

## MODULE 17: MEDICAID

### Objectives

Below are the objectives established for *Module 17: Medicaid*. HIICAP counselors will learn about the Medicaid program which provides vital coverage for older people and people with disabilities.

*For Medicare beneficiaries*, Medicaid can:

- Substitute for a Medigap policy, by subsidizing Medicare deductibles and coinsurance, if services are from providers who accept Medicaid as well as Medicare;
- Automatically qualify you for Extra Help with Part D costs.
- Provide access to health services that Medicare does not cover, including long-term nursing home care, home care and other community-based long term care services, dental and vision care, orthopedic shoes, medical supplies and equipment, and over-the-counter prescriptions.

*For people who do not have Medicare* (under age 65, over age 65 but lack qualified immigration status or sufficient work quarters, or receive Social Security Disability benefits and are in 24-month waiting period), Medicaid can:

- Be the sole health insurance coverage for all primary, acute, rehabilitative and long-term care and prescription drugs, or
- Serve as secondary payor to health insurance obtained through an employer or retiree group plan, or may even pay the COBRA premium to maintain group health coverage in some cases.

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 65 or age 65+), whether one has a disability, or has high medical bills. The Affordable Care Act that became effective January 2014 heightened the differences between the Medicaid eligibility rules for those receiving Medicare and those who do not.

### 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

## MEDICAID

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. 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 more savings than the SSI program allows may 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 for medical care for those who cannot travel by public transportation.

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. In recent years, the model for delivering and paying for health care services has changed. Most Medicaid recipients who do not receive Medicare (including those age 65+ if on SSI) are required to enroll in Medicaid "managed care" plans. The state Medicaid program pays those plans a flat monthly premium, called a capitation rate, for their care, and the managed care plans in turn pay the medical providers for services. The same model is now used to deliver home care and other long-term care services to those with both Medicare and Medicaid (Dual Eligibles) through *managed long term care* plans, which will be mandatory statewide by the end of 2015. See more discussion below.

### **The New York State Department of Health (DOH) oversees the state's Medicaid program.**

Each county administers its own local Medicaid program through the County Department of Social Services (DSS). Until January 1, 2014, local DSS offices determined whether every person applying for Medicaid and/or a Medicare Savings Program was eligible, and authorized coverage. In 2014, the State DOH took over the function of processing Medicaid applications and determining eligibility for certain applicants – *those who do not have Medicare* -- who now apply for Medicaid on the New York State of Health online Exchange. Medicare beneficiaries still apply for Medicaid and the Medicare Savings Program at their local DSS.

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/).

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

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 insurance for persons of any age. Medicaid is available to persons who are financially needy. For all Medicaid applicants, this means they must have low *income* – with varying income limits for different categories of people. For those Medicaid applicants who *do not have Medicare*, there is no longer a limit on the amount of their financial resources or assets. Only *income* is limited, which includes interest earned on savings or investments. But for Medicare beneficiaries (age 65+, disabled or blind), there is also a limit on the amount of their resources.

The particular rules for the Medicaid program are unique in each state, both for eligibility and services covered. It is dangerous to give anyone advice about Medicaid if they live in another state.

Medicare	Medicaid
Health insurance for individuals age 65 and older (or disabled) of any income level.	Health insurance for individuals of any age with very low income and, for Dual Eligibles, low 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 and a monthly “spend-down” if income exceeds the Medicaid limits.
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 fully insured status, and must be age 65+ or have received Social Security Disability benefits for 24 months. If not fully insured, individual or State may “buy-in” to gain coverage.	Eligibility is based on financial need. For people with Medicare, this means having low income and low assets. For most people without Medicare, only income is limited, no limit on assets.
Immigration status: U.S. citizen, or legal resident alien residing continuously in the US for at least 5 years	Immigration status: Broader eligibility than Medicare. In addition to citizens and permanent resident aliens (those with “green card”), also includes those “permanently residing under color of law” (PRUCOL). See <a href="http://www.wnyc.com/health/entry/33/">http://www.wnyc.com/health/entry/33/</a> . But some PRUCOL immigrants under 65 are now being transitioned to the new “Essential Plan”

Medicare	Medicaid
	instead of Medicaid.

**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).*

Note that in 2015 and 2016, New York State enacted legislative changes that may reduce when and how much Medicaid will subsidy Part B coinsurance.

1. Original Medicare – Medicaid will only pay the 20% coinsurance if the Medicaid rate is higher than the Medicare rate for the service. NY Social Services Law 367-a, subd. 1(d)(iii), as amended 2015. The provider is prohibited from balance billing the individual as a Medicaid or QMB beneficiary.
  - a. Exceptions - Medicaid/QMB will pay the full coinsurance for the following services, regardless of the Medicaid rate: ambulance, psychologist, hospital outpatient clinic, and certain facilities for people with developmental disabilities, psychiatric disability, and chemical dependence (Mental Hygiene Law Articles 16, 31 or 32).
  - b. Example: The Medicare rate for a doctor's visit is \$100, so the 20% coinsurance would be \$20. If the Medicaid rate for the same service is only \$80 or less, Medicaid would pay nothing, as it would consider the doctor fully paid.
2. Medicare Advantage – Medicaid will pay 85% of the 20% coinsurance or co-payment charged by the Medicare Advantage plan. This payment will be made regardless of the Medicaid rate for this service, unlike Original Medicare. NY Social Services Law 367-a, subd. 1(d)(iv), added 2016.
  - a. Exceptions: Medicaid/QMB will pay the full coinsurance for ambulance and psychologist.
  - b. Example: Mary's Medicare Advantage plan pays \$150 for her specialist visit and Mary is charged a copayment of \$50. The Medicaid rate for the same service is \$150. Medicaid will pay the specialist 85% of the \$50 copayment, which is \$42.50. The doctor is prohibited by federal law from "balance billing" QMB beneficiaries for the balance of that copayment.<sup>1</sup> Since provider is

<sup>1</sup> CMS reminded Medicare Advantage plans of the rule against Balance Billing in the 2017 Call Letter for plan renewals, available at <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Announcement2017.pdf>

getting \$192.50 of the \$200 approved rate, provider will hopefully not be deterred from serving Mary or other QMBs/Medicaid recipients.

