**Medicare Minute Teaching Materials – June 2017**
**Medicare and Medicaid**

## 1. What is Medicaid?

Medicaid is a federal and state program that covers medical care for certain people with limited income and assets. The income and asset limits vary from state to state above federal limits. People who are eligible for Medicare may also be eligible for Medicaid if their income and assets are below the limits in their state.

You must meet a certain income and asset limit to qualify for Medicaid. This is different from Medicare, which does not have an income or asset limit. Instead, you qualify for Medicare when you are 65 or older, have received Social Security Disability Insurance (SSDI) for 24 months, have ESRD, or the first month you receive SSDI for amyotrophic lateral sclerosis (ALS).

Each state runs different Medicaid programs for various groups of people (see questions 6 through 8). If you have Medicare and Medicaid, you likely have Medicaid for individuals who are aged, blind, or disabled. This type of Medicaid is often called aged, blind, or disabled (ABD) or traditional Medicaid. This is the most common type of Medicaid that Medicare beneficiaries have. State Medicaid programs also run the Medicare Savings Programs, including the Qualified Medicare Beneficiary (QMB) program, that help cover some Medicare costs.

## 2. How do Medicare and Medicaid work together?

If you qualify for Medicare and Medicaid, the two programs work together to cover your health care needs. People with Medicare and Medicaid are known as dual eligibles. Many people who qualify for Medicaid also qualify for a Medicare Savings Program (MSP) called Qualified Medicare Beneficiary (QMB). QMB pays for your monthly Medicare premiums and cost-sharing, such as deductibles, coinsurance charges, and copayments. When you have Medicare, QMB, and Medicaid, the programs cover all of your health costs.

If you are a dual eligible and have no other coverage, Medicare pays first for your health care services and Medicaid pays second. Medicaid is the payer of last resort, which means it pays for your health care costs after all other insurance has paid. For example, if you have Medicare, retiree insurance, and Medicaid, then Medicaid will pay for your health care costs after Medicare and your retiree insurance have paid.

For services that both Medicare and Medicaid cover, you will usually not have to pay Medicare cost-sharing. For example, Medicare and Medicaid both cover inpatient hospital care. If you get inpatient hospital care from a hospital that accepts Medicare and Medicaid, then Medicare pays first and Medicaid pays second. Note that if you have Medicare and Medicaid, but you do not have QMB, you may owe a small copayment for your services. If you have Medicare, Medicaid, **and** QMB, you will not owe anything for the services.

Medicaid can also provide coverage for items and services that Medicare does not cover, depending on your state. If your state Medicaid program covers services that are not covered by Medicare, then Medicaid will pay first for those services. For example, some state Medicaid programs cover dental services. If you live in one of those states, then you could receive Medicaid-covered covered dental services as long as you see a

Medicaid provider and follow the coverage rules in your state. To learn more about your state Medicaid program, contact your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is on the last page of this document.

**3. What are mandatory Medicaid benefits?**

All state Medicaid programs are required to cover the following benefits at a minimum. These are known as mandatory benefits, and include:

- Inpatient and outpatient hospital services
- Nursing facility services
- Home health services
- Physicians' services, laboratory services, and x-rays
- Rural health clinic services
- Transportation to medical services
- Family planning services, nurse midwife services, tobacco cessation counseling for pregnant people, state-licensed freestanding birth centers
- Pediatric and certified family nurse practitioner services

Note that Medicaid covers inpatient and outpatient hospital services, home health care, and physician services, which are also covered by Medicare.

**4. What are optional Medicaid benefits?**

The following Medicaid benefits are optional, and are not be available in all states.

- Prescription drugs
- Physical, occupational, and speech therapy
- Dental services and dentures
- Prosthetics
- Optometry and eyeglasses
- Chiropractic services
- Personal care
- Case management
- Hospice care
- Podiatry
- Private duty nursing

Coverage is different from state to state. To learn more about your state Medicaid program, contact your SHIP. Contact information for your SHIP is on the last page of the Teaching Materials.

**5. How are my prescription drugs covered when I have Medicare and Medicaid?**

If you have Medicare and Medicaid, you will usually get your drugs covered by Medicare Part D, the Medicare prescription drug benefit. Medicaid will not pay for drugs that could be covered under Part D. In limited cases, Medicaid might pay for drugs that are not covered by Medicare, like over the counter

medications. If you have Medicare and Medicaid, you will also likely be enrolled in Extra Help (see question 9), a program that helps pay for some of your drug costs.

If you have Medicare, Medicaid, and Extra Help and do not choose a Part D plan, Medicare will automatically enroll you in a benchmark Part D plan. Benchmark Part D plans have a premium below the specified amount for the state, which means that Extra Help will pay the full cost of the premium. Medicare will send you a notice telling you which plan it enrolled you in and what your costs are. If this plan does not fit your needs, you can choose another plan by calling 1-800-MEDICARE.

