

## MODULE 9: MEDICAID AND THE MEDICARE SAVINGS PROGRAMS (QMB, SLMB, QI-1 AND QDWI)

### Objectives

Below are the objectives established for *Module 9: Medicaid and the Medicare Savings Programs (QMB, SLMB, QI-1 and QDWI)*. HIICAP counselors will learn about programs that assist people who have problems paying their Medicare premiums, deductibles, and coinsurance, and who have gaps in coverage. This is important information for counseling clients who have financial difficulties paying for a Medigap policy or other supplemental insurance.

At the end of this module are the Study Guide Test and Answer Key.

### What is Medicaid?

A program designed to provide health care for low-income individuals and families. Financial eligibility is defined in terms of income and resources. The rules for financial eligibility are different depending on one's age (under 21, 65+, or in between), whether one has a disability, or has high medical bills.

### What are the differences between Medicare and Medicaid?

- Medicare is a federal government program that provides health insurance for individuals age 65 and over, or the disabled
- Medicaid is a joint federal and state government program
- Medicaid is “means-tested” – that is, people have to meet certain income and resource criteria to be eligible.
- Medicare provides limited long-term care services (short-term rehabilitation, limited home health care), while Medicaid in New York State covers many types of home care up to 24 hours per day and long-term nursing home care

### What are the Medicare Savings Programs?

The Medicare Savings Programs provide low-income people with Medicare with help with their Medicare premiums, deductibles and coinsurance. There are four Medicare Savings Programs. Each program has different eligibility criteria and provides different benefits. The Medicare Savings Programs are administered through the local Medicaid offices.

- Qualified Medicare Beneficiary (**QMB**)
- Specified Low-Income Medicare Beneficiary (**SLMB**)
- Qualified Individual 1 (**QI-1**)
- Qualified Disabled and Working Individual (**QDWI**)

### MEDICAID

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People eligible for Medicare are required to pay a substantial amount of money in premiums, deductibles, and coinsurance. These out-of-pocket costs have risen rapidly over the past decade.

Additionally, Medicare does not cover most long-term care services, whether in a nursing home or in the community.

For those living in poverty, these costs eat up almost a quarter of their entire annual income. There is a program designed to help. Congress created the Medicaid program in 1965 to assist states in providing health care for the poor. Medicaid covers the health care expenses for millions of Americans including recipients of **Supplemental Security Income (SSI)**, which provides cash assistance to the needy elderly, certified blind, and certified disabled who qualify because of low income and few resources. Many people who don't qualify for SSI because they have high Social Security or savings may also qualify for Medicaid with the spenddown program (see more below).

Medicaid is administered by the states and financed jointly by the states and the federal government. Federal law requires each state to provide a minimum benefit package that includes hospital inpatient and outpatient services, physician services, skilled nursing, home care, laboratory and X-ray services, health screening follow-up services for children under 21, nurse-midwife services, family planning services, rural health clinic services and transportation services.

Individual states have the option to cover other medically needy people and have the ability to structure their programs to meet the special needs of their citizens.

Many states, including New York, have Medicaid programs that cover more health care services than those required by the federal government. Payment for health care services is made by the state Medicaid program directly to health care providers.

**The New York State Department of Health oversees the state's Medicaid program.** Each county administers its own local Medicaid program through the County Department of Social Services (DSS). Local DSS offices help determine if a client is eligible for Medicaid, and, if so, will enroll him or her in this assistance program that pays for many health care expenses. DSS offices are also obligated to evaluate clients for other benefits, including the Medicare Savings Programs. The DOH Medical Assistance Reference Guide, used by all local districts to explain the eligibility rules, is available online at [http://www.health.state.ny.us/health\\_care/medicaid/reference/mrg/](http://www.health.state.ny.us/health_care/medicaid/reference/mrg/).

**2014 Alert!** Effective January 1, 2014 Medicaid eligibility will be expanded in NYS for most people under age 65 because of the Affordable Care Act. This outline generally discusses those changes, but details will not be available until later in 2013. Eligibility rules for people age 65+ or who are disabled or blind is NOT changing.

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## **MEDICARE? MEDICAID? IS THERE A DIFFERENCE?**

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Most definitely! However, most Americans confuse Medicare and Medicaid. Both have to do with health care. Both are part of the Social Security Act.

Medicare is a federal government program that provides health insurance for individuals who are disabled, as well as for individuals who are 65 or older. Medicare is available for persons of any income level. Medicare coverage is the same in every state in the country.

Medicaid is a joint federal and state government program that provides health assistance for persons of any age. Medicaid is available to persons of low income and resources and the Medicaid program is unique in each state.

Medicare	Medicaid
Health insurance for individuals age 65 and older (or disabled) of any income level.	Health assistance for individuals of any age with very low income and resources.
Federal program: federal administration and funding, contractor implementation.	Cooperative program: federal, state and county funding, state administration, and county implementation.
Medicare program is uniform in all states.	Medicaid programs vary by state.
Participants pay premiums, deductibles, and coinsurance.	Participants may pay small co-payments.
Benefits are limited: hospital, medical, limited preventive and very limited long-term care. Generally, dental care and transportation are not covered.	Benefits are comprehensive: hospital, long-term care, dental care, transportation, additional health care services and supplies.
Eligibility is based on Social Security or Railroad Retirement eligibility and age 65+ or disability.	Eligibility is based on financial need.

**Why would a Medicare beneficiary need both Medicare and Medicaid?**

Seniors who reach age 65 and are enrolled in Medicare may question why they would need Medicaid as well. Medicare is a health insurance program for individuals age 65 or older or certified disabled, but substantial gaps in Medicare coverage may leave an individual financially liable for medical costs they can't afford. Medicare and Medicaid can work together to pay health care costs for low-income senior and disabled Americans. Medicare will pay first. Medicaid will then cover many, often all, of the costs not covered by Medicare. These Medicare gaps include:

- (1) **Medicare deductibles, coinsurance and premiums** - Part A hospital deductible, hospital coinsurance, the cost of days in the hospital if Medicare coverage runs out, a Medicare Part B medical deductible every year, 20 percent of Medicare's approved amount for doctors' services, and the monthly Medicare Part B premium. *Medicaid may pay all of these costs as "secondary payor," after Medicare pays. The beneficiary must use providers that accept Medicaid as well as Medicare. In some cases, Medicaid may pay Part B premium, putting dollars back into the monthly Social Security check (see Medicare Savings Programs below).*
- (2) **Services that Medicare generally does not pay for** - long-term care (home care or nursing home), eyeglasses, hearing aids, and dental care. *Medicaid may pay for these services, if services are provided by a Medicaid provider, subject to limitations set by the State. Home care has special requirements discussed below.*
- (3) **Part D - Medicaid is a pathway to Extra Help**, the subsidy that makes Part D affordable. If a Medicare beneficiary qualifies for Medicaid in just one month in an entire calendar year, s/he automatically receives Extra Help for the rest of that calendar year. And if the one-month of Medicaid eligibility is in the second half of the calendar year, Extra Help eligibility even extends to the entire following calendar year.

Even people whose income is too high for Extra Help may qualify through "spenddown," described below.



**Caution:** If the client receives care from a doctor who is not a Medicaid provider, the 20 percent coinsurance of Medicare’s approved amount may be his or her responsibility. A Medicare provider is not required to accept Medicaid. Also, providers themselves are sometimes confused by the Medicare/Medicaid relationship.

**Can people who do not have Medicare qualify for Medicaid?**

Yes. People who have Medicare may need Medicaid to pay for long-term care, or to obtain “Extra Help” for Part D. People with both Medicare and Medicaid are called “Dual Eligibles.” People under age 65 only have Medicare if they have received Social Security Disability benefits for two years. If they receive Social Security early retirement benefits, they may not receive Medicare. Disabled individuals in the two-year waiting period for Medicare, or early retirees may qualify for Medicaid or for Family Health Plus, discussed in Chapter 17.

People age 65+ who do not have Medicare but qualify may enroll in Medicare through the Part A “Buy-In”, described in the Medicare Savings Program part of this Module.

Medicaid recipients must enroll in Medicare when they become eligible at age 65, as a condition of Medicaid eligibility.

**ELIGIBILITY FOR MEDICAID**

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**When would an individual qualify for Medicaid?**

Medicaid financial eligibility rules are different for different categories of people. Some rules changed in 2010, and rules will change significantly again in 2014 for people under age 65. It is important to identify which of these categories the individual is in:

- (1) **CATEGORY 1: Age 65 or over, or under age 65 but disabled or blind – “Disabled Aged, Blind” (DAB).**
- (2) **CATEGORY 2: Under age 65, and not disabled or blind (may be receiving Social Security early retirement benefits). *Eligibility for this category will expand in 2014.***
  - (2)(a) **If under 65, and not disabled or blind, but is a grandparent or other relative taking care of a child, grandchild, or other relative under age 21 who lives with them, there are slightly different rules.**

**CATEGORY 1: Disabled, Age 65+, or Blind – “DAB” -- Rules on Income and Resources**

These individuals may qualify for Medicaid if their income and resources are very low. People receiving Supplemental Security Income (SSI) are automatically eligible, but people not eligible for SSI because they have higher income or resources may also be eligible.

**A. RESOURCES - for Aged, Disabled or Blind**

- **A resource is** property of any kind. A resource may be “liquid” such as bank accounts, or property that can readily be converted to cash. It may be “non-liquid,” meaning that it may not be easily or quickly converted to cash, such as stocks. Resources include both real and personal property, and tangible as well as intangible property.
- **Cash or liquid resources** include bank accounts, CDs, property, cash value of most life insurance, stocks, bonds, etc. In **2013**, an individual may have resources that total:

**Resource (Assets) Limit**

Household Size	Age 65+, Disabled or Blind < 65 Not Working	Disabled or Blind < 65 Working (MBI-WPD)
One	\$14,400	\$20,000
Two (married)	\$21,150	\$30,000

Check for updates at <http://www.wnyc.com/health/afile/15/314/> or [http://www.health.ny.gov/health\\_care/medicaid/#income](http://www.health.ny.gov/health_care/medicaid/#income).

**Resources do not include the following “exempt” resources-- if client has “excess resources” consider using them to purchase these things:**

- the value of one’s **home** and contiguous property (including multiple-family dwellings),
  - If the equity in the home is more than \$802,000, client is not eligible for Medicaid home care services unless she/he lives in the home with a spouse or disabled or minor child (under age 21) (Before January 1, 2013 the limit was \$786,000).
  - Though the home is exempt, Medicaid may in some cases place a lien on the home if s/he later enters a nursing home on a permanent basis, or if s/he dies with the home in her Estate. Clients who own homes should be referred to elder law attorneys for advice on Medicaid and estate planning. Find referrals at [www.naela.org](http://www.naela.org). Transfers of a home may have serious tax consequences and raise other legal issues, for which professional legal advice is necessary.
- An automobile, clothing, furniture, appliances and personal belongings;
- Tools and equipment necessary for the applicant’s trade or business;
- IRA’s – IRA’s are treated differently depending on if client is age 65+, and if under 65 and disabled, depending on whether she is working. But either way, they should not have to cash in the IRA to qualify for Medicaid.
  - **Age 65+ OR Disabled/Blind < Age 65 and Not Working.** **They don’t have to cash in their IRA, but they must take regular distributions from the IRA annually.** The IRA of the applicant or a spouse, if the applicant is age 65+, disabled or blind, is exempt as a resource, as long as the IRA is in distribution status, meaning that the individual/ spouse is taking distributions from the IRA according to IRS distribution tables. These distributions are counted as income, but the principal balance of the IRA is not counted as a resource. While the IRS only requires these distributions for people over age 70-1/2, anyone wanting Medicaid must take them at younger ages.
  - **Under age 65, disabled and working -- in Medicaid Buy-In for Working People with Disabilities. (MBI-WPD).** Since October 1, 2011, IRAs are totally exempt for this group even if the recipient is not taking distributions. See more on this program below.
  - **Under age 65, not disabled** – There is no asset limit for this category, so the IRA principal is exempt and it is not required to take distributions. However, if distributions are taken they count as income.
- Money set aside for burial and life insurance:
  - The applicant and his/her spouse may each have a \$1500 **burial fund**, if kept in a separate bank account from their other savings
  - Up to \$1500 of the cash value of a **life insurance policy** may count as the burial fund, in lieu of a cash burial fund. If the cash value of the policy exceeds \$1500, the remaining cash value is counted as a resource

- In addition, all Medicaid applicants and recipients can spend any amount of money on burial expenses when funds are placed in a non-refundable **irrevocable funeral agreement**. See <http://wnylc.com/health/entry/36/> for guide to funeral planning for Medicaid recipients. Note that limited funeral agreements can be set up for client's spouse, children and some other designated relatives.
- **Holocaust reparations** are not counted. See <http://wnylc.com/health/entry/65/>
- For a complete list of less common exemptions, see <http://wnylc.com/health/download/3/>.

**If a client still has resources exceeding the limits**, she/he might consider a Medicare Savings Program without Medicaid, and EPIC, since these programs have no resource limits. If she/he needs Medicaid in order to obtain long-term care services, she/he should consult an elder law attorney. Transferring assets does not disqualify an individual or spouse for Medicaid services in the community, including home care and assisted living. However, a transfer of assets may disqualify an applicant or spouse from having Medicaid pay for nursing home care if either spouse needs it within five years after making a transfer.

## B. INCOME - for Aged 65+, or Disabled or Blind

- **Income** means any payment from any source. It includes not only payments of money, but also “payments” in goods and services. Income can be a payment made on a one-time basis or on a recurring basis. Income can be earned, such as compensation received as a result of working, such as wages, tips, bonuses, and commissions. Income can also be unearned, such as dividends, interest, and pension benefits.
- Gross income is counted, including Social Security, pensions, distributions from IRA's, unemployment compensation, workers compensation, wages, and rental income. Both the applicant's income and the spouse's income are counted, but generally income of other household members is not counted, even if related.
- Deductions from gross income include:
  - \$20 per month per individual or couple (as shown in income chart below, this effectively raises income limit by \$20/month)
  - Medical insurance premiums - Part B, Part D, Medicare Supplement (Medigap) Insurance premiums
  - Earned income deductions - If Aged/Disabled/Blind beneficiary or his/her spouse is working, the first \$65 of monthly gross earned income, and **half** of the remaining monthly gross earned income, is disregarded. This is an incentive to work.
  - The first \$90 per month of any income received from a non-family roomer or boarder is deducted.
- Excluded income – not counted for Medicaid includes:
  - Holocaust reparations
  - Federal energy assistance payments;
  - Food stamp coupons
- In-kind income – If anyone other than a legally responsible relative pays the client's expenses directly to the vendor, such as paying rent directly to the landlord, or paying an electric bill directly, this “in-kind” income is not counted. Children are never legally responsible for their parents. Parents are never legally responsible for children over age 21. If the money is given to the client however, this is a gift of cash and is countable income.

