

## FACT SHEET #12

### Process for Medicaid Eligibility

*This fact sheet is intended to give Navigators, Assistors and Certified Application Counselors an idea of the questions and informational needs that people with disabilities may have about Medicaid when they are looking into purchasing private insurance in the Marketplace*

#### Q1. What is Medicaid?

**A.** In all states, Medicaid provides health coverage for some low-income people, families and children, pregnant women, seniors, and people with disabilities. In some states the program covers all low-income adults below a certain income level. Medicaid is a joint federal-state program that has existed for many years. The federal government establishes basic guidelines for Medicaid's operation, but each state also has considerable discretion to make rules on eligibility and the availability, scope and length of specific Medicaid services, for example. States can also choose to provide Medicaid benefits for free, or to charge premiums and/or set out-of-pocket expenses such as co-pays and deductibles for some groups of beneficiaries, though these are generally much less than those charged by private insurance for comparable coverage. Medicaid is the single greatest source of the long-term services and supports (LTSS) needed by many people with disabilities and chronic conditions; Medicare does not pay for LTSS.

#### Q2. How do I qualify for Medicaid?

**A.** Some states have chosen to expand eligibility for their Medicaid program to new populations. Even if you were told you didn't qualify for Medicaid in the past, you may qualify under these new expansion Medicaid rules that do not require you to fit into traditional coverage categories and allow for higher income and asset levels. Check the chart on the HealthCare.gov website to find out if you might qualify for expansion Medicaid, which is based solely on income and family size. If your state is expanding Medicaid, you'll probably qualify if you make up to \$15,060 a year for 1 person (\$31,200 for a family of 4). Medicaid will provide free or low-cost health care for individuals or families who then do not need to buy a Marketplace plan.

Be aware, though, that not every state has expanded their Medicaid programs. Check this chart: <https://www.healthcare.gov/lower-costs/> to see if your state is participating in the Medicaid expansion. If you live in one of the states that has **not** expanded its Medicaid programs, your eligibility will depend on three main factors. You must fit within one of the traditional Medicaid coverage categories (e.g., minor foster youth, over 65, person with disabilities, receiving Supplemental Security Income, parent(s)/caretaker relatives of dependent children, pregnant), your assets must fall below and remain under a certain maximum, and your income must remain below a certain maximum which can be dramatically lower in some states than the 138% of Federal Poverty Level (FPL) that enables eligibility for expansion Medicaid.

- If you are a person with a disability, or if your disability does not qualify you but you have dependent minor children and your state has a more generous Medicaid eligibility threshold, you might be eligible for traditional Medicaid based on your state's existing rules, even if your state isn't participating in the expansion.
- Overall, among the 10 states not moving forward with the Medicaid expansion at this time, the median eligibility level for adult parents without disabilities is just 47% of FPL, and only two states (TN, and WI) cover parents with incomes at or above poverty level.<sup>1</sup>
- If your income is more than 100% of the federal poverty level -- \$15,060 a year as a single person or about \$31,200 for a family of 4 in 2024, you likely will not be eligible for Medicaid,<sup>2</sup> but you will be able to buy a private health insurance plan in the Marketplace and you may qualify for advance premium tax credits and/or cost-share reductions based on your household size and income.

### **Q3.** How do I apply for Medicaid?

**A.** You can apply for Medicaid online in 2 main ways: 1) Visit your state's Medicaid website. You can select your state after clicking on the "Get Insurance" menu item running across the top of the HealthCare.gov website, or 2) Fill out the Health Insurance Marketplace application on the HealthCare.gov website.<sup>3</sup> This application is based on a "no wrong door" policy. This means that the information you provide on this single application<sup>4</sup> will determine your eligibility for any insurance affordability program that you qualify for, including Medicaid and the Marketplace premium assistance and cost-share reduction programs. After you have completed the on-line application, the site will tell you which programs you qualify for. You can also apply by calling 1-800-318-2596, 24 hours a day, 7 days a week (TTY: 1-855-889-4325).

Each state Medicaid agency has chosen whether the Marketplace will only make a preliminary assessment or a final determination of Medicaid eligibility for people applying through the Marketplace. In general, the Marketplace will only be assessing or determining eligibility for expansion Medicaid and not traditional Medicaid. However, the Marketplace will be making final Medicaid determinations temporarily for a few states, such as Texas, Tennessee and Wisconsin that are *not* expanding Medicaid, but need to conform their state Medicaid systems with the Affordable Care Act. Regardless

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<sup>1</sup> See <https://www.kff.org/affordable-care-act/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>

<sup>2</sup> See <https://nationaldisabilitynavigator.org/ndnrc-materials/fact-sheets/fact-sheet-15/>

<sup>3</sup> The Marketplace application and insurance is still available for individuals who have certain recent life changes, or who otherwise qualify for a "special enrollment period."