- (2) **Services that Medicare generally does not pay for** - long-term care (home care or nursing home), eyeglasses, hearing aids, dental care, medical supplies. *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. However, if client is enrolled in the QMB Medicare Savings Program, the provider may not bill the client for the coinsurance, even though Medicaid will not pay it either if the provider does not accept Medicaid.<sup>2</sup> 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. 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 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. The rules changed significantly in 2014 when the Affordable Care Act expanded Medicaid eligibility for most people who do not have Medicare – most people under age 65 and seniors who do not have Medicare. It is important to identify which of these categories the individual is in:

1. **MAGI CATEGORY – (Modified Adjusted Gross Income)** – This is the new eligibility category under the Affordable Care Act and applies to most people *not* receiving Medicare, so it includes most people under age 65 (may be receiving Social Security early retirement

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<sup>2</sup> See CMS MMCO [Informational Bulletin](#), titled “Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs),” dated issued January 6, 2012, posted at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf>.

benefits or disability benefits and in 2-year Medicare waiting period). Some people age 65+ may still be in this category if not receiving Medicare, or if they take care of a child, grandchild, or other relative under age 21 who lives with them.

a. **MAGI Features:**

- i. Higher income limits – 138% Federal Poverty Level.
- ii. No asset test
- iii. Access to full Medicaid benefit package, including home care and nursing home care.
- iv. Simplified and fast online application process on NY State of Health Exchange (though a small group of people, including those seeking to enroll in Managed Long Term Care or who need nursing home care, must apply at the LDSS)

b. **New Essential Plan** – New plan in 2016 for adults between age 19 - 65 who would be in the MAGI category but have income that is too high. Income must be above 138% FPL but below 200% FPL. This covers the same benefits as Medicaid except for no long-term care. The Essential Plan is also for certain immigrants whose income is below 138% FPL but whose immigration status is either PRUCOL or subject to the 5-year bar on federal law. See more at pp. 17-42 – 17-43.

2. **NON-MAGI** – Everyone else, who still use the old Medicaid eligibility rules, income and resource limits

a. **“Disabled, Aged, Blind” (DAB)** – This is the main non-MAGI category, which includes all Medicare beneficiaries (age 65+, *or* under age 65 but disabled or blind). This is most HIICAP clients, but not all.

i. Medicaid Buy-In for Working People with Disabilities (under age 65 only)

b. **Other non-MAGI** categories – a few small eligibility groups use non-MAGI if they do not qualify under MAGI rules first - Medicaid Cancer Treatment Program (MCTP) for Breast, Cervical or Prostate Cancer, adult home residents, those seeking Medicaid subsidy for COBRA premium, etc.

c. **NON-MAGI Features:**

- i. Use income limits that existed before Affordable Care Act, which for Medicare beneficiaries are much lower than the new ACA income limits.
- ii. Asset test – same as existed before the ACA
- iii. Application filed at local DSS, not online

**Group 1: NON-MAGI: Disabled, Age 65+, or Blind (DAB)**

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. They are sometimes called “SSI-Related” because they are in the same category as SSI recipients – Age 65+, disabled or blind – but have more income or assets than SSI allows.

**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 **2016**, 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	\$14,850	\$20,000
Two (married)	\$21,750	\$30,000

Check for updates at <http://www.wnylc.com/health/download/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 \$828,000, 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) (2015-16 limit)
  - 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 under 65 and disabled or blind**  
 The applicant or recipient does not have to cash in their IRA, as long as s/he takes regular distributions from the IRA on a periodic basis (monthly, quarterly or annually). In other words, the IRA of an applicant who is age 65+, disabled or blind, is exempt as a resource, as long as the IRA is in distribution status, meaning that the individual 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.
    - **What about the tax penalty for early withdrawals?** While the IRS only requires these distributions for people over age 70-1/2, people may take withdrawals after age 59-1/2, paying income taxes but no penalty. The IRS waives any tax penalties for distributions before age 59-1/2 if the individual is disabled.

- **TIP:** If client doesn't have Medicare may be eligible under MAGI category and IRA does not count – no asset test.
- **SPOUSE of aged, disabled or blind applicant** – If the spouse is not also seeking Medicaid, the spouse does not have to take distributions from his/her IRA. The IRA is exempt for community Medicaid for applicant. DOH GIS 06 MA/004 - Treatment of Community Spouses' Retirement Funds;<sup>3</sup> MRG p. 316. However, the spouse's IRA may count toward the Community Spouse Resource Allowance (CSRA) if the applicant is seeking institutional Medicaid for nursing home care.
- **EXCEPTION – if under age 65, disabled and working – then qualifies for 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.
  - The distributions from the IRA count as income. This income may be placed in a supplemental needs trust or pooled trust, as discussed elsewhere.
- **Under age 65, not disabled – (MAGI) -** 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 (updated June 2015). Note that 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/>.
- **ABLE accounts** (not yet available as of May, 2016) – For those who were certified disabled before age 26, this new law will allow people on SSI and/or Medicaid to accumulate up to \$100,000 in gifts from donors – who *together* can give up to annual gift tax exclusion (\$14,000). New Article 84 of Mental Hygiene Law enacted 12/2015, eff. 4/1/16 but not yet implemented.

