waiver program, Medicare still covers medical services you may need beyond your long-term services and supports. For example, if you need to go to a doctor or specialist's office, Medicare will pay first for most of these services, and Medicaid will pay second by covering your remaining costs, such as coinsurances, copayments, and deductibles.

There are a few things you should keep in mind before applying for Medicaid HCBS waiver program:

- Medicaid HCBS waiver programs may consider you and your spouse together when counting your income and assets, but you may be able to set aside a certain amount of your income and assets for your spouse to keep. If your state allows you to set aside a certain amount for your spouse, this amount will not be counted when you apply for Medicaid.
- If you own your home, be sure to talk to an elder law attorney about how your Medicaid coverage will be affected. The equity from your home may count as an asset when you are screened for Medicaid eligibility. When you no longer need long-term care, or when you are deceased, such assets may be used to repay Medicaid for the care that it covered for you.
- Even if you meet the eligibility guidelines for a Medicaid HCBS waiver program, there are generally limits on the number of people who can receive these benefits in your state. Check with your local Medicaid office to see if there is a Medicaid HCBS waiver program waiting list.

7. What is a Medicaid spend-down?

If your income is above the Medicaid income guidelines in your state, your state may offer a spend-down for aged, blind, and disabled individuals who do not meet Medicaid income eligibility requirements. A spend-down allows you to deduct certain medical expenses from your income so that you can qualify for ABD Medicaid benefits. If you have medical expenses that significantly reduce your usable income, you can use them to qualify for Medicaid coverage.

Below are the general guidelines to the Medicaid spend-down process. Contact your local Medicaid office to learn if a spend-down program is available in your state, and the rules for applying.

- Your spend-down amount will be the difference between your income and the Medicaid eligibility limit, as determined by your state over a given length of time (one to six months). Some states require you to submit receipts or bills to Medicaid to show your monthly expenses. Other states may let you pay a monthly premium directly to Medicaid for the amount that your income is over your state's Medicaid spend-down level. Spend-down income limits may be lower than the Medicaid income limits for people who do not have a spend-down.
    - Each period that you have enough medical expenses to meet your spend down, you will have Medicaid coverage. If you do not meet your spend-down amount for a certain period of time, you will not have Medicaid coverage for that time. You can still get Medicaid coverage later if you meet your spend-down amount during another period of the year.
    - Medicare will pay first for covered services, and Medicaid will pay second for qualifying costs, such as Medicare cost-sharing.
    - Your state may require you to qualify and apply for spend-down for multiple periods in order to qualify for Medicaid inpatient hospital coverage.
    - States with spend-down programs may allow you to use the spend-down program to qualify for Medicaid coverage of your nursing facility stay or home- and community-based waiver services.
        - Note: If your state does not have a spend-down program, it should have more generous Medicaid income guidelines for people who need nursing home care than for those who do not.
    - You will automatically qualify for Extra Help the first month that you meet your Medicaid spend-down amount until the end of the calendar year (even if you do not meet your spend-down amount every period).
- Trusts—such as Miller Trusts and Supplemental Needs Trusts or Special Needs Trusts—are available in some states to help you become Medicaid eligible. Trusts allow people with disabilities and income or assets higher than Medicaid eligibility guidelines to place a portion of their income or assets into the trust, where it will not be counted. Rules about how these trusts work vary greatly by state. For more information, contact your local Medicaid office or an elder law attorney.
- Some states offer the Medicaid Buy-In program, which allows people who are under age 65 and have a disability to work (as little as one hour per month) and still receive Medicaid benefits.

- The program is designed to help people with disabilities who would otherwise not be eligible for Medicaid health coverage because their income or assets are too high. If you qualify, you may be able to receive Medicaid by paying a premium to buy in to the program. Financial eligibility guidelines vary by state. Check with your local Medicaid office for eligibility information.
- If you decide to work and are receiving Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI), check with your local Medicaid office to see how much earned income you are allowed to have without losing those benefits.

8. How can I apply for Medicaid?
This is a general guide to the Medicaid application process. Be sure to contact your local Medicaid office for state-specific rules.

Note: Your Medicaid office may be called the Department of Health, the Department of Social Services, the Department of Family Services, or another name.

