

MEDICAID BASICS: A QUESTION AND ANSWER GUIDE ABOUT ELIGIBILITY, COVERAGE, AND BENEFITS



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—from a declaration of the American Bar Association

Medicaid Basics: A Question and Answer Guide about Eligibility, Coverage, and Benefits

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In January 2006, American Health Lawyers Association (Health Lawyers) released a *Medicaid Consumer Information Fact Sheet*. The *Fact Sheet* was prepared to help those who needed to navigate the unfamiliar requirements of different states' Medicaid programs and to help those who were dealing with Medicaid for the first time. The *Fact Sheet* provided easy-to-use website links and phone numbers for the Medicaid programs in all 50 states and was a starting point to aid those needing assistance in obtaining payment for medical care.

After all the destruction that has happened in the Gulf Coast areas and Florida, we wanted to provide a publication that would help individuals who are unfamiliar with their new state health laws. I'm confident that our newly published Medicaid Consumer Information Fact Sheet will help those displaced individuals and the healthcare community find, quickly and easily, the Medicaid information they need for their new area of relocation.

The *Fact Sheet* is now a part of *Medicaid Basics: A Question and Answer Guide about Eligibility, Coverage, and Benefits (Guide)*. Initiated in 2004, the Public Information Series is one aspect of Health Lawyers' public interest commitment as a tax-exempt educational association. Written primarily for a public audience, the Public Information Series enables Health Lawyers' to share its expertise on topics of interest to healthcare attorneys and the broader healthcare community, including healthcare professionals, healthcare executives, public health agencies, pro bono attorneys, and consumer groups.

The question and answer format in the *Guide* is designed to assist individuals understand the basics about the Medicaid program. It includes a general overview about the program, eligibility, and coverage; a glossary of selected healthcare terms; and *Fact Sheets* in English, Spanish, and traditional Chinese.

Health Lawyers' Public Interest Commitment

Health Lawyers' Public Information Series is one of a variety of public interest activities conducted by the 10,000-member educational association under its mission statement pledge "...to serve as a public resource on selected healthcare legal issues." The Association fulfills its public interest commitment through two types of activities. The Public Information Series and outreach activities to pro bono attorneys, legal aid soci-

eties, and consumers provide avenues through which Health Lawyers shares its members' legal expertise with society at large. Health Lawyers' commitment to public interest also includes a variety of nonpartisan public policy-related activities that seek to further the development of sound health policy. These include sponsorship of the Conversations with Policymakers teleconference series and periodic issue briefings for health policy analysts and reporters. Health Lawyers' public interest activities are financed, in part, through financial contributions from its members and their firms or organizations.

Acknowledgements | About the Authors

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members of the health bar and healthcare consumers.

If you have suggestions for future publications in Health Lawyers' Public Information Series, please contact Kerry B. Hoggard at (202) 833-0760 or khoggard@healthlawyers.org or Katherine E. Wone, J.D., Manager of Public Interest, at (202) 833-0787 or kwone@healthlawyers.org.



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Medicaid Basics: A Question and Answer Guide about Eligibility, Coverage, and Benefits

The complexity of the Social Security Act and its healthcare programs, including Medicare and Medicaid, is daunting. Indeed, even the courts entrusted with understanding and interpreting provisions related to these programs freely acknowledge their bewilderment when confronted with thorny issues relating to their administration. As a result, terms like “Byzantine,” “unintelligible to the uninitiated,” “impenetrable,” and “Serbian bog” abound in Medicare and Medicaid case law.

Given this complexity and the frequency with which Congress amends and reforms these programs, it should come as no surprise that many Americans do not understand the basic structure of these programs or the fundamental differences between them. Even worse, the beneficiaries of these programs—many of whom are elderly, poor, and/or unsophisticated—are often forced to navigate these programs with little or no assistance. Moreover, even where assistance or resources are available from state Medicaid programs, legal aid attorneys or personnel, potential beneficiaries may have no idea of where to turn for help in understanding their rights and benefits.

Recognizing the plight of many potential Medicaid beneficiaries and of the attorneys and other individuals who may be enlisted to assist them, the American Health Lawyers Association (Health Lawyers) determined that it could furnish timely and useful information in this area. As such, the Association developed *Medicaid Basics: A Question and Answer Guide about Eligibility, Coverage and Benefits (Guide)*, as part of its Public Information Series. The *Guide* will be updated periodically to account for new trends and additional information. The *Guide* can be downloaded free of charge at www.healthlawyers.org/medicaidguide and at www.healthlawyers.org/factsheet. We hope it will provide needed information to potential Medicaid beneficiaries struggling with basic questions about the program as well as to attorneys who are confronted with such questions but who may not be as conversant with Medicaid as they would like.

This *Guide* is divided into multiple sections. The preface identifies the need that led to the development of the publication. It is an excellent articulation of Health Lawyers’ public interest commitment and acknowledges the individuals whose time, efforts, and expertise were invaluable in producing this resource.

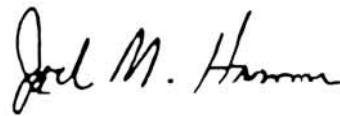
The Question and Answer component of the publication is divided into several categories:

- Basic information about Medicaid;
- Eligibility issues;
- Coverage questions; and
- General inquiries.

Legal citations are furnished in footnotes to enable attorneys to conduct additional research if needed. The Questions and Answers are the heart of the publication, and although many questions about Medicaid are invariably state-specific, Health Lawyers has endeavored to furnish general information with pertinent details. The Association also encourages readers to contact it with additional questions and answers or supplemental information that would bolster the publication or help keep it current.

Three appendices complete this publication. Appendix A is the *Medicaid Consumer Information Fact Sheet*, which includes the web addresses and phone numbers for all state Medicaid agencies. Those addresses may be utilized to obtain further contact information and to answer questions about a particular state’s Medicaid program and its policies. Appendix B is the Spanish version of Appendix A, and a version in traditional Chinese is available online. Finally, Appendix C is a glossary of relevant terms related to the Medicaid program.

Health Lawyers hopes that this publication will become an indispensable resource not only to its members but also to Medicaid consumers and others who work and provide assistance in this area. Health Lawyers is pleased to offer this publication as an integral part of its mission to educate its members and the public on health law issues.



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American Health Lawyers Association Public Information Series

Produced as a part of Health Lawyers' public interest commitment to serve as a public resource on selected healthcare legal issues, these resources enable the Association to share its members' expertise on topics of interest both to healthcare attorneys and the broader healthcare community, including health professionals, healthcare executives, public health agencies, pro bono attorneys, and consumer groups. Additional resources in the Public Information Series include:

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Life-Limiting Conditions One Pagers
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Medicaid Basics: A Question and Answer Guide about Eligibility, Coverage and Benefits
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1. What is Medicaid?

Medicaid is a joint federal and state entitlement program that provides coverage for medical and related services. Enacted in 1965 by Congress as a companion to the Medicare program, Medicaid was originally designed as a healthcare program for welfare recipients.¹ Today the program is a \$270 billion public health insurance program for low-income individuals and the largest long-term care program for the disabled and elderly.²

2. Is Medicaid a state or federal program?

Medicaid is a federal and state partnership. The federal government has established broad guidelines for the program and pays for a share of the program's costs under a statutory formula.³ Medicaid is a voluntary program for states and territories. States that choose to participate are required to meet certain minimum federal standards regarding eligibility and services covered, but otherwise retain broad flexibility in administering their individual Medicaid programs.⁴ Despite the voluntary nature of the program, every state and territory participates in Medicaid.