<sup>4</sup> See <http://www.nationaldisabilitynavigator.org/ndnrc-materials/fact-sheets/fact-sheet-9/>

of the model the state has chosen for determining eligibility, the process should be streamlined with minimal burden on you. The state Medicaid agency will continue to have final oversight of the accuracy of all eligibility determinations, including those made by Marketplaces. If you only want to apply to a state's traditional Medicaid program, it might be best to apply directly through that state.<sup>5</sup>

**Q4.** Can I apply for Medicaid after March 31, 2014 when the period of open health insurance enrollment has ended?

**A.** You can apply for and enroll in Medicaid or the Children's Health Insurance Program (CHIP) any time of year. There is no limited enrollment period for either program. If you qualify, your coverage can begin immediately. Once you qualify for Medicaid in your state, the program requires you to undergo a "redetermination" of continuing eligibility where you will have to indicate that key factors such as your income, your family size, or your disability remain unchanged. The redetermination generally happens annually. If upon redetermination you are found not eligible to continue on Medicaid, this is a loss of healthcare coverage that triggers a "special enrollment period" and you can apply for Marketplace coverage outside of period of open health insurance.

**Q5.** I am not eligible for Medicaid, but I have a daughter who is autistic. Would she qualify for Medicaid?

**A.** The Children's Health Insurance Program (CHIP) provides low-cost health coverage to children in families that earn too much money to qualify as a unit for Medicaid. Every state offers CHIP coverage, and works to coordinate its state CHIP and Medicaid programs. A few states have completely incorporated their CHIP programs into their Medicaid program. In those states that administer CHIP separately, the program can provide health benefits for children who don't qualify for Medicaid. In some states, parents and pregnant women qualify for CHIP coverage, too. Since the income qualification levels for CHIP coverage can be higher than the qualification levels for expansion Medicaid, it is possible for one or some household members to qualify for Medicaid/CHIP as children, while the adult family members will be above their own expansion Medicaid income threshold. In such a case, the other adult family members are likely to qualify for Marketplace insurance with premium subsidies and/or cost-share reductions. When you fill out an application for the Marketplace, the site will tell you which programs you and your family qualify for. If it looks like anyone is eligible for CHIP, the Marketplace administrator will let the CHIP agency know so your application can be finalized.

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<sup>5</sup> If you think you may qualify for Medicaid under *either* your state's traditional Medicaid rules or your state's Medicaid expansion, you should carefully consider whether there is a difference between the benefits offered under each program, and if there is, consider also whether you may qualify as medically frail under Medicaid expansion. See Medically Frail Status Fact Sheet (<http://www.nationaldisabilitynavigator.org/ndnrc-materials/fact-sheets/fact-sheet-8/>).

**Q5.** If my child with a disability qualifies for CHIP, what health benefits will she be eligible to receive?

**A.** The services covered through CHIP are different in each state, which can be found here <https://www.insurekidsnow.gov/coverage>, but all states provide coverage that includes:

Routine check-ups  
Immunizations  
Doctor visits  
Prescriptions

Dental and vision care  
Inpatient and outpatient hospital care  
Laboratory and X-ray services  
Emergency services

**Q6.** I think I am eligible for Medicaid, but I would rather buy a plan in the Marketplace to ensure that I can see the doctor who is knowledgeable about my disability. May I buy a health insurance plan through the Marketplace?

**A.** If you're eligible for Medicaid, you already have what is considered “minimum essential coverage” and would not be eligible for the Marketplace savings programs such as the premium credit or any cost-sharing reductions. You would benefit most financially from enrolling in Medicaid rather than buying private health coverage. A Marketplace plan will be more expensive than Medicaid and usually won't give you additional coverage or benefits. Keeping your own experienced providers is naturally a concern for you. First, ask your provider if he or she accepts Medicaid payments. Next, you will need to figure out how Medicaid services are delivered in your state. If you are required to join a managed care plan as a Medicaid beneficiary, you should check with the Medicaid health plan choices in your locale to see if your preferred provider participates in any of their physician networks.

**Q7.** I am currently being treated for cancer and require regular lab tests. If I am eligible for expansion Medicaid, what health benefits will I get?