- Contact your local Medicaid office to ask how you need to submit your application. Some states require you apply in person, while others may allow you to apply by mail, online, by telephone, or at locations in the community, such as health centers and community organizations.
- Find out which documents and forms of identification you may need in order to apply. Your Medicaid office may ask you to show the following:
  - Proof of date of birth (e.g., birth certificate)
  - Proof U.S. citizenship or lawful residence (e.g., passport, driver's license, birth certificate, green card, employment authorization card)
  - Proof of all types of income, earned and unearned (e.g., paycheck stubs, retirement benefits, Supplemental Security Income)
  - Proof of resources (e.g., bank or stock statements, life insurance policies, property)
  - Proof of residence (e.g., rent receipt, landlord statement, deed)
  - Medicare card and any other insurance cards (you can also provide a copy of the insurance policy)
- State Health Insurance Assistance Programs (SHIPs) can also help you apply for Medicaid. See the last page for SHIP contact information.

Note: Medicaid coverage is available, regardless of citizenship status, if you are pregnant or require treatment for an emergency medical condition. A doctor must certify that you are pregnant or had an emergency, and you must meet all other eligibility requirements.

Troubleshooting
- If you have any problems applying at a Medicaid office, ask to speak with a supervisor.
- If you do not receive a timely decision on your Medicaid application or are turned down for Medicaid, you can appeal by asking for a state fair hearing (not a city or local one). Follow the instructions printed

on your denial notice if you have received one. Check with your Medicaid office to learn more about requesting a fair hearing. To find fair hearing assistance in your area, use the Eldercare Locator by calling 1-800-677-1116 or visiting https://eldercare.acl.gov/Public/About/Aging_Network/AAA.aspx

- Once you have Medicaid, you must recertify (show that you remain eligible for Medicaid) to continue to get Medicaid coverage. When you submit your Medicaid application, be sure to ask when and how you will need to recertify. In many states, recertification is an annual process.
- Improper billing of people enrolled in both Medicare and Medicaid has been known to occur. As explained by Justice in Aging, "Improper billing (also sometimes referred to as "balance billing") occurs when doctors, hospitals, or other providers charge beneficiaries with both Medicaid and Medicare for co-pays, co-insurance, or deductibles. Patients who have both Medicaid and Medicare (including Medicare Advantage) should never be charged for services covered under Medicaid or Medicare. Billing for covered services is illegal under both federal and state law. As more and more dual eligible patients move to managed care plans, improper and illegal billing may increase due to doctor & hospital confusion. (https://www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/). Senior Medicare Patrol (SMP) programs help beneficiaries understand Medicaid fraud, errors, and abuse. See the last page for SMP contact information.

9. How does Medicaid work with Medicare Part D?
If you have Medicare and Medicaid (dually eligible), your drugs are usually covered by the Medicare Part D prescription drug benefit and Extra Help (see number 10). In cases like those described below, Medicaid may cover drugs that Medicare does not.

In many states, Medicaid covers some of the drugs that are excluded from Medicare coverage by law. Drugs excluded from Medicare coverage by law that may be covered by your state's Medicaid program include:

- Drugs for
  - Anorexia, weight loss, or weight gain
  - Fertility
  - Cosmetic purposes or hair growth
  - Relief of cold symptoms (like cough or stuffy nose)
- Prescription vitamins and minerals (except prenatal vitamins and fluoride preparations)
- Non-prescription drugs (over-the-counter drugs)
- Off-label drugs, meaning drugs that are prescribed for a reason other than the use approved by the FDA

In some states, Medicaid covers additional medications for people with Part D.

You will only pay a small copayment for prescriptions that are covered by Medicaid in your state. Keep in mind that all states have a Medicaid formulary, which is a list of covered drugs. For more information on the Medicaid formulary in your state, ask your pharmacist or contact your local Medicaid office. If you need a prescription that is not on the Medicaid formulary, you may still be able to have it covered. For more

information understanding how Medicaid may help pay for medications, call your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is on the last page of this document.

10. What is Extra Help?
Extra Help is a federal program that helps pay for some to most of the out-of-pockets costs of Medicare prescription drug coverage. It is also known as the Part D Low-income Subsidy (LIS).

If you are enrolled in Medicaid, you automatically qualify for Extra Help regardless of whether you meet Extra Help's eligibility requirements. You should receive a purple-colored notice from the Centers for Medicare and Medicaid Services (CMS) informing you that you do not need to apply for Extra Help.