**6. Does Medicaid cover nursing home care?**

Yes. All states have a Medicaid program for people who need nursing home or long-term care. This is important to know, because Medicare covers long-term care in very limited circumstances. Some people who need long-term care may qualify for Medicaid coverage of their health care needs. This is called Medicaid for residents of an institution, or institutional Medicaid. Medicaid for residents of an institution covers nursing facility services and general health care. This type of Medicaid may pay for a stay in a nursing home if you need a nursing home level of care and your income and assets are under a certain limit. A state generally looks at your need for help with activities of daily living (ADLs) to decide if you need nursing home care.

If you qualify for Medicaid for residents of an institution, there are a few things to keep in mind. First, this type of Medicaid considers you and your spouse together when looking at income and assets.

Second, all states have a look-back period of up to five years for Medicaid for residents of an institution. This means that the state will look at any assets that you transferred in the past five years. If the state thinks you transferred assets in a way that broke the Medicaid rules against transfers for less than fair market value, it may not pay for part or all of your nursing home stay. Examples of transfers that are not allowed include gifts, certain loans, or paying more for items than they are worth.

Third, be aware that your assets will be affected when you no longer need nursing home care. Some of your assets (including the value of your home in some situations) may be used to repay Medicaid for the care that it covered. If you or a loved one is thinking about applying for Medicaid for residents of an institution, speak with an elder law attorney and local Medicaid office to learn more.

**7. Does Medicaid cover long-term care in the community?**

Yes. Medicaid covers long-term care that you receive in a home or community-based setting. This Medicaid program is called the Medicaid home and community-based services (HCBS) waiver. Each state's HCBS waiver program or programs may look different. In general, an HCBS waiver aims to provide integrated care to help you stay in your home when you need long-term care. This means care in a community setting, rather than an institution, like a nursing home. The types of settings that are considered home or community-based vary, but some examples include an individually owned private home or individualized community day activities.

This type of Medicaid may pay for your care if you meet your state's functional eligibility requirements and your income and assets are under a certain limit. A state generally looks at your need for help with activities of daily living (ADLs) to decide if you qualify for an HCBS waiver program to cover your care. Services covered through an HCBS waiver program may include personal care, homemaker services, case management, adult day care, skilled nursing care, and therapy services. The program may also cover home modifications, respite care, and help with chores. The amount and type of services that Medicaid covers vary by state.

If you qualify for a Medicaid HCBS waiver program, there are a few things to keep in mind. First, this type of Medicaid considers you and your spouse together when looking at income and assets. You will typically be able to set aside a certain amount of your income and assets for your spouse to keep. If your state lets you set aside money for your spouse, this amount will not be counted when you apply for the waiver program.

Second, if you own your home, you should speak to an elder law attorney about how your Medicaid coverage may be affected. Some of the value of your home may be counted as part of your assets.

Even if you meet the eligibility guidelines, there are generally limits on the number of people who can receive these benefits in each state. You should check with your local Medicaid office to see if there is a Medicaid HCBS waiver program waiting list.

**8. What is MAGI Medicaid?**

MAGI Medicaid is a type of Medicaid for people who live in states that expanded their Medicaid coverage under the Affordable Care Act (ACA). This type of Medicaid has higher income limits than ABD Medicaid, the most common type of Medicaid that a Medicare beneficiary has (see question 1). MAGI Medicaid uses someone's Modified Adjusted Gross Income (MAGI) to determine if they are eligible for Medicaid. ABD Medicaid uses a different method to determine if you are eligible.

MAGI Medicaid is available to people who meet the income limits and are in one of the following categories:

- Childless adults age 19 to 64
- Pregnant people
- Children up to age 19 (or 21, depending on the state)
- Parent and relative caretakers

If you have MAGI Medicaid and become eligible for Medicare, your MAGI Medicaid will end. You should receive a notice about the transition process around the date that you need to recertify for MAGI Medicaid, or around the time that you become eligible for Medicare. The timing and agency involved with this transition depend on the rules in your state. **In general, follow the instructions on any notices you receive.** Know that you will need to be evaluated for traditional Medicaid and the Medicare Savings Program (MSP), a program that helps with Medicare costs. If you have any questions, contact your SHIP. Contact information for your SHIP is on the last page of this document.

**9. What other programs may I be eligible for if I have Medicaid?**
If you have Medicaid, you are likely also enrolled in a Medicare Savings Program (MSP) and Extra Help. These programs help you with your Medicare costs.