**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 s/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.

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<sup>3</sup> Available at [http://www.health.ny.gov/health\\_care/medicaid/publications/](http://www.health.ny.gov/health_care/medicaid/publications/) .

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

- **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, pension benefits, or cash gifts.
- **Gross income** is counted, though some deductions may be taken, described below. Gross income includes Social Security, pensions, distributions from IRA’s, unemployment compensation, worker’s compensation, wages, self-employment and rental income, and cash gifts
  - The **spouse’s** income is also counted, but generally income of children other household members is not counted, even if related.
  - **Since 2013: Must apply for Social Security** as a condition of eligibility for Medicaid or the Medicare Savings Program, with income counted even if it causes a spend-down. One may not defer applying in order to maximize amount of Social Security. See <http://www.wnyc.com/health/entry/185/>.
- **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, employment or retiree health 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 (SNAP)
  - VA benefits but only if for Aid & Attendance
  - **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 directly, 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://wnyc.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.

**2016 Income Limits for Age 65+, Disabled or Blind who have Medicare (non-MAGI)**

Household Size	Monthly Income
One	<b>\$825</b> (\$845 if age 65+, disabled, blind – after \$20 disregard)
Two (married)	<b>\$1,209</b> (\$1229 if age 65+, disabled, blind – after \$20 disregard)



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

▪ **Consumer Tip One – Spousal Impoverishment Protections**

If a married individual is applying for Medicaid because s/he needs Medicaid home care services, and if his/her spouse does NOT need Medicaid or home care, the applicant can benefit by using “spousal impoverishment protections” after she is enrolled in a Managed Long Term Care plan. Spousal impoverishment budgeting, previously only for nursing home and waiver programs such as Lombardi, is now available to married couples where one spouse is in Managed Long Term Care (MLTC).<sup>4</sup>

- If applicant has a “**community spouse**,” meaning a spouse who is not on Medicaid, the community spouse may keep her own income and enough of the applicant spouse’s income to total \$2,980.50 /month (and up to \$74,820 of individual and joint assets). The applicant spouse also keeps an allowance of \$384.00.
- It works almost the same as for nursing home, but with some minor variations.
- **WARNING:** State policy currently says this budgeting may not be used when first applying for Medicaid to obtain MLTC. It is “post-eligibility.” So initially spouse needs to file a “spousal refusal” for excess income and/or assets. As soon as enrolled in the MLTC plan, ask the Medicaid agency to revise the budget. These protections will eliminate any “spend-down” in many cases.
- For more information see this article <http://www.wnyc.com/health/entry/165/>. The State DOH form to request spousal budgeting is at page 9 of this link - [http://www.health.ny.gov/health\\_care/medicaid/program/update/2014/mar14\\_mu.pdf](http://www.health.ny.gov/health_care/medicaid/program/update/2014/mar14_mu.pdf)

▪ **Consumer Tip Two – Spousal Refusal:**

If a married couple’s income exceeds the limits for a couple, and the applicant does not need Managed Long Term Care, they cannot use the Spousal Impoverishment Protections. If only one spouse needs Medicaid, she/he may apply alone, and indicate that the non-applying spouse fails or refuses to contribute his/her income toward the medical bills of the applicant. Medicaid must only count the applicant’s income and resources. 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

<sup>4</sup> N.Y. Dep’t of Health, General Information System Message: Spousal Impoverishment and Transfer of Assets Rules for Certain Individuals Enrolled in Managed Long Term Care, GIS 13 MA/018 (September 24, 2013). Available at [http://www.health.ny.gov/health\\_care/medicaid/publications/](http://www.health.ny.gov/health_care/medicaid/publications/)

a child, grandchild, or other relative, whose income exceeds the MAGI limits. People between age 21 - 65 who have no relative under age 21 living with them and who are not disabled, whose income exceeds the MAGI limits, may not use spousal refusal.

▪ **Consumer Tip Three – 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 2016, gross income may be as high as \$60,420 for an individual and over \$81,132 for a couple. Net monthly income, after deducting more than half of gross earned income, must be under \$2,475 (single) and \$3,338 (couple) (2016). Resource limits are \$20,000 for single and \$30,000 for couple. IRA’s do not count for this program and do not have to be put in pay-out status.

For more information see [www.nymakesworkpay.org](http://www.nymakesworkpay.org) and

<http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1275&context=edicollet> - TOOLKIT for MBI-WPD

[http://www.nyhealth.gov/health\\_care/medicaid/program/buy\\_in/index.htm](http://www.nyhealth.gov/health_care/medicaid/program/buy_in/index.htm)

• **Consumer Tip Four – Nursing Home or Adult Home Transition Shelter Allowance<sup>5</sup> - Reduces Spend-down**

If an individual has been in a nursing home or adult home for at least 30 days, and Medicaid paid for at least part of the stay, if they enroll in an MLTC plan to be discharged back to the community, then they are allowed to keep more income, reducing or eliminating their spend-down. The chart below shows how much extra income they can keep in addition to the regular Medicaid limit (\$845 for single). Please note that if the individual is married and takes advantage of “spousal impoverishment budgeting” (Consumer Tip One above), then they may not also use this extra income deduction.

