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WHAT TO DO IF YOUR MEDICAID APPLICATION IS DENIED

If you apply for long-term care assistance through Medicaid and your application is denied, it may feel hopeless. The good news is that you can appeal the decision.

Medicaid is a program for low-income individuals, so it has strict income and asset eligibility requirements. Qualifying for Medicaid requires navigating the complicated application process, which has many potential stumbling blocks. However, a Medicaid denial does not mean you will not eventually qualify for benefits.

The Medicaid agency may deny a Medicaid application for a number of reasons, including the following:

- **Missing documentation**. You need to show proof that you are eligible for benefits, which usually means providing Social Security statements, bank records, property deeds, retirement accounts, and insurance records, among other things.

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- **Excess assets**. In order to be eligible for Medicaid benefits a nursing home resident may have no more than $2,000 in "countable" assets (in most states).
- **Transferred assets**. If you transferred assets for less than market value within five years before applying for benefits, you may be subject to a penalty period before you become eligible for benefits.

The Medicaid agency is required to issue the denial notice with 45 days of the application (or 90 days if you filed for benefits on the basis of a disability). When you get a denial notice, read it carefully. The notice will explain why the application was denied and specify how to file an appeal.

Before filing a formal appeal, you can try informally asking the agency to reverse the decision. If you made a mistake on the application, this is the easiest and quickest way to proceed. If the caseworker made a mistake, it may be more complicated and require escalation to a supervisor or a formal appeal.

Appealing a Decision

The denial notice will tell how long you have to file an appeal—the deadline may be as short as 30 days or as long as 90 days after the denial notice. It is important to file the appeal before the deadline. Whether the denial notice requires it or not, you should submit your request for an appeal in writing, so that there is a record of it.

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Once your appeal is submitted, the Medicaid agency will set a hearing date. Applicants must attend the hearing or their cases will be dismissed. You have a right to have witnesses testify at the hearing and to question the Medicaid agencies witnesses. It is a good idea to have an attorney to help you through the appeal process. An attorney can make sure you have all the correct documentation and information to present at the hearing.

If you win the appeal, your benefits will be retroactive to the date of your eligibility—usually the date of your application. If you lose the appeal, the notice will explain how to appeal the decision. The next step in the appeal process usually involves submitting written arguments. If the next appeal is unsuccessful, then you will have to appeal to court. It is crucial to have the assistance of an attorney for this.

Reapplying for Benefits

If your application was denied correctly due to excess assets or income, there are steps you can take to spend down your assets or put your income in a trust. Contact an attorney to find out what actions you can take to qualify for benefits. Once you do this, you can then reapply for benefits. Note that when you reapply for benefits, your eligibility date will change to the date of the new application.

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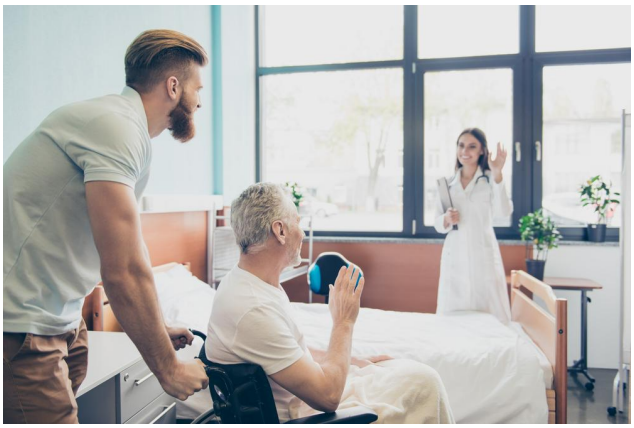
WHEN TO LEAVE A NURSING HOME AND MOVE BACK HOME



Leaving a nursing home to return home is a goal for many residents and their families, but it requires careful consideration. While returning home is a good move for some, it won't work for everyone.

A nursing home stay does not have to be permanent. Many residents enter a facility temporarily to recover from an illness or accident and are able to easily transition back to living at home. For residents who continue to need care but would rather be at home, moving out of a nursing home is more complicated.

Before considering moving out of a nursing home, here are some questions to bear in mind:

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- Can you receive the care you need at home? Some patients require help with eating, dressing, and going to the bathroom. You need to consider whether you can adequately get that care at home.
- Who will be providing the care? The care can come from family members or hiring in-home health care. If family members aren't available, is there money to hire help? All 50 states have Medicaid programs that offer at least some home care. You will need to check with your state to see if you qualify.
- Will you be able to take the medications you need at home?
- How is your physical and emotional stamina? Moving back home requires determination and an ability to manage problems, since not everything will be taken care of as in a facility.
- Is the house set up to safely accommodate you? Are there a lot of stairs? Does the bathroom have rails? If the patient has dementia, there may be other considerations to take into account.
- Is there transportation available to get to doctor's or other appointments?

If you determine that moving back home is the best option, then you can begin to craft a plan based on where you will live and who will provide care. Contact your local Area Agency on Aging to get help finding and coordinating services.

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There is a federal program called Money Follows the Person that is designed to make it easier for nursing home residents who qualify for Medicaid to move out. Currently, 34 states and the District of Columbia participate in the program, which provides personal and financial support to help eligible nursing home residents live on their own or in group settings.

For tips on transitioning from a nursing home to the community, click here.

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MEDICARE NOW COVERS THE COST OF COVID AT-HOME TESTS

If you have Medicare, you can now receive up to eight free rapid at-home Covid-19 tests a month at participating pharmacies.

The free tests are available without a Prescription to all Medicare beneficiaries with Part B, including those enrolled in a Medicare Advantage plan. If you only have Medicare Part A, Medicare won't cover the cost.

To get the tests, you can visit one of the pharmacies participating in the program (for a partial list of participating pharmacies, click here). You do not have to be a current customer of the pharmacy in order to receive the tests, and Medicare Advantage plan enrollees may use an out-of-network pharmacy. You should bring your red, white, and blue Medicare card (even if you have a Medicare Advantage or Medicare Part D plan), but the pharmacy may be able to get the information it needs to bill Medicare without the card.

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Unlike with private insurance, there is no upfront cost for the tests. As long as you do not order more than eight tests in a calendar month, you will not pay anything. Note that tests are often packaged with two in each box, so eight tests may not mean eight boxes. If you pay for a test yourself, Medicare will not reimburse you. Medicare enrollees who order tests from covidtests.gov do not need to count those tests against Medicare's eight-test-per-month limit.

When the Biden administration originally announced it was requiring private insurers to reimburse the cost of up to eight rapid at-home Covid tests a month purchased at retail stores and pharmacies, this news left out the nation's 62 million Medicare beneficiaries – seniors and people with disabilities who are at the highest risk of death from Covid-19. If paid for out-of-pocket, tests typically cost more than $20 for a package of two, which can discourage many Americans from getting tested.

The problem in the case of tests for Medicare beneficiaries was that the federal program's rules did not permit coverage of over-the-counter tests. Amid pressure from Congress and advocacy groups, officials scrambled to find a regulatory workaround.

For more information about the free COVID tests from the Centers for Medicare & Medicaid Services, click here.