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My Client Received a Medicaid Denial... Now What?

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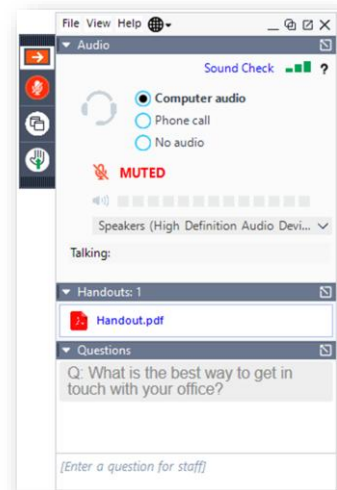
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1

Questions & Handouts

- Download **today's handouts** from the GoToWebinar toolbar.
- Don't forget to **complete the survey** at the end of the presentation!



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2

About Us

Krause Agency is a national wholesaler of insurance products tailored to the senior market. With a focus on asset preservation solutions, we provide products, training, and support to agents and advisors helping clients plan for retirement and long-term care.



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3



30+
Years of
Experience



400+
Clients Helped
Monthly



1,300+
Active Agents



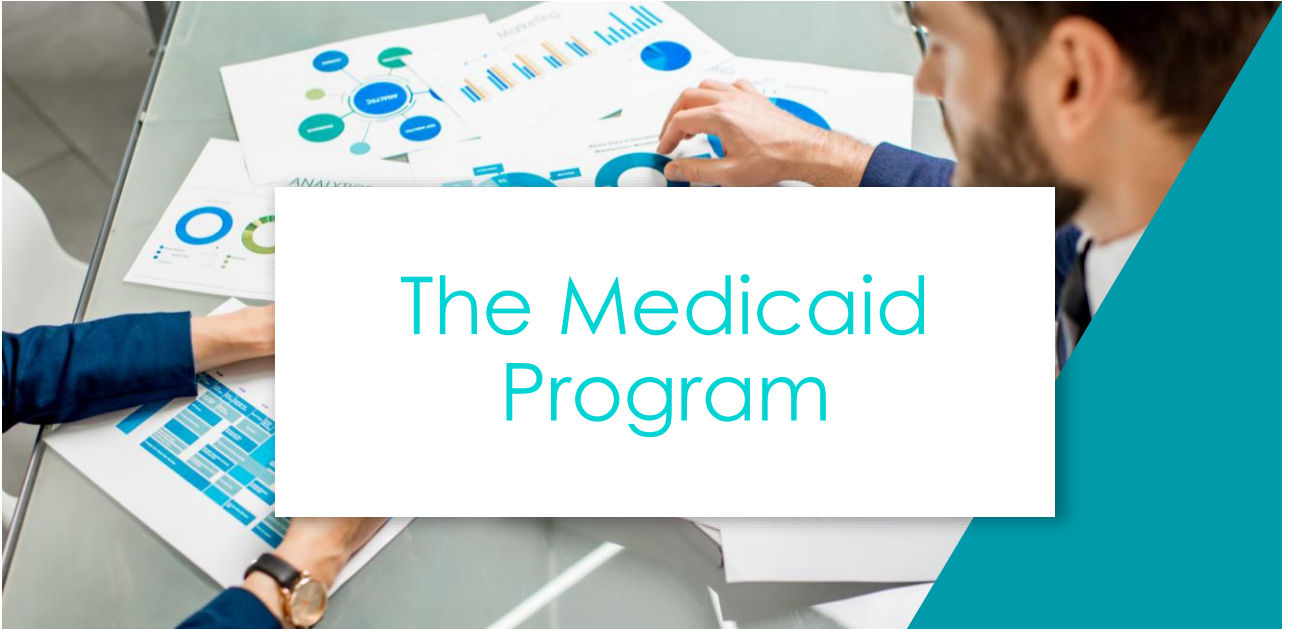
Today's Goals

- 1.** Identify the most common reasons for a Medicaid denial.
- 2.** Explore best practices to avoid a Medicaid denial.
- 3.** Discuss the steps to take if your client receives a denial and pursue a fair hearing if necessary.

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4





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5

What is Medicaid?

- Medicaid is a joint **federal and state program** designed for individuals with limited means.
- Applicants must **meet specific financial and non-financial criteria** to qualify.
- Specific rules can **vary by state**.