Region	Counties	Deduction <sup>6</sup>
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	\$384
Long Island	Nassau, Suffolk	\$1,060
NYC	Bronx, Kings, Manhattan, Queens, Richmond	\$1,094
Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	\$440
North Metropolitan	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	\$837

<sup>5</sup> N.Y. Dep’t of Health, Administrative Directive: Special Income Standard for Housing Expenses for Individuals Discharged from a Nursing Facility who Enroll into the Managed Long Term Care (MLTC) Program, 12 OHIP/ADM-5 at 2-4 (October 1, 2012), at [http://www.health.ny.gov/health\\_care/medicaid/publications/index.htm](http://www.health.ny.gov/health_care/medicaid/publications/index.htm)

<sup>6</sup> Figures are for 2016 - N.Y. Dep’t of Health, General Information System Message: 2016 Medicaid Only Income and Resource Levels and Spousal Impoverishment Standards, [GIS 15 MA/021](http://www.health.ny.gov/health_care/medicaid/publications/index.htm) (Dec. 22, 2015), at [http://www.health.ny.gov/health\\_care/medicaid/publications/index.htm](http://www.health.ny.gov/health_care/medicaid/publications/index.htm)

Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	\$400
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	\$342

▪ **Consumer Tip Five - QMB – Qualified Medicaid Beneficiary**

If an individual is enrolled in QMB, Medicaid will pay the Medicare deductibles, coinsurance and copayments even if the individual is not also enrolled in Medicaid. This is true whether Medicare is through Original Medicare or Medicare Advantage. Since QMB has higher income limits than Medicaid (Single \$990 vs. \$825 per month), and no asset test, QMB enrollment can accomplish a main goal of Medicaid for many people who would have a spend-down for Medicaid. QMB subsidizes Medicare out of pocket costs, including Part D by automatically qualifying you for Extra Help. The only benefits QMB will not help with are services only paid by Medicaid, and not Medicare, such as dental care and routine vision care, eyeglasses, hearing aids, long-term care, etc.

- Note that Medicaid will pay the Part A and Part B coinsurance only if a provider is enrolled as a Medicaid provider. But in 2012 CMS made clear that even providers who only accept Medicare and not Medicaid may not bill QMB enrollees for the out-of-pocket costs.<sup>7</sup>
- See pages 17-4 to 17-5 above regarding 2015 and 2016 changes that reduce how much Part B cost-sharing assistance Medicaid pays for QMB recipients.

▪ **Consumer Tip Six - Medicaid Spend-down:**

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 Spend-down 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 spend-down amount is the difference between their income and/or resources and the Medicaid limit.** Assuming resources are within the Medicaid limits, if a single person aged 65 has a total net monthly income, after deductions, of \$895, she/he would need to spend or incur monthly medical bills of \$50 a month in order to become Medicaid eligible because Medicaid’s monthly income limit for a household of one is \$825, and there is a \$20 disregard. Medical bills are applied to meet the spend-down only if they are not covered by any third party, such as private health insurance or Medicare. Also the individual has the option of choosing to “pay-in” his or her spend-down 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 now has MAGI Medicaid (see next section) with increased income limits at 133% of the Federal Poverty Line, with a 5% income disregard.

<sup>7</sup> See CMS Information Bulletin, *Billing or Services Provided to Qualified Medicare Beneficiaries*, Jan. 6, 2012, at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf> ; CMS Medicare Learning Network Bulletin, *Prohibition on Balance Billing Qualified Medicare Beneficiaries*, revised Mar. 2014, available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf> ; see also <http://www.wnyc.com/health/entry/99/#QMB>.

- **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 spend-down once. After that, they are eligible for Medicaid with no resource spend-down, but medical bills used to offset excess resources cannot also be used to meet an income spend-down. Once individuals accumulate bills equal to their spend-down 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 spend-down. The individual will be responsible for those payments.
- **Important Note: Medical bills do not have to be paid to count toward the spend-down.** 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:**

- A. Medicare and private health insurance **deductibles and coinsurance** or co-payments, including Part D.
- B. **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, which is generally for six years – the time a provider has to bring a legal collection action).
- C. **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.
- D. 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, between July 1<sup>st</sup> and October 1<sup>st</sup>. He applied for Medicaid in October. Since the prescription costs were incurred in the 3 calendar months before he applied for Medicaid, these costs can be applied to meet his spenddown. His monthly 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. If he submits three bills with his application, he can activate Medicaid for six months.

**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 with his application 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.

- o **Consumer Tip Seven – 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 in Year One, an individual will qualify for Medicaid for that month, and in turn, will qualify for Part D Extra Help for that entire calendar year (Year One), and for the entire next year (Year Two) if the Medicaid eligibility occurs in the last half of Year One. This helps people whose income is above the limit for Extra Help or a Medicare Savings Program.

- o **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 after Part B deduction 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 MAGI Medicaid because she has Medicare (and too much income).

Her Medicaid spenddown is \$671/month, which she cannot afford to pay with her rent and other living expenses. Her resources are under the Medicaid limit of \$14,850 (2015). You ask her if she has any old medical bills -- she has an old hospital bill from 3 years ago of \$2013, 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 \$2013, 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 Eight - 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 NYLAG Evelyn Frank Legal Resources Program'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. See more at <http://www.wnyc.com/health/14/>.

**GROUP 2: MAGI Medicaid – The New Expanded Medicaid under Affordable Care Act**

For individuals who are *not receiving* Medicare, unless they live with and care for a minor child or relative under age 18, or under age 18 if in school. They have:

**A. NO RESOURCE LIMIT**

There is no limit on resources for MAGI Medicaid. This continues New York’s elimination of the resource/asset test in 2010 for Medicaid for singles and childless couples, and families with children. 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 one’s savings generate too much interest or dividends.

