

Commonly Asked Medicaid Questions

1. What is the difference between Medicaid and Medicare?

Medicaid is a federal health program available to disabled individuals and seniors who are 65 or over. Eligibility for Medicaid benefits is determined through a review of the assets held by the applicant and the applicant's spouse.

Medicare is an entitlement program and is not means based tested for the most part.

Medicaid is a federal-state partnership, which provides health care coverage to elderly and disabled individuals based upon strict income and asset guidelines.

Medicare rules are generally the same in every state. Medicaid rules vary from state to state. This website generally describes the Indiana Medicaid guidelines for adults.

2. Who is covered by Medicaid in Indiana?

Hoosiers who are aged (65 or older), blind, or disabled are eligible for Medicaid.

Community individuals generally must have income of less than \$973 per month and \$1,311 for a married couple. They also must have less than \$2,000.00 in countable resources for a single person and \$3,000 for a married couple on the first day of each month to remain eligible for Medicaid. There is no longer a spend down program in Indiana as of June 1, 2014.

Medicaid has been expanded in 2014 as part of the Affordable Health Care Act. This website will provide more details once Indiana decides how to implement this new law through the HIP 2.0 Plan.

3. Can I get help with my Medicare premiums and monthly deductible?

Yes, there is help for deductibles, co-insurance, and premiums for Parts A, B, and D for low-income persons called the Medicare Enhanced Savings Program if your income is between 100% and 185% of the Federal Poverty Guidelines. Please visit the Medicare website (www.medicare.gov) for information about Qualified Medicare Beneficiary Status and Special Low-Income Beneficiaries.

4. Are adult children responsible for the medical bills of their parents?

Medicaid does not permit states to use the income or assets of a non-spouse in determining eligibility for benefits. States cannot collect from children for benefits provided to their parents. While Indiana has a law saying financially capable children are responsible for helping with the cost of medical care for their parents, this law is not being used at present and is of questionable legality.

5. Will Medicaid or the nursing home take my home?

The answer is “no” with proper planning. Nursing homes do not take property. Nursing homes expect to be paid for their services like any business. There are complicated rules involving Medicaid eligibility for nursing home care. When a loved one is facing nursing home placement, the family should seek advice from a knowledgeable elder law attorney.

6. My friend told me I can give each of my children \$10,000 without creating a Medicaid penalty, is this true?

NO NO NO! As of January 1, 2014, Federal gift tax laws allow you to gift any person \$14,000 per year without a reporting requirement. Medicaid only ignores small gifts of a total of \$1,200 made to family members or charities each year. Please consult an elder law attorney before making gifts.

7. My loved one may have to enter a nursing home in the near future or they are already in the nursing home. Is it too late to do planning?

No, you can do planning to help him/her qualify for Medicaid even after he/she enters the nursing home.

8. What is a “snapshot date”?

When a husband or wife is institutionalized (hospital or nursing home) for more than 30 consecutive days, on or after September 30, 1989, the first date of entry is the snapshot date should that person need nursing home care and Medicaid in the future.

Please note, Mom and Dad will almost always have different snapshot dates.

9. Why is the snapshot date important?

A resource assessment is done to document assets owned on the snapshot date to determine the amount of assets a couple may keep and qualify for Medicaid.

10. Are well spouses legally responsible for the medical expenses of an ill spouse?

The general rule is yes. Please see the article entitled “Planning for the Cost of Nursing Home Care” under the More Materials Section of our website for a detailed description of the spousal impoverishment rules involving married couples.

11. Mom or Dad has finally qualified for Medicaid, but we owe the nursing home \$20,000. What can we do?

Medicaid has a deviation process which allows the current liability to be used to pay for old medical bills and, in some cases, income taxes. This process involves the term “liability” and “deviation”.

Liability is the amount of a person’s income that goes to pay for his/her care. Generally, a person’s monthly income, less the cost of supplemental insurance, less a personal needs allowance, produces the monthly liability for a nursing home resident.

<u>Mom</u>	
Social Security	\$ 970.00
Pension	<u>240.00</u>
Total Income	\$1,210.00
Less:	
Supplemental insurance cost	125.00
Personal Needs Allowance	<u>52.00</u>
Monthly Liability	\$1,033.00

Mom must pay \$1,033 to the nursing home each month. She can ask her Medicaid caseworker for a “deviation” of her current “liability” to pay for old medical bills as long as those bills were not incurred during a penalty period created by an improper transfer.

Mom owes the nursing home \$20,000 because she was over-resourced for four months prior to her Medicaid eligibility. She can ask for her current liability to be deviated to pay this old bill. She will still pay the nursing home \$1,033 each month, but the nursing home will apply this sum each month to the old bill until it is paid in full. Medicaid will pay the full current bill until the old bill is paid off.

