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Trends in Retroactive Medicaid Coverage

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Medicaid is a federally-created state-implemented program that provides medical coverage to the neediest of populations. The interest in ensuring that those in need can access affordable care is an important factor in keeping our nation healthy. Medicaid is an incredible resource for our aging population. Those entering long-term care are faced with an inevitably exorbitant expense for their escalating level of care needs. For elders with limited resources, Medicaid provides a way to fund this care. Medicaid recipients in long-term care receive the care they require, and healthcare facilities receive compensation for the services they render.

In addition to this general coverage, Congress also included retroactive benefits in Medicaid coverage under federal law. This ensures that those eligible for Medicaid coverage will be protected during the three months immediately before the application process. To be eligible for retroactive coverage, the applicant must have been otherwise eligible for Medicaid during that time period.

Because the need for long-term care often arises unexpectedly, say, due to a fall or other catastrophic medical event, entrants are often faced with the necessity to swiftly access Medicaid coverage to fund their impending medical care costs. The medical expenses that can be accrued in the months prior to realizing the need for Medicaid assistance are a critical concern for applicants. Those needy enough to qualify for Medicaid benefit greatly from the availability of

retroactive coverage. The need for long-term care is not always obvious. Many hope that recovery, not institutionalization, is on the horizon. Mounting expenses for medical care leading to the determination that long-term care is needed is a common concern. Many states provide retroactive Medicaid coverage to help with these costs in these sorts of situations. Unfortunately, some states sidestep this coverage. In this issue of ElderCounselor™, we will explore how some states are eliminating retroactive coverage, the consequences therefrom, and if other states will likely follow suit.

A Way Out: 1115 Waivers

The federal government recognizes that each states' population is different. The needs of the citizens of New York may differ from the needs of those residing in Montana. To promote a Medicaid program that is suitable and useful for individual states, there is a process by which state governments can seek to deviate from the federally-mandated Medicaid rules. The purpose of the program is to not only allow states leeway in implementing the Medicaid program given their unique population but to also allow for the testing and development of different rules to see if the Medicaid program as a whole could benefit from the new rules.

This process of deviation from the federal rules entails submitting a waiver to Centers for Medicare and Medicaid Services (CMS). For a waiver to be granted, it must increase recipient coverage, strengthen available provider networks, improve health outcomes for recipients, or increase the effectiveness of care via service delivery networks. If granted, waivers are approved for 5 years, typically. Additional extensions may be granted.

So, even though Federal law requires retroactive coverage for Medicaid recipients, states may seek renunciation of the obligation by submitting a demonstration waiver to CMS. Successfully procuring a waiver allows the state to skirt the well-established retroactive coverage rule. Many states rationalize these waiver requests by showing a combination of several factors including a showing that the waiver promotes the use of Medicaid or commercial insurance, prior to medical need arising; a financial benefit to the state; a history of infrequent use; and the presence of other coverage or presumptive eligibility.

Promoting Consistent Coverage and Access to Other Coverage

Some states that have successfully obtained waivers focus on the importance of encouraging individuals to obtain and retain consistent health care coverage. An individual covered prior to a Medicaid application would, theoretically, not need the retroactive payments. A needy person eligible for Medicaid coverage should do so when they first become eligible – this eliminates a surprise bill for the states when retroactive coverage applies. Those not impoverished enough to qualify for Medicaid should prudently obtain other, commercial coverage.

Proactively Accessing Medicaid: One could argue that continuous coverage via Medicaid saves the state money over the long term because these individuals have regular access to medical care, keeping them healthier longer. On the other hand, unlimited access to Medicaid-paid healthcare can incentivize an eagerness to seek out medical care for otherwise rudimentary conditions. A Medicaid-covered individual is far more likely to visit the ER for a bad cold than another individual with a $250 ER copay. Such use is certainly not cost saving for the states.

Proactively Accessing Commercial Coverage: Keeping up on one's health logically increases the likelihood of staying healthy. Thus, having consistent coverage promotes this objective. Unfortunately, though, the inability to qualify for Medicaid coverage due to being over-resourced does not mean that these individuals can afford commercial coverage – let alone the costly copays and deductibles associated with the plans. For many, paying out-of-pocket for commercial insurance impoverishes them, yet they still cannot qualify for Medicaid because, without the expense, they are not needy enough.

Because many cannot afford commercial coverage but still do not qualify for Medicaid, they go without health insurance altogether. If a medical event happens that renders them unable to work, and then they may qualify for Medicaid without their income. For example, say a senior receives Social Security benefits and works part-time. With those two income sources combined, their income is over the limit, and they cannot qualify for Medicaid. If the senior suffers a fall and cannot work at their part-time job, their income falls below the limit, and they are otherwise eligible. Retroactive benefits would cover the cost of the medical event if it were determined that they lost their job and didn't have that additional income at the time immediately following the fall. Without retroactive coverage, the person may qualify after the hefty bills from the medical event were accrued and leave them unable to pay the debt personally.

To further the problem, commercial insurers do not cover long-term care. Many states' waivers include those age 65 and older – the most obvious group of people likely to be forced into long-term care. An individual receiving long-term care services experiences no benefit from having commercial coverage. Without retroactive coverage for these long-term care costs, an individual scrambling to get the necessary documentation ready for an application for Medicaid benefits could be left with extensive medical debt incurred pre-application. Eliminating retroactive coverage leaves medical facilities providing pre-application care at a loss because those eligible for Medicaid do not have the resources to pay the incurred debt. Thus, the state may financially benefit, but at the expense of medical care institutions.