- Retroactive benefits under the SSI program are disregarded for 9 months, and tax refunds and some other types of income have time-limited disregards, giving the client time to spend them down to the Medicaid resource limit;
- Other less common deductions and exclusions are listed in <http://wnylc.com/health/download/1/> and the Department of Social Services regulations at 18 NYCRR §§ 360-4.6, 360-4.7. Once the above deductions are taken from gross income, one is eligible if the remaining net income is under the following limits.

**2013 Income Limits for Age 65+, Disabled or Blind (or under 65 and live with and take care of a child or other relative under age 21)**

Household Size	Monthly Income
One	<b>\$800</b> (\$820 if age 65+, disabled, blind)
Two (married)	<b>\$1,175</b> (\$1195 if age 65+, disabled, blind)



**Consumer Tips: strategies to help people with higher incomes access Medicaid:**

- **Consumer Tip One - Spousal Refusal:**  
If a married couple’s income exceeds the limits for a couple, but only one spouse needs Medicaid, she/he may apply even if the other spouse does not also apply. If applicant indicates that the spouse fails or refuses to contribute his/her income toward the medical bills of the applicant, then Medicaid must only count the applicant’s income. The county has the right to sue the “refusing spouse” for support. Find out the policy in your county for determining which spouses are likely to be sued. Form used for spousal refusal in NYC can be downloaded here -- <http://www.wnyc.com/health/download/66/> -- and used as a template in other counties.  
**Note: Not everyone may use spousal refusal. People Age 65+, Disabled or Blind may use spousal refusal**, as may people under 65 who take care of and live with a child, grandchild, or other relative, **but not** people between age 21 - 65 who have no relative under age 21 living with them and who are not disabled).
- **Consumer Tip Two - Medicaid Buy-In for Working People with Disabilities (MBI-WPD):**  
People over age 16 and under **age 65** who are disabled may qualify for Medicaid even if they have incomes higher than the limits above, if they are working. They do not have to work any minimum amount - it can be just an hour a month, as long as they are paid for their work, or self-employed. In 2013, gross income may be as high as \$58,476 for an individual and over \$76,692 for a couple. Net monthly income, after deducting more than half of gross income, must be under \$2,394 (single) and \$3,232 (couple) (2013). Special enhanced resource limits are stated in the chart on page 9-5 above.  
For more information see <http://www.ilr.cornell.edu/edi/mbi-wpd/> and [http://www.nyhealth.gov/health\\_care/medicaid/program/buy\\_in/index.htm](http://www.nyhealth.gov/health_care/medicaid/program/buy_in/index.htm)  
[http://www.health.ny.gov/health\\_care/medicaid/program/buy\\_in/docs/working\\_people\\_with\\_disabilities\\_030413.pdf](http://www.health.ny.gov/health_care/medicaid/program/buy_in/docs/working_people_with_disabilities_030413.pdf) - TOOLKIT for MBI-WPD
- **Consumer Tip Three - Medicaid Spenddown:**  
Some individuals may qualify for Medicaid with income or resources higher than

Medicaid's specific limits. If an individual's hospital and medical bills are high enough to reduce their income or resources to the Medicaid qualifying level, they may be able to enroll in the Medicaid Spenddown Program. In 2010, the State Dept. of Health improved its online information about spend-down rules, posted at [http://nyhealth.gov/health\\_care/medicaid/excess\\_income.htm](http://nyhealth.gov/health_care/medicaid/excess_income.htm).

- **The spenddown amount is the difference between their income and/or resources and the Medicaid limit.** If a single person aged 65 has a total net monthly income, after deductions, of \$869 with resources at or below the Medicaid level, she/he would need to spend or incur monthly medical bills of \$49 a month in order to become Medicaid eligible because Medicaid's monthly income limit for a household of one is \$800, and there is a \$20 disregard. These medical bills are applied to meet the spenddown even if they are not covered by any third party, such as private health insurance. Also the individual has the option of choosing to "pay-in" his spenddown directly to the Local Department of Social Services.
- **Only Age 65+, Disabled or Blind and families living with minor children under 21 may use spenddown.** People between age 21 - 65 who have no relative under age 21 living with them and who are not disabled may not use spend-down. This is the population that will benefit from the expansion of Medicaid in 2014.
- **If individuals have to spend down their resources,** their medical expenses will be applied first to their excess resources. They only need to meet the resource spenddown once. After that, they are eligible for Medicaid with no resource spenddown, but medical bills used to offset excess resources cannot also be used to meet an income spenddown. Once individuals accumulate bills equal to their spenddown amount, their Medicaid coverage will begin and Medicaid will pay for additional medical expenses to Medicaid providers. Medicaid will not cover the bills used to meet the spenddown. The individual will be responsible for those payments.
- **Important Note: Medical bills do not have to be paid to count toward the spenddown.** Bills only need to be incurred (and not covered by any other third party). The Medicaid office may not demand proof that the medical bill was paid. This does not change the fact that the client is responsible for the payments.

**Medical expenses that can be used to meet the spenddown are:**

1. Medicare and private health insurance **deductibles and coinsurance** or co-payments, including Part D.
2. **Bills for medically necessary services,** including doctor, dental and therapy bills (they do not have to be Medicaid providers), lab tests, transportation to medical appointments, hearing aids, eyeglasses, medical supplies, prescription and over-the-counter medications. May use bills for services not covered by Medicaid, such as chiropractors.
  - Bills may be paid or unpaid (so long as they remain viable).
3. **The costs paid by EPIC or ADAP** for prescriptions, *plus* the EPIC copayments and deductibles paid by the EPIC member, can be used to meet the spenddown. To find out how much EPIC or ADAP have paid, call EPIC 1-800-332-3742 or ADAP 1-800-542-2437. Ask for a statement of all costs paid by EPIC and the EPIC member in the three calendar months before the month client is applying for Medicaid.
 

**Note:** With EPIC restoring most of its benefits in 2013, using EPIC bills to meet the Medicaid spend-down will again be possible.
4. Bills listed above for the **spouse**, as well as the applicant, may be used.

○ **Using Past Medical Bills to Meet the Spenddown**

When one first enrolls in the Medicaid spenddown program, one may submit past medical bills to be counted toward the current spenddown amount. Once a bill is used to meet the spenddown for a particular month, the bill cannot be used again.

**Past paid medical bills** may be used for medical services that were provided and paid for within the three calendar months before the month one applied for Medicaid with a spenddown. They may be used to meet the spenddown for up to six months beginning in the month one applies. (One may opt to begin the six-month maximum period retroactively, up to three months before one applied, if one wants “retroactive coverage” for Medicaid to pay recent medical bills). These rules are now explained on the State Medicaid website at

[http://nyhealth.gov/health\\_care/medicaid/excess\\_income.htm](http://nyhealth.gov/health_care/medicaid/excess_income.htm).

- Bills paid by **EPIC** or ADAP in the three months before the month in which you applied for Medicaid may be used to meet your spenddown.
- **EXAMPLE 1:** Ann paid her dental bill in June for dental care provided in May. She applies for Medicaid in August. She may use the paid dental bill toward her spenddown in August, since the service was provided and paid for within 3 calendar months before the month in which she applied.
- **EXAMPLE 2:** EPIC paid \$250 for Henry’s prescriptions, and he paid \$60 in co-payments for them, in the 3 months before October, when he applied for Medicaid. His spenddown is \$50. The total of \$310 that Henry and EPIC paid for his prescriptions can meet his spenddown for six months beginning in October.

**Past unpaid medical bills** may be used to meet one’s spenddown amount even if they are old, as long as they are still viable, meaning that the medical provider is still able to bring a legal action to collect them. Generally this means the bills can be six years old. These bills may be applied to meet one’s spenddown *indefinitely* into the future. Medicaid is certified in periods of up to six months, but unpaid bills can be carried forward to subsequent periods.

- **EXAMPLE:** Eric has a \$2000 hospital bill from four years ago and received a collection notice from the hospital last year. His spenddown is \$200. He may submit this bill to meet his spenddown for ten consecutive months. The initial Medicaid coverage will be for six months, using up \$1200 of the hospital bill. Eric will then be recertified for a period of four more months, using the balance of \$800 of the hospital bill.

○ **Consumer Tip Four – Spenddown as Pathway to Extra Help:**

Even when one has a high spenddown, it is worth gathering past medical bills, even very old unpaid bills. If the bills meet the spenddown for just one month, an individual will qualify for Medicaid for that month, and in turn, will qualify for Part D Extra Help for that entire calendar year, and for the entire next year if the Medicaid eligibility occurs in the last half of the year. This helps people whose income is above the limit for Extra Help or a Medicare Savings Program.

○ **Example of Using Past Bills to Obtain Part D Extra Help**

Mary is 63 years old, single, disabled and has Medicare. Her Social Security Disability benefits are \$1500/month, which exceed the limit for the Medicare Savings Programs as well as for Full and Partial Extra Help for Part D. She comes to you in September, after falling into the doughnut hole in August. Her prescriptions cost

\$1000/month. She is too young for EPIC, and is not eligible for Family Health Plus because she has Medicare (and too much income).

Her Medicaid spenddown is \$713/month, which she cannot afford to pay with her rent and other living expenses. Her resources are under the Medicaid limit of \$14,400. You ask her if she has any old medical bills -- she has an old hospital bill from 3 years ago of \$2139, plus her Part D plan just billed her for \$1000 in medications sent by mail order in August -- she had ordered them before she realized she was in the doughnut hole.

- **SOLUTION:** She applies for Medicaid in September, submitting a copy of the old hospital bill of \$2139, which meets her spenddown for three months. Medicaid approves her with retroactive coverage for August, September and October. You ask her pharmacy to fill her prescriptions, billing her only for the Extra Help copayments, by providing the Medicaid notice as “Best Available Evidence” of her eligibility for Extra Help. You also mail back the Part D plan’s bill for the August prescriptions, enclosing a copy of the Medicaid notice, and explaining that they may only bill her for the Extra Help copayments, citing the notice as Best Available Evidence of her eligibility. She will have Extra Help for the remainder of the current calendar year, and the entire subsequent year, even though she will no longer meet the Medicaid spenddown after October.

**Special Six-Month Spenddown Rule for Inpatient Hospital Coverage.** If the amount of one’s past paid and unpaid medical bills meets the spenddown for a full six months, then she/he is certified eligible for inpatient as well as outpatient Medicaid coverage (i.e., including inpatient care in a hospital) for a six-month period. If the amount of past bills meets the spenddown for only two months, then the individual is eligible for only two months of Medicaid outpatient coverage and Medicaid will not pay for inpatient care during that period. If, after the initial six-month certification period, the individual has additional unpaid bills, she/he may use the remaining unpaid bills to be authorized for another certification period of up to six months. Remaining paid bills cannot be carried forward past the initial six months.

**Month-to-Month Spenddown Coverage** -- After an individual has used up all of his/her past paid and unpaid medical bills to meet the spenddown, she/he must meet the spenddown each month solely with medical bills for services provided in that month. She/he must submit medical bills for these services -- paid or unpaid -- to the social services district Medicaid office one month at a time. Some Medicaid offices accept bills by fax. She/he can also enroll in the Pay-In program, in which she/he pays the spenddown amount to the district, up to six months at a time. There will be a gap in coverage each month while the Medicaid office processes the medical bills.

- **Consumer Tip Five - Eliminating Spenddown Using a Supplemental Needs Trust:** Under special federal rules, if a Medicaid recipient who is disabled, of any age including seniors, deposits his or her spenddown into a Supplemental Needs Trust each month, and the trust is approved by the Medicaid program, the local district must re-budget the income and disregard the amount paid into the Trust. In essence, this procedure makes the spenddown vanish. Since this policy was approved in 2005, thousands of New Yorkers who would otherwise have a high spenddown have accessed Medicaid this way. There are many rules and requirements to use this procedure.

**If Age 65, Must Use a Pooled Trust.** There are two types of Supplemental Needs Trusts -- individual trusts drafted for the individual client, and “pooled trusts” run by non-profit organizations, in which many clients enroll by setting up their own account

within the trust. People with disabilities under age 65 have a choice and can use either, if they follow the complex rules. People over age 65 may only use a pooled trust.

**Disability Requirement:** People under age 65 who use these trusts usually have Social Security Disability income, which is sufficient proof that they are disabled. People over age 65 receive retirement benefits, rather than disability benefits, from Social Security. Medicaid requires proof that they are disabled in order to enroll in these trusts.

**For Forms and More Information:** See Selfhelp’s guide to supplemental needs trusts at <http://wnylc.com/health/entry/2/>, with links to a step-by-step guide to enrolling in a pooled trust, links to the disability forms, and a link to a list of pooled trusts in New York State.

**CATEGORY 2: Under age 65, and not disabled or blind - Financial Eligibility Rules**

For individuals who are under age 65 and not disabled or blind, such as those receiving Social Security early retirement benefits, the rules are different than those described above.

**A. RESOURCES -- The good news is that since January 1, 2010, they have no resource limits.**

All the rules for people age 65+ or disabled, set forth above, about limits on bank accounts, IRAs, burial funds, etc. do not apply to them, as long as they do not need permanent nursing home care. If they need permanent nursing home care, the resource rules described above would apply. Also, if their resources generate interest and dividends, this interest counts as income. For this category, there is no spenddown permitted -- either they meet the income limits or they don’t. So, as a practical matter, there is a limit on resources if they generate interest or dividends.

**B. INCOME**

The income limits for this category are lower than the ones set forth above for people age 65+, disabled or blind. However, an exception is made for non-disabled adults under age 65 who have a child, grandchild or other relative under age 21 living with them who they take care of. In that case, they use the same income limits as the ones for Age 65, Disabled, or Blind (Medicaid Category 1)

**2013 Income Limits for UNDER 65, Not Disabled or Blind and Not Caring for a Relative Under Age 21**

Household Size	Monthly Income
One	\$750
Two (married)	\$936

The deductions from gross income are also different for this category. Unlike people age 65+, disabled and blind, there is:

- NO \$20/month deduction from income.
- NO deduction for health insurance premiums
- A less generous deduction from earned income. Only \$90 per month is deducted from gross income.

**No Spenddown** -- An important rule for people under age 65 who are not disabled or blind is that they may NOT qualify for Medicaid if their income exceeds the limits in the Table above by using “spenddown”. If income is \$1 over the limit, they are not eligible, regardless of their medical expenses. *They may be eligible for Family Health Plus.* An exception is made for people **under 65, who are not disabled or blind, but who have a child, grandchild,** or other relative **under age 21** who they live with and take care of. They are allowed to use spenddown.