**B. INCOME**

Income limit for most people is 138% of the Federal Poverty Line. NOTE that income limit is higher for pregnant women and infants < age 1 (223% FPL) and children (154% FPL). The rules for counting income are very different than the rules described above for Medicaid for Aged, Blind and Disabled. The rules are based on the federal income tax rules, hence the term MAGI, which stands for Modified Adjusted Gross Income.

**2016 MAGI Income Limits**

Pregnant women and children have higher limits up to 223% FPL.

<b>Household Size</b>	<b>Monthly income Gross= 138% FPL</b>
One	\$1,367
Two	\$1,843

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
- NO deduction from earned income, in contrast to disregard of over HALF of all earned income for Disabled, Aged, Blind Medicaid.

On the other hand, some income counts for DAB category that does not count for MAGI category – Worker’s compensation, VA benefits, cash gifts, see more below.

**No Spenddown** -- An important rule for people under age 65 is that they may NOT qualify for MAGI Medicaid if their income exceeds the limits in the Table above by using “spenddown.” However, they may be eligible for Advance Premium Tax Credits and coinsurance subsidies if they purchase a Qualified Health Plan on the Exchange. Also, children under 21 or their parents and caretaker relatives as well as people with disabilities and seniors who do not have Medicare have the option of applying for Medicaid the old-fashioned way, and using spend-down.

## Who is in MAGI HOUSEHOLD, for determining whose income counts?

MAGI uses a tax filing unit, with limited exceptions. 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. These rules are very complicated, and not fully explained here. As an example of how the rules impact people over age 60, Uncle Matt, age 63 and not receiving Medicare, lives with his niece, Mary, and her husband and 2 children. Mary and her husband claim Uncle Matt as a tax dependent because he is the type of relative who can be counted as a dependent under the tax law, he lives with them, his income is under \$3900/year, and they provide more than half of his support. As their dependent, when Mary and her husband apply for Medicaid for their family, they must include Uncle Matt's income in their household income, but also benefit from the increased family size. However, Matt is allowed to apply for MAGI Medicaid on his own as a Household of One, even though he is counted as their dependent. This is a special Multi-Generation Household Size rule. This allows Matt to qualify for Medicaid without having to count the income of his niece and her husband. For a full explanation of these complicated rules see: [NYS DOH 13ADM-03 - Medicaid Eligibility Changes under the Affordable Care Act \(ACA\) of 2010](#) –download at [http://www.health.ny.gov/health\\_care/medicaid/publications/pub2013adm.htm](http://www.health.ny.gov/health_care/medicaid/publications/pub2013adm.htm) and NYLAG's PowerPoint on MAGI Medicaid posted at <http://www.wnyc.com/health/download/453/>.

## WHAT INCOME IS COUNTED?

Gross income counted for MAGI includes:

- Wages (gross) (but excludes amount contributed to a pre-tax cafeteria flex spending plan for health care or child care)
- Social Security income – includes ALL SS income, even part that is not taxable
- Interest and dividends – even if non-taxable
- Unemployment benefits
- Pensions
- IRA distributions
- Alimony
- Income from self-employment - Only net income after expenses – use Schedule C
- Rental income – net income after expenses

EXCLUSIONS – The following income does NOT count for MAGI budgeting, unlike “DAB” Medicaid for Disabled, Aged, Blind:

- Veteran's benefits – NOT COUNTED – both disability and pension
- Child support received
- Gifts, inheritances, and lump sums (lawsuit settlements – lump sums or structured settlements)
- American Indian income
- Worker's Compensation

DEDUCTIONS from income:

- Alimony paid,

- certain moving expenses,
- student loan interest,
- self-employed health insurance contributions and self-employment tax,
- IRA deduction
- Income contributed to a flex spending cafeteria plan for health care or child care pre-tax

### **SPECIAL MAGI FEATURES –**

- are eligible for “benchmark benefits” – Includes everything now covered under Medicaid except including long term care.
- have continuous eligibility for 12 months, despite changes in income, unless reach 65 during the 12 months, then MAGI ends at age 65.<sup>8</sup>
- apply for Medicaid on the online Exchange, not at Medicaid offices (with exception of people needing managed long term care or nursing home care).

### **SOME PEOPLE MAY CHOOSE MAGI or NON-MAGI BUDGETING:**

- If individual is disabled under age 65, she may choose MAGI or non-MAGI budgeting, *but only if she is not yet receiving Medicare*. Once she receives Medicare, she may not use MAGI budgeting UNLESS she lives with and cares for her child, grandchild or other relative under age 18 (19 if student).
- Parent/caretaker relatives who are disabled or over 65 may choose MAGI or Non-MAGI, *even if they receive Medicare*, if they live with and care for a child under age 18 (19 if a student).
- Disabled children may choose MAGI or NON-MAGI, *unless they are in a waiver program (eg. Katie Beckett program)*.
- **PRO’s of MAGI BUDGETING–**
  - Higher income limit - 138% FPL vs. 87% FPL = **\$1367 vs. \$825/month**  
  
EX. Alice receives \$1200/mo. SS Disability and is not yet on Medicare. Her income is under 138% FPL. With MAGI she will have Medicaid with no spend-down.
  - **Workers comp, VA benefits, child support, inheritances, gifts not counted**
  - **No asset test!**

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<sup>8</sup> NYS DOH [GIS 15 MA/022 - Continuous Coverage for MAGI Individuals](http://www.health.ny.gov/health_care/medicaid/publications/pub2015gis.htm) (12/23/15), available at [http://www.health.ny.gov/health\\_care/medicaid/publications/pub2015gis.htm](http://www.health.ny.gov/health_care/medicaid/publications/pub2015gis.htm).