In general, an MSP pays for your Part B premium. Many people with Medicaid qualify for the Qualified Medicare Beneficiary (QMB) MSP, which means the program covers their Medicare cost-sharing, like deductibles, coinsurance charges, and copayments (see question 2). If you owe a premium for Part A, QMB pays for that premium as well.

Extra Help is a federal program that helps with your prescription drug costs. It pays for your Part D plan premium up to a certain amount, and you will have very low copays at the pharmacy.

The takeaway point is that if you have Medicaid, you should likely receive assistance from an MSP and/or Extra Help. If you think that you qualify for one of these programs but you are not enrolled, contact your SHIP. Contact information for your SHIP is on the last page of this document. If you enrolled in an MSP and receive charges for services that you think Medicare and Medicaid should have paid for on your behalf, contact your Senior Medicare Patrol (SMP). Contact information for your SMP is on the last page of this document.

**10. How do I apply for Medicaid?**
Generally, you need to apply for Medicaid with your local Medicaid office. Some people automatically qualify for Medicaid based on their status with Social Security. Contact your local Medicaid office or your SHIP to ask how to submit the application. Many states allow you to submit your application online, through the mail, or through community health centers and related organizations. Some states may require a face-to-face meeting at the Medicaid office in order to apply.

Medicaid also has residency and citizenship requirements. In general, if you are not a United States citizen, you must be a lawful resident or green card holder who has lived in the U.S. for five consecutive years. Note that not all states have this residency requirement.

States often require documentation to support your application, such as:
- Proof of age, like a birth certificate
- Proof of identity and citizenship or immigration status, like a passport or green card
- Proof of address, such as a utility bill
- Proof of income, like a pay stub or Social Security Administration award letter
- Proof of assets, like a bank statement

**11. What is the Medicaid spend-down?**
Many states have a Medicaid spend-down, which is a way that helps you lower your income in order to qualify for Medicaid, even if your total income is over the limit in your state. A spend-down allows you to subtract medical expenses from your income so that you can qualify for ABD Medicaid. Contact your local Medicaid office or your SHIP to learn if there is a spend-down available in your state.

Your spend-down amount will be the difference between your income and the Medicaid spend-down income limit in your state. You will have to meet the spend-down for a certain amount of time, according to the rules in your state. This time period can be from one to six months. Some states require you to submit bills to show your monthly expenses. Other states may let you pay in to the Medicaid program for the amount that your income is over the limit.

For example, let's say that your state has a Medicaid spend-down with an income limit of $1,000 per month. You must meet the spend-down amount each month in order to qualify for Medicaid. If you are $100 over the Medicaid spend-down limit in your state, you will have to show that you have $100 of medical bills each month so that you can qualify for Medicaid. A medical bill could be something like an uncovered Medicare deductible or other out-of-pocket medical costs. If you do not have $100 worth of medical bills one month, you will not meet the spend-down. You can qualify for the spend-down again the next month if you have enough medical bills.

The takeaway point is that even if your income appears to be over the Medicaid income limit in your state, you could still qualify through a spend-down, if one is available. Contact your local Medicaid office or SHIP to learn more.

**12. What are trusts?**
Trusts are another way you can lower your income and qualify for Medicaid. Certain trusts can be used as an alternative to a spend-down in states that do not have a spend-down option. These trusts keep your income and assets from counting for Medicaid purposes, as long as the trusts meet strict requirements about how they are established and administered, and who receives the remainder of the money when the trust beneficiary passes away. You or your relatives can put a portion of your monthly income or assets into one of these types of trusts. That are limits to the way the money can be spent.

Rules about how these trusts work vary greatly by state. Contact your local Medicaid office or an elder law attorney to learn more.

**13. What if I get a bill for charges that I think should have been covered by QMB?**
The Centers for Medicare & Medicaid Services (CMS) is working to stop QMB beneficiaries from being inappropriately billed for Medicare cost-sharing. This is known as improper billing. You can refer to your Medicare & You handbook or www.medicare.gov to learn more about improper billing. Customer service representatives at 1-800-MEDICARE can see if you have QMB and can help you resolve improper billing issues. First, they will suggest that you speak with your provider to let them know that you have QMB and should not be billed for costs like deductibles or coinsurances. If the issues continue, the representatives can refer your case to the Medicare Administrative Contractor (MAC). The MAC is an organization that is involved in Medicare billing. They will contact your provider to make sure that they do not bill you. The MAC should also follow up with you to learn if the problem has been resolved.

Your Senior Medicare Patrol (SMP) can also provide one-on-one assistance in helping you sort out suspected inappropriate billing.