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6

Why is Medicaid Important?

- In a nursing home, Medicaid pays for a person's **custodial care**.
- Without financial assistance, the median cost of a semi-private nursing home room in the U.S. is **\$9,581 per month**.*
- Qualifying for Medicaid benefits can provide much-needed **financial relief** to those receiving long-term care.

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*CareScout Cost of Care Survey, 2025



7

Non-Financial Requirements

- In order to meet Medicaid's non-financial eligibility requirements, an individual must:
 - *Be a U.S. citizen or qualified non-citizen*
 - *Be age 65 or older, blind, or disabled*
 - *Reside in a Medicaid-approved facility*



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8

Financial Requirements

- Financial requirements can generally be divided into two categories:

Income

Assets

- There are specific rules and considerations for each category.

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9

Income Requirements

- In most states, the institutionalized person's income from all earned and unearned sources must be **less than the private pay rate** of the facility.
- Some states may require a Qualified Income Trust for income exceeding \$2,982/month (in 2026).
- There are **no limits** on the income of the community spouse.
- However, if their income is below a certain amount, known as the **Monthly Maintenance Needs Allowance (MMNA)**, they may be entitled to a portion of the institutionalized spouse's income.

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10

Asset Requirements

Institutionalized Individual

The Medicaid recipient is entitled to an Individual Resource Allowance, which is **\$2,000 in most states.**

Community Spouse

The community spouse can retain a separate amount known as the **Community Spouse Resource Allowance, no more than \$162,660.**

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11

Exempt vs. Countable Assets

Exempt assets do not count toward one's resource allowance.

- Primary residence (home equity limit of \$752,000 to \$1,130,000 may apply)
- One vehicle
- Personal property
- Life insurance (face value of \$1,500 or less in most states)
- Funeral expense trusts (face value of \$15,000 or less in most states)

Countable Assets do count toward one's resource allowance.

- Checking, savings, and other bank accounts
- Stocks, bonds, and mutual funds
- Deferred annuities
- Additional property and vehicles
- IRAs (in most states)

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12

Applying for Medicaid

- Once the client is eligible for benefits (both from a financial and non-financial perspective), a Medicaid application must be submitted.
 - This can be done by the client, a family member, you (if you offer it as part of your services), or an elder law attorney.
- Each state has their own application documents.
- Once it's been reviewed by a caseworker, you will receive a Notice of Decision.
- ***In some cases, this may result in a denial of benefits!***

Necessary Application Documents

- State identification card
- Proof of citizenship
- House or property deed
- Vehicle title
- Bank statement
- Life insurance policy
- Social Security declaration of benefits
- Rental lease or mortgage bill
- Homeowners or renters insurance bill
- Documentation regarding transfers during the lookback period (including the source, mode, and transaction receipt, if applicable)

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13

Common Reasons for a Medicaid Denial

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14

Incomplete Application

- Submitting an incomplete application without certain proof or failing to provide supporting documentation in a timely manner may result in a Medicaid denial.
- Make sure your client submits all required documents and responds quickly to any requests by the local Medicaid office for additional documentation.

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15

Not Medically Qualified

- An individual must be age 65 or older, blind, or disabled to order to be eligible for Medicaid benefits for long-term care.
- They must also be a resident of a Medicaid-approved facility (i.e., they must currently be receiving care in the right type of facility before applying for benefits).

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16

Too Many Assets

- Medicaid employs strict limits on the amount of countable assets the client can retain and still qualify.
 - **For single applicant:** \$2,000 in most states
 - **For a married applicant with a community spouse at home:** \$162,660
- Common examples of countable assets include checking and savings accounts, non-compliant life insurance and annuities, and retirement accounts in most states.

 **Tip:** We recommend retaining slightly less than the asset limit to avoid the edge of Medicaid eligibility.

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17

Disqualifying Transfer

- The Medicaid agency will impose a penalty period of ineligibility if the client gave away assets during the five-year lookback period.
- The penalty period is determined by totaling the value of the divested assets and dividing that figure by the state-specific Divestment Penalty Divisor.
 - **Example:** If the client divested \$50,000, and the Divestment Penalty Divisor is \$10,000, the client will incur a penalty period of five months.
- Make sure you understand whether the client made unintentional divestments during the lookback period and plan accordingly.