- **CON's FOR MAGI -**
  - If disabled person is **working**, traditional “DAB” Medicaid has better income disregards for earned income and, if under age 65, higher income limits
    - Medicaid-Buy-In for People with Disabilities under age 65 – income limit **250% FPL**
    - 50% of gross earned income “disregarded” in non-MAGI Medicaid – better than 5% MAGI deduction. Applies at any age.
  - Can't use MAGI if you have Medicare, unless you live with your child/relative <18 or < 19 if in school
- **NEW CHOICES in 2016 FOR PEOPLE UNDER AGE 65 with income > 138% FPL** so not eligible for non-MAGI Medicaid, and client is disabled but does not have Medicare– Choose between:
  1. If does not need long term care, eligible for the **ESSENTIAL PLAN** if income < 200% FPL.
  2. Medicaid spend-down – if needs home care or long-term care or
  3. Qualified Health Plan on Marketplace with premium and cost-sharing subsidies – but no long-term care on Exchange

### **Transitioning from MAGI Medicaid to Medicare (at 65 or based on disability)**

When an individual who is enrolled in MAGI Medicaid through the Marketplace becomes eligible for Medicare due to age or disability, they should expect their Medicaid through the Marketplace to end and their case to be transferred from the Marketplace to their Local Department of Social Services (LDSS). The transition occurs at a different time depending on whether the client is aging on to Medicare at age 65, or became enrolled in Medicare after 24 months on Social Security Disability. Either way, the process is the same. When someone ages into Medicare, they should expect to be disenrolled from their Medicaid Managed Care plan in the month they turn 65 and have their case transferred to the LDSS in the same month. For individuals who start receiving Medicare because of their disability, they should expect to be removed from their Managed Care plan during or right after the month they start receiving Medicare.

- *MAGI Medicaid Enrollee Turning 65*  
In the month that a MAGI Medicaid enrollee turns 65, they should expect to be disenrolled from their Medicaid Managed Care plan and have their Medicaid case through the Marketplace end. Even though their Marketplace Medicaid is ending, they should continue to receive Fee for Service Medicaid while their case is transferred to the Local DSS, which should send the client a notice with either a re-certification form and Supplement A or a new Medicaid application. This transitional period of Fee for Service coverage will last up to four months (outside NYC) or five months (in NYC), counting the month of transition as the first month. It could be shorter if your Local DSS specifies an earlier date on the application. To determine when Fee for Service coverage ends, call your Local DSS. Note that the 12 months

of continuous MAGI eligibility is cut off when the individual turns 65. NYS DOH [GIS 15 MA/022 - Continuous Coverage for MAGI Individuals](#) (12/2015).

- *MAGI Medicaid Enrollee Obtaining Medicare after Receiving 24 Months of Social Security Disability Insurance Payments*

When an individual enrolled in MAGI Medicaid starts to receive Medicare due to their Social Security disability payments, they should expect to be disenrolled from their Medicaid Managed Care plan. They will continue to have Fee for Service Medicaid in the Marketplace through the end of their 12 month continuous care period. While they have Fee for Service through the Marketplace, they can call the Marketplace to request Part B premium reimbursements.

At the end of their 12 month period, their case will be transferred to the Local DSS and go through the same process as above for those turning 65. Once the case is sent to the Local DSS, the client should receive a notice from their LDSS with either a re-certification form and Supplement A or a new Medicaid application. This transitional period of Fee for Service coverage will last up to four months (outside NYC) or five months (in NYC), counting the month of transition as the first month. It could be shorter if your Local Department of Social Services specifies an earlier date on the application. To determine when Fee for Service coverage ends, call your Local Department of Social Services.

- **Extra Issue for MAGI Medicaid recipients who were enrolled in a Managed long term care plan which provided them with Medicaid personal care or other home care services.** As said above, they will be disenrolled from their mainstream managed care plan once they start receiving Medicare. This can cause disruption of their home care services if they were receiving them from the managed care plan. In 2015, the State introduced procedures that require these individuals to be assigned to an MLTC plan if they do not select one after being given notice of the opportunity to do so. See [MLTC Policy 15.02: Transition of Medicaid Managed Care to MLTC](#). This should ensure a seamless transition to an MLTC plan to continue the home care services. However, this procedure works only if the individual becomes eligible for Medicare based on turning 65, but not if based on disability.
  - These cases require troubleshooting. If an individual is becoming eligible for Medicare and was receiving home care from a managed care plan, be proactive and ensure that they enroll in an MLTC plan immediately. Make sure the new MLTC plan continues the same services provided before by the mainstream plan.
  - If there is a problem, call ICAN.

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 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. Also, in 2015 and 2016, the New York State law has restricted how much Medicaid will pay for Part B coinsurance in both Original Medicare and Medicare Advantage. See pp. 17-04 and 17-05 above.
- **A dual eligible may 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, with a few exceptions and caveats 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 \$828,000 (2015-16 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 \$828,000 (as of January 1, 2015), 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. Note that the limit is on equity value, not market value; the equity value can be reduced by taking out a mortgage.
- **Married couples - Spousal Impoverishment protections and Spousal Refusal** can lower or even eliminate excess income or resources or spend-down. See above.