For more information see:

- From CMS: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf.
- From the Consumer Financial Protection Bureau: https://www.consumerfinance.gov/about-us/blog/what-do-if-youre-wrongfully-billed-medicare-costs/

**14. Who can I contact if I have questions?**

**Local Medicaid office:** Contact your local Medicaid office to learn more about the program in your state. The Medicaid office can provide you with information about how to apply and what the benefits are like in your state. To find your local Medicaid office, go to https://www.medicaid.gov/about-us/contact-us/index.html and choose your state from the drop-down menu on the right. You can also visit https://www.benefits.gov/benefits/browse-by-category/category/21 for more information.

**State Health Insurance Assistance Program (SHIP):** Contact your SHIP if you have questions about the Medicaid programs in your state. A SHIP counselor can help you understand how Medicaid works with your Medicare benefits. Contact information for your SHIP is on the last page of this document.

**1-800-MEDICARE:** Contact 1-800-MEDICARE if you enrolled in the QMB program and you have been unable to resolve billing issues with your provider.

**Senior Medicare Patrol (SMP):** Contact your SMP if you have concerns about Medicare and Medicaid fraud, errors, and abuse such as suspicious charges on your Medicare statements from providers you didn't see. SMPs can also provide individualized assistance if you receive charges for services you think Medicare and Medicaid should have covered on your behalf. Contact information for your SMP is on the last page of this document.

**15. Case Studies**

**SHIP case example**
Sean recently turned 65 and enrolled in Medicare. He had Medicaid when he enrolled in Medicare, and a Medicare representative told him that he would continue to receive Medicaid and that Medicaid would automatically enroll him in an MSP. Sean understood that the MSP would pay his Part B premium. However, six months after enrolling in Medicare, Sean received a letter from Social Security informing him that his Part B benefits ended because he hadn't been paying his premiums.

**What should Sean do?**

- Sean should contact his SHIP.
    - If he doesn't know how to find his SHIP, he can go to www.shiptacenter.org or call 877-839-2675 for assistance.

- A SHIP counselor can let Sean know that he should contact Social Security to tell them he is enrolled in Medicare and Medicaid and that there is likely a mistake in their database. The SHIP counselor can encourage Sean to advocate for himself to ask Social Security to restore his Part B benefits, since they were terminated due to an error.
- If Social Security is unable to help, Sean should call his local Medicaid office and ask about the Medicare Savings Program. If needed, a SHIP counselor can help Sean apply for the Medicare Savings Program. The counselor can also help Sean make sure that the Medicaid office is providing Social Security with correct information about his benefits.

**SMP case example**

Ingrid is 76 years old and has Original Medicare, Medicaid, and QMB. She has recently been diagnosed with Alzheimer's, but does not have a caregiver living in her home. Her children live several hours away, and she is doing her best to remain independent. Her daughter Debbie helps her pay her bills every month. At a recent health care appointment, Ingrid was charged a $125.00 copayment for her services. She didn't have enough money in her purse at the time, and now the past due bills are coming in the mail. Ingrid is worried about being able to afford the bill and is unable to understand the complexities of her health care. Debbie doesn't understand why Ingrid is being charged in the first place. She had helped her mother enroll in Medicaid and QMB four months ago. She knows her mother won't be able to sort this out on her own, and her mother certainly can't afford to pay the bill.

**What should Debbie do?**

- She should contact the local SMP to explain the situation.
    - If doesn't know how to find the local SMP, she can go to www.smpresource.org or call 877-808-2468 for assistance.
- The SMP representative will educate Debbie about Ingrid's rights as a dual-eligible and QMB enrollee, reassuring that the charges are likely in error. Debbie should also contact the local Medicaid office to ensure that her mother's Medicaid is active.
- The SMP representative will recommend that Debbie reach out to the provider to explain Ingrid's coverage and get the error corrected.
- If the provider will not correct the error, Debbie can contact the SMP again for education and assistance in reporting the problem to the proper authorities on Ingrid's behalf, such as by contacting 1-800-MEDICARE.
- If the SMP suspects fraud or abuse based on the information collected, they will also report the situation to the proper authorities, and will remain in contact with Debbie until Ingrid's case is resolved.

| Local SHIP Contact Information | Local SMP Contact Information |
|---|---|
| **SHIP toll-free: 1-800-562-6900**<br>**SHIP email: shiba@oic.wa.gov**<br>**SHIP website: www.insurance.wa.gov/shiba**<br>**To find a SHIP in another state:**<br>Call 877-839-2675 or visit www.shiptacenter.org. | **SMP toll-free: 1-800-562-6900**<br>**SMP email: shiba@oic.wa.gov**<br>**SMP website: www.insurance.wa.gov/shiba**<br>**To find an SMP in another state:**<br>Call 877-808-2468 or visit www.smpresource.org. |

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