### **Preview of 2014 Medicaid Expansion**

Beginning January 1, 2014, many individuals under age 65 will be eligible for Medicaid under new eligibility standards. These rules do not apply to people age 65+, disabled or blind, whose eligibility will not change from the rules described above. The new Medicaid groups are known as “MAGI” because their eligibility is determined by tax rules using their Modified Adjusted Gross Income (MAGI) under IRS rules. Briefly, the new rules are:

- The eligibility limit will be 133% of the Federal Poverty Level for a household, which will be redefined as a tax filing unit, with limited exceptions to protect children who would be part of a Medicaid household under previous rules. MAGI budgeting utilizes a 5% income disregard. For this reason, the effective eligibility level is up to 138% FPL (133% FPL plus 5% disregard). While the Federal Poverty Level for 2014 is not yet available, using the 2013 levels for comparison, the new monthly income limits for people under age 65 are (these are 138% of FPL):  
ONE - \$1,321 TWO - \$1,784 THREE \$2,246
- Household income is redefined for the MAGI group to include the income of all members of the tax filing household, with some exceptions for members who are not required to file tax returns.
- Pregnant women and infants under one year are eligible for full Medicaid coverage up to 200% of the FPL. Family size includes household members plus the number of children the woman expects to deliver.
- MAGI groups have continuous eligibility for 12 months, despite changes in income.
- More details will be available later in 2013 on how income is calculated, etc.



### **What if an individual becomes eligible for Medicaid and has a Medigap insurance policy?**

Low-income Medicare beneficiaries need some secondary insurance to help fill in Medicare’s gaps. They often struggle to pay coinsurance, deductibles, and non-covered services with a very limited income. If they qualify, **Medicaid** can wrap around Medicare coverage and pay many of the costs Medicare does not pay.

In order to encourage the dually eligible (people with Medicare and Medicaid) to keep a private **Medigap** health insurance policy, health insurance premiums are an allowable deduction from income for people age 65+, disabled, or blind. Since the amount of the premium is deducted from gross income, a Medigap policy reduces their “spenddown,” described above. If an applicant is income-eligible without using the health insurance as a deduction (meaning their countable income is below the Medicaid limit), Medicaid may even pay for the premium, if it is determined to be cost-effective.

**Caution: Can the senior afford Medigap? Is it necessary for a dual eligible with Medicaid to supplement Medicare?**

Even when the Medigap premium is deducted from their gross income for Medicaid eligibility, many low-income older adults and people with disabilities cannot afford the cost of a Medigap policy. They may deprive themselves of necessities so that they will have the money to pay the insurance policy premiums.

- If they qualify for Medicaid, they would not need a Medigap policy unless they wish to choose doctors who do not accept Medicaid patients. Even then, if they qualify for QMB, a non-Medicaid doctor may not bill them for the Part B coinsurance, though Medicaid will not pay non-Medicaid doctors for QMB co-insurance. See <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf>. It should be noted that this is not so easy to apply in practice. If a person with Medicare receives services from non-Medicaid doctors, they may prefer to have a Medigap policy so that those doctors are assured of getting paid.
- To allow the dually eligible to temporarily suspend their Medigap coverage, since it may not be necessary because they have Medicaid, the Omnibus Budget Reconciliation Act (OBRA) of 1990 enables people with Medicare to suspend a Medigap policy if they become eligible for Medicaid. They must request that their policy be suspended within 90 days of becoming Medicaid eligible.

During the suspension period, which can last up to 24 months, the Medigap insurer charges no premiums and provides no benefits. If a person with Medicare loses Medicaid eligibility, he or she must notify their Medigap insurer within 90 days. The Medigap insurer must reinstate their Medigap coverage effective on the date their Medicaid coverage was terminated.



**Consumer Tip:** The Medicare Savings Programs may help those dually eligible and other low income Medicare beneficiaries to afford a desired Medigap policy, since the Part B premium is paid by the MSP program. Many seniors may be reluctant to apply for government assistance, even when they desperately need it. **Medicaid, and the QMB, SLMB, QI-1, and QDWI programs are part of the public safety net.**

**Are there special eligibility rules to receive Medicaid long-term care services?**

In addition to paying hospital and medical bills for low-income New Yorkers, Medicaid will also pay for long-term care, both in the community and in nursing homes. The services available are described below under SERVICES. Here, we will discuss some special eligibility rules that apply to receiving long-term care.

**Eligibility for community-based services.** The rules for resources and income for people age 65+, blind, or disabled, set forth above, apply for all community-based home care and other non-institutional services, except that there is a limit on the equity value of one's home. See below. The spend-down program, described above, makes it possible for many seniors and people with disabilities to qualify for Medicaid coverage of long-term care needs.

- **No transfer penalty for community-based services.** If an individual's resources/assets exceed the Medicaid limits, there is no penalty for transferring these assets if one only seeks community-based Medicaid, including home care services. Someone may transfer assets in one month, and apply for Medicaid for community-based services, including home care, the first of the following month. However, that individual or his/her spouse may be disqualified from having Medicaid pay for nursing home care should she/he need it

any time during the five years after the transfer. This “transfer penalty” is explained below. For this reason, legal advice from an elder lawyer is recommended before transferring assets, even for community-based services which have no transfer penalty.

**Home equity limit of \$802,000 (2013 rate).** Beginning January 1, 2006, a Medicaid applicant/recipient of institutional and non-institutional long-term care services is subject to a home equity limit. If the value of your equity interest in your home exceeds \$802,000 (as of January 1, 2013), and no spouse, child under 21 or certified blind or certified disabled child resides in the home, you are not eligible for Medicaid coverage for long-term care services. For married couples, the home is protected for the spouse who continues to live there regardless of the equity amount.

**Institutional long-term care (nursing home or skilled nursing facility).**

All of a Medicaid recipient’s income, except for a small monthly allowance for personal needs (generally \$50/month) and certain deductions such as health insurance premiums, will be used to help pay for the cost of care. Medicaid will pay the balance up to the Medicaid rate if one is determined to be Medicaid eligible. There are “spousal impoverishment provisions” that mandate additional financial protection for the spouse in the community and other dependent relatives, discussed below.

**If I sell or, give away resources, or transfer any money, can I still get Medicaid to pay for nursing home care?**

A transfer occurs when money or property is given away or sold for less than it is worth. You can keep certain money or property for you and your family and still get Medicaid. If either spouse has transferred money or property within five years before applying for Medicaid, she/he may be ineligible for Medicaid coverage of nursing home facility services. This includes transfers to individuals, charities, or to a trust.

**LOOKBACK PERIOD** - Applicants must disclose every statement for all assets - bank accounts, investment accounts, etc. - back five years before filing the Medicaid application. This is called the **lookback period**.

**How long is the transfer penalty and when does it begin?**

The length of the transfer penalty is calculated by the amount of money transferred divided by a regional penalty transfer rate that is set each year. The 2013 rates are in [http://www.health.ny.gov/health\\_care/medicaid/publications/gis/13ma001.htm](http://www.health.ny.gov/health_care/medicaid/publications/gis/13ma001.htm) (also lists which counties are in each of these seven regions).

- Central \$8,432
- Long Island \$12,034
- New York City \$11,350
- Northeastern \$8,950
- Rochester \$9,782
- Western \$8,682
- Northern Metropolitan \$10,737

For transfers made on or after February 8, 2006, the period of ineligibility for nursing facility services (transfer penalty) generally begins the first month of institutionalization and in which

a completed application for Medicaid is filed, where the applicant would otherwise be eligible for Medicaid coverage of nursing facility services. In other words, the applicant must at the time have resources within the Medicaid resource limits (\$14,400 in 2013 plus the exempt assets such as a pre-paid funeral agreement and IRA in pay-out status).

This is a change from how the penalty was assessed previously. Previously, the penalty period started when the asset was transferred, so that one could transfer the asset while living in the community, and the penalty period would start immediately, and be finished by the time you needed nursing home care. Now, the penalty period does not begin until you are actually in a nursing home, even if it is as much as 5 years after the transfer.

**Example:** Susan lives in Rochester and transferred \$97,820 to her daughter in March 2009, and applied for Medicaid to receive certified home health agency services in April 2009. These services were approved because there is no transfer penalty for community-based services. In March 2013, Susan had a stroke, was hospitalized and then was placed in a nursing home. Other than the money she transferred in March 2009, her assets were within the 2013 Medicaid limit for a single person - \$14,400. She applies for Medicaid in June 2013, after her rehab care covered by Medicare and her Medigap policy ends. Assuming that there are no exemptions from the transfer penalty (discussed below), the penalty runs for 10 months -- \$97,820 divided by \$9,782. Since she is institutionalized, is applying for and is otherwise eligible for Medicaid, the transfer penalty begins in June 2013. Medicaid will not pay for her nursing home care for the next ten months beginning June 2013. One option around this penalty is for her to return home from the nursing home after the penalty starts "running--" any time between July 2013 and April 2014. Once it starts, the 10-month penalty would continue to run out while she was at home, and Medicaid would pay for community-based home care and other medical care, which has no transfer penalty.

**Exceptions can occur when money or property is transferred to certain members of your family. An applicant may still be eligible for Medicaid coverage of nursing home care in the following circumstances:**

- You transfer assets to your spouse;
- You transfer assets or property to your child who is certified blind or certified disabled, or to a trust established solely for the benefit of such child;
- You transfer assets to a trust established solely for the benefit of any individual under age 65 who is certified disabled - including a trust for yourself if you are under age 65.
- The property transferred was your home, and it was transferred to:
  - your spouse, child under age 21, or child of any age who is certified blind or certified disabled;
  - your brother or sister who already has an equity interest in part of your home and who lived in the home for at least one year immediately before you became institutionalized.
  - your child of any age if your child was living in your home for at least two years immediately before you became institutionalized and your child took care of you so that you could stay home rather than enter a nursing home.
- You intended to sell the asset for what it was worth or to get something else of equal value in exchange;

- The asset was transferred exclusively for some reason other than to qualify for Medicaid coverage of nursing facility services, or
- Despite all your attempts, you cannot get the money or property back or get something of equal value, and you cannot get the medical care you need without Medicaid, or the transfer penalty would deprive you of food, clothing, shelter, or other necessities of life. You must work with the LDSS in trying to get the money or property back.
  - All of the transferred assets have been returned.



**Consumer Tip** - Transfer rules are complicated. Refer to an experienced elder law attorney if the person seeking long-term care, whether in the community or in a nursing home, or his or her spouse, owns a home, has assets exceeding the Medicaid limits, or transferred assets in the past and now needs nursing home care.

### **New York State’s Spousal Impoverishment Provisions for Couples where One is in a Nursing Home or in a Community-Based “Waiver” Program**

When a husband or wife enters a nursing home for long-term care, the spouse at home (the community spouse) may fear financial devastation - becoming impoverished, losing the family home, having to use all monthly income, or depleting savings to pay the nursing home. Married couples have special protection, because the federal spousal impoverishment provisions allow the community spouse to keep a certain amount of the couple’s total countable resources and also a monthly income allowance before beginning to pay for the nursing home care of the institutionalized spouse.

This law allows each state to decide on a dollar figure up to a maximum dollar amount that the community spouse can keep. Therefore, the amount allowed varies from state to state. New York State allows the community spouse to retain a high amount of resources and the highest amount of monthly income allowed by federal law. The maximum income allowance is increased yearly to reflect changes in the federal consumer price index (but did not increase in 2010 or 2011).

Here’s how the law works. When one spouse must enter a nursing home, a “snapshot” is taken of the couple’s total countable resources. The couple’s home, car, household possessions, and certain funds established for burial expenses are not counted as resources. IRA’s are also exempt, as long as distributions are being taken, under the same rules that apply for community Medicaid.

**Income Protections for Spouse.** In 2013, the community spouse of an institutionalized Medicaid recipient is permitted to retain up to \$2,898 of monthly income. If the community spouse has personal income in excess of \$2,898 per month, he or she will not receive any allowance from the institutionalized spouse, and will be asked to contribute 25 percent of his or her income that exceeds \$2,898 toward the cost of care of the institutionalized spouse. If the community spouse’s income is below that figure, s/he will receive the institutionalized spouse’s income up to the amount needed to bring her total income up to \$2,898.

**Resource Protections for Spouse.** The community spouse is permitted to retain resources, called the Community Spouse Resource Allowance (CSRA), equal to the *greater* of the following:

- \$74,820, or

- the “spousal share,” which is 1/2 of the total value of the countable combined resources of the couple up to \$115,920 (2013) or
- an amount established by fair hearing, or;
- an amount transferred to the community spouse by court order

In addition, the institutionalized spouse can retain up to \$14,400 in countable resources, can place any amount of money in a nonrefundable irrevocable funeral agreement, and in some cases, may also have a burial fund. **Four possible scenarios that further illustrate these changes follow below.**

**Scenarios for Spousal Impoverishment**

▪ **Example 1:**

A couple has total countable resources of \$78,000.

**Step 1:** Figure the Spousal Share:  $\$78,000 \times 1/2 = \$39,000$ .

The community spouse would be entitled to keep \$74,820 because that amount is greater than the spousal share.

**Step 2:** Figure the institutional spouse’s resource eligibility

Total Countable Resources	\$78,000
Minus CSRA	<u>- 74,820</u>
	\$ 3,180

The remaining resources are less than the \$14,400 resource limit for the institutionalized spouse; therefore, if otherwise eligible, the institutionalized spouse would be eligible for Medicaid.

▪ **Example 2:**

A couple has total countable resources of \$98,000.

**Step 1:** Figure the spousal share:  $\$98,000 \times 1/2 = \$49,000$

The community spouse would be entitled to keep \$74,820 because that amount is greater than the spousal share.

**Step 2:** Figure the institutionalized spouse’s resource eligibility.

Total Countable Resources	\$98,000
Minus CSRA	<u>- 74,820</u>
	\$23,180
Medicaid Resource Limit for the institutionalized spouse	<u>- 14,400</u>
Excess Resources	\$8,780

The couple has \$8,780 in resources over the Medicaid resource limit. If these resources are in the institutionalized spouse’s name, she/he would be ineligible for Medicaid until the excess resources are spent, used to set up a pre-paid, nonrefundable irrevocable burial agreement or until the institutionalized spouse incurs out-of-pocket medical bills at least equal to the amount of his or her excess resources. Alternatively, the institutionalized spouse may transfer the excess assets to the community spouse. Transfers to the spouse are exempt from any transfer penalty. If the community spouse issues a “spousal refusal” for the excess resources the institutionalized spouse may not be denied Medicaid. The county may, however, sue the “refusing” spouse for support.

▪ **Example 3:**

A couple has total countable resources of \$152,000.

**Step 1:** Figure the spousal share  $\$152,000 \times 1/2 = \$76,000$ .

The community spouse would be entitled to keep \$76,000 because in this case, the spousal share is between \$74,820 and \$113,640.