**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 enough to pay Medigap or other 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. NOTE that if a new nursing home resident reasonably expects to return home, he or she can request “community budgeting,” which allows him/her to keep the regular Medicaid allowance (\$845/mo in 2015 including \$20 disregard) rather than \$50/month. The purpose of this is to have money to pay rent to maintain an apartment. This is usually authorized for six months subject to renewal. A five-year lookback of assets is still required, described below. See more at <http://www.wnylc.com/health/entry/117/>.

**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 for a period of time based on the amount transferred during the five years. This includes transfers to individuals (gifts), charities, or to a trust.

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**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 2016 rates are in GIS 15 MA/023 - Policy Change for Determining the Appropriate Medicaid Regional Rate for Calculating a Transfer Penalty Period and the Regional Rates for 2016, at [http://www.health.ny.gov/health\\_care/medicaid/publications/gis/15ma023.htm](http://www.health.ny.gov/health_care/medicaid/publications/gis/15ma023.htm). (also lists which counties are in each of these seven regions).

- Central \$9,252
- Long Island \$12,633
- New York City \$12,029
- Northeastern \$9,806
- Rochester \$11,145
- Western \$9,630
- Northern Metropolitan \$11,768

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, if 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 (\$14,850 in 2015 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 \$100,730 to her daughter in March 2011, and applied for Medicaid to receive certified home health agency services in April 2011. These services were approved because there is no transfer penalty for community-based services. In March 2016, Susan had a stroke, was hospitalized and then was placed in a nursing home. Other than the money she transferred in March 2011, her assets were within the 2016 Medicaid limit for a single person - \$14,850. She applies for Medicaid in June 2016, 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 -- \$100,730 divided by \$10,073. Since she is institutionalized, is applying for and is otherwise eligible for Medicaid, the transfer penalty begins in June 2016. Medicaid will not pay for her nursing home care for the next ten months beginning June 2016. One option around this penalty is for her to return home from the nursing home after the penalty starts "running--" any time between July 2016 and April 2017. 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 five years 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 or Managed Long Term Care (MLTC) Plan**

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. New York State allows the community spouse to retain the highest amount of resources and monthly income allowed by federal law. The maximum income allowance does not always get an annual increase.

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Here's how the law works. When one spouse enters a nursing home – or enrolls in a Managed Long Term Care plan or a “waiver” program, 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 2016, the community spouse of an institutionalized Medicaid recipient is permitted to retain up to \$2,980.50 of monthly income. If the community spouse has personal income in excess of this amount, 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 this amount 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 \$2,980.50. The applicant spouse is entitled to keep an additional \$384 of monthly income.

**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 \$119,220 (2016) 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 \$14,850 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.

### **Spousal Protections Now Apply to Managed Long Term Care**

The spousal impoverishment protections described above now apply not only for couples where one spouse is in a nursing home, but couples where one spouse is enrolled in a Managed Long Term Care (MLTC) plan. This policy continues the longstanding use of spousal impoverishment protections in the Lombardi program (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/>. Since the Lombardi program was phased out and merged with the managed long term care program beginning April 2013, the State has continued these same protections in the MLTC program. See <http://www.wnylc.com/health/entry/165/>.

**SERVICES COVERED BY MEDICAID**

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Medicaid covers a broad package of services, described below. However, the way that these services are authorized and obtained is changing. Most Medicaid recipients must enroll in Medicaid managed care plans in order to obtain all Medicaid services. Medicare beneficiaries and those with a spend-down have always been excluded from these “mainstream” Medicaid plans, but this is changing, especially for those who need Medicaid long-term care services. These changes are described later.

**What services does Medicaid pay for?**

Medicaid pays for the following, subject to various limits. For Medicare beneficiaries, Medicare is always the primary payor for any Medicare services, and Medicaid is secondary payor.

- **Hospital** inpatient and outpatient services
- **Laboratory** and X-ray services
- **Nursing home** care - short-term rehabilitation as well as long-term care
- **Outpatient or clinic** treatment and preventive health and **dental and vision** care (doctors, dentists, optometry)
- **Eyeglasses and hearing aids**
- Treatment in **psychiatric hospitals** (for persons under 21 or 65 and older), mental health facilities, and developmental disabilities facilities
- **Family planning services**
- **Medicine (prescription and over-the-counter) and supplies** - HOWEVER 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. Medicaid no longer covers any drugs that the Part D plan could cover but does not include on its formulary. This is true even for HIV/AIDS drugs, post-transplant, anti-psychotic and anti-depressant drugs, all of which, before April 1, 2011, had special Medicaid protections. Now if the Part D plan does not cover a drug in these classes, or any drug, the dual eligible’s only recourse is to appeal the denial of the drug to the plan or change 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. In June 2013, these standards were finally issued, but still are very strict. Adults with HIV/AIDS or other diseases or conditions who require:
  - supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, and have a body mass index (BMI) under 18.5, **or** under 22 plus a documented, unintentional weight loss of 5 percent or more within the previous 6 month period, may have up to 1,000 calories per day; **OR**
  - require total oral nutritional support, have a permanent structural limitation that prevents the chewing of food, and placement of a feeding tube is medically contraindicated.

People denied Ensure despite a strong doctor’s letter should contact the Empire Justice Center at 1-800-724-0490. Links to guidelines at: <http://www.wnyc.com/health/entry/190/>.