Although states are responsible for operating their individual Medicaid programs, the federal government possesses significant oversight over these programs. For example, each state must maintain a written state Medicaid plan (known as a "State Plan") in order for services provided to its Medicaid population to qualify for federal funding. The State Plan must provide details about administration, eligibility, coverage of services, beneficiary protections, and reimbursement methodologies. Exercising its oversight function, the federal government must

approve all State Plans and any changes that are made to the Plans (State Plan Amendments).⁵

3. Who pays for Medicaid?

The Medicaid program is generally funded by federal and state government dollars. The federal government reimburses states for a share of costs associated with their Medicaid programs. This federal financial participation (FFP) is available for two types of costs incurred by states: those relating to services for Medicaid recipients and those relating to administering the program.⁶ The level of FFP for service costs varies by state—that is, the federal government pays a greater share of Medicaid service costs for some states than it does for others. This is because the statutory formula that determines FFP provides greater federal assistance to states with lower per capita incomes.⁷ FFP for Medicaid services may range from 50% to 83%.⁸ Administrative costs in all states are generally matched by the federal government at 50% (with the exception of higher federal contributions for certain types of services).⁹

States also have the authority to impose limited cost sharing on certain Medicaid recipients. These obligations, such as enrollment fees, premiums, deductibles, coinsurance, or co-payments, must be identified and approved in the State Plan.¹⁰ Notably, recent changes in federal law have provided states with additional flexibility to utilize cost sharing. (See Question 13 for additional information.)

4. What is the difference between Medicaid and Medicare?

Although the Medicare and Medicaid programs were enacted by Congress at the same time, they were designed to target different groups of people

¹ Social Security Act ("SSA") Amendments of 1965, Pub. L. No. 89-97; *Medicaid: A Timeline of Key Developments*. Kaiser Family Foundation, available at: www.kff.org/medicaid/medicaid_timeline.cfm (last visited April 1, 2008).

² Historical Health Insurance Tables, U.S. Census Bureau; *Medicaid: A Primer*, Kaiser Commission on Medicaid and the Uninsured (July 2005).

³ SSA § 1903 (42 U.S.C. § 1396b).

⁴ *Medicaid: A Primer*, Kaiser Commission on Medicaid and the Uninsured (July 2005).

⁵ See SSA § 1902 (42 U.S.C. § 1396a) (setting forth requirements for State Plans).

⁶ SSA §§ 1903(a), 1905(b) (42 U.S.C. §§ 1396b(a), 1396d(b)).

⁷ SSA §§ 1101(a)(8), 1903(a)(1), 1905(b) (42 U.S.C. §§ 1301(a)(8), 1396b(a)(1), 1396d(b)).

⁸ *Id.*

⁹ SSA § 1903(a)(2)-(7) (42 U.S.C. § 1396b(a)(2)-(7)).

¹⁰ SSA § 1916 (42 U.S.C. § 1396o); 42 C.F.R. § 447.50 *et seq.*

and to operate in significantly different ways. Both are entitlement programs—meaning, all individuals have a legal right to apply for the programs, and, if they meet the eligibility criteria, they are entitled to receive coverage.¹¹

Medicare is a federally administered, nationwide healthcare coverage program for the elderly and the disabled.¹² Individuals who reach the age of 65 or those who qualify for federal disability benefits under Title II of the Social Security Act are eligible to enroll in the Medicare program.¹³ The program is uniform: one set of requirements applies to all Medicare participating providers and Medicare beneficiaries.¹⁴ For example, under the traditional Medicare program, all Medicare beneficiaries are entitled to the same coverage of services and supplies.¹⁵ Healthcare providers and suppliers must enroll directly with the federal government in order to participate, and they, in turn, are directly reimbursed for treating Medicare beneficiaries by the federal government.¹⁶ Under the traditional Medicare program, reimbursement for most services and supplies, except for prescription drugs, is made according to uniform fee schedules set by the federal government.¹⁷

Conversely, as described above, **Medicaid** is a joint federal and state partnership that provides healthcare coverage for certain low-income individuals. Although there are minimum federal standards regarding eligibility, coverage and reimbursement, states have considerable discretion in designing their Medicaid programs.¹⁸ Thus, there are significant differences among state Medicaid programs with respect to covered populations, benefits, cost sharing, delivery systems and reimbursement to providers. To understand how a particular state Medicaid program works, individuals should consult individual state websites and the website for the Centers for Medicare and Medicaid Services (CMS), at www.cms.hhs.gov/, for more information.

5. What is CMS?

The Centers for Medicare and Medicaid Services (CMS) is a federal agency within the United States Department of Health and Human Services.¹⁹ The

agency is charged with administering the Medicare program and overseeing state Medicaid programs. As noted above, with respect to Medicaid programs, CMS's role includes approving the fundamental parameters of the state Medicaid programs as well as any changes made to the state Medicaid programs. CMS also oversees other aspects of Medicaid programs. For example, CMS has recently assumed an increasingly active role in overseeing how states finance their Medicaid programs, given the fact that federal dollars match state expenditures.

6. Why should I apply for Medicaid coverage?

Medicaid pays for healthcare services that are “medically necessary.” Services include: some prescriptions, physician visits, adult day health service, some dental care, ambulance services, some home health, X-ray and laboratory costs, orthopedic devices, eyeglasses, hearing aids, and some medical equipment. Medicaid is also the biggest single payer for long-term care. An individual may need these items and services and may qualify if he or she fits within certain categories and satisfies federal and state financial conditions.

Medicaid is a means-tested program that provides benefits to certain categories of people who meet rigorous income and asset rules. Additionally, people who need long term care must meet categorical, financial, and functional eligibility criteria to receive Medicaid-funded long term care services. They must be elderly or disabled (meet a state or federal definition of disability), have limited financial resources, and meet level-of-care criteria for long term care services. Supplemental Security Income (SSI) and other categorically-related recipients are automatically eligible. Nationwide, of the 52.4 million people enrolled in Medicaid in 2003, about 4.7 million (9 percent) were elderly and 8.4 million (16 percent) qualified on the basis of disability.

There are a number of ways of meeting Medicaid's financial eligibility criteria, and elderly and non-elderly people, especially those with long-term care needs, often take different paths to Medicaid eligibility. The majority of the disabled in Medicaid arrive at eligibili-

11 For example, if Medicaid applications are denied or not acted upon within a reasonable amount of time, applicants must be afforded due process protections. U.S. Const. amend. XIV; SSA § 1902(a)(3) (42 U.S.C. § 1396a(a)(3)); 42 C.F.R. §§ 435.911-.912.

12 SSA § 1811 (42 U.S.C. § 1395c); *Medicare Payment Policies*. Congr. Research Serv., RL30526 (Feb. 23, 2005).

13 SSA §§ 201, 1811 (42 U.S.C. §§ 401, 1395c).

14 For certain “high income” Medicare beneficiaries, however, Congress has imposed higher premium payments than are required of lower income beneficiaries.

15 SSA §§ 1812, 1832 (42 U.S.C. §§ 1395d, 1395k).

16 SSA §§ 1814-1815, 1833 (42 U.S.C. §§ 1395f-1395g, 1395l).

17 *Id.*

18 *Medicaid: A Primer*, Kaiser Commission on Medicaid and the Uninsured (July 2005).

19 See www.cms.hhs.gov/ (last visited April 1, 2008).

ty via a “welfare-related pathway.” That is, they qualify for Medicaid because they also qualify for some other form of public assistance. On the other hand, the elderly primarily enroll in Medicaid once they need nursing home care and after they have spent down their income and assets. They qualify through a “medically needy” or “spend-down” pathway. The determination of Medicaid eligibility can involve complex calculations with rules that vary widely across states.

In general, an individual should apply for Medicaid if his or her income is limited and that person matches one of the descriptions of the eligibility groups. (If there is uncertainty as to Medicaid eligibility, qualified caseworkers in the states are available to evaluate the situation.)