The Extra Help program:

- Pays for your Part D premium up to a state-specific benchmark amount;
- Lowers the cost of your prescription drugs;
- Gives you a Special Enrollment Period (SEP) once per calendar quarter during the first nine months of the year to enroll in a Part D plan or to switch between plans (You cannot use the Extra Help SEP during the fourth calendar quarter of the year (October through December). You should use Fall Open Enrollment during this time to make prescription drug coverage changes.); and
- Eliminates any Part D late enrollment penalty you may have incurred if you delayed Part D enrollment.

To receive Extra Help assistance, your prescriptions should be on your plan's formulary and you should use pharmacies in your plan's network.

Remember that Extra Help is not a replacement for Part D nor is it a plan on its own. You must still have a Part D plan to receive Medicare prescription drug coverage and Extra Help assistance. If you do not choose a plan, you will in most cases be automatically enrolled in one.

SHIP case study
Jerry has Original Medicare and a Part D prescription drug plan. He is finding that it is difficult to cover the costs of his Medicare premiums and cost-sharing on his limited income, and he does not have many assets. He also would like to get some services that Medicare doesn't cover—like vision care and transportation to his doctors' appointments.

What should Jerry do?

- Jerry should call his State Health Insurance Assistance Program (SHIP) for assistance
    - If Jerry doesn't know how to reach his SHIP, he can call 877-839-2675 or visit www.shiptacenter.org to find out.
- The SHIP counselor can screen Jerry for Medicaid and for other low-income programs that might be able to relieve some of his financial strain.

  - The SHIP counselor can see if his income and assets are low enough that he will qualify for Medicaid. If they are, the SHIP counselor can direct him to his local Medicaid office for help applying. If his income and assets are too high, the SHIP counselor can tell him if there is a spend-down option in his state to become Medicaid eligible.
  - The SHIP counselor can also see if he qualifies for the Medicare Savings Program (MSP). If Jerry enrolls in the MSP, he will no longer have to pay the Part B premium and, depending on the MSP level he qualifies for, it might cover other costs for him.
  - If Jerry qualifies for Medicaid and/or the MSP, he will automatically be enrolled in Extra Help. The SHIP counselor can also inform Jerry about how to apply for Extra Help separately. Extra Help can pay all or part of Jerry's Part D prescription drug costs.
- If Jerry qualifies for Medicaid, it will pay second, after Medicare pays, for many covered services. The SHIP counselor can also tell Jerry which additional services, like transportation and vision care, are covered by Medicaid and direct him to his local Medicaid office for more information about how to access them.

SMP Case Study
Harriet has Medicare, the Qualified Medicare Beneficiary (QMB) level of the Medicare Savings Program (MSP), and Medicaid. She does not have to pay anything out of pocket when she visits her primary care physician. However, she received a bill in the mail for a portion of the costs for her last visit to her primary physician. Harriet is confused. She thought the government was helping her with these costs. She wonders if Medicare changed again and if she needs to pay the bill. She doesn't want to confront her doctor's office, who she likes, but she also cannot afford to pay.

What should Harriet do?

- Harriet should contact her Senior Medicare Patrol (SMP) for assistance.
  - If Harriet doesn't know how to contact her SMP, she should call 877-808-2468 or visit www.smpresource.org
- The SMP will tell Harriet that her provider should not be charging her for Medicare cost sharing because she is enrolled in QMB MSP.
- The SMP can advise Harriet to reach out to her doctor's office to alert them about the improper bill. It could easily have been an innocent error.
- If Harriet's doctor's office does not correct the improper bill, the SMP can help by reporting the activity to the proper authorities.
- The SMP can also advise Harriet about ways to protect herself, the Medicare program, and the Medicaid program from future improper bills or even fraud and abuse. For example, she should keep a calendar of her doctor's appointment and health care services and compare that to the statements that she receives from Medicare, so she can be aware of and report any suspicious activity.

[See the next page for SHIP and SMP program contact information.]

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: **SHIP email:** **SHIP website:** **To find a SHIP in another state:** Call 877-839-2675 or visit www.shiptacenter.org.	**SMP toll-free:** **SMP email:** **SMP website:** **To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

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