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Medicaid – 2023

What is Medicaid?

Medicaid is a federal/state program that gives certain groups of people a card that can be used to get free medical care, nursing home care, and prescription drugs at reduced prices. In general, eligibility for Medicaid is for people who have low income and low resources (property).

Who can get Medicaid?

Many different groups of people automatically are eligible for Medicaid. Some of the more important ones are listed here.

- Adults ages 19 or older and under age 65 with income at or below 138% of poverty who do not qualify for any other Medicaid category
- Aged, blind or disabled people with income up to 300% of the SSI payment rate who have been screened and approved to receive services in a nursing home or through one of the Medicaid Home and Community-Based Waivers. In 2023, this is 3 x \$914 = \$2,742/month.
- Auxiliary Grant (AG) enrollees who live in Assisted Living Facilities
- Certain people who lost SSI because their income or living situation changed.
- Certain refugees for a limited time period.
- Children from birth to age 19 whose family income is at or below 133% of poverty.
- Children under age 21 who are in foster care or subsidized adoptions.
- Infants born to Medicaid eligible women.
- Low Income Families with Dependent Children. This includes all people who receive Temporary Assistance to Needy Families (TANF) benefits. If you received TANF in three of the last six months, but no longer receive TANF because of increased earnings or work hours, you keep getting Medicaid for four months after TANF stops.
- Medically Needy Individuals who meet Medicaid covered group rules, but have excess income.
- Persons who are age 65 or older, blind or disabled whose income does not exceed 80% of poverty.

- Persons who are terminally ill and have chosen to receive hospice care.
- Pregnant women whose family income is at or below 148% of poverty.
- Supplemental Security Income (SSI) enrollees who are age 65 or older, blind or disabled, who also meet Medicaid resource limits.
- Women screened by the Center for Disease Control and Prevention's National Breast and Cervical Center Early Detection Program who have been diagnosed with and need treatment for breast or cervical cancer.

What are the resource rules to get Medicaid?

If you are eligible for Medicaid based on being in the 19-64 age range and at or below 138% of poverty, there is no resource rule. Your Medicaid eligibility is focused on your income. You must not be eligible for any other Medicaid category to apply this rule.

For all other categories, you must tell about all resources you own when you apply for Medicaid. This includes cash, bank accounts, real property (house and land), motor vehicles, boats, other personal property, and life insurance policies. You must report all resources. The resource rules vary according to the covered group. Not all resources are counted. For example, the house you own and live in, one motor vehicle, household furnishings, personal effects, some life insurance policies, some burial funds and cemetery plots, and some irrevocable trusts are not counted.

What if I have too many resources to get Medicaid?

If this happens, you may become eligible for Medicaid by reducing your resources below the limit. However, *if you give away or sell resources for less than what they are worth, you will be found ineligible for Medicaid coverage for long-term care services (such as nursing home care) for a long period of time.* You will be asked about any resources you transferred in the last 60 months. Transfers that you make after you are eligible for Medicaid also can result in you being ineligible for Medicaid coverage for long-term care services for a long period of time

What are the income rules to get Medicaid?

When you apply for Medicaid, you must tell about all income you receive. This includes wages, as well as unearned income such as Social Security, SSI, pensions, unemployment compensation, worker's compensation, Veterans benefits, child support and spousal support. You must report all income. The income rules vary according to the covered group.

What if I have too much income to get Medicaid?

If this happens, you still may get a Medicaid card under the "spenddown program." The spenddown program is like having a large insurance deductible. To get a Medicaid card under the spenddown program, you must "incur" or be billed for a certain amount of medical care in a six month period. You do not have to have already paid the bills to use them for the spenddown.

Once this happens, you get a Medicaid card for the rest of the six months. When the six months are up, you must reapply for Medicaid.

What does Medicaid cover?

Full Medicaid benefits include these services:

- In-patient hospital services, with limitations and deductibles.
- Outpatient hospital and rural health clinic services.
- Nursing home care.
- Medicare Part B premiums, deductibles and co-payments.
- Physician services.
- Medically necessary transportation.
- Long-term care alternatives, such as personal care services.
- X-ray and laboratory services.
- Home health care services.
- Clinic services.
- Prescription drugs.
- Medical supplies and equipment in limited circumstances.
- Physical therapy and related services.
- Emergency hospital services.

What additional services are available for children?

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a special Medicaid program for children up to the age of 21. It detects and treats health care problems early through:

- Regular medical, dental, vision, and hearing check-ups.
- Diagnosis of problems.
- Treatment of dental, eye, hearing, and other medical problems found during check-ups.