Financial Benefit to the State

States can easily argue that eliminating retroactive payments would benefit the state financially. Obviously, not paying for services rendered is money not spent. However, reimbursement for

retroactive costs may not be the greatest source of expense to the states, and the lack thereof may harm both individuals and medical care facilities.

Lack of Use

An element of retroactive Medicaid coverage is based upon the presence of neediness during the months preceding application. In order to avail themselves of retroactive benefits, the applicant must have been Medicaid eligible during that retroactive period. If an applicant would not have been eligible based on their financial condition during the retroactive coverage period, then that backdated coverage would not be accessible.

For example, if an individual with too many resources for Medicaid eligibility expends their wealth on expensive medical care until their level of need meets Medicaid requirements, the individual would not be eligible for the retroactive coverage until the exact point they were otherwise financially eligible. There could be a gap in responsibility during this time. These individuals have no way to pay for further pre-application expenses because paying for previous care led them to poverty. And if retroactive benefits are not available, the Medicaid applicant could have an even larger gap in responsibility while he or she gathered the necessary paperwork to submit a successful Medicaid application.

These cases account for much of the lack of use argument. If the number of ineligible applicants is great enough, then states can argue that the program is of no realistic benefit and should be eliminated based on the scarcity of its use.

Repercussions

Medicaid coverage is critical for impoverished elders nearing the necessity for long-term care. Retroactive coverage protects those that are not anticipating the shift into long-term care and postpone their application for benefits. Once the need becomes clear, and individuals turn to Medicaid, retroactive protection assists applicants with the cost of care that led them to the conclusion that their needs are beyond management without the help of a long-term care environment.

Elimination of this feature only creates increased hardship for those that do not prematurely seek out Medicaid. Several states have successfully argued for waiver of retroactive coverage. In some of those states, an individual that accesses Medicaid benefits early, and creates a financial burden for services they seek out over time, is in a better position than those that delay the request for help. Those that try to delay the request for medically-based financial help from the state are essentially penalized for their postponement. Those that purchase commercial healthcare plans are either led to poverty because of the expense, or they are of limited benefit – especially when the expenses are due to long-term care costs, which commercial plans avoid.

Qualifying for long-term care Medicaid is also document-driven. It usually takes a lot of paperwork and information to have an application successfully submitted. Not only does the state require income and asset information for long-term care services to be covered, but also any information regarding transfers for the prior five years (three in California). Because of the vast array of information needed, it sometimes takes applicants and their counsel several weeks to gather and analyze the documentation. Having the retroactive period helps applicants by not demanding every item needed immediately. It gives applicants and their attorneys a bit more time to do a thorough and complete application.

State of the Union

Several states have 1115 waivers eliminating retroactive Medicaid coverage that effects seniors – Arizona, Florida, Iowa, Indiana, Massachusetts, Rhode Island, and Tennessee. In Delaware, Hawaii, and New Mexico, retroactive coverage has been eliminated, but institutionalized individuals are exempt. For Arkansas, Kentucky, and New Hampshire, the previously enacted elimination of retroactive benefits is currently held up in litigation. So, while the litigation is pending, the entire waiver – including the elimination of retroactive benefits – has been set aside.

Where the Issue is Heading

There has been a recent trend in using 1115 waivers to restrict access to Medicaid. In addition to the elimination of retroactive coverage, such waivers have been used to impose Medicaid work requirements or impose a time limit on coverage. Other 1115 restrictions include premiums or monthly cost contribution requirements, tobacco premium surcharges, and the authority to cap enrollment.

The Trump Administration has made it clear that restrictions such as work requirements and the elimination of retroactive benefits fall in line with their policy. There is a limit to restricting Medicaid, however. CMS Administrator Seema Verma has rejected waivers aimed to put lifetime limits on Medicaid coverage. Needless to say, the direction of CMS in granting waivers directly relates to the direction of the current presidential administration. If a change in administration is forthcoming in the current years, the trend in Medicaid restrictions may cease or reverse. For now, states are free to submit waivers to eliminate retroactive coverage, and CMS has indicated through prior action that they would likely grant such waivers.

Conclusion

States may try to rationalize the elimination of retroactive coverage, but not all agree with their logic. Requiring individuals that are eligible for Medicaid to apply early only increases their medical costs over time – as those without coverage are not as likely to seek out care as those with free or low-cost access. Paying the three months' worth of medical services leading up to an individual application for benefits is likely less than the cost of years of routine care over the long-term. Requiring individuals, living paycheck to paycheck, or on a fixed income, yet not

needy enough for Medicaid, to purchase expensive commercial coverage is an excellent way to increase the likelihood of their impoverishment. Consequently, such a practice will result in the creation of a new group of Medicaid-eligible individuals.

States requesting a waiver to eliminate retroactive Medicaid may be thinking shortsightedly. While these states may save in the short-term by avoiding payment for those few months of expenses, the long-term prognosis is likelier to create substantially more cost to the state. Delaying the request for help from the state should not be castigated, it should be promoted. Retroactive payments are a logical reward. “Thank you for trying to manage your healthcare needs for as long as you could. Let us ease the burden of the costs you could not pay for, now that you are eligible for assistance.” Not, “You should have covered your bases from the get-go. You are on your own for the medical debt you acquired.” Such a thought goes against the fundamental principles of the Medicaid program.

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