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18

Misunderstanding by the Caseworker

- This is the most common cause for a denial that we encounter.
- The local Medicaid office may have misunderstood the case facts, the terms of a planning product, or their state's rules.
- The matter can often be resolved by supplying additional information or documentation to the caseworker.



Tip: A cover letter should accompany the application to explain any crisis planning strategies you've employed to make it easy for the case worker to understand the client's situation.

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19



What to do When
You Receive a
Denial

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20

Identify the Key Issue

- Review the Notice of Decision carefully—a Medicaid denial can come in many forms:
 - A straightforward denial of benefits
 - A denial of benefits related to certain programs
 - The application of a penalty period
 - The incorrect attribution of income or assets
- If there is no clear reason for denial, contact the caseworker to narrow the issue.

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21

Communicate with the Caseworker

- After you've identified the issue either from the notice or from discussion with the agency, work with the caseworker to resolve the issue.
- You may need to:
 - Provide additional supporting documentation
 - Clarify a misunderstanding by the caseworker of the Medicaid regulations
 - Escalate the conversation to a supervisor to see if they agree with the original determination
- Most denials can be resolved at this level—through clarifying any miscommunications or misunderstandings related to the Medicaid application or the crisis planning strategy.

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22

Request a Fair Hearing

- If the denial still stands after review by a caseworker, it's time to file for a fair hearing.
- Check the Notice of Decision for fair hearing deadlines and instructions and be sure to file within the allotted timeframe.
- If you have not worked with an attorney up to this point, it can be a good decision to consult one to assist through the process.
 - We always recommend you work with an elder law attorney in your area on any crisis Medicaid planning case!

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23

Preparing the Brief

- After a fair hearing date has been set, you will need to prepare a brief.
- Be sure to include all possible arguments to preserve on appeal.
- Include the specific statutory basis that supports the argument and any persuasive or binding case law.
- Also include any evidence that may support the argument (copies of checks, financial statements, signature dates, etc..).
- Include a list of expert witnesses if applicable to provide testimony during the hearing.

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24

Issuing a Decision

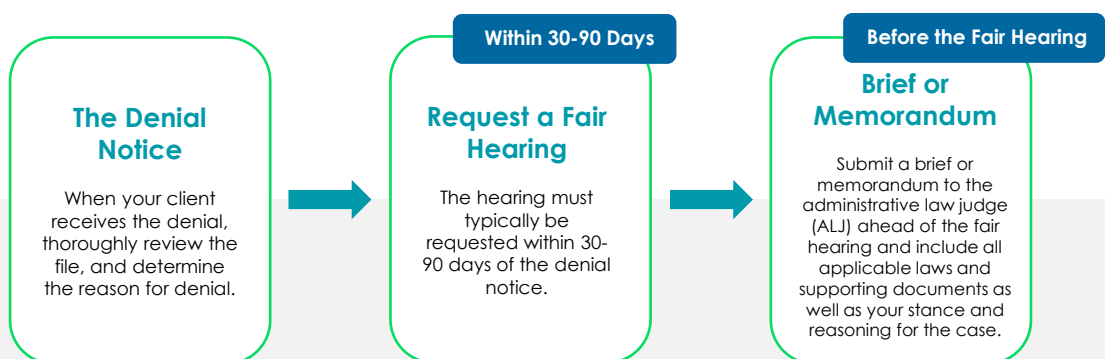
- If both parties agree on facts, it may simply be a review by the FHO/ALJ to interpret the relevant law and issue a decision.
- Alternatively, they may want to hear from both parties verbally via telephonic hearing.
 - This is most common—rarely is an in person hearing required.
- The court may ask for a post-hearing brief to address any arguments made during the hearing and/or address any questions the FHO/ALJ may have had.
- Once a decision is formally issued and the agency formally adopts the decision, client can accept the result or appeal again.

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25

Fair Hearing Timeline



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26

Fair Hearing Timeline



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27

Denial and Fair Hearing Support

- If your client receives a Medicaid denial due to a product purchased through our office, contact us immediately!
- We can help provide the necessary information, documentation, and statutory support to resolve the issue at the caseworker level.
- Should a fair hearing become necessary, we can work with you and the client's attorney during that process as well and provide expert testimony if needed.

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28



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29

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30

Thank you

for attending today's session!

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