Your child's physician may be able to use the EPSDT program to obtain additional medically necessary treatments that are not already covered by Medicaid but would be helpful to improve your child's health or to prevent your child's health condition from worsening.

When does Medicaid start?

Medicaid coverage usually starts on the first day of the month you apply and are found to be eligible. Medicaid can start as early as three months before the month in which you applied if you meet all eligibility rules and received a covered medical service during that time.

What are the costs to get Medicaid?

Medicaid charges co-payments for the following services.

| <u>Service</u> | <u>Co-Payment Amount</u> |
|----------------------------|---|
| In-patient hospital | \$100.00 per admission |
| Outpatient hospital clinic | \$3.00 per visit |
| Clinic visit | \$1.00 per visit |
| Physician office visit | \$1.00 per visit |
| Other physician visit | \$3.00 per visit |
| Eye examination | \$1.00 per examination |
| Prescription | \$1.00 per prescription for generic \$3.00 per prescription for brand name |
| Home health visit | \$3.00 per visit |
| Rehabilitation service | \$3.00 per visit |

What is not covered under Medicaid?

Medicaid will not cover all medical services. Among them are these:

- Abortions, unless the pregnancy is life-threatening or health-threatening.
- Acupuncture.
- Artificial insemination, in-vitro fertilization, or other services to promote fertility.
- Alcohol and drug abuse therapy (except as provided through EPSDT or for pregnant women through the Community Service Boards and under the BabyCare program).
- Certain drugs not proven effective.
- Certain experimental surgical and diagnostic procedures.
- Chiropractic services.
- Cosmetic treatment or surgery.
- Day care and sitter services for the elderly (except for some Home and Community-Based Waiver services).
- Dentures if you are age 21 or older.
- Doctor services during non-covered hospital days.
- Eyeglasses if you are age 21 or older.
- Friday or Saturday hospital admission for non-emergency reasons, or admission for more than one day before surgery, unless the admission on those days was authorized in advance.
- Hospital charges for days of care not authorized for coverage.
- Immunizations if you are age 21 or older.
- In-patient hospital care in an institution for the treatment of mental disease if you are under age 65 (unless you are under age 22 and receiving in-patient psychiatric services).
- Medical care received from providers who are not enrolled in or will not accept Virginia Medicaid.
- Personal care services and private duty nursing (except for some Home and Community-Based Waiver services).
- Psychological testing done for educational, institutional or court purposes.
- Routine dental care if you are age 21 or older.
- Routine school physicals or sports physicals.
- Sterilizations if you are under age 21.
- Weight loss clinic programs.

How do I apply for Medicaid?

You have several options to apply for Medicaid.

Via Telephone - Apply for coverage with the Cover Virginia Call Center (833-522-5582) or the Federal Marketplace (800-318-2596). This is a great option if you need language translation.

Via the Internet – You can apply on the Virginia CommonHelp website (<https://www.commonhelp.virginia.gov>) or the Federal Marketplace (<https://www.healthcare.gov>)

Via Paper Application – You can mail or take the “Application for Health Coverage & Help Paying Costs” paper application to your city or county’s Department of Social Services (DSS) or mail it to the Federal Health Insurance Marketplace.

The agency has 45 days to make a decision on your application. When an application is based on your disability, DSS has 60 days to decide your claim. The Medicaid disability rules are the same as those for Social Security and SSI disability. If the Social Security Administration (SSA) has approved disability, DSS will follow that. If SSA has denied disability within the past year, DSS also will follow that.

How does COVID-19 affect Medicaid eligibility?

During the federal public health emergency (PHE), Medicaid cases generally could not be closed, aside from some limited exceptions. The PHE has been in place since January 27, 2020 and goes through at least January 11, 2023.

After the PHE ends, Virginia Medicaid will return to normal enrollment. In addition, Virginia will review eligibility for all Medicaid recipients. Virginia will have 12 months after the PHE ends to make sure recipients still are eligible. If a recipient no longer qualified for Medicaid, they will get:

- Notice of when Medicaid coverage will end.
- Information on how to file an appeal.
- Referral to the Federal Marketplace & information about buying other health coverage.

How do I appeal a Medicaid decision I disagree with?

If Medicaid is denied or ended, or if you disagree with any action on your Medicaid care, you may file an appeal by asking for a fair hearing, in writing, at the local DSS office. You must file an appeal within 30 days of learning that Medicaid has been denied or ended. In a Medicaid termination case, if you file an appeal before the effective date of the action, Medicaid benefits continue pending the hearing and decision.