**Step 2:** Figure the institutionalized spouse's Medicaid eligibility:

Total Countable Resources	\$152,000
Minus CSRA	<u>- 76,000</u>
	\$76,000

Medicaid Resource Limit for the institutionalized spouse	<u>- 14,400</u>
Excess Resources	\$61,600

If the excess \$61,600 in resources are in the institutionalized spouse's name, the institutionalized spouse is over the Medicaid resource limit by that amount and, therefore, would be ineligible for Medicaid until the excess resources are spent, used to set up a nonrefundable, irrevocable pre-need funeral agreement, or until the institutionalized spouse incurs out-of-pocket medical bills at least equal to the amount of his or her excess resources. Alternatively, the institutionalized spouse may transfer the excess assets to the community spouse. Transfers to the spouse are exempt from any transfer penalty. If the community spouse issues a "spousal refusal" for the excess resources, the institutionalized spouse may not be denied Medicaid. The county may, however, sue the "refusing" spouse for support.

▪ **Example 4:**

A couple has total countable resources of \$220,000.

**Step 1:** Figure the spousal share:  $\$220,000 \times 1/2 = \$110,000$ .

The community spouse would be entitled to keep \$115,920 because the spousal share is higher than \$110,000.

**Step 2:** Figure the institutionalized spouse's Medicaid eligibility:

Total Countable Resources	\$220,000
Minus CSRA	<u>- 115,920</u>
	\$104,080

Medicaid Resource Limit for the institutionalized spouse	<u>- 14,400</u>
Excess Resources	\$89,680

If the excess \$89,680 in resources are in the institutionalized spouse's name, the institutionalized spouse is over the Medicaid resource limit by that amount and would be ineligible for Medicaid until the excess resources are spent, used to set up a nonrefundable, irrevocable funeral agreement, or the institutionalized spouse incurs out-of-pocket medical bills at least equal to the amount of his or her excess resources. Alternatively, the institutionalized spouse may transfer the excess assets to the community spouse. Transfers to the spouse are exempt from any transfer penalty. If the community spouse issues a "spousal refusal" as to the excess resources, the institutionalized spouse may not be denied Medicaid. The county may, however, sue the "refusing" spouse for support. Refer couple to elder law attorney for other planning options.

### **Spousal Protections where One Spouse is in a “Waiver” Program**

The spousal impoverishment protections described above generally apply only for couples where one spouse is in a nursing home, not when both spouses live at home. An exception to this is for couples where one spouse receives services from a Home-and-Community-Based Services Waiver program. As of a 2012 change, these programs include the Lombardi (long term home health care program), the Traumatic Brain Injury Waiver Program (TBI), and Nursing Home Transition and Diversion (NHTD) waiver programs. See <http://wnylc.com/health/news/32/>. However, the Lombardi program is being phased out and merged with the managed long term care program beginning April 2013, which is when this update is being written. These protections do NOT apply where one spouse is receiving other types of Medicaid home care services, including managed long term care, though the State has asked CMS to approve providing these protections to these individuals. Reportedly, Lombardi participants required to transfer to the managed long term care program after April 2013 will retain their spousal impoverishment protections.

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## **SERVICES COVERED BY MEDICAID**

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### **What services does Medicaid pay for?**

Medicaid may help pay for:

- Hospital inpatient and outpatient services
- Laboratory and X-ray services
- Nursing home care - short-term rehabilitation as well as long-term care
- Treatment and preventive health and dental care (doctors and dentists)
- Treatment in psychiatric hospitals (for persons under 21 or 65 and older), mental health facilities, and mental retardation and developmental disabilities facilities
- Family planning services
- Medicine (prescription and over-the-counter) and supplies
  - BUT Medicare beneficiaries must enroll in a Part D plan, and will not receive any Medicaid help with prescriptions, except for those classes of drugs not covered by Medicare at all and certain over-the-counter prescriptions.
  - As of April 1, 2011, Medicaid no longer covers any drugs that the Part D plan could cover but does not include on its formulary. Before that date, this “wraparound” coverage was limited but was still important since it covered HIV/AIDs drugs, post-transplant, anti-psychotic and anti-depressant drugs).
  - Nutritional supplements – (Ex. - Ensure) In 2011, Medicaid limited these supplements to people who were tube-fed. The state 2012 budget directed DOH to develop standards to expand access to persons diagnosed with HIV and other illness and conditions. As of April 2013, these standards are still not developed. People needing Ensure should have their doctors request it and if denied contact either the Empire Justice Center at 1-800-724-0490 or NYLAG at [eflrp@nylag.org](mailto:eflrp@nylag.org). Orthotics and inserts -- The 2011 state budget limits these to prostheses for amputees or as part of a diabetic treatment plan, or for children with development problems. The budget also limits compression stockings. Under court orders inn May 2012 and January 2013, the state must inform Medicaid providers and suppliers of the availability of coverage for compression stockings and orthopedic footwear. Here’s the link to the posting on the NYS Dept of Health website: [http://www.health.ny.gov/health\\_care/medicaid/program/update/2013/noticejan2013.htm](http://www.health.ny.gov/health_care/medicaid/program/update/2013/noticejan2013.htm).

If you know of Medicaid recipients who have been unable to get Medicaid coverage for these services, please contact the Health Law Unit at the Empire Justice Center at 1-800-724-0490. See more information at <http://www.wnyc.com/health/entry/182/>

- Clinic services and other health services
  - Emergency ambulance transportation to a hospital
  - Transportation to medical appointments, including bus fare and car mileage. Note that in May 2012, New York City is starting a new system for receiving approval for and scheduling this transportation. <http://www.nycmedicaidride.net>
  - CAUTION: In every county in NYS, most Medicaid recipients who do not have Medicare and who do not have a spend-down are required to enroll in a Medicaid managed care insurance plan, and to receive most of the services listed above from providers in the plan's network and using the authorization procedures in that plan. More on this later.

**Medicaid Community-based long-term care (home care) services.** NYS has many Medicaid home care programs, but in 2012 and 2013 is radically changing how these services are delivered. In general, these services include:

- Personal care services (also known as home attendant or housekeeping)
- Consumer-Directed Personal Assistance Program (CDPAP) – a variation of personal care services in which consumers may hire their own aides, including family members other than a spouse or a parent, and aides may perform skilled tasks that normally can only be performed by nurses or family. See more at <http://www.wnyc.com/health/entry/40/>.
- Home health care from a Certified Home Health Agency (CHHA) (visiting nurse, visiting physical or occupational therapist, home health aide)
- Private Duty Nursing care
- Durable medical equipment (wheelchairs, orthopedic shoes, etc.)
- Adult day health care (medical model)
- Long-term health care in the home, under the Long-Term Home Health Care Program (LTHHCP or Lombardi) – as of April 1, 2013, no new enrollment in this program will be allowed statewide for people who do not have Medicare – they must obtain home care through a Medicaid managed care plan. Adult (age 21+) Dual eligibles living in areas with mandatory Managed Long Term Care will also no longer be allowed to enroll in the Lombardi program, and those who are enrolled will be required to transfer to a long term care plan. As of April 1, 2013, these mandatory areas are New York City, Nassau, Suffolk and Westchester. See MLTC section below for more. In other counties to find the LTHHCP, home health care, or hospice program in your county, see <http://homecare.nyhealth.gov/>.
- Other home care services, including Nursing Home Transition Diversion Waiver, Traumatic Brain Injury waiver, and the Assisted Living Program, see [http://www.nyhealth.gov/health\\_care/medicaid/program/longterm/](http://www.nyhealth.gov/health_care/medicaid/program/longterm/)
- Assisted Living Program.

The way the above long term care services are accessed is changing in NYS. As of April 2013, in NYC, Nassau, Suffolk and Westchester counties, most of the above services can only be accessed through a managed long term care plan, discussed below. In other counties, they still can be accessed the old way, which varies by service. Information on these programs can be found at [http://www.nyhealth.gov/health\\_care/medicaid/program/longterm/](http://www.nyhealth.gov/health_care/medicaid/program/longterm/) and <http://wnyc.com/health/entry/41/>.

For each county every certified home health agency, hospice, licensed home care services agency, and Lombardi/ Long Term Home Health Care program can be found at <http://homecare.nyhealth.gov/>.

## MANAGED LONG TERM CARE (“MLTC”)

New York has had managed long term care plans for many years. Before, however, enrollment was voluntary, and MLTC was just one option of several types of Medicaid home care one could choose. On September 4, 2012, the federal government Medicaid agency CMS approved the state's request for an "1115 waiver" that allows NYS to require that all *dually eligible* (those who have Medicare and Medicaid) adults age 21+ now receiving -- or who will apply for -- community-based long-term care services -- particularly personal care/home attendant services, long-term Certified Home Health Agency services, Consumer-Directed Personal Assistance Program services (CDPAP), private duty nursing and medical adult day care -- to enroll in a Managed Long-Term Care (MLTC) plan. The MLTC plan will now control access to, approve, and pay for all Medicaid home care services and other long-term care services in the MLTC service package. This is the only way to obtain these services for adults who are dually eligible, unless they are exempt or excluded from MLTC.

The State Medicaid program pays a fixed monthly amount to the managed long term care plan, with the expectation that the plan will save money on clients who need few services, and spend more on high-need individuals. This is known as “spreading the risk”.

If they do not choose a MLTC plan then they will be auto-assigned to a plan. The requirement to enroll in an MLTC plan is being rolled out gradually throughout the State, starting in NYC in September 2012, then in Long Island and Westchester in January 2013, and then to other counties. (See roll-out schedule for mandatory enrollment below.) People who live in counties that are not yet mandatory do not have to enroll in an MLTC plan - they may still apply for Medicaid personal care services at their local county DSS, or obtain CHHA, adult day care, or private duty nursing services.

**There are two models of MLTC** – the fully capitated PACE and Medicaid Advantage Plus programs and partially capitated managed long term care (MLTC) plans.

### 1. Fully capitated plans – PACE and MAP

In a fully capitated plan, the member essentially gives up her Medicare and Medicaid cards and agrees to use one insurance plan for all Medicare and Medicaid services. All services must be in the plan’s network. The plan is responsible for not only long term care but also primary and acute and emergency medical care.

#### o *Program for All-Inclusive Care for the Elderly (PACE)*

A PACE organization provides a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission. Both Medicare and Medicaid pay for PACE services (on a capitated basis).

PACE members are required to use PACE physicians and providers (they cannot go “out of plan”) and an interdisciplinary team develops care plans and provides on-going care management. The PACE is responsible for directly providing or arranging all primary, inpatient hospital and long-term care services required by a PACE member. Most participants are dually eligible for Medicare and Medicaid, with a small number in only one or the other.

Some social and environmental services not normally reimbursed by Medicaid and Medicare may be included.

Enrollees must attend medical adult day care, supplemented by other services.

Lists of PACE plans: [http://www.health.ny.gov/health\\_care/managed\\_care/mltc/mltcplans.htm](http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm) (official DOH list); <http://www.wnyc.com/health/afile/114/371/> (Compiled by NYLAG). Spousal impoverishment protections apply.<sup>1</sup>

○ *Medicaid Advantage Plus (MAP)* –

Like PACE, fully capitated. Unlike PACE, this is more of a pure insurance model, not based on any particular provider network. The individual joins a “Medicare Advantage Plan” and then joins the connected Medicaid Advantage Plus plan operated by the same company, thus combining both Medicare and Medicaid services.

Lists of plans – same lists as above for PACE. Model MAP contract posted at [http://www.health.ny.gov/health\\_care/managed\\_care/mltc/](http://www.health.ny.gov/health_care/managed_care/mltc/).

## **2. Partially Capitated Plan -- Managed Long Term Care Plans (MLTC)**

"Managed long-term care" plans are the most familiar and have the most people enrolled – 80,000 in NYS as of April 2013, mostly in New York City. They provide Medicaid long-term care services (like home health, adult day care, and nursing home care) and ancillary and ambulatory services (including dentistry, optometry, audiology, podiatry, eyeglasses, and durable medical equipment and supplies), and receive *Medicaid payment only*, with NO Medicare coverage.

These plans DO NOT cover most primary and acute medical care. Members continue to use their original Medicare cards or Medicare Advantage plan, and regular Medicaid card for primary care, inpatient hospital care, and other services. The MLTC plan does not control or provide any Medicare services, and does not control or provide most primary MEDICAID care. Managed long-term care plan enrollees must be at least age 18, but some require a minimum age of 21. See state's chart with age limits. [http://www.health.ny.gov/health\\_care/managed\\_care/mltc/mltcplans.htm](http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm)

It is this partially capitated MLTC plan that is becoming mandatory for adults age 21+ who need Medicaid home care and other community-based long-term care services. But consumers have the option of enrolling in "fully capitated" plans as well -- so it's important to know the differences.

The following services are included in capitation – clients must use all IN-NETWORK providers affiliated with plan. WARNING: Medicaid will not pay for these services if provider is not in plan or referral not obtained.

- Home Care, including:
  - Personal Care (Home attendant or Housekeeping)
  - Certified Home Health Agency Services (home health aide, visiting nurse, visiting physical or occupational therapist)
  - Private Duty Nursing
  - Consumer Directed Personal Assistance Program
- Adult Day Health Care (medical model and social adult day care)
- Personal Emergency Response System (PERS),
- Nutrition -- Home-delivered meals or congregate meals
- Home modifications
- Medical equipment such as wheelchairs, medical supplies such as incontinent pads, prostheses, orthotics, respiratory therapy
- Physical, speech, and occupational therapy outside the home
- Hearing Aids and Eyeglasses
- Four Medical Specialties:

- Podiatry
- Audiology + hearing aids and batteries
- Dental
- Optometry + eyeglasses
- Non-emergency medical transportation to doctor offices, clinics (ambulette)
- Nursing home care

**Who Must Enroll in MLTC?**

Medicaid recipients who live in NYC and certain counties as they become “mandatory” – so far as of April 2013 - Westchester, Nassau and Suffolk - and who:

- Are dually eligible - they have Medicare AND Medicaid, AND
- Are age 21 or older, AND
- Need long-term care -- Who are receiving or are applying for CERTAIN SPECIFIED Medicaid home care and other community-based long term care services. “Long-term” means you need home care or other long-term care services for more than 120 days.
  - Which long-term care services require enrollment in MLTC is being phased in on the roll-out schedule below.
- And is not "exempt" or "excluded" from enrolling in an MLTC plan. See below.