**A.** The Affordable Care Act requires states that are expanding their Medicaid programs to provide an Alternative Benefit Package (ABP) that includes a comprehensive bundle of items and services, known as Essential Health Benefits (EHBs) to people who are newly eligible for Medicaid. EHBs must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Also, a full range of preventive tests within the EHB categories must be provided without cost sharing. ABPs must also comply with the Mental Health Parity and Addiction Equity Act.<sup>6</sup> In addition, all children under 21 who are enrolled in an ABP must receive “Early

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<sup>6</sup> See <http://www.nationaldisabilitynavigator.org/ndnrc-materials/fact-sheets/fact-sheet-7/>

and Periodic Screening, Diagnostic and Treatment (EPSDT), including pediatric oral and vision services. ABPs must also offer family planning services and supplies, federally qualified health clinic and rural health clinic services, and non-emergency medical transportation.

**Q8.** I have multiple medical conditions and disabilities for which I need care. I have been told that due to my health status, I probably will be identified as “medically frail.”<sup>7</sup> Consequently, I might be eligible to choose traditional Medicaid in my state rather than the Medicaid expansion program. Which program is better for me?

**A.** Your state’s traditional Medicaid coverage package may not necessarily be better than the Alternative Benefit Package that will be offered through the Medicaid expansion. For example, the state’s traditional Medicaid package may have longstanding limitations on when, how, and for how long services such as physical therapy are available when the treatment purpose is solely to avoid pain and slow down functional loss. In another example, rehabilitative and habilitative services and devices is a required EHB category. Yet expensive and medically necessary individualized durable medical equipment such as certain power wheelchairs might not be approved under traditional Medicaid.<sup>8</sup>

Substance use disorder treatment is yet another area where a state’s expansion benefit plan, which must meet EHB requirements and offer benefits in the category of mental health and substance use disorder, could give you significantly greater coverage than that state’s traditional Medicaid program.

If you are deemed to be “medically frail,” you should contact your state Medicaid office and ask which program provides the range of specific services and benefits you need.

**Q9.** What can I do if I am denied Medicaid coverage and I disagree with the decision?

**A.** All state Medicaid agencies have existing appeals processes. With the introduction of the Marketplace into a state’s Medicaid application and determination process, states have three choices about how Medicaid appeals can be handled. They can choose to process all appeals within the Medicaid agency, delegate the appeals process to the Marketplace, or delegate appeals to a third-party agency or department in the state. Each of these options has been chosen by different states, but most of the Marketplace states have matched their choice to the entity that is making the final Medicaid decision. That is, if the state is retaining the right to make a final Medicaid decision, even if the Marketplace makes an initial assessment, then the Medicaid appeal is through the usual state process. If the Marketplace is making the final Medicaid determination, then the appeal is delegated to the federal Department of Health and Human Services (HHS),

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<sup>7</sup> See <http://www.nationaldisabilitynavigator.org/ndnrc-materials/fact-sheets/fact-sheet-8/>

<sup>8</sup> See <http://www.nationaldisabilitynavigator.org/ndnrc-materials/fact-sheets/fact-sheet-4/>

which also hears appeals on advance premium tax credit decisions.<sup>9</sup> Even if a state delegates the appeal to the Marketplace, however, consumers in the state continue to have a right to appeal to the state Medicaid agency instead. Contact your state Medicaid agency to find out your state's choice and your current rights of appeal.

**Q10.** If ultimately I am found ineligible for Medicaid in my state, do I have to start the Marketplace application process all over again? What if the open enrollment period is over by the time I get my Medicaid determination?

You should not have to completely reapply in the Marketplace as long as you originally applied for insurance through the Marketplace. If a state ultimately denies your Medicaid application after the Marketplace gives you an initial positive assessment, the state is required to transfer your account back to the Marketplace. The state's final Medicaid determination will be accepted and the Marketplace will assess your account for enrollment in a Qualified Health Plan, as well as your eligibility for premium subsidies and cost-share reductions. The entire process should occur quickly, but may involve some delay that could extend beyond the end of the open enrollment period, especially if you request an appeal of the Medicaid decision. At the time of this fact sheet's writing, the administration has announced a "special enrollment period" of a few weeks for individuals who attest that they began to apply for coverage in the Marketplace, but through no fault of their own, were unable to complete enrollment in the Marketplace before the March 31 deadline. This reasoning seems to be broad enough to encompass individuals who did not enroll due to an erroneous or administratively delayed Medicaid determination. A special enrollment period also applies if an individual's application is erroneously directed or delayed by a Marketplace employee. Note, however, that there is no special enrollment period for anyone who only applied for Medicaid through their state or county agencies and never tried to apply for anything through the Marketplace.

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<sup>9</sup> Additional information about the HHS External Review Process can be found at <https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/>.

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