ELIGIBILITY

7. Who qualifies for Medicaid coverage?

Medicaid does not cover everyone who is poor and uninsured. Under federal law, states are required to include only certain groups of people in their Medicaid programs.²⁰ These groups are collectively known as “mandatory categorically needy,” which generally includes low-income children; pregnant or postpartum women; the aged, blind, or disabled; certain low-income children and families who qualify for federal welfare assistance; and low-income Medicare beneficiaries.²¹

Federal law also permits states to expand Medicaid coverage to other optional groups of individuals. These groups fall into two categories – “optional Categorically Needy”²² and “Medically Needy.”²³ Although these individuals share many characteristics with those in the mandatory categories, they generally have too much money or resources to qualify for Medicaid under those categories.²⁴

States may also cover other individuals under “waiver” programs. These waiver programs allow CMS to “waive” certain federal Medicaid requirements, thus allowing states, for example, to expand coverage of populations who would not otherwise be able to be covered under Medicaid.²⁵ More information on “waiver programs” may be found at www.cms.hhs.gov/ and/or individual state Medicaid programs’ websites.

8. May I have both Medicare and Medicaid at the same time?

Yes, individuals may be covered under both Medicare and Medicaid at the same time. Any Medicare beneficiary who meets the eligibility standards for Medicaid (either under a mandatory or covered optional category) may qualify for coverage for both Medicare and Medicaid at the same time. For these “dual eligibles,” state Medicaid programs generally pay for certain cost sharing that is not covered by Medicare and certain services that are not otherwise covered by Medicare (such as long term care services). For example, Medicaid programs must pay for all Medicare premiums, deductibles, and coinsurance for Medicare beneficiaries with incomes at or below 100% of the federal poverty level (FPL) and who meet certain Medicaid criteria.²⁶

9. What is Medicaid planning and how does it affect eligibility?

Medicaid planning is the process by which people who would not immediately qualify for Medicaid “rearrange” their assets to qualify for Medicaid benefits, usually for nursing home or long-term care. The Medicaid program is not an age-based entitlement program like Social Security, but is a “means-tested program,” meaning that it is intended to provide assistance to those individuals whose incomes and assets are not enough to pay for their healthcare. The goal of Medicaid planning is therefore to minimize the financial impact of the cost of health and long-term care on the individual and his/her family. Medicaid planning involves a process of analysis and advice, the goal of which is to make the individual eligible to receive Medicaid benefits, if possible.

There is considerable debate about whether “Medicaid planning” is appropriate. Opponents argue that individuals who have assets should be required to use those assets to pay for their care (often long-term care) until they meet the eligibility rules for Medicaid. They argue “rearranging” or “diverting” those assets unfairly shifts the cost of the care to the government (in other words, to taxpayers). Proponents argue that because the cost of long-term care is higher than many people can afford, and because the rules do not prohibit individuals from “rearranging” “or “reconfiguring” their assets so as to qualify for Medicaid nurs-

20 See SSA § 1902(a)(10)(A)(i) (42 U.S.C. § 1396a(a)(10)(A)(i)).

21 SSA § 1902(a)(10)(A)(i) (42 U.S.C. § 1396a(a)(10)(A)(i)); 42 C.F.R. § 435.100 *et seq.*

22 SSA § 1902(a)(10)(A)(ii) (42 U.S.C. § 1396a(a)(10)(A)(ii)); 42 C.F.R. § 435.200 *et seq.*

23 SSA §§ 1902(a)(10)(C), 1905(a) (42 U.S.C. §§ 1396a(a)(10)(C), 1396d(a)); 42 C.F.R. § 435.300 *et seq.*; 42 C.F.R. § 435.800 *et seq.*

24 *Medicaid At-a-Glance*, Ctrs. For Medicare & Medicaid Servs (2005).

25 See SSA § 1115 (42 U.S.C. § 1315).

26 SSA § 1905(p) (42 U.S.C. § 1396d(p)). These individuals are also known as “Qualified Medicare Beneficiaries” or “QMBs.”

ing home benefits, it is justified to shift the cost of long-term care from the individual to the government in this way.

Whichever view is more correct, Medicaid planning is very complicated and federal law changes have recently made it harder not to spend those assets for an individual's care.²⁷ Medicaid planning usually involves getting advice from an attorney.

10. What assets may I own and still qualify for Medicaid?

As explained above, Medicaid is a "means-tested" program and not everyone is entitled to it. To limit public expenditures, an individual must meet financial and categorical eligibility criteria in order to qualify for Medicaid. To receive Medicaid covered long-term care services, for example, a person's income must be under certain levels, and he/she must have assets of less than a certain value. The monthly income cap generally ranges from approximately \$1,500 to \$2,400, and the amount varies every year and in every state.

Every state also has a limit on what things ("assets") a Medicaid recipient may own and keep. "Countable assets" consist of all investments such as stocks, bonds, mutual funds, checking and savings accounts and certificates of deposit. Countable assets also include personal or real property (land) as well as any art and collectibles. Generally, an individual may keep a certain amount of "countable assets" without having to sell them to qualify for Medicaid.

All assets that are not specifically excluded are considered countable. The following are examples of "excluded" assets and not counted in determining Medicaid eligibility, but these may vary from state to state:

A home or a life estate in a home, up to a certain value;²⁸

- In some states, a certain amount of the individual's personal possessions or property, like household goods and clothing;
- One car, though a state may limit the value of the vehicle that can be excluded;
- A prepaid irrevocable funeral contract, though some states limit the cost of that contract;
- Funds to cover burial and funeral costs, in an

amount that varies by state;

- Burial spaces costs and related items for an individual and his/her immediate family;
- Life insurance, long-term care insurance, and certain other types of term insurance;
- The value of income-producing real property;
- Certain annuities.

In addition, assets that the individual does not have the legal right to use or sell without the consent of anyone else or that he/she has been unable to sell are generally considered excluded.

Assets in an irrevocable trust (*see* Question 12 below), in some instances, may be excluded. However, the portion of the principal of the trust from which payment can be made to or for a person's benefit is considered a countable asset. Furthermore, payments of trust income must be used to pay for that person's care. The assets of both a husband and wife are considered together. All of the countable assets owned by either spouse are totaled as of the first day one spouse enters a hospital or nursing home for long-term care. The total assets are then divided equally between them. The spouse at home ("community spouse") is permitted to retain a certain amount, which again varies by state.

11. What are the "spend down" provisions of Medicaid?

If individuals have the resources to pay for their care, either in assets or income, Medicaid requires them to use that money to pay for their healthcare services. On the other hand, Medicare has the primary responsibility for the cost of care even if the beneficiary could otherwise pay for it. Under Medicaid, income from Social Security, pensions, interest, dividends and rents must be used to pay for care. But, Medicaid allows recipients in nursing homes to keep a certain small amount per month as a "personal needs allowance" to be used for things like stamps, newspapers, haircuts, etc.

The process under which an individual depletes his/her assets before qualifying for Medicaid is called "spend down" because those assets must be "spent down" to the level that makes the person financially eligible for Medicaid in his/her state.

Some people are tempted to give away their assets to qualify for Medicaid. There are strict rules, however,

²⁷ Deficit Reduction Act of 2005, §§ 6011-6016.

²⁸ While this amount used to be unlimited, Section 6014 of the Deficit Reduction Act of 2005 capped at \$500,000 the amount of home equity a person can exclude from their assets. A state has the option to increase that cap to \$750,000,000, however.

that limit this. Under federal law, if a person gives away or sells assets for less than they are worth during the “look-back” period, he/she is not eligible for Medicaid. The “look back” period is the 60 months before that individual goes into a nursing home and is eligible to apply for Medicaid. If an individual transfers his/her home or any countable assets for less than fair market value during this period, he/she will be ineligible for Medicaid assistance for nursing home care or community-based care. The period of ineligibility is determined by dividing the fair market value of the property transferred by the average monthly cost of nursing home care in the state, which results in the number of months that person has to wait to get Medicaid.