**Phased In Enrollment**

- Phases One and Two started in September 2012 – but as of April 2013 --
  - Personal Care, CDPAP, Medical adult day care, long-term CHHA recipients, and Lombardi long term home health care program participants in NYC, Westchester, Nassau and Suffolk counties are receiving mandatory enrollment packages, requiring them to select an MLTC plan (or at their option PACE or MAP) within 60 days or be randomly assigned to a plan. All these recipients aren’t receiving notices at the same time – it is over 80,000 people, with notices rolling out over months, starting in NYC in September 2012.
  - In those same counties, new applicants for:
    - Personal Care or CDPAP can only access these services through an MLTC, PACE or MAP plan.
    - But new applicants for medical model adult day care or CHHA may still contact providers of those services directly and receive these services FFS (Fee-for-Service Medicaid). Eventually they will be required to enroll in MLTC. DOH says “front door is not closed” for these services.
- Phase III (June 2013): Rockland and Orange counties
- Phase IV (December 2013): Albany, Erie, Onondaga and Monroe counties (tentative)
- Phase V (June 2014) Other counties with capacity.

Cannot become mandatory in any county until a choice of at least 2 plans with capacity. To see plans in your county with enrollment as of March 2013 see

<http://www.wnylc.com/health/download/371/>.

**In NYC and Counties Where MLTC is Mandatory, WHO DOES NOT HAVE TO ENROLL IN MLTC? (Exemptions & Exclusions)**

**Who is EXCLUDED from MLTC?**

- Individuals in Waiver Programs. These include: Nursing Home Transition & Diversion waiver, Traumatic Brain Injury waiver, Office for People with Developmental Disabilities

waiver, and individuals with complex mental health needs receiving services through ICF and HCBS waiver

- Nursing Home residents;
- Medicaid Assisted Living Program residents;
- Persons receiving hospice services (they may still apply to CASA/DSS for personal care services to supplement hospice);
- Residents of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Alcohol & Substance Abuse Long Term Care Residential Program, adult Foster Care Home, or psychiatric facilities.
- Children under age 18
- NOTE - the (2/2013) New York Medicaid Choice MLTC Exclusion Form (<http://www.wnylc.com/health/afile/114/399/>) excludes an individual certified by physician to have a developmental disability.

**WHO MAY ENROLL IN MLTC BUT IS NOT REQUIRED TO? (WHO is EXEMPT FROM MLTC?)**

- Native Americans;
- Dual eligible individuals age 18- 21 who require home care or other long-term care services, and require a “nursing home level of care,” meaning they could be admitted to a nursing home based on their medical and functional condition;
- Adults over age 21 who have Medicaid but not Medicare (If they require a “nursing home level of care”) -- However, they are likely required to enroll in a [mainstream Medicaid managed care plan](#) anyway - unless they qualify for VERY narrow exceptions, and those plans now control personal care, so enrollment in MLTC may be a preferable option. They *may enroll* in MLTC as an alternative to mainstream Medicaid managed care if they would be functionally eligible for nursing home care. If they enroll in an MLTC, they would receive other Medicaid services that are not covered by the MLTC plan on a fee-for-service basis, not through managed care (such as hospital care, primary medical care, prescriptions, etc.)
- Working Medicaid recipients under age 65 in the [Medicaid Buy-In for Working People with Disabilities \(MBI-WPD\)](#) program (If they require a “nursing home level of care”).
- Adults living in counties that are not yet "mandatory" for MLTC, according to the [Phased-in Roll-out schedule](#) above. WARNING: If they are now receiving Medicaid home care through their county DSS/CASA office, and voluntarily enroll in an MLTC/MAP/ or PACE plan in a county that is not yet mandatory, they risk having their home care services reduced, because they are not entitled to the [60 Day Transition Period](#) services described below for the mandatory counties.

**Letters Sent by NY Medicaid Choice to Clients subject to Mandatory Enrollment**

Current recipients of PCA, CDPAP, CHHA, Lombardi program, and medical model Adult Day Care in Mandatory counties receive a series of letters by mail.

1. "ANNOUNCEMENT " LETTER - [Important Medicaid Notice--http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/1.1-am\\_notice-english-unenrolled.pdf](#) . This "announcement letter" is sent to people with 120 days left on their authorization period for Medicaid personal care telling them "MLTC" is coming. It does not state that they have to enroll yet. It just says that it is coming and to expect a letter.
2. MANDATORY ENROLLMENT PACKET - Sent by a company under contract with the State to serve as enrollment broker, called MAXIMUS or NY Medicaid Choice. Letters are sent 30 days after the first "announcement" letter - stating recipient has 60 days to select a

plan OR will be assigned to an MLTC plan. The first packets were sent in Manhattan in July 2012, telling them to select a plan by September 2012, later extended to October 2012. The Packet includes:

- o Form Letter -- <http://wnylc.com/health/download/318/> It also includes the toll-free number of the enrollment broker, NY Medicaid Choice, for consumers to call with questions about MLTC and help picking a plan.: 888-401-6582.
- o [Managed Long Term Care Brochure](#) -- Official Guide to Managed Long Term Care, written and published by NY Medicaid Choice (Maximus) – Slightly different version in each County. Download them here - .  
<http://www.nymedicaidchoice.com/program-materials>
- o List of plans in County, organized by type (MLTC/PACE, MAP). Download lists for each mandatory county here (look under Long Term Care Plans.  
<http://www.nymedicaidchoice.com/program-materials>

**CHOOSING AND ENROLLING IN A PLAN -**

See [TOOLS FOR CHOOSING AN MLTC PLAN](#). <http://www.wnyc.com/health/entry/169/>

CONTINUITY OF CARE -- One important factor in choosing a plan is whether you can keep your aide that worked with you when CASA/DSS or a CHHA authorized your care before you enrolled in the MLTC plan. In New York City, Nassau, Suffolk, and Westchester -- which are all of the mandatory enrollment counties as of April 2013, all MLTC plans are required to contract with all existing home attendant or housekeeping and personal care vendors that had contracts with HRA/LDSS through December 31, 2013. See *MLTC Policy 13.04: Personal Care Contracting* -- [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/mltc\\_policy\\_13.04\\_personal\\_care\\_contract.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_13.04_personal_care_contract.pdf) If the MLTC plan refuses to allow the client to keep her aide, call the State Dept. of Health at 1-866-712-7197 (MLTC Complaint Line).

- For consumer-directed [CDPAP consumer-directed services](#), the requirement that all plans contract with the local CDPAP vendors goes through 10/31/13 so consumers can keep their current aides. See *Policy for the Transition of Consumer Directed Personal Assistance Services into Managed Care*.  
[http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/final\\_transitional\\_care\\_policy\\_cdpap.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/final_transitional_care_policy_cdpap.pdf) However, as a practical matter, not every plan has entered contracts with every single home attendant vendor in NYC.

If you don't select and enroll in a plan, midway through the 60-day period to select a plan, you will receive a letter with the name of the MLTC plan to which you will be randomly assigned if you do not select a plan. You will still have until the third Friday of that month to select your own plan. For example, the first assignment letters to lower Manhattan residents were sent October 2, 2012. If those individuals enrolled in a different plan by October 19, 2012, their own selection would trump the auto-assignment, and they would be enrolled in their selected plan as of November 1, 2012.

**HOW DO I ENROLL IN A PLAN --**

ONCE you select a plan, you can enroll either directly with the Plan, by signing their enrollment form, OR if you are selecting an MLTC Partially Capitated plan, you can enroll with [NY Medicaid Choice](#). If you are selecting a Medicaid Advantage Plus (MAP) or PACE plan, you must enroll directly with the plan.

**WHEN IS MY ENROLLMENT IN AN MLTC PLAN EFFECTIVE?**

Enrollment in MLTC, MAP and PACE plans is always effective on the 1st of the month. The plan is paid its "capitation" rate or premium on a monthly basis, so enrollment is effective on the 1st of the month.

If you enrolled late in the month (after the third Friday of the month), the enrollment will not be effective -- and the new plan will not take charge of your care -- until the first of the *second* month after you enroll.

**Transition Period: MLTC Plan Must Continue Services Previously Authorized by LDSS or CHHA for 60 Days**, then provide Notice & Appeal Rights of Reduction

MLTC plan must provide the same services and the same number of hours as CASA/DSS/CHHA had authorized for 60 days. The [CMS Special Terms & Conditions](#) at Par. 28(d) [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/partnership\\_amendment\\_stc.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/partnership_amendment_stc.pdf) states:

*"Initial transition into MLTC from fee-for-service. Each enrollee who is receiving community-based long-term services and supports that qualifies for MLTC must continue to receive services under the enrollee's pre-existing service plan for at least 60 days after enrollment, or until a care assessment has been completed by the [MLTC], whichever is later."*

- Midway through this 60-day transition period, by Day 30, the plan must assess the new member's needs in her home. The plan's nurse will decide how much care the plan will approve for after the 60-day transition period.
- **NOTICE OF A REDUCTION IN SERVICES AFTER TRANSITION PERIOD** If the plan wants to reduce or end the services you previously received from CASA/DSS, CHHA, Adult Day Care, or CDPAP, the plan must give a **WRITTEN NOTICE** stating the amount of home care and other services they will give you effective on Day 61 of your enrollment. The notice will explain your right to appeal.
- On February 6, 2013 DOH issued [MLTC Policy 13.01 REVISED: Transition of Care for Fee for Services Participants in Mandatory Counties](#) posted at [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/mltc\\_policy\\_13.01\\_revised.pdf/](http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_13.01_revised.pdf/)

This directive requires MLTC plans to continue previously authorized long-term care services unchanged for 60 days when a consumer initially transfers into MLTC plans. This is called the Transition Period, required in the [CMS Special Terms and Conditions](#) p. 17 par. 28(d) cited above. These directives remind plans of their obligation to provide notice before reducing services at the end of the 60-day transition period. They must continue services unchanged during the internal appeal and until a hearing is decided, known as "Aid Continuing," when a member appeals the plan's proposed reduction or terminates a service.

The directive states, "This means that, for any individual receiving fee for service Medicaid community based long term services and supports and enrolling under any circumstance, the plan must provide 60 days of continuity of care. Further, if there is an appeal or fair hearing as a result of any proposed Plan reduction, suspension, denial or termination of previously authorized services, the Plan must comply with the aid to continue requirement identified above. In particular, if the enrollee requests a State fair hearing to review a Plan adverse determination, aid-to-continue is to be provided until the fair hearing decision is issued."

The revised directive of February 6th clarifies that the requirement to continue past services unchanged for the first 60 days of MLTC enrollment applies to these services:

- Personal care (home attendant and housekeeping in NYC)
- Consumer-Directed personal assistance (CDPAP)
- Home Health (CHHA) services
- Adult Day health care
- Private Duty Nursing

**See this article regarding Appeals and Grievances in Managed Long Term Care --**  
<http://www.wnyc.com/health/entry/184/> - for more information on your right to appeal.

Note that you must first request an Internal Appeal within the plan, and then, if you lose, you will receive a notice from the plan explaining you have the right to request a Fair Hearing.

**Requests to MLTC Plan for New or Increased Services** – see this article for consumer rights on when plan must decide requests

<http://www.wnyc.com/health/entry/114/#new%20service%20requests>

**The New Housing Disregard - Higher Income Allowed for Nursing Home Residents to Leave the Nursing Home by Enrolling in MLTC**

MLTC Policy 13.02: MLTC Housing Disregard --

[http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/mltc\\_policy\\_13.02.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_policy_13.02.pdf) -- A policy issued January 24, 2013, but effective October 15, 2012, creates a special income standard to help pay for housing expenses is available for certain nursing home residents who are Medicaid eligible recipients and can safely transition back to the community. To be eligible for this special income standard, the nursing home resident must:

- be age 18+,
- must have been in a nursing home for 30 days or more,
- must have had Medicaid pay toward the nursing home care, and
- must NEWLY enroll in a Managed Long Term Care (MLTC) plan (presumably new since 10/15/2012)
- must have a housing expense

The rates vary by region - and were already reduced for 2013 from 2012 -- NYS GIS 13 MA/04 -- [2013 Special Income Standards for Housing Expenses](#) -- 2013 -- \$1003 in NYC, \$1045 in Long Island, \$805 in N. Metropolitan Region including Westchester, other rates listed

See NYS DOH 12- ADM-05 - Special Income Standard for Housing Expenses for Individuals Discharged from a Nursing Facility who Enroll into the Managed Long Term Care (MLTC) Program

For more information on Managed Long Term Care and its implementation in 2012-13, see <http://wnyc.com/health/entry/114/> which have links to numerous other web-based information, and advocacy concerns at <http://www.wnyc.com/health/news/39/>

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**DELIVERY OF MEDICAID SERVICES – FEE FOR SERVICE CARE vs. MANAGED CARE**

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After an application is approved, most persons will get a plastic card called a Common Benefit Identification Card. When they get medical care, they must tell the provider, who is enrolled as a Medicaid provider, that they have Medicaid and give this card to the Medicaid provider, the doctor, pharmacist, or other medical provider. Their bills will be sent to the State to be paid. Whether the beneficiary can go to any Medicaid provider, or certain providers within a network, depends on whether they are enrolled in Medicaid Managed Care or receive Medicaid fee-for-service.

### **What is a Medicaid Managed Care Program and how is it different from fee-for-service?**

Most, but not all Medicaid beneficiaries in New York State who do not also have Medicare and who do not have a spend-down must now join a Medicaid managed care plan. (See more below on who is required to join a plan, and who is exempt or excluded from having to join). With original “fee for service” Medicaid, beneficiaries can go to any doctor that accepts Medicaid. This is called fee-for-service because the doctor or provider bills Medicaid for a fee every time the beneficiary receives a service. In Medicaid managed care, beneficiaries must join a managed care plan and can only see the doctors and other health providers in their plan’s network. In addition, they will be assigned a primary care provider and must go to this provider in order to get a referral for specialty care and hospitalizations. In managed care, Medicaid pays the managed care plan a capitated rate (flat monthly fee), from which the plan then pays its contracted network providers for services provided to its members.

For most medical services, Medicaid managed care members use their plan’s membership card instead of their regular Medicaid card. But they must keep their regular Medicaid card to obtain some important benefits that are not covered (“**carved out**”) by their Medicaid managed care plan. *However, in the NYS Budgets enacted in 2011 and 2012*, some services that were formerly “carved out” will now be covered by the Medicaid managed care plan. This includes prescriptions, over the counter medications (effective October 1, 2011), and personal care, chemical dependence outpatient treatment, certain mental health treatment, and some other services.

### **Where is Medicaid Managed Care mandatory?**

As of April 2013, Medicaid recipients in all counties and New York City are generally required to join a managed care plan, unless they are excluded or exempt.

- In New York City, Nassau, Suffolk, and at least 17 upstate counties, recipients receive mandatory enrollment packets from **New York Medicaid Choice**, a private company contracted to handle managed care enrollments and disenrollments.

**New York Medicaid Choice Contact 1-800-505-5678.** Special number for SSI beneficiaries: **1-800-774-4241; TTY: 1-888-329-1541.**

Generally individuals receiving mandatory packets will be randomly assigned into a Medicaid managed care plan if they do not choose a plan within 30 days.

