Chapter 4

Medicaid

Sean Bell, Esq.
Bell Law Firm, LLC

SYNOPSIS

The purpose of this chapter is to highlight important information about Medicaid. The information is provided for general educational purposes. This is an important topic that is also subject to much potential change. As such, all numbers and qualification criteria must be verified with a professional or other appropriate advisor.

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 $2,382 per month for 2021. 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 $91.35 per month of their income toward their care. Medicaid is the payor of last resort, so other insurance, including Medicare, must pay first.

Visit www.healthfirstcolorado.com for a list of covered services.

How to Apply for Medicaid

Apply for Medicaid at your county Department of Social or Human Services. You can also apply online at https://coloradopeak.secure.force.com. 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 $2,382 in 2021), 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.com or (844) 704-9613). In Colorado Springs, the PACE contract is managed by Rocky Mountain PACE (www.rmhcare.org or (719) 314-2327); in Pueblo, it is managed by InnovAge (www.myinnovage.com 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 $2,382 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 $2,155 and $3,259.50 of the couple's monthly income, while the institutionalized 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 $130,380 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.

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.

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 current 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).

The Effective Date

The 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.

4-3. 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 $1,094 for one person, and $1,472 for a couple.

Similarly, a Special Low-Income Medicare Beneficiary (SLMB) receives only payment of Medicare premiums. The SLMB income maximum is higher: $1,308 for one person or $1,762 for two.

Finally, a similar program called QI-1 can provide assistance with Medicaid premiums with income up to $1,469 for one person and $1,980 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.

4-4. Resources

For more information about Medicaid, contact an appropriate professional, call your nearest senior center, visit the State of Colorado's website at www.healthfirstcolorado.com, or visit your local county Department of Social Services office.

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