- **Orthotics, inserts and compression stockings** – A court decision in December 2013 struck down limits enacted by the state legislature in 2011 that limited these items to prostheses for

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amputees or as part of a diabetic treatment plan, or for children with development problems. [https://www.emedny.org/ProviderManuals/communications/Prescription\\_Footwear\\_Benefit\\_Update\\_Provider\\_communication\\_Final\\_Version.pdf](https://www.emedny.org/ProviderManuals/communications/Prescription_Footwear_Benefit_Update_Provider_communication_Final_Version.pdf). This decision was affirmed in part on appeal in March 2016, but was sent back to the trial court for further proceedings.<sup>9</sup> Medicaid recipients who have been unable to get Medicaid coverage for these services may contact the Empire Justice Center at 1-800-724-0490. See more information at <http://www.wnyc.com/health/entry/182/>

- **Emergency ambulance** transportation to a hospital
- **Transportation to non-emergency medical** appointments, including bus fare, ambulettes and car mileage. Since May 2012, New York City has used a new system – LogistiCare -- for approval for and scheduling this transportation. <http://www.nycmedicaidride.net>. LogistiCare is NOT used for people in Managed Long Term Care (MLTC) plans, whose members instead must request and obtain medical transportation through their MLTC plan.
- **Assisted Living Program (ALP)** – Medicaid covers the cost of assisted living in a limited number of facilities. These are not the private assisted living programs familiar to many people, many run by national chains. These are generally units within “adult homes.” For people with very low incomes, the cost is paid through a combination of SSI and Medicaid. People with higher incomes (over \$1415/month) do not receive SSI, but Medicaid supplements the payment they make with their income. For a statewide list of ALPs see [http://www.nyhealth.gov/facilities/assisted\\_living/licensed\\_programs.htm](http://www.nyhealth.gov/facilities/assisted_living/licensed_programs.htm). For more information see <http://www.wnyc.com/health/entry/150/>.
- **Medicaid home care and other community-based long-term care** – personal care, consumer-directed personal assistance program (CDPAP), home health aides, adult day care, Personal Emergency Response System – NY has a rich array of these services, but the model for providing them is changing radically. See section in Managed Long Term Care below.
- **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.

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<sup>9</sup> Download *Davis v. Shah* decision here. <http://caselaw.findlaw.com/us-2nd-circuit/1729831.html>

## **Managed Long Term Care -- Medicaid Community-based long-term care (home care) services**

Since late 2015 all adult Dual Eligibles (age 21+) who need Medicaid home care or other long-term care services, with very few exceptions, have been required to be enrolled in a Managed Long Term Care (MLTC) plan in order to receive these services on a long-term basis, meaning more than 120 days. The MLTC plan now controls access to, approves, and pays for all Medicaid home care services and other long-term care services in the MLTC service package, including:

- 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) – if needed beyond 120 days
- Private Duty Nursing care
- Durable medical equipment and medical supplies (wheelchairs, orthopedic shoes, compression stockings, adult diapers, etc.)
- Adult day health care (medical model and social model).

### **Who Must Enroll in MLTC?**

Medicaid recipients who live in NYC or another county that has become “mandatory” – see schedule below, who

- Are dually eligible - they have Medicare AND Medicaid, including those who have a “spend-down” or excess income, 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. (Note that having a spend-down is NOT an exemption or exclusion from MLTC). See more below.

### **Managed Long Term Care is now Mandatory Statewide**

As of September 2015, all counties have mandatory MLTC. Here is what this means for people who were previously receiving Medicaid home care through other programs, and for people newly applying for home care.

1. **People who were Already Receiving Medicaid Home Care Services when their County became mandatory** - They received a series of letters from New York Medicaid Choice, the enrollment broker contracted with the State Dept. of Health, giving them 60 days to select a plan, and if they didn’t pick one, they would be auto-assigned to an MLTC plan.
  - **WHO is auto-assigned** – Those receiving Personal Care, CDPAP, Medical adult day care, long-term CHHA recipients, and Lombardi long term home health care program receive letters from the state’s enrollment broker, a company called New York Medicaid

Choice (Maximus), with a list of local MLTC plans and a brochure on MLTC.<sup>10</sup> The letter requires them to select an MLTC plan within 60 days or they will be randomly assigned to a plan.

- Participants in the local Long-Term Home Health Care or “Lombardi” Program is closing down, and all participants who have Medicare over age 21 must transition to an MLTC plan. Those Lombardi participants who do not have Medicare must transition to a “mainstream” Medicaid managed care plan.
- 60-Day Enrollment letter and package sent for mandatory enrollment:
  - Form Letter -- <http://wnylc.com/health/download/318/> It 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.
  - Managed Long Term Care Brochure -- Official Guide to Managed Long Term Care, written and published by NY Medicaid Choice (Maximus) – Download them here - <http://www.nymedicaidchoice.com/program-materials><sup>11</sup>
  - 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 a plan – see section below.

○ **90- Day Transition Period:**

MLTC plan must provide the same services and the same number of hours as CASA/DSS/ CHHA/Lombardi program had authorized for first 90 days after enrollment. This time period was lengthened from 60-90 days by a May 2013 State directive -- [MLTC Policy 13.10: Communication with Recipients Seeking Enrollment and Continuity of Care](#), available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/policy\\_13\\_10\\_guidance.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_10_guidance.pdf), During this 90-day period, 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 90-day transition period.

1. NOTICE OF A REDUCTION IN SERVICES AFTER TRANSITION PERIOD ends --Before a plan reduces or stops services you previously received from CASA/DSS, CHHA, Adult Day Care, Lombardi, or CDPAP, the plan must give advance WRITTEN NOTICE stating the amount of home care and other services they will give you at least 10 days before the effective date. The notice will explain your right to appeal. *See more on Appeal Rights below.*

2. **NEW APPLICANTS for community-based long-term care