Please note, you cannot deviate the liability to pay the liability. Mom would have owed \$1,033 for each month if she was on Medicaid. For purposes of illustration, let’s say Mom owed the nursing home for the months of May through August, resulting in a bill of \$20,000. Mom became eligible for Medicaid September 1st. She cannot use the deviation process to pay the \$1,033 she would have owed each month. For this reason,

we often have Mom pay the nursing home a lump sum amount, but have the nursing home apply it to her monthly past liability rather than the current bill.

12. What can I do if I disagree with a decision made by Medicaid?

You have the right to appeal any Medicaid decision to an Administrative Law Judge. You generally have 30 days after receipt of a decision to file an appeal. You should appeal any decision you disagree with as soon as possible. You can appeal by faxing a copy of the notice you are appealing and a signed letter saying “I appeal” to Hearings and Appeals, Indiana Division of Family Resources, at fax number (317) 232-4412, or by ordinary mail to MS04, FSSA Hearings & Appeals Section, 402 West Washington Street, Room E-034, Indianapolis, Indiana 46204. Be sure and keep a copy for yourself. You will then need to attend an informal hearing.

13. What are the new health care laws?

The Indiana Family and Social Services Administration made major changes in the Indiana Medicaid Program. The Indiana Medicaid rule changes which went into effect on June 1, 2014, include:

- (1) Indiana will now defer to disability determinations made by the Social Security Administration.
- (2) Folks on SSI will automatically be enrolled in Medicaid.
- (3) The “spend down” provisions will be eliminated for most folks receiving Medicaid benefits in the community.
- (4) The asset limit will increase from \$1,500 to \$2,000 for a single person and from \$2,250 to \$3,000 for a married couple.
- (5) The “spend down” system will be replaced by four programs, depending on your income.
 - (A) Hoosiers who are aged, blind and disabled at 100% of the Federal Poverty Level (which is \$11,670 annually for a single person, \$15,730 for a married couple, and an extra \$4,432 for a qualifying child) will be enrolled in Medicaid without cost and without a “spend down”.
 - (B) The Medicare Savings Program will be expanded for dual eligibles – folks who qualify for Medicaid and Medicare.
 - (C) Folks earning more than 100% of FPL will be eligible to purchase a health insurance plan on the federal marketplace.
 - (D) Hoosiers with severe mental illness whose income exceeds 100% of FPL, who are not eligible for full Medicaid, may join the new Behavioral and Primary Healthcare Coordination Program.

(6) As of December 2013, 65,642 Hoosiers had a “spend down”. These folks experienced the following changes on June 1, 2014:

- On June 1, 2014, 23,869 Hoosiers were entitled to full Medicaid because they are at or below 100% of the FPL. They were automatically enrolled in this program.
- On June 1, 2014, 26,879 Hoosiers between 100% and 150% of the FPL on Medicare automatically joined the Medicare Savings Program. Indiana pays for the Part B premium, the annual Part A & B deductibles, and Medicare copayments/coinsurance.
- Dual eligibles between 150% and 185% of FPL have their Part B premium paid by the State but lost their right to “spend down”. There are 6,906 Hoosiers in this category.
- 7,997 dual eligible Hoosiers with income in excess of 185% of FPL were removed from the “spend down” program and will not be eligible for the Medicare Savings Program.

(7) Hoosiers receiving nursing home care or waiver services with monthly income above \$2,199 need to have a qualified income trust.

You can view these changes at <http://www.in.gov/fssa/4859.htm>

14. Do I need to keep my supplemental health insurance once I am approved for Medicaid?

We generally recommend Medicaid recipients keep their supplemental insurance policies. When a person is in the nursing home, their income, less the cost of supplemental insurance, and less the personal needs allowance of \$52, is paid to the nursing home. When you drop your supplemental insurance, you simply pay more to the nursing home each month.

Please inform us immediately if a supplemental insurance policy has a premium increase so we can notify Medicaid. We report this change to Medicaid so your monthly liability to the nursing home will decrease.

There are some situations when a person should drop their supplemental insurance. This would be the case if it would cause your spouse to receive more income each month and in some cases when a deviation of liability is in place to pay off an old medical bill.

We advise our clients, on an individual basis, on whether they should keep their supplemental insurance policy in effect. We generally advise clients to keep this insurance in 9 out of 10 situations.

15. Will the nursing home and/or Medicaid take my income when I am approved for Medicaid?

No—your income comes in just as it always has. You simply have to pay a portion of your income to the nursing home as your monthly liability. The liability is based upon your income, your spouse's income, the cost of your supplemental insurance, and your status as a veteran. We calculate your liability and guide you to make the proper liability payment each month.

16. Will Medicaid provide help to keep my parents at home?

Yes, there is a Medicaid Waiver program that allows for seniors to live at home if they meet nursing home level of care but can stay at home at a cost that is less than the cost of a nursing home. The Spousal Impoverishment Rules apply. Please see our booklet Planning for the Cost of Nursing Home Care for more information about Waivers.

**Dale, Huffman & Babcock
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