12. What is a Medicaid Trust?²⁹

Medicaid Trusts are usually used or set up when an individual has too much income to qualify for Medicaid. According to CMS, a Medicaid-qualifying trust” is a trust or similar legal device that a person (or his/her spouse, guardian or legal representative) creates, under which (a) that person is the beneficiary of all or part of the payments from the trust, and (b) the amount of those payments is determined by one or more trustees who have discretion as to how much they distribute to that individual. An attorney almost always drafts legal instruments like trusts.

In certain states, another type of trust can be used when a person exceeds the state’s Medicaid income limits but does not get enough income to pay his/her medical bills. These instruments are called “Miller Trusts” or “Qualified Income Trusts” and, although money from the trust is used to pay for that person’s care, the use of the Trust may allow that individual to qualify for Medicaid even though he/she is technically over the income limits. These also are complicated legal instruments and are best handled by attorneys.

COVERAGE

13. What does Medicaid cover?

State Medicaid programs are required to cover broad categories of services for the majority of Medicaid beneficiaries. Required Medicaid services include: inpatient and outpatient hospital services; physician

services; rural health clinic and federally qualified health center services; laboratory and x-ray services; nursing facility services for individual 21 and over, except for certain mental health populations; early periodic screening, diagnosis, and treatment (EPSDT) for individuals under 21; pregnancy-related services; family planning services and supplies; and home healthcare services for individuals entitled to nursing facility services.³⁰ (Unlike Medicare and the majority of commercial insurers, Medicaid programs generally must provide coverage of long term care services.)

States may also choose to provide a wide range of optional services under their Medicaid programs. These services include prescription drugs, dental services, and physical therapy.³¹ States have wide latitude to determine what optional services to provide. However, if they choose to offer any optional service, they are generally required to provide that same service to all Medicaid recipients covered under the State Plan.³²

States may also cover other types of services under “waiver” programs. As noted above, waiver programs allow CMS to “waive” certain federal Medicaid requirements, which includes allowing states to expand coverage of services that would not otherwise be covered under Medicaid, as well as to impose a different type of Medicaid benefit package that would otherwise be required under federal law.³³ More information on “waiver programs” may be found at www.cms.hhs.gov/ and/or individual state Medicaid programs’ websites.

Recent changes to federal law will also allow states to alter benefit packages based on “benchmarks” for certain populations through State Plan Amendments. States, however, have yet to utilize this option.³⁴

14. What are the most commonly covered optional services under the Medicaid program?

Although states have the discretion to determine which optional services they choose to provide, there are some consistencies among coverage across different Medicaid programs. The most commonly available optional services include dental services; physical and occupational therapy; prescription drugs; prosthetics and eyeglasses; and hospice care.³⁵

29 See CMS State Medicaid Manual §3215 and 3259.

30 SSA §§ 1902(a)(10)(A), 1905(a); 42 C.F.R. § 440.210.

31 SSA §§ 1902(a)(10)(A), 1905(a) (42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)); 42 C.F.R. § 440.225.

32 SSA §§ 1902(a)(10)(B)-(C), 1905(a) (42 U.S.C. §§ 1396a(a)(10)(B)-(C), 1396d(a)).

33 SSA §§ 1115, 1915(c)-(e) (42 U.S.C. §§ 1315, 1396n(c)-(e)).

34 See Deficit Reduction Act of 2005, § 6044, Pub. L. No. 109-362 (Feb. 8, 2006).

35 See *Medicaid At-a-Glance*, Ctrs. For Medicare & Medicaid Servs (2005).

15. Do I have to obtain pre-authorization from Medicaid before I can receive healthcare services?

It depends on the state. Federal law permits states to impose different types of utilization controls on the use of both mandatory and optional Medicaid services. For example, states may impose limits on the number of visits that may be covered.³⁶

States also have the option of utilizing managed care principles in the operation of their Medicaid programs – either through a “waiver” program or through a State Plan Amendment approved by CMS.³⁷ One of the commonly used techniques for controlling costs in Medicaid managed care programs is the use of prior authorization (PA), which requires individuals to seek PA before they are able to receive the service.³⁸ Although many states recently have been using PA as a mechanism to control the significant increase in prescription drug costs, the use of PA varies from state to state. To determine if a particular state Medicaid program requires PA for services, an individual should consult the particular state Medicaid program’s website.

See Appendix A for State contact information.

16. Can I obtain Medicaid coverage if I am out of state?

Yes. State Medicaid programs are required to cover certain Medicaid services when Medicaid recipients are out-of-state (to the extent these services would be covered if the individual received the same service in-state). These services include: (i) services for a medical emergency, (ii) services that are needed because the individual’s health would be endangered if he/she were required to travel to his state of residence, (iii) when necessary medical services are more readily available in other states, or (iv) when it is a general practice for Medicaid recipients to use medical resources in another state.³⁹

17. What do I have to pay for if I am on Medicaid?

States have the authority to impose cost sharing on certain Medicaid recipients. These obligations, such as enrollment fees, premiums, deductibles, coinsurance, or copayments, must be identified and approved in the state Medicaid plan.⁴⁰ Cost-sharing obligations will vary state by state.

Historically, states may impose only nominal deductibles or co-payments on Medicaid recipients: co-payments generally may not exceed \$3, deductibles may not exceed \$2 per family per month, and coinsurance must remain below 5% of the amount paid by the state for the service.⁴¹ States are prohibited from imposing cost-sharing on some individuals and services: children under age 18; pregnant women; institutionalized individuals; and family planning, emergency, and hospice services.⁴² Providers are prohibited from denying services to Medicaid recipients who are unable to pay any cost-sharing expenses.⁴³

Recent changes in federal Medicaid law, however, provide states with additional flexibility, which includes the ability to increase cost-sharing amounts, to place cost-sharing requirements on previously protected populations, to establish tiered co-payments, and to permit providers to condition the provision of care upon payment of cost-sharing.⁴⁴

GENERAL QUESTIONS

18. Will I be able to select any healthcare provider if I have Medicaid?

No. An individual on Medicaid may select any healthcare provider that accepts Medicaid. For nursing care, only those facilities that have been certified by the Medicaid program accept this form of payment.

19. Where do I go for help in getting on Medicaid?

Although the Federal government establishes general guidelines for the program, the Medicaid program requirements are actually established by each State. Whether or not a per-

36 SSA § 1902(a)(10)(B) (42 U.S.C. § 1396a(a)(10)(B)); 42 C.F.R. § 440.230.

37 See, e.g., SSA §§ 1915(b), 1932 (42 U.S.C. § 1396n(b), 1396u-2).

38 See, e.g., SSA § 1927(d)(5) (42 U.S.C. § 1396r-8(d)(5)). PA, however, may not be applied to emergency services or certain EPSDT services.

39 SSA § 1902(a)(16) (42 U.S.C. § 1396a(a)(16)); 42 C.F.R. § 431.52.

40 SSA § 1916 (42 U.S.C. § 1396o); 42 C.F.R. § 447.50 *et seq.*

41 SSA § 1916 (42 U.S.C. § 1396o); 42 C.F.R. § 447.54.

42 SSA § 1916 (42 U.S.C. § 1396o); 42 C.F.R. § 447.53.

43 *Id.*

44 Deficit Reduction Act of 2005, §§ 6041-43, Pub. L. No. 109-362 (Feb. 8, 2006).

son is eligible for Medicaid will depend on the State where he or she lives.

American Health Lawyers Association has included its Medicaid Consumer Fact Sheet, in both English and Spanish, which lists both website links and phone numbers in each state. To find out more about Medicaid call the toll free number or visit the website for your State.

A list of toll free numbers can also be found on the federal Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov/medicaid/consumer.asp

CMS has resources available on its website to help you determine how to apply for Medicaid benefits. Use the following link for a list of state contacts: www.cms.hhs.gov/apps/contacts/

For more information, see:

www.cms.hhs.gov/medicaid/eligibility or www.cms.hhs.gov/medicaid/whoiseligible.asp or www.cms.hhs.gov/MedicaidEligibility/downloads/MedGlance05.pdf

20. What if I don't qualify for Medicaid? Is there any other help for me?

Medicaid is a large program made up of many separate programs designed to assist individuals in various family and medical situations. When a person applies for Medicaid, the information furnished on the Medicaid Application and any required verification will be used to determine which program(s) the applicant qualifies for, and which program is best for that individual. For example, individual states have care support programs that are an adjunct to, but are separate from, the traditional federal-state Medicaid programs described above.

Also, Medicare may cover up to 100 days of skilled nursing care. All persons over 65 who have made Social Security contributions are entitled to Medicare benefits. Health Maintenance Organizations (HMOs) and other health plans may offer long-term care coverage. In addition, purchasing low cost health insurance may also be an option.

21. What can I do if I disagree with a decision made by my Medicaid program?

An applicant may appeal any adverse Medicaid decision, particularly those related to eligibility. He or she may even file an appeal if there is a delay in making an eligibility determination. There will be information on how to appeal printed on the decision notice sent in the mail.

APPENDIX A
FACT SHEET IN ENGLISH

APPENDIX B
FACT SHEET IN SPANISH

APPENDIX C
GLOSSARY

NOTE: Fact Sheet is also available in traditional Chinese. The English, Spanish, and Chinese versions can be downloaded at healthlawyers.org/factsheet

Medicaid Benefits and Eligibility

AHLA Medicaid Consumer Information Fact Sheet

During the summer of 2005, our Gulf Coast region experienced hurricanes and flooding that resulted in unprecedented numbers of people being forced to relocate from their homes to new locations, often in new communities and states. Some of these individuals were dependent on medical assistance before the storms. Others lost jobs and resources and are now in need of such assistance. Consequently, many people now must attempt for the first time to navigate the unfamiliar requirements of different states' Medicaid programs.

This document is prepared to help these individuals and those who assist them: physicians, case workers and the like who themselves may be dealing, for the first time, with Medicaid. The document provides easy-to-use website links to the Medicaid programs in the 50 states. The document is not a comprehensive discussion of Medicaid and how to qualify for benefits under the program. Instead, it is a starting point to aid those who may need assistance in obtaining payment for medical care. We hope that you find it useful.

The Medicaid Program
Medicaid is a program that provides medical benefits to low-income individuals. Medicaid eligibility, unlike eligibility for Medicare, does not depend on the applicant's age, but instead turns on one's financial resources. Also,

unlike the federally administered Medicare program, Medicaid is administered by each state, which establishes its own requirements for eligibility, covered services, and payment subject to broad federal parameters.

Medicaid provides three types of essential health protection:

- Health insurance for low-income families, children, the elderly, and people with disabilities.
- Long term care for older Americans and individuals with disabilities; and
- Supplemental coverage for certain low-income beneficiaries.

Eligibility

In order to be considered a Medicaid beneficiary and receive Medicaid services, an individual must be eligible for and enrolled in the Medicaid program in the state in which he or she resides. States are required to include certain individuals under their Medicaid plans and may include others. Typically, states classify individuals into eligibility groups, which include the categorically needy (whom states must cover), the medically needy, and other special groups. Eligibility for each state differs, so check your state's Medicaid website to see if you are eligible.

Colorado Medical Assistance Program

<http://www.chcpf.state.co.us/>
(800) 221-3943

Connecticut

Department of Social Services
<http://www.dss.state.ct.us/svs/mcdical/index.htm>

(800) 842-1508 (in-state only);
(860) 424-4908

Connecticut Medical Assistance Program
<http://www.ctmedicalprogram.com/>

Delaware
Delaware Health and Social Services
<http://www.dhss.delaware.gov/dhss/dss/medicaid.html>

(800) 372-2022 (in-state only);
(302) 255-9040

District of Columbia

Department of Health (Medical Assistance Administration)
<http://doh.dc.gov/doh/site/>
(202) 442-5988

Florida

Medicaid Services
<http://www.fdhc.state.fl.us/Medicaid>
(888) 419-3456

Georgia

Georgia Department of Community Health
<http://dch.georgia.gov>

Georgia Medicaid page:
http://dch.georgia.gov/00/channel_title/0_2094_31446711_31944826.00.html
(800) 766-4456

Hawaii

Hawaii Med Quest (Hawaii State Department of Human Services)
<http://www.med-quest.us/>
(808) 587-3521

Alabama

Alabama Medicaid Agency
<http://www.medicaid.state.al.us/>
(800) 362-1504

Alaska

Alaska Health and Social Services
<http://www.hss.state.ak.us/>
(907) 465-3030

Health Care Services: Medicaid
<http://www.hss.state.ak.us/dhcs/Medicaid/default.htm>
(907) 465-5824

Public Assistance: Medicaid
<http://www.hss.state.ak.us/dpa/programs/medicaid/>
(907) 465-3347

Arizona

Arizona Health Care Cost Containment System
<http://www.ahcccs.state.az.us/>
(800) 523-0231

Arkansas

Arkansas Medicaid
<http://www.medicaid.state.ar.us/>
(800) 482-5431

Arkansas Medicaid: Proposed rules for public comment:

<http://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx>

California

Medi-Cal
<http://www.medi-cal.ca.gov/>
(800) 541-5555

California Department of Health Services
<http://www.dhs.ca.gov>
(916) 445-4171

Colorado

State of Colorado Department of Health Care Policy and Financing
<http://www.chcpf.state.co.us/HCPF/refmat/wdwichc.html>
(800) 221-3943

Idaho

Department of Health and Welfare
<http://www.healthandwelfare.idaho.gov/>
(877) 200-5441

Illinois

Department of Healthcare and Family Services
<http://www.hfs.illinois.gov/>
(866) 468-7543

Indiana

Family and Social Services Administration
<http://www.in.gov/fssa/healthcare/>
(800) 889-9949

Iowa

Department of Human Services: Health Care - Division of Financial, Health and Work Supports
http://www.dhs.state.ia.us/dhs2005/dhs_homepage/children_family/healthcare/medicaid.html
(800) 972-2017

Kansas

Department of Social and Rehabilitation Services
<http://www.srskansas.org/>
(800) 766-9012

Kentucky

Kentucky Department for Medicaid Services
<http://chfs.ky.gov/dms/>
(800) 635-2570

Louisiana

Bureau of Health Services Financing: Louisiana Medicaid
<http://www.dhh.state.la.us/offices/?ID=92>
(225) 342-9500

*All sites on this page were last visited April 1, 2008

Medicaid Benefits and Eligibility

- Maine**
Office of MaineCare Services
<http://www.state.me.us/bms/>
(800) 321-5557
- Maryland**
Maryland Medical Assistance
<http://www.dhmh.state.md.us/mma/mmahome.html>
(800) 492-5231
- Massachusetts**
Mass Health
<http://www.mass.gov/portal/index.jsp?pageID=eohhs2subtopic&L1=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=MassHealth&sid=Eoohhs2>
(800) 325-5231
- Michigan**
Michigan Department of Community Health
http://www.michigan.gov/mdch/0,1607,7-132-2943_4860-00.html
(517) 373-3740
- First Health Michigan Medicaid**
www.michigan.fhsc.com/
(804) 965-7619
- Minnesota**
Department of Human Services: Health Care
http://www.dhs.state.mn.us/main/group/health-care/documents/pub/dhs_id_006254.hcsp
(800) 657-3739
- Mississippi**
Mississippi Division of Medicaid
<http://www.dom.state.ms.us>
(800) 421-2408
- Missouri**
Department of Social Services
<http://www.dss.mo.gov>
(800) 392-0938
- Services of Missouri Medicaid**
<http://www.dss.mo.gov/mhd/index.htm>
- Montana**
Montana Medicaid
<http://www.dphhs.mt.gov/hpsd/medicaid/index.htm>
(800) 362-8312
- Nebraska**
Nebraska Health and Human Services: Medicaid Program
<http://www.hhs.state.ne.us/med/medprog.htm>
(800) 430-3244
- Nevada**
Division of Healthcare Financing and Policy (NV Medicaid)
<http://dhcfp.state.nv.us/>
(775) 684-3676
- New Hampshire**
Department of Health and Human Services: Medicaid Program
<http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm>
(800) 852-3345 x 4344
- New Jersey**
Department of Human Services: Medical Assistance and Health Services
<http://www.state.nj.us/humanservices/dmahs/dhsmmed.html>
(800) 356-1561
- New Mexico**
NM Human Services Department - Medical Assistance Division
<http://www.state.nm.us/hsd/mad/Index.html>
(888) 997-2583
- New York**
Department of Health: Medicaid
http://www.health.state.ny.us/health_care/medicaid/index.htm
(877) 472-8411
- North Carolina**
North Carolina Division of Medical Assistance
<http://www.dhhs.state.nc.us/dma/>
(800) 688-6696
- North Dakota**
Department of Human Services: Medicaid:
<http://www.nd.gov/dhs/services/medicalserv/medicaid/>
(800) 755-2604
- Ohio**
Ohio's Medicaid Program
<http://jfs.ohio.gov/ohp/index.stm>
(800) 324-8680
- Oklahoma**
Health Care Authority
<http://www.ohca.state.ok.us/>
(800) 522-0310
- Oregon**
Oregon Health Plan
<http://www.oregon.gov/DHS/healthplan/index.shtml>
(800) 527-5772
- Pennsylvania**
Department of Public Welfare: Medicaid
<http://www.dpw.state.pa.us/Services/Programs/MedicalAssistance/003670296.htm>
(800) 692-7462
- Rhode Island**
Rhode Island Department of Human Services
<http://www.dhs.ri.gov/index.htm>
(800) 964-6211
- South Carolina**
Department of Health and Human Services: Medicaid
<http://www.dhhs.state.sc.us/dhhsnew/medicaid.asp>
(888) 549-0820
- South Dakota**
South Dakota Medical Services
<http://www.state.sd.us/social/medical/>
(800) 452-7691 (in-state only); 773-3495 (605)
- Tennessee**
Department of Human Services: Medicaid
<http://www.state.tn.us/humanserv/medl.htm>
(800) 523-2863
- Texas**
Texas Medicaid Program
<http://www.hhsc.state.tx.us/Medicaid/>
(877) 787-8999
- Utah**
Utah Medicaid Program
<http://health.utah.gov/medicaid/>
(800) 662-9651
- Vermont**
Agency of Human Services: Medicaid
http://www.path.state.vt.us/Programs_Pages/Healthcare/medicaid.htm
(800) 250-8427
- Virginia**
Department of Social Services: Medicaid Coverage
http://www.dss.state.va.us/benefit/medicaid_coverage.html
(804) 796-7000
- Washington**
Department of Social and Health Services: Medical Programs
<https://www2.wa.gov/dshs/onlinecs/Medical.asp>
(800) 562-3022
- West Virginia**
Department of Health and Human Resources: Medicaid
http://www.wvdhhr.org/bcf/family_assistance/medicaid.asp
(304) 558-1700
- Wisconsin**
Wisconsin Medicaid
<http://dhfs.wisconsin.gov/Medicaid/index.htm?ref=hp>
(800) 362-3002
- Wyoming**
Wyoming Medicaid
<http://wyequalitycare.acs-inc.com/>
(800) 251-1270
- Resources:**
An Advocate's Guide to the Medicaid Program
<http://www.healthlaw.org>
Medicaid Home Page with many Medicaid-related links
<http://www.cms.hhs.gov/home/medicaid.asp>
Individual state plans and state plans amendments
<http://www.cms.hhs.gov/medicaid/stateplans>
50 state map of Medicaid information
<http://www.cms.hhs.gov/medicaid/stateplans/map.asp>

Medicaid Ventajas y Elegibilidad

Folleto informativo de la Asociación americana de abogados de la salud pública (AHLA, por su sigla en inglés) para los beneficiarios del programa Medicaid

Como es de público conocimiento, nuestra región de la Costa del Golfo se ha visto abalada por recientes huracanes e inundaciones, que han obligado a un sin número de personas, como nunca antes acontecido, a tener que abandonar sus hogares y trasladarse hacia sitios nuevos, por lo general, en nuevas comunidades y estados. Parte de estos individuos dependían de asistencia médica antes de padecer la llegada de estas tormentas. Otros perdieron sus trabajos y sus bienes y, ahora es cuando más necesitan de dicha asistencia. En consecuencia, muchas personas se acercan para interiorizarse, por primera vez, acerca de las condiciones de elegibilidad para acceder a los programas de Medicaid, conforme a los criterios adoptados por cada estado en particular.

Mediante esta publicación se pretende ayudar a todas aquellas personas y a quienes se ponen al servicio de los necesitados. Nos estamos refiriendo a los médicos profesionales, asistentes sociales y otras personas en esta categoría, que pudieran tener que tratar con Medicaid por primera vez. Asimismo, se facilita la información necesaria para un fácil acceso a enlaces de sitios web, en los cuales se describen los programas de Medicaid vigentes en 50 estados. La intención de esta publicación no es crear un debate acerca de Medicaid, ni tampoco dar a conocer los criterios de elegibilidad en virtud de los cuales una persona adquiere el derecho de acceso a las prestaciones y servicios ofrecidos por el programa. Sin embargo, se trata de establecer el punto de partida para colaborar con aquellos individuos que pueden necesitar asistencia en la obtención del pago por atención médica. Esperamos que la información suministrada le sea de utilidad.

El programa Medicaid es un programa que tiene como finalidad ofrecer prestaciones médicas a ciertos individuos y familias de bajos ingresos y recursos económicos. Según el criterio de elegibilidad de Medicaid, en contraposición a las condiciones de elegibilidad para acceder

er a las prestaciones de Medicare, la edad del solicitante no representa un obstáculo para considerarse beneficiario de las prestaciones y servicios, sino que, por el contrario, el programa se limita a considerar los recursos financieros de dicha persona. Asimismo, a diferencia del programa Medicare de alcance nacional, el plan Medicaid que administra individualmente cada estado, conforme a su propio criterio, establece las condiciones de elegibilidad, los servicios cubiertos y el nivel de pago sujeto a amplios parámetros federales.

Medicaid ofrece tres clases de protección de la salud que resultan esenciales:

- seguro de salud para familias, niños, ancianos y personas con discapacidades de bajos ingresos y recursos económicos;
- atención a largo plazo para ancianos americanos e individuos con discapacidades; y
- cobertura suplementaria destinada a ciertos beneficiarios de las prestaciones, quienes se consideran de bajos ingresos y recursos económicos.

Condiciones de elegibilidad

A fin de poder acceder a las prestaciones y servicios de Medicaid en calidad de beneficiario, es necesario cumplir con las condiciones de elegibilidad dispuestas por el programa e inscribirse en el estado en el cual se mantiene el lugar de residencia.

Los estados tienen el compromiso de incluir a ciertos individuos, conforme a sus planes Medicaid, como así también pueden incorporar a otros. Típicamente, los estados clasifican a los individuos en grupos, conforme a distintos criterios de elegibilidad, los cuales contemplan a los necesitados categóricamente (a quienes los estados deben cubrir), los necesitados que requieren atención médica y otros grupos especiales. Por cuanto cada estado dispone individualmente sus condiciones de elegibilidad, es recomendable remitirse al sitio web de Medicaid, según corresponda a su lugar de residencia, a fin de verificar si reúne los requisitos necesarios para obtener el derecho a las prestaciones y servicios de salud.

Alabama
Centro de servicios de Medicaid en Alabama
<http://www.medicaid.state.al.us/>
(800) 362-1504

Alaska
Servicios sociales y prestaciones de la salud en Alaska
<http://www.hss.state.ak.us/>
(907) 465-3030

Servicios de asistencia sanitaria: Centro de servicios de Medicaid

<http://www.hss.state.ak.us/dhcs/Medicaid/default.htm>
(907) 465-5824

Asistencia pública: Centro de servicios de Medicaid
<http://www.hss.state.ak.us/dpa/programs/medicaid/>
(907) 465-3347

Arizona

Sistema de contención de costos de asistencia sanitaria en Arizona
<http://www.ahcccs.state.az.us/>
(800) 523-0231

Arkansas

Centro de servicios de Medicaid en Arkansas
<http://www.medicaid.state.ar.us>
(800) 482-5431

Medicaid Arkansas: Normas propuestas para la opinión pública:

<http://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx>

California

Medi-Cal
<http://www.medi-cal.ca.gov/>
(800) 541-5555

Departamento de asistencia sanitaria de California
<http://www.dhs.ca.gov>
(916) 445-4171

Colorado

Departamento de política y financiamiento de la prestación de asistencia sanitaria en el estado de Colorado
<http://www.chcpf.state.co.us/HCPF/refmat/wdwichc.html>
(800) 221-3943

Programa de asistencia médica de Colorado
<http://www.chcpf.state.co.us/>
(800) 221-3943

Connecticut

Departamento de servicios sociales de servicios de Medicaid
<http://www.dss.state.ct.us/svcs/medical/index.htm>
(800) 842-1508 (dentro del estado, únicamente); (860) 424-4908

Programa de asistencia médica de Connecticut
<http://www.ctmedicalprogram.com/>

Delaware

Servicios sociales y prestaciones de la salud en Delaware
<http://www.dhss.delaware.gov/dhss/dss/medicaid.html>
(800) 372-2022 (dentro del estado, únicamente); (302)255-9040

Districto de Columbia

Departamento de salud (Administración de asistencia médica)
<http://doh.dc.gov/doh/site/>
(202) 442-5988

Florida

Centro de servicios de Medicaid
<http://www.fdhcs.state.fl.us/Medicaid>
(888) 419-3456

Georgia

Departamento de salud comunitaria de Georgia
<http://dch.georgia.gov>
Página de Medicaid:
http://dch.georgia.gov/00/channel_title/0.2094.31446711_31944826.00.html
(800) 766-4456

Hawaii

Hawaii Med Quest
(Departamento de servicios humanos del estado de Hawaii)
<http://www.medquest.us/>
(808) 587-3521

Idaho

Departamento de salud y bienestar social
<http://www.healthandwelfare.idaho.gov/>
(877) 200-5441

Illinois

Departamento de servicios a la familia y prestaciones de la salud
<http://www.hfs.illinois.gov/>
(866) 468-7543

Indiana

Administración de servicios sociales y de la familia
<http://www.in.gov/fssa/healthcare/>
(800) 889-9949

Iowa

Departamento de servicios humanos: Asistencia sanitaria – División de soportes financiero, asistencia sanitaria y trabajo
http://www.dhs.state.ia.us/dhs2005/dhs_homepage/children_family/healthcare/medicaid.html
(800) 972-2017

Kansas

Departamento de servicios sociales y de rehabilitación
<http://www.arkansas.org/>
(800) 766-9012

Kentucky

Departamento de cargo de las prestaciones de Medicaid en Kentucky
<http://chfs.ky.gov/dms/>
(800) 635-2570

*All sites on this page were last visited April 1, 2008

Medicaid Ventajas y Elegibilidad

Louisiana
Comité de financiamiento de la prestación de asistencia médica: Centro de servicios de Medicaid en Louisiana
<http://www.dhhs.state.la.us/offices/?ID=92>
(225) 342-9500

Maine
Oficina de Servicios de MaineCare
<http://www.state.me.us/brns/>
(800) 321-5557

Maryland
Asistencia sanitaria en Maryland
<http://www.dhhr.state.md.us/mma/mmahome.html>
(800) 492-5231

Massachusetts
Salud pública
<http://www.mass.gov/portal/index.jsp?pageID=eohhs2subtopic&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=MassHealth&sid=Eeohhs2>
(800) 325-5231

Michigan
Departamento de salud pública de Michigan
http://www.michigan.gov/mdch/0,1607,7-132-2943_4860--00.html
(517) 373-3740

First Health – Centro de servicios de Medicaid en Michigan
<http://www.michigan.fhsc.com/>
(804) 965-7619

Minnesota
Departamento de servicios humanos: Asistencia sanitaria
http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_006254.hcsp
(800) 657-3739

Mississippi
División de Medicaid en Mississippi
<http://www.dom.state.ms.us>
(800) 421-2408

Missouri
Departamento de servicios sociales
<http://www.dss.mo.gov>
(800) 392-0938

Prestaciones de Medicaid en Missouri
<http://www.dss.mo.gov/mhd/index.htm>

Montana
Centro de servicios de Medicaid en Montana
<http://www.dphhs.mt.gov/hpsc/medicaid/index.htm>
(800) 362-8312

Nebraska
Servicios humanos y prestaciones de la salud en Nebraska: Centro de servicios de Medicaid
<http://www.hhs.state.ne.us/med/medprog/hgm>
(800) 430-3244

Nevada
División de política y financiamiento de la prestación de asistencia sanitaria (Medicaid en NV)
<http://dhcnp.sate.nv.us>
(775) 684-3676

New Hampshire
Departamento de salud y servicios humanos: Centro de servicios de Medicaid
<http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm>
(800) 852-3345 x 4344

New Jersey
Departamento de servicios humanos: Asistencia médica y prestaciones de la salud
<http://www.state.nj.us/humanservices/dmahs/dhsmmed.html>
(800) 356-1561

New Mexico
Departamento de servicios humanos de NM División de asistencia médica
<http://www.state.nm.us/hsd/mad/Index.html>
(888) 997-2583

New York
Departamento de salud: Centro de servicios de Medicaid
http://www.health.state.ny.us/health_care/medicaid/index.htm
(877) 472-8411

North Carolina
Departamento de asistencia médica en North Carolina
<http://www.dhhs.state.nc.us/dma/>
(800) 688-6696

North Dakota
Departamento de servicios humanos: Centro de servicios de Medicaid:
<http://www.nd.gov/dhs/services/medicalserv/medicaid/>
(800) 755-2604

Ohio
Centro de servicios de Medicaid en Ohio
<http://jfs.ohio.gov/ohp/index.stm>
(800) 324-8680

Oklahoma
Entidad a cargo de la asistencia sanitaria
<http://www.ohca.state.ok.us/>
(800) 522-0310

Oregon
Plan de salud en Oregon
<http://www.oregon.gov/DHS/healthplan/index.shtml>
(800) 527-5772

Pennsylvania
Departamento de bienestar social: Centro de servicios de Medicaid
<http://www.dpw.state.pa.us/ServicesPrograms/MedicalAssistance/003670296.htm>
(800) 692-7462

Rhode Island
Departamento de servicios humanos de Rhode Island
<http://www.dhhs.rhodeisland.gov/index.htm>
(800) 964-6211

South Carolina
Departamento de salud y servicios humanos: Centro de servicios de Medicaid
<http://www.dhhs.state.sc.us/dhhsnew/medicaid.asp>
(888) 549-0820

South Dakota
Asistencia médica en South Dakota
<http://www.state.sd.us/social/medical/>
(800) 452-7691 (dentro del estado, únicamente); (605) 773-3495

Tennessee
Departamento de servicios humanos: Centro de servicios de Medicaid
<http://www.state.tn.us/humanserv/medi.htm>
(800) 523-2863

Texas
Centro de servicios de Medicaid en Texas
<http://www.hssc.state.tx.us/Medicaid/>
(877) 787-8999

Utah
Centro de servicios de Medicaid en Utah
<http://health.utah.gov/medicaid/>
(800) 662-9651

Vermont
Oficina de servicios humanos: Centro de servicios de Medicaid
http://www.path.state.vt.us/Programs_Pages/Healthcare/medicaid.htm
(800) 250-8427

Virginia
Departamento de servicios sociales: Cobertura de Medicaid
http://www.dss.state.va.us/benefit/medicaid_coverage.html
(804) 726-7000

Washington
Departamento de servicios sociales y prestaciones de la salud: Programas médicos
<https://wsws2.wa.gov/dshs/onlinereco/Medical.asp>
(800) 562-3022

West Virginia
Departamento de recursos humanos y prestaciones de la salud: Centro de servicios de Medicaid
http://www.wvdhhr.org/bcf/family_assistance/medicaid.asp
(304) 558-1700

Wisconsin
Centro de servicios de Medicaid en Wisconsin
<http://dhfs.wisconsin.gov/Medicaid/index.htm?ref=hp>
(800) 362-3002

Wyoming
Centro de servicios de Medicaid en Wyoming
<http://wyequalitycare.acs-inc.com/>
(800) 251-1270

Recursos:

An Advocate's Guide to the Medicaid Program (Guía del programa Medicaid para abogados)
<http://www.healthlaw.org>

Medicaid Home Page with many Medicaid-related links (Página principal de Medicaid con varios enlaces relacionados a este programa)
<http://www.cms.hhs.gov/home/medicaid.asp>

Individual state plans and state plan amendments (Planes individuales dispuestos por cada estado y modificaciones al plan estatal)
<http://www.cms.hhs.gov/medicaid/stateplans>

50 state map of Medicaid information (Mapa informativo de Medicaid en cada uno de los 50 estados)
<http://www.cms.hhs.gov/medicaid/stateplans/map.asp>

APPENDIX C

GLOSSARY

Assets – To be eligible for Medicaid, a person’s income must be under certain levels and he/she must have assets of less than a certain value. Every state has a limit on what assets a Medicaid beneficiary may own and keep for purposes of financial eligibility. “Countable assets” consist of all investments such as stocks, bonds, mutual funds, checking and savings accounts, certificates of deposits, personal and real property, art and collectibles. “Excluded” assets are not counted in determining Medicaid eligibility and vary from state to state but generally include a home or life estate in a home, burial space costs and related items, life insurance, long-term insurance, other types of term insurance, the value of income-producing real property, and certain annuities.

Beneficiary – An individual who is eligible for and enrolled in their state’s Medicaid program.

Categorically Needy – Certain groups of Medicaid beneficiaries who qualify for the basic mandatory package of Medicaid benefits which generally includes low-income children, pregnant or postpartum women, the aged, blind, or disabled, certain low-income children and families who qualify for federal welfare assistance, and low-income Medicare beneficiaries.

Co-payment – A fixed amount paid by a Medicaid beneficiary at the time the beneficiary receives a covered service from a participating provider.

Centers for Medicare & Medicaid Services (CMS)
The Centers for Medicare & Medicaid Services (CMS) is a Federal agency within the U.S. Department of Health and Human Services with the responsibility of administering the Medicaid, Medicare, and the State Children’s Health Insurance programs. CMS was formerly known as the Health Care Financing Administration (HFCA).

Dual Eligibles – Individuals who are eligible for both Medicare and Medicaid coverage. State Medicaid programs generally pay for certain cost sharing and services that are not otherwise covered by Medicare including nursing home services, prescription drugs, and payment of Medicare premiums, deductibles, and co-insurance.

Federal Financial Participation (FFP) – The federal matching funds paid to states for expenditures for Medicaid services or administrative costs. The level of FFP for service costs varies from state to state

because the statutory formula that determines FFP provides greater federal assistance to states with lower per capita incomes. Administrative costs are generally matched by the federal government at 50%.

Fee-for-Service – A method of payment for services whereby doctors and hospitals are paid for each service they provide.

Financial Eligibility – Financial eligibility requirements vary from state to state and from category to category, but generally financial eligibility requirements put limits on the amount of income and assets an individual may have in order to qualify for coverage.

Medicaid Trust: A trust or similar legal device that a person (or his/her spouse, guardian or legal representative) creates, under which (a) that the person is the beneficiary of all or part of the payments from the trust, and (b) the amount of those payments is determined by one or more trustees who have discretion as to how much they distribute to that individual.

Medical Assistance – The term used in the federal Medicaid statute to refer to payment for items and services covered under a state’s Medicaid program on behalf of individuals eligible for benefits.

Medically Needy – An optional Medicaid eligibility group made up of individuals who qualify for coverage because of high medical expenses. These individuals also must be categorically eligible but their income is too high to qualify them for “categorically needy.”

Prior Authorization – When an item or service requires prior authorization, the state Medicaid agency will not pay for the item or service unless approval is obtained in advance by the beneficiary’s treating provider.

Spend-Down – In some eligibility categories, individuals may qualify for Medicaid coverage even though their incomes are higher than the specified income through a process called “spending down.” Under this process, the medical expenses that an individual incurs during a specified period is subtracted from the individual’s income during that period and once the individual’s income reaches a state-specified level, the individual qualifies for Medicaid benefits for the remainder of the period.

Spousal Impoverishment – A set of rules that states are required to apply in a situation where a Medicaid beneficiary resides in a nursing facility and his or her spouse remains in the community. The rules specify the amounts of income and

resources each spouse is allowed to obtain without jeopardizing the institutionalized spouse's eligibility for Medicaid benefits and are designed to prevent the impoverishment of the spouse residing in the community.

State Medicaid Plan – A written plan meeting federal statutory requirements that is required to be submitted and approved by the Secretary of the Department of Health and Human Services (HHS) for each state in order to participate in the Medicaid program. The State Plan must provide details about administration, eligibility, coverage of services, beneficiary protections, and reimbursement methodologies. Any changes to the State Plan, known as State Plan Amendments, must also be approved by the Secretary of HHS.

State Children's Health Insurance Program (SCHIP) – SCHIP is a federal-state matching program of health care coverage for uninsured, low-income children. Children who are eligible for Medicaid are not eligible for SCHIP.

Supplemental Security Income (SSI) – A Federal entitlement program that provides cash assistance to low-income aged, blind, and disabled people. Generally, individuals receiving SSI benefits are eligible for Medicaid coverage.

Waivers – The Secretary of HHS may, upon the request of a state, allow the state to receive federal Medicaid matching funds for services for which federal matching funds are not otherwise available. For example, a state may use the waiver program to receive federal matching funds for home and community-based services or to cover certain categories of individuals for which federal matching funds are not otherwise available.

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ABOUT THE PRACTICE GROUPS

Long Term Care, Senior Housing, In-Home Care and Rehabilitation (LTC-SIR): provides a forum for attorneys who represent providers across the entire spectrum of long term care services including skilled nursing facilities, assisted living, senior housing, home health, hospice, and long term care pharmacy; follows and addresses developments in the long term care segment of the healthcare industry including legal trends, regulatory policy, and operational and transactional issues; attempts to provide practical analysis of these legal and business trends by producing summaries and brief analyses of forms, models, approaches,

structures, and legal analyses relevant to the providers of long term care services; the goal is to keep the members informed of the most up-to date and relevant case law, legislative initiatives, and important trends in the industry.

Regulation, Accreditation, and Payment (RAP): addresses issues related to reimbursement and coverage, including Medicare and other government payor laws, regulations, and instructions, as well as issues related to healthcare organizational accreditation such as The Joint Commission and other accrediting entity standards.



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