- **About 25 Upstate districts that do not contract with NY Medicaid Choice do their own enrollments** but the timelines are the same – 30 days to choose a plan before they are auto-assigned

A list of managed care plans available by county is at

[http://www.health.ny.gov/health\\_care/managed\\_care/mcplans.htm](http://www.health.ny.gov/health_care/managed_care/mcplans.htm)

Once enrolled in a plan, enrollees should get a member handbook explaining how managed care works. Recipients have 90 days to change plans. If they do not switch within 90 days, they are “**locked-in**” to the assigned plan and cannot switch to a different plan for the following 9 months, unless they have good cause to do so. After the lock-in period ends, recipients can change plans for any reason at any time. Enrollees are supposed to receive notice of this right 60 days prior to the end of the lock-in period.

**Does everyone in New York City and the counties with mandatory managed care have to join a managed care plan?**

Almost. Some people are EXCLUDED from Medicaid Managed Care, meaning they cannot join a Medicaid managed care plan even if they would like to. Others are EXEMPT from managed care, meaning they may request an exemption that must be approved.

The types of Beneficiaries that are **excluded** were significantly cut in the 2011, 2012, and 2013 NYS Budgets. As of April 1, 2012, the only EXCLUDED beneficiaries who are not allowed to join Medicaid Managed care are the following – but in the April 2013 budget, the legislature gave DOH authority to eliminate all of these exclusions when it determines program features are ready. But as of April 2013 EXCLUDED people are still those who:

- Are in the Medicaid Spenddown or Excess Income program;
- Receive hospice services at time of enrollment;
- Are under 65 and were determined eligible by the Breast Cancer Screening & Treatment Program (for Breast, Cervical, Colorectal and Prostate Cancer),
- Have Medicare (dual eligibles), though they may enroll in Medicaid Advantage, which is a type of managed care that combines Medicare Advantage with Medicaid managed care to cover all Medicare and Medicaid services
- Are enrolled in a managed long term care plan or a Long Term Home Health Care Program
- Receive family planning services only, who are not otherwise eligible for Medicaid and whose net available income is 200% or less of the federal poverty level,
- Get Medicaid for less than 6 months – unless pregnant (for example, they get Emergency Medicaid as an undocumented immigrant);
- only use Medicaid for tuberculosis (T.B.) related services;
- Are covered by other comprehensive private insurance as primary payor;
- Live in certain institutions: permanent residents of residential health care facilities (nursing homes), resident of State-operated psychiatric facilities, Residents of state certified or voluntary operated treatment facilities for children, infants living with a mother in jail
- Blind or disabled children living separate from their parents for 30 days or more
- Adolescents admitted to Residential Rehabilitation Services for Youth (RRSY)
- Foster care children placed in voluntary agencies or in the care and custody of the Office of Family and Children Services (Foster children in direct placement are enrolled at LDSS option) – but as of April 1, 2013, those outside of NYC are being required to enroll in managed care.
- Individuals under 65 and working and eligible for Medicaid Buy-in for Working People with Disabilities (MBI-WPD) and are required to pay a premium. (Earned income between 150% and 250% FPL)

As of April 1, 2012, beneficiaries not in one of the above excluded categories may be granted an **exemption** from managed care only if:

- They are **Native American**; or
- they have a **chronic medical condition** and are being treated by a specialist who does not participate with *any* Medicaid managed care plans -- they may defer enrollment into the HMO but only for **six months** or until the course of treatment is complete, whichever occurs first;
- Residents of Intermediate Care Facilities for the Developmentally Disabled

- Participants in certain **Waiver** programs -- Developmentally or physically disabled individuals receiving services through a Home and Community Based Services (HCBS) Waiver, the OPWDD waivers, Children in Care-at-Home Waivers, Bridges to Health (B2H) waivers for children in Foster Care, and Nursing Home Transition and Diversion Medicaid Waiver (NHTD)
- Residents of Chemical Dependence Long Term Residential Program
- Non-institutionalized foster care – but this exemption ends April 1, 2013 outside NYC
- Individuals eligible for Medicaid buy-in for the working disabled and not required to pay a premium

See NYC HRA Chart of Managed Care Exclusions and Exemptions, effective 4/1/12, posted at <http://wnylc.com/health/afile/160/54/>. Also see

**Many exemptions have been eliminated** - Many people who used to be exempt or excluded from Medicaid managed care must now enroll, including SSI recipients, people with HIV/AIDS, homeless individuals, and adults with serious and persistent mental illness (SPMI) and children with serious emotional disturbances (SED) (this exemption was removed along with the SSI exemption in the same counties and New York City).

**For more information about Medicaid managed care:**

- **Information by The Legal Aid Society** -- <http://wnylc.com/health/entry/160/> (forms and strategies for requesting exemptions, identifying and troubleshooting access issues, appeal and hearing rights, guidelines on behavioral health carve-outs and transportation)
- **NYS DOH website** [http://www.nyhealth.gov/health\\_care/managed\\_care/index.htm](http://www.nyhealth.gov/health_care/managed_care/index.htm) - Download the Model Member Handbook, model contracts, and links to statewide online map showing status of managed care in each county
- **NY Managed Care Assistance Program Advocate's Guide** <http://www.communityhealthadvocates.org/node/677> (updated August 2012)

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## QUESTIONS AND ANSWERS ON MEDICAID

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### 1. How does someone apply for Medicaid?

When someone is applying for or getting Public Assistance or Supplemental Security Income, they do not have to fill out a separate application for Medicaid. However, if they are applying for Public Assistance, they must also check on the application that they are applying for Medicaid.

If someone wants to apply for Medicaid and lives outside of New York City, the applicant should call or visit his/her Local Department of Social Services in the county where she/he lives and ask for an application package.

If a client lives in New York City, she/he should call the Human Resources Administration Info line at 311 or (718) 557-1399 for information about how and where to apply for Medicaid.

If a client is a patient of one of the following, she/he should contact the office listed after the name of the facility:

- New York State Office of Mental Health Facility - Patient Resource Office
- New York State Office of People With Developmental Disabilities Facility - Revenue Support Field Office

**2. What are the immigration or citizenship requirements for Medicaid?**

Medicaid does not require one to be a citizen or a lawful permanent resident (also known as having a “green card”). Medicaid also is available to other immigrants who are Permanently Residing Under Color of Law (PRUCOL). A Desk Guide for identifying immigrants who are PRUCOL as well as for documenting citizenship is at [www.nyhealth.gov/health\\_care/medicaid/publications/docs/gis/08ma009att.pdf](http://www.nyhealth.gov/health_care/medicaid/publications/docs/gis/08ma009att.pdf). A Handbook called “Immigrant Eligibility for Publicly Funded Health Care Benefits,” written for New York State, is at <http://www.wnyc.com/health/entry/25/>. Other resources for non-citizens are at <http://wnyc.com/health/entry/33/>.

**3. Is there a limit on how many Medicaid services someone may receive?**

The number of times Medicaid will pay for visits to doctors or clinics, labs, and drug stores may be limited. This limit is called Medicaid Utilization Thresholds. See more info at <http://wnyc.com/health/entry/89/>. In the April 1, 2011 state budget, new limits were passed. **Occupational Therapy, Physical Therapy and Speech Therapy/Pathology** are limited to 20 visits per year. This is a flat limit on services – the physician may not request an override on an individual basis. The new limits do not apply to people with developmental disabilities or a Traumatic Brain Injury.

**4. Can Medicaid pay for past medical bills?**

Medicaid may be able to pay for care given during the three calendar months before the month in which the client applied for help. The client should tell his/her eligibility worker if he/she has any paid or unpaid medical bills. At the client’s option, some bills may be used to meet her spenddown, discussed above, and once the spenddown is met, may be reimbursed. See more information at <http://wnyc.com/health/entry/18/>.

**5. Can Medicaid pay for medical care someone gets outside of New York State?**

Maybe. Medicaid will pay for medical care someone gets out of state if:

- People from a border county usually get medical care in that state.
- The Local Department of Social Services placed the individual in a nursing home or foster care in another state.
- The provider (such as a doctor) has received prior approval for the individual to get medical care out-of-state.
- The individual needs emergency medical care while traveling in another state and the out-of-state provider is enrolled (or is willing to enroll) in the New York State Medicaid program.

**6. Can Medicaid pay for the Medicare premiums?**

Yes, if one is eligible. Ask the caseworker if you qualify for one of the Medicare Savings Programs, discussed more below.

**7. Should a Medicaid applicant or recipient cancel any other health insurance he/she already has?**

Generally, no. Medicaid is the insurer of last resort, and pays after any other “primary” health coverage the consumer has, including Medicare, employer group health insurance and Medigap. As discussed above, an individual who has Medigap may decide s/he no longer needs that coverage because Medicaid will fill the gaps in Medicare. Wait and ask this question at the

interview. As an incentive to retain other primary health coverage, Medicaid allows the cost of all health insurance premiums to be deducted from income in determining eligibility -- for people age 65, disabled, or blind, or children under 21 and their caretaker relatives. Once someone drops his or her Medigap policy, they may not be able to get it back because insurers are not permitted to sell these policies to Medicaid recipients, since it is duplicative coverage.

If someone is paying a high premium for private health coverage, s/he may be eligible to have Medicaid pay for that premium -- if it is cost-effective for Medicaid to help him/her keep their private coverage. COBRA policies are an example - continued health coverage after losing a job.

**8. Can I still keep some of my income if I am in a nursing home or other medical facility?**

Yes, people *permanently* placed in a nursing home can keep a small amount for your personal use. The allowance is \$50/month generally (\$55 if you receive SSI). Additionally, if there is a reasonable expectation that you will return home, you are allowed to keep income up to the community Medicaid level, which in 2013 is \$800 per month. The income deductions or disregards that are used in the community would be used to calculate the spenddown just as in the community. Refer to sections above for information about nursing home Medicaid and “community budgeting” during temporary nursing home admissions at <http://wnylc.com/health/entry/96//> . However, this generally does not continue for more than six or 12 months.

You can also keep some of your income for your spouse and family, if they are dependent on you. (See Spousal Protections discussed above.)

**9. Can a lien (legal claim) be put on my home?**

Yes. If you are a permanent resident in a nursing home, an intermediate care facility, or a residential treatment facility and not expected to return home, a lien may be put on your real property unless a spouse or certain relatives reside in the home. Also if you receive medical services paid for by Medicaid on or after your 55<sup>th</sup> birthday, whether at home or in a nursing home, Medicaid may recover the amount of the costs of these services from the assets in your Estate upon your death, with certain exceptions. These exceptions include if you have a surviving spouse or a disabled or minor child. If you own a home you should see an experienced Elder Law attorney for advice and planning regarding your home. See more information at <http://wnylc.com/health/entry/96/>.

**10. What if I have emergency medical needs?**

New York State law requires hospitals to give you emergency care, even if you cannot pay for it. If you have a medical emergency, such as a heart attack or other life-threatening illness, before you find out if you are able to get Medicaid or before you have applied for Medicaid, go to a hospital right away. If you are sick and need medical care right away and you have applied but have not gotten your Common Benefit ID card, your social worker may be able to help you get a temporary card for the medical help you need. You must show the card when you get medical treatment. If the provider is willing to treat you while your Medicaid application is pending, and the provider accepts Medicaid, the provider can bill Medicaid later, retroactively, for the care s/he provided.

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## MEDICARE SAVINGS PROGRAMS [MSP]

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Many older adults and people with disabilities have low incomes, but not quite low enough to qualify for Medicaid. Medicare Savings Programs [MSP] are available under Medicaid that provide relief for lower income seniors and individuals with disabilities by covering the cost of the Medicare Part B and D premiums, and sometimes part or all of Medicare coinsurance and deductibles. An extra benefit of an MSP is automatic enrollment into *Extra Help* for Part D. The MSP programs are:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualified Individual 1 (QI-1)
- Qualified Disabled and Working Individual (QDWI)

**Although Medicaid pays for Medicare Savings Program benefits, an MSP recipient does not have full Medicaid benefits unless she/he applies for Medicaid in addition to the MSP.** People who have QMB and SLMB may apply for and receive Medicaid, if they want services that Medicaid offers that Medicare may not, such as dental care and home care. QI-1 recipients may not also have Medicaid.

### Background

Congress first enacted Medicare Savings Programs as part of the Medicare Catastrophic Coverage Act of 1988. The programs were subsequently expanded by Omnibus Budget Reform Act (OBRA) of 1990, the Balanced Budget Act of 1997 (BBA), and Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) of 2008. These programs are sometimes called the Medicare Buy-In or the Medicare Premium Payment Programs. To avoid confusion with the Medicaid Buy-In for Working People with Disabilities, (MBI-WPD), in New York they are called Medicare Savings Programs (MSP).

The state and federal governments fund the Medicare Savings Programs jointly. The administrative costs for the programs (QMB, SLMB, QI and QDWI) are split between the federal (50 percent), state (25 percent) and county (25 percent) government. The costs of the benefits for QMB, SLMB and QDWI are split the same way. The QI-1 benefits, however, are fully federally funded. The state Medicaid office within the New York State Department of Health, Office of Health Insurance Programs, administers all of the programs.

### Entitlement vs. Block Grant

- The QMB, SLMB, and QDWI programs are entitlement programs. This means that anyone eligible for the benefit will be able to receive it.
- The QI-1 program is funded by block grants. A block grant program is different from an entitlement program. With a block grant, a specific amount of money is allocated to the state. Eligible beneficiaries receive benefits only up to the point where the allocation is exhausted. Thus the benefit is “first come-first served,” and contingent on the availability of funds. To date, New York State has never used its full allocation for the QI-1 benefits.

**Currently, the QI-1 program has been reauthorized through December 31, 2013.**

**Four Extra Benefits of Enrolling in an MSP –**

- **Benefit 1. Back Door to Medicare Part D "Extra Help" or Low Income Subsidy**  
 All MSP recipients are automatically enrolled in Extra Help, the subsidy that makes Part D affordable. They have no Part D deductible or doughnut hole, the premium is subsidized, and they pay very low copayments. Once they are enrolled in Extra Help by virtue of enrollment in an MSP, they retain Extra Help for the entire calendar year, even if they lose MSP eligibility during that year. Many people will qualify for an MSP but would not qualify directly for "Full" Extra Help – because the MSPs have no asset limit. People applying to the Social Security Administration for Extra Help might be rejected for this reason.
- **Benefit 2. MSPs Automatically Waive Late Enrollment Penalties for Part B**  
 If one does not enroll in Part B within the strict enrollment periods that depend on turning age 65, whether one is still working and insured under an employer sponsored group health plan, whether one has End Stage Renal Disease, and other factors, one might have to pay higher Part B premiums for life as a Late Enrollment Penalty (LEP). Enrollment in an MSP automatically eliminates such penalties even if one later ceases to be eligible for the MSP.
- **Benefit 3. No Medicaid Lien on Estate to Recover MSP Benefits Paid**  
 Generally speaking, states may place liens on the Estates of deceased Medicaid recipients to recover the cost of Medicaid services that were provided after the recipient reached the age of 55. Since 2002, states have not been allowed to recover the cost of Medicare premiums paid under MSPs. Further, states may not place liens on the Estates of Medicaid recipients who died after January 1, 2010 to recover costs for co-insurance paid under the QMB program for services rendered after January 1, 2010. The federal government made this change in order to eliminate barriers to enrollment in MSPs. See NYS DOH GIS 10-MA-008 - Medicare Savings Program Changes in Estate Recovery. The GIS clarifies that a client who receives both QMB and full Medicaid is exempt from estate recovery for these Medicare cost-sharing expenses.
- **Benefit 4. SNAP (Food Stamp) benefits not reduced despite increased income from MSP - at least temporarily**  
 Many people receive both SNAP (Food Stamp) benefits and MSP. Income for purposes of SNAP/Food Stamps is reduced by a deduction for medical expenses, which includes payment of the Part B premium. Since approval for an MSP means that the client no longer pays for the Part B premium, his/her SNAP/Food Stamps income goes up, so their SNAP/Food Stamps go down. Here are some protections:

  - Do these individuals have to report to their SNAP worker that their out of pocket medical costs have decreased? And will the household see a reduction in their SNAP benefits, since the decrease in medical expenses will increase their countable income?
  - The good news is that MSP households do NOT have to report the decrease in their medical expenses to the SNAP/Food Stamp office until their next SNAP/Food Stamp recertification. Even if they do report the change, or the local district finds out because the same worker is handling both the MSP and SNAP case, there should be no reduction in the household's benefit until the next recertification. New York's SNAP policy per administrative directive 02 ADM-07 is to "freeze" the deduction for medical expenses between certification periods. Increases in medical expenses can be budgeted at the household's request, but NYS never decreases a household's medical expense deduction until the next recertification. Most elderly and disabled households have 24-month SNAP certification periods.

- Eventually, though, the decrease in medical expenses will need to be reported when the household recertifies for SNAP, and the household should expect to see a decrease in their monthly SNAP benefit. It is really important to stress that the loss in SNAP benefits is NOT dollar for dollar. A \$100 decrease in out of pocket medical expenses would translate roughly into a \$30 drop in SNAP benefits.
- See more info on SNAP/Food Stamp benefits at <http://www.empirejustice.org/issue-areas/public-benefits/food-stamps/whats-new-in-snap.html> and <http://otda.ny.gov/programs/food-stamps/>

### Recent Changes Make Applying Easier

Recent changes in the programs make it easier for people to get MSP benefits. A large number of individuals who are eligible do not receive these benefits. As a HIICAP counselor, you have an opportunity to inform people who may be eligible about these benefits and help them apply.

- **NO RESOURCE LIMIT** – there hasn’t been a resource test for QMB, SLIMB, or QI-1 since April 1, 2008.
- **MAIL-IN APPLICATION** – Effective December 26, 2007 the face to face interview requirement was eliminated for the Medicare Savings Programs. Individuals may apply using the shortened **DOH-4328** application and can mail it to the local department of social services. This application is included at the end of the module or online at [http://www.nyhealth.gov/health\\_care/medicaid/program/update/savingsprogram/msapp.pdf](http://www.nyhealth.gov/health_care/medicaid/program/update/savingsprogram/msapp.pdf) . Applicants must still document income.

**If an applicant wishes to apply for Medicaid in addition to QMB, SLIMB, or QDWI, applicants must complete a Medicaid application (LDSS 2921)** (download at <http://www.nyhealth.gov/nysdoh/fhplus/application.htm>. **As of April 1, 2010, a face-to-face interview is no longer required.** (See State directive at [http://www.health.state.ny.us/health\\_care/medicaid/publications/docs/adm/10adm-4.pdf](http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/10adm-4.pdf)).

The application may be mailed or brought to the local Medicaid office. If all required documents (citizenship, identity, income, resources) are not submitted with the application, the local Medicaid office will request them from the client, and must give 10 days to submit them.

- Medicaid is not available to QI-1 beneficiaries. If their assets are within the Medicaid limits, they must choose between Medicaid with a spend-down or QI-1.
- Applications for all of these programs may be downloaded.
  - **MSP only - DOH-4328** - [http://www.nyhealth.gov/health\\_care/medicaid/program/update/savingsprogram/msapp.pdf](http://www.nyhealth.gov/health_care/medicaid/program/update/savingsprogram/msapp.pdf)
  - **Medicaid application (LDSS 2921)** (download at <http://www.nyhealth.gov/nysdoh/fhplus/application.htm> - ignore the “Family Health Plus” heading for the page - this is the right application).

### Some People Should Be Automatically Enrolled in an MSP:

- Clients receiving even \$1 of **Supplemental Security Income** should be automatically enrolled into the QMB program under New York State’s Medicare Savings Program Buy-in Agreement with the federal government, once they become eligible for Medicare. SSI recipients who do not have Medicare Parts A or B should automatically be enrolled in both programs through the

Buy-In program. Contact your local DSS if SSI recipient is being charged for a Medicare premium - this is an error and needs to be corrected.

- Clients who are **already eligible for Medicare when they apply for Medicaid** should be automatically assessed for MSP eligibility when they apply for Medicaid, even without specifying they want MSP on their Medicaid application. ([NYS DOH 2000-ADM-7](#) and [GIS 05 MA 033](#)).
- MIPPA requires local Medicaid programs to contact anyone who applied to the Social Security Administration (SSA) for Extra Help, whether in person or on-line, and was rejected. MIPPA requires an application for the federal Extra Help or Low Income Subsidy (LIS) to be considered an application for the Medicare Savings Program (MSP). **The procedures that local districts should follow in contacting these individuals are in [http://www.nyhealth.gov/health\\_care/medicaid/publications/docs/adm/10adm-3.pdf](http://www.nyhealth.gov/health_care/medicaid/publications/docs/adm/10adm-3.pdf).** The effective date of the MSP application must be the same date as the Extra Help application. Signatures will not be required from clients. In cases where the SSA data is incomplete, NYSDOH will forward what is collected to the local district for completion of an MSP application. The State implementing procedures are in [DOH 2010 ADM-03](#).
- **Can MSP Be Retroactive?** MSP benefits should be retroactive, including those that will be processed through the new SSA data-sharing procedure described above. This means that the client should be reimbursed for the Part B premium that had been withheld from their Social Security check (or that client paid separately if not receiving Social Security). **The retroactive date is different for QMB than for SLMB and QI-1.**
  - For QMB – MSP is retroactive to the month following the month of the MSP application. For SSA data-sharing applications, MSP is retroactive to the month following the month the Extra Help application was filed with SSA, and
  - For SLMB and QI-1 - MSP is retroactive to the month of the MSP application, and if the client was eligible, back to three months before that application. For SSA data-sharing applications, MSP is retroactive to the month of the Extra Help application filed with SSA, and up to three months before if client was eligible.

### What Income is Counted for MSP Programs?

MSPs use the same rules used by Medicaid for determining which income counts, what deductions apply, and what income is excluded. Since anyone eligible for an MSP is aged 65+, blind or disabled, the Medicaid rules for that category (Aged 65+, blind, or disabled) are used. These are explained earlier in this chapter.

WARNING - Per [GIS 13 MA/05](#), as of March 2013, MSP applicants and recipients age 65 and older who are eligible for, but not receiving Social Security retirement benefits, must apply for Social Security as a condition of receiving MSP. Some people prefer to wait to apply for Social Security until after age 70 to increase their benefit. If they want MSP, however, they must apply. See <http://www.wnyc.com/health/entry/185/>.

### QUALIFIED MEDICARE BENEFICIARY (QMB) PROGRAM SNAPSHOT

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- **Medicaid will pay** the Medicare Part A and Part B premiums directly to Medicare. QMB recipients receive a Medicaid card, even if they are not also receiving Medicaid. Their doctors and other providers use the card to bill Medicaid for the Medicare Part A and Part B coinsurance and deductibles.

- Doctors who are not Medicaid providers may not bill Medicaid for the Medicare coinsurance. However, whether or not Medicaid pays the provider the coinsurance, the provider may not bill a QMB recipient. See <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf> and also see <http://wnylc.com/health/entry/99/>.
- Unlike full Medicaid, the QMB program will not pay for extra services and supplies, such as dental care and eyeglasses that Medicare does not cover.
- **Income limit - 100% Federal Poverty Level**
  - **Individuals:** Monthly income less than \$958 + \$20 (2013)
  - **Couples:** Monthly income less than \$1,293 + \$20 (2013)
- There is **no resource test** if applying for QMB only
- **Must be entitled to or eligible for Medicare Part A**
  - If the applicant does not have Medicare Part A they must apply for QMB using the Part A buy-in process, described at end of this Module.
- **Application for QMB only** – Like all MSPs, applicants can apply by mail using the short DOH-4328 application. No face to face interview is required if applying for the Medicare Savings Program only, but one must document income.
  - **Application for Medicaid and QMB** – Applicants must complete a Medicaid application (LDSS 2921), After April 1, 2010, no face-to-face interview is required.
- Applicant may spenddown to become eligible for Medicaid if she/he completes the LDSS 2921, but spenddown will be increased by amount of Part B premium since QMB benefit pays.
- There is **no retroactive eligibility** for this benefit – it becomes effective in month following month of application
- QMB is an **entitlement** - all those who are eligible will receive the benefit

### **SPECIFIED LOW INCOME MEDICARE BENEFICIARY (SLMB) PROGRAM SNAPSHOT**

- **Medicaid pays Medicare Part B premium only**
- **Income limit – 120% Federal Poverty Level**
  - **Individuals:** Monthly income from \$959 to \$1,149 + \$20 (2013)
  - **Couples:** Monthly income from \$1,294 to \$1,551 + \$20 (2013)
- There is **no resource test** if applying for SLMB only
- **Must be entitled to or eligible for Medicare Part A**
- **Application for SLMB only** – Like all MSPs, applicants can apply by mail using the short DOH-4328 application. No face to face interview is required if applying for the Medicare Savings Program only, but must document income.
  - **If want to apply for Medicaid and SLMB** - Applicants must complete a Medicaid application (LDSS 2921). After April 1, 2010, no face-to-face interview required.
- Applicant may spenddown to become eligible for Medicaid if she/he completes the LDSS 2921, but spenddown will be increased by amount of Part B premium since SLMB benefit pays it.
- Eligibility can be **retroactive** back to three months before the month of application, if client's income was within limits. The client will be reimbursed for Part B premium back to that date.
- Benefit is an **entitlement** - all those who are eligible will receive the benefit

## QUALIFIED INDIVIDUAL (QI-1) PROGRAM SNAPSHOT

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- **Medicaid pays Medicare Part B premium only**
- **Income limit – 120 - 135% Federal Poverty Level**
  - **Individuals:** Monthly income from \$1,150 to \$1,293 + \$20 (2013)
  - **Couples:** Monthly income from \$1,552 to \$1,745 + \$20 (2013)
- There is no Resource Limit
- Must be entitled to Medicare Part A
- **APPLICATION** - Like all MSPs, applicants can apply by mail using the short DOH-4328 application. No face to face interview is required, but the applicant must document income.
- Applicants **may not receive Medicaid and QI-1** at the same time.
  - Because of higher income, a potential QI-1 recipient would have a Medicaid spenddown if they chose to apply for Medicaid. It is their choice whether to enroll in QI-1 or Medicaid with a spenddown. This will depend on their need for Medicaid services not provided by Medicare, such as home care.
- Eligibility can be **retroactive** back to three months before the month of application, but must be within the same calendar year. Only retroactive if client's income was within limits. The client will be reimbursed for Part B premium back to that date.
- Benefit is **not an entitlement**. It is provided on a “first-come, first-served” basis. As a block grant originally enacted by the Balanced Budget Act of 1997, this program must be reauthorized by Congress, unlike the other MSPs, which are permanent programs.

## QUALIFIED DISABLED AND WORKING INDIVIDUAL PROGRAM (QDWI) SNAPSHOT

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- **Medicaid pays the Medicare Part A premium only, not the Part B premium**
- **Must be a disabled worker under age 65 who lost Part A** benefits because of a return to work
- **Income and resource limits** – unlike other MSPs, there are resource limits. Income up to 200% Federal Poverty Level
  - **Individuals:** Monthly income up to \$1,916 + \$20 (2013)  
Resources up to \$4,000 (2013)
  - **Couples:** Monthly income up to \$2,586 + \$20 (2013)  
Resources up to \$6,000 (2013)
- **Must be eligible for Medicare Part A and B**
- **Application for QDWI ONLY** -- Like all MSPs, may apply by mail using the short DOH-4328 application. No face to face interview is required if applying for QDWI only, but must document income and resources.
- **If want to apply for Medicaid and QDWI** -- Must complete a Medicaid application (LDSS 2921). After April 1, 2010, no face-to-face interview required.
- Applicant may spenddown to become eligible for Medicaid if he/she completes the LDSS 2921, but spenddown will be increased by amount of Part B premium since QDWI benefit pays it.
- Eligibility can be **retroactive** back to three months before the month of application, if income and resources were within limits.
- Benefit is an **entitlement**. All those who are eligible will receive this benefit.

## **QMB PART A BUY-IN -- ASSISTANCE FOR INDIVIDUALS WITHOUT FREE PART A**

At age 65, most people are eligible for Medicare Part A, but it is not always free. Some people have not worked the 40 quarters (10 years) needed to get premium-free Part A. These individuals can purchase Part A if they are a US citizen or permanent legal resident and meet US residency requirements. If these individuals are low income, they may qualify for the Qualified Medicare Beneficiary (QMB) Program to pay their Part A premiums. By paying the premiums on behalf of these individuals, the federal Medicare program becomes the primary payer for their health care to preserve Medicaid expenses.

### **How can people without premium-free Part A obtain Medicare and QMB?**

In New York it depends upon whether they have SSI (Supplemental Security Income).

- **If individuals have SSI**, they should automatically be enrolled in full Medicaid, Medicare Parts A and B, and in QMB without needing to file an application. Medicare becomes their primary insurance and Medicaid becomes secondary in most instances.
- **Individuals who do not have SSI** must apply for QMB using the **Part A Buy-In** process. These individuals may only have Medicaid or are uninsured.
  - **Requirements for Part A Buy-In** – must be
    - at least 65 years of age,
    - and a U.S. citizen or
    - lawfully admitted, permanent legal resident who has lived in the U.S. for at least 5 years in a row prior to qualifying.
- **Benefits of Part A Buy-In** –
  - enrolls you in Medicare Part A (Hospital Insurance),
  - Medicare Part B (Medical Insurance),
  - facilitation into Medicare Part D (a Medicare private drug plan),
  - and QMB (Qualified Medicare Beneficiary), which pays for both Parts A and B of Medicare.
  - By virtue of having QMB, you are also automatically deemed eligible for Full Extra Help with Part D drug costs and
  - Entitled to an ongoing Special Enrollment Period to switch Part D drug plans.

For more information about the Part A buy-in process, see the Medicare Rights Center’s Step-by-Step Guide at <http://www.medicareinteractive.org/uploadedDocuments/Part-A-Buy-In-Packet.pdf> .

Also see the Social Security Administration’s Program Operations Manual (POMS), at: <http://policy.ssa.gov/poms.nsf/lnx/0600801140>

Also see the 2004 State directive [http://www.health.state.ny.us/health\\_care/medicaid/publications/docs/gis/04ma013](http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/04ma013)

You can find more information about the Part B Buy-In Agreement through the Social Security Administration’s Program Operations Manual (POMS): <http://policy.ssa.gov/poms.nsf/lnx/0600815000>.

For updates on MSP and links to other information, see <http://wnylc.com/health/entry/99/>.

**2013 MEDICARE SAVINGS PROGRAMS SUMMARY CHART**

Name of Program	Benefit (What Medicaid Pays)	Monthly Income Eligibility (add \$20)		Resource Limits		Retro-active?
		Individual	Couple	Individual	Couple	
<b>Qualified Medicare Beneficiary (QMB)</b> 100% FPL	Medicare premiums, deductibles and coinsurance  People 65+ eligible for but without Medicare may enroll in Part A, B & QMB through Buy-In	Under \$958	Under \$1,293	None	None	No - effective in month following month of application
<b>Specified Low Income Medicare Beneficiary (SLMB)</b> 120% FPL	Medicare Part B premium	\$959 to \$1,149	\$1,294 to \$1,551	None	None	Yes - 3 months before month of application
<b>Qualified Individual 1 (QI-1)</b> 135% FPL	Medicare Part B premium	\$1,150 to \$1,293	\$1,552 to \$1,745	None	None	Yes - 3 months but in same calendar year
<b>Qualified Disabled and Working Individual (QDWI)</b> 200% FPL Under age 65 only	Medicare Part A premium	\$1,916	\$2,586	\$4,000	\$6,000	Yes - 3 months before month of application

## Sources of Assistance

**New York State Medicaid Helpline (NYS Dept. of Health)** **1-800-541-2831**  
**1-518-486-9057**

**NYS OFA HIICAP Hotline** **1-800-701-0501**

**Medicare Hotline** **1-800-MEDICAR(E)**

**1-800-633-4227**

**NY State Office for Aging Senior Hotline** **1-800-342-9871**

**Managed Care Consumer Assistance Program (MCCAP)**

### **Technical Assistance Hotlines:**

- Community Services Society Community Health Advocates **1-888-614-5400**
- Empire Justice Center/Legal Services for the Elderly,  
Disabled of Western New York **1-800-635-0355**
- The Legal Aid Society - Statewide Hotline **1-888-500-2455**
  - NYC Hotline **1-212-577-3575**
- Medicare Rights Center HIICAP Hotline **1-800-480-2060**
- New York Legal Assistance Group (NYC only)  
(M, W, Thurs., 9 AM - 3 PM) **1-212-613-5000**
- Evelyn Frank Legal Resources Program at NYLAG
  - NYC Hotline or [eflrp@nylag.org](mailto:eflrp@nylag.org) **1-212-971-7658**

**Check for news items and information on <http://nyhealthaccess.org> - a joint project of Empire Justice Center, Legal Aid Society, and Selfhelp Community Services.**

**MODULE 9 APPENDIX**

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**Medicare Savings Program Application**



**PAYMENT OF YOUR MEDICARE PREMIUM IS A MEDICAID BENEFIT**

**PENALTIES:** I understand that my application may be investigated, and I agree to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Medicaid benefits or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Medicaid or if you conceal or fail to disclose facts that would effect the right of someone for whom you have applied to obtain or continue to receive Medicaid benefits; and such benefits must be used by the other person and not for yourself.

**CHANGES:** I agree to inform the agency **promptly** of any change in my needs, income, property, living arrangements or address to the best of my knowledge or belief.

**SOCIAL SECURITY NUMBER (SSN):** If you are applying for the Medicare Savings Program, you must report your SSN, unless you are a pregnant woman. The laws requiring this are: 18NYCRR Sections 351.2, 360-1.2, and 360-3.2(j)(3); 42USC 1320b-7. SSNs are used in many ways, both within the local social services districts and also between local social services districts and federal, state, and local agencies, both in New York and in other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if absent parents can get health insurance for applicants, to see if applicants can get child support and to see if applicants can get money or other help.

**CERTIFICATION OF CITIZENSHIP & IMMIGRATION STATUS:** I certify, under the penalty of perjury, by signing my name on this application, that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. I understand that information about me will be submitted to the United States Citizenship and Immigration Services (USCIS) for verification of my immigration status, if applicable. I further understand that the use or disclosure of information about me is restricted to persons and organizations directly connected with the verification of immigration status and the administration and enforcement of the provisions of the Medicaid program.

**NON-DISCRIMINATION NOTICE:** This application will be considered without regard to race, color, sex, disability, religious creed, national origin, or political belief.

**CERTIFICATION:** In signing this application, I swear and affirm that the information I have given or will give to the Department of Social Services as a basis for Medicaid is correct. I also assign to the Department of Social Services any rights I have to pursue support from persons having legal responsibility for my support and to pursue other third-party resources. I understand that Medicaid paid on my behalf may be recovered from persons who had legal responsibility for my support at the time medical services were obtained.

**CONSENT:** I understand that by signing this application/certification form I agree to any investigation made by the Department of Social Services to verify or confirm the information I have given or any other investigation made by them in connection with my request for Medicaid. If additional information is requested, I will provide it.

**Applicant/Representative Signature X** \_\_\_\_\_ Date \_\_\_\_\_

**Spouse Signature X** \_\_\_\_\_ Date \_\_\_\_\_

**Representative Address, Phone Number and Relationship** \_\_\_\_\_

**If after reading and completing this form, you decide that you DO NOT want to apply for the Medicare Savings Program please sign on the following line.**

I consent to withdraw my application \_\_\_\_\_ Date \_\_\_\_\_

SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION: <b>x</b>		DATE:		EMPLOYED BY:		
Eligibility Determined By Worker: _____ (DATE)				Eligibility Approved By: _____ (DATE)		
CENTRAL/OFFICE	APPLICATION DATE	UNIT ID	WORKER ID	CASE TYPE	CASE NO	REUSE IND.
CASE NAME		DISTRICT		REGISTRY NO.		VER.
Effective Date _____ MA Disp. Denial Withdrawal				REASON CODE		PROXY: Yes No

**STUDY GUIDE MODULE 9: Medicaid and the Medicare Savings Programs (QMB, SLMB, QI-1 and QDWI)**

Medicare Parts A and B leave people with Medicare responsible for significant health care costs: premiums, deductibles, co-payments, excess charges, and services that Medicare does not cover at all. Low-income Medicare enrollees may be eligible for Medicaid or the Medicare Savings Programs. Both can help pay costs not covered by Medicare.



Read your *HIICAP Notebook* for information on Medicaid and the QMB, SLMB, QI-1, and QDWI Programs. Read Medicaid information from the New York State Department of Health, in your *HIICAP Notebook* for additional information on New York State’s Medicaid Program.

**Use the information from your *HIICAP Notebook* and *Medicare & You* handbook for the following lessons regarding Medicaid and the Medicare Savings Programs.**



**1. DIFFERENCES BETWEEN MEDICARE AND MEDICAID**

**Group Activity**

**Medicare? Medicaid?** Explain the differences between these two health care programs by listing on a flip chart or chalkboard:

- a. What each program provides
- b. Who may participate in each program
- c. How each program is administered
- d. Services each program covers



**2. HOW MEDICARE AND MEDICAID WORK TOGETHER**

Refer to the “Medicaid/QMB/SLMB/QI-1/QDWI Fact Sheet.” The Medicaid column on the left will clarify how Medicaid may pay the costs that Medicare does not.



List together the specific Medicare costs that Medicaid in New York State will pay.



**3. HOW MEDICARE AND THE QMB PROGRAM WORK TOGETHER**

Refer to the “Medicaid/QMB/SLMB/QI-1/QDWI Fact Sheet” at the end of Module 9. The QMB column will clarify how the QMB program may pay some of the costs that Medicare does not.



List together the specific Medicare costs that the QMB program will pay.



Refer to the “Medicaid/QMB/SLMB/QI-1/QDWI Fact Sheet” at the end of Module 9. Discuss how the SLMB Program’s single benefit can significantly help seniors with modest incomes.



#### 4. MEDICAID COVERAGE OF LONG-TERM CARE

Mark each of the following statements *True* or *False*

- a. Medicaid can pay for the cost of your long-term care in a nursing home or at home when you have spent your assets down to a very low level and can no longer pay for your own care, if you are otherwise eligible.     T\_\_\_\_\_F\_\_\_\_\_
- b. Medicaid includes the value of your automobile when calculating your total resources.  
T\_\_\_\_\_F\_\_\_\_\_
- c. A federal law protects couples from having to spend any of their resources (savings, CDs, stocks and bonds, etc.) when one of them must receive long-term care.     T\_\_\_\_\_F\_\_\_\_\_
- d. HIICAP counselors may give older adults the general qualification guidelines for Medicaid. Applications for Medicaid, however, are taken at Local Departments of Social Services or Area Agencies on Aging.     T\_\_\_\_\_F\_\_\_\_\_



Review and explain your answers with your group.



**In Summary: Review these basic concepts of Medicaid and the Medicare Savings Programs.**

- If an individual’s income is low, he/she may qualify for Medicaid or the Medicare Savings Programs.
- Medicaid will pay the Medicare Part B premium, Medicare deductibles and coinsurance, and some of the health care costs that Medicare does not pay.
- The QMB Program will pay the Medicare Part B premium as well as the Medicare deductibles and coinsurance.
- The SLMB and QI-1 program will pay only the Medicare Part B premium.
- Spousal impoverishment provisions protect some of the income and resources of the spouse who is married to an institutionalized spouse but is not an institutionalized spouse himself/herself. These provisions help to ensure that the community spouse will not have to spend all of his/her monthly income and resources on the cost of care of the institutionalized spouse.

**ANSWER KEY MODULE 9: Medicaid and the Medicare Savings Programs (QMB, SLMB, QI-1 and QDWI)**

Medicare Parts A and B leave people with Medicare responsible for significant health care costs: premiums, deductibles, co-payments, excess charges, and services that Medicare does not cover at all. Low-income Medicare enrollees may be eligible for Medicaid or the Medicare Savings Programs. Both can help pay costs not covered by Medicare.



Read your *HIICAP Notebook* for information on Medicaid and the QMB, SLMB, QI-1, and QDWI Programs. Read Medicaid information from the New York State Department of Health, in your *HIICAP Notebook* for additional information on New York State’s Medicaid Program.

**Use the information from your *HIICAP Notebook* and *Medicare & You* handbook for the following lessons regarding Medicaid and the Medicare Savings Programs.**



**1. DIFFERENCES BETWEEN MEDICARE AND MEDICAID**

**Group Activity**

**Medicare? Medicaid?** Explain the differences between these two health care programs by listing on a flip chart or chalkboard:

- a. What each program provides
- b. Who may participate in each program
- c. How each program is administered
- d. Services each program covers

*Answer chart appears at the end of the test.*



**2. HOW MEDICARE AND MEDICAID WORK TOGETHER**

Refer to the “Medicaid/QMB/SLMB/QI-1/QDWI Fact Sheet.” The Medicaid column on the left will clarify how Medicaid may pay the costs that Medicare does not.



List together the specific Medicare costs that Medicaid in New York State will pay.

**3. HOW MEDICARE AND THE QMB PROGRAM WORK TOGETHER**

Refer to the “Medicaid/QMB/SLMB/QI-1/QDWI Fact Sheet” at the end of Module 9. The QMB column will clarify how the QMB program may pay some of the costs that Medicare does not.



List together the specific Medicare costs that the QMB program will pay.

Refer to the “Medicaid/QMB/SLMB/QI-1/QDWI Fact Sheet” at the end of Module 9. Discuss how the SLMB Program’s single benefit can significantly help seniors with modest income. *By paying the Medicare Part B premiums, the SLMB program assures seniors with modest incomes of continuing Medicare Part B coverage. In the past, these same individuals may have allowed their Part B coverage to lapse.*



#### 4. MEDICAID COVERAGE OF LONG-TERM CARE

Mark each of the following statements *True* or *False*

- a. Medicaid can pay for the cost of your long-term care in a nursing home or at home when you have spent your assets down to a very low level, and can no longer pay for your own care, if you are otherwise eligible. *True*
- b. Medicaid includes the value of your automobile when calculating your total resources. *False*.
- c. A federal law protects couples from having to spend any of their resources (savings, CDs, stocks and bonds, etc.) when one of them must receive long-term care. *False*
- d. HIICAP counselors may give older adults the general qualification guidelines for Medicaid. Applications for Medicaid, however, are taken at local Departments of Social Services or Area Agencies on Aging. *True*



#### **In Summary: Review these basic concepts of Medicaid and the Medicare Savings Programs.**

- If an individual's income is low, he/she may qualify for Medicaid or the Medicare Savings Programs.
- Medicaid will pay the Medicare Part B premium, Medicare deductibles and coinsurance, and some of the health care costs that Medicare does not pay.
- The QMB Program will pay the Medicare Part B premium as well as the Medicare deductibles and coinsurance.
- The SLMB and QI-1 program will pay only the Medicare Part B premium.
- Spousal impoverishment provisions protect some of the income and resources of the spouse who is married to an institutionalized spouse but is not an institutionalized spouse himself/herself. These provisions help to ensure that the community spouse will not have to spend all of his/her monthly income and resources on the cost of care of the institutionalized spouse.

**Answer chart for Group Activity Question 1:**

	<b>Medicare</b>	<b>Medicaid</b>
<b>Provides:</b>	Health insurance	Health assistance
<b>Participants:</b>	People of any income level, age 65 and over, and some people with disabilities under age 65	People of any age with low income and resources
<b>Administration:</b>	Federal; program is uniform in all states	Federal/state/county partnership in NYS; programs vary by state
<b>Services Covered:</b>		<i>May Cover:</i>
	Basic hospital	Basic hospital
	Physician	Physician
	Therapy	Therapy (limits on PT, OT, ST - 20 visits/year)
	Limited skilled nursing facility services and home health care	Nursing home care
	Limited prevention-oriented	Physical exams
		Dental care
		Eyeglasses
		Laboratory and x-ray services
		Transportation to medical appointments
		Private insurance premiums for some people
		Home/community-based care for frail elderly and people with disabilities