

Elder Law NEWS

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What Does "Medicaid Pending" Mean?

In today's world, it is crucial to have healthcare insurance. So, it can be concerning if your application status is still "Medicaid Pending." Medicaid Pending status means that your application or your parent's application has not yet been approved or denied. Essentially, your application is in limbo. Here is why this status is important:



Some elderly patients who suffer from chronic illnesses may see their medical bills pile up while they wait for a final decision from Medicaid.

Senior patients needing long-term care, like admittance into a nursing home, must pay for nursing home services out of pocket until their Medicaid application is approved. To avoid mounting medical bills, it is vital that you keep an eye on a senior patient's application. There are some long-term care facilities that accept Medicaid pending patients. However, the patient or their family may pay a share of the cost of the services in the interim.



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A Medicaid application usually takes between 45 and 90 days to process. According to the state where you live, a Medicaid application may take longer or shorter than this estimate. In addition, the time it takes for you to gather the required documents may delay your application.

Applicants and families should keep in mind that most states require proof of the following documents in order to file for Medicaid:

- Birth certificate
- Proof of income
- Proof of identity (i.e., driver's license, state ID card, green card, or passport)
- Proof of income (i.e., check stubs, tax returns, SSI, or retirement benefit statement)

If your application is denied, patients and families can file an appeal or begin the application again depending on the reason for the denial. If your application is denied because one of the above documents was not included in the original application, you must restart the application from scratch. In cases where you were denied coverage for a substantive issue, you have a right to appeal.



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The Appeal Process

The Medicaid appeal process follows these steps:

- Medicaid will send you a denial letter. In the denial letter, Medicaid must explain the reason for the denial. The letter will also state the deadline for filing an appeal.
- The patient must initiate the appeal. To begin your appeal, you must send a notice of appeal to the Medicaid office. You might get contacted by the office, and a Medicaid representative may negotiate a settlement with you to avoid an appeal hearing.
- The final step is an appeal hearing. This appeal is heard in an administrative law court and decided by an administrative law judge. You can present witnesses and evidence at the hearing to persuade the administrative judge to rule in your favor.
- If you want an attorney to represent you but cannot afford it, you can reach out to a legal aid office in your area.

Information about Medicaid is available online at [medicaid.gov](https://www.medicaid.gov). Visit this website If you want to learn more about the process of applying for coverage or eligibility. [For additional guidance, contact a qualified elder law attorney in your area, as the rules can vary from state to state.](#)



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At-Home COVID Tests, Accessible for People Who Are Blind or Have Low Vision, Now Available

For Americans who are blind or have other visual impairments, reading the instructions or deciphering the results of a traditional at-home COVID-19 rapid test can prove difficult, if not impossible. Tests designed to be more accessible to people with these disabilities are now available for free.



Individuals can place an order for 12 of these more accessible at-home tests, either [online through the U.S. Postal Service](#) or by calling 1-800-232-0233. Shipments are made in six separate packages, with two tests included per package.

Using the test requires you to have a compatible, [Bluetooth-enabled smartphone](#) and to install a free app. Coupled with the app, the test provides step-by-step directions for performing the test as well as the results in an audio format.



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If you need additional tests, Medicare will cover up to eight per month, including these more accessible versions.

Supplies are limited. Individuals with disabilities who may need additional help accessing these tests can contact the Administration for Community Living's [Disability Information and Access Line](#).



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It Pays to Be a Smart Shopper When Buying a Medigap Insurance Policy

Medigap premiums for plans from insurance companies offering the same benefits vary widely, so it pays to be a smart shopper. Federal law requires that each insurance company offers the same benefits for each of the Medigap plans lettered A through M, but each company sets its own premium rates.



A Medigap insurance company sets premiums in three ways:

- Community-rated, where the premiums are the same, regardless of age
- Issue or entry age-related, where premiums are cheaper if purchased at a younger age
- Attained-age-related, where premiums are based on your age at the time of purchase



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When choosing a [Medigap plan](#), compare the different benefits each plan offers and the price for each company's plan. Consider your current health status, what your health care needs might be in the years to come, as well as your future health care budget.

Insurers will also consider the state and city where you live. [The American Association for Medicare Supplement Insurance Price Index reports](#) found the cost in 2022 of a Plan G policy, the most popular Medigap plan, was \$99.24 per month in Dallas, Texas, versus \$278.25 per month in New York City.

When shopping for a Medigap policy, get quotes from two or more insurance agents working for different insurance brokers. Every insurance broker may not represent all of the insurers offering a plan in the state or city where you live.

It may take time to shop around, but the money you save can be worth it.

Learn more about [choosing the right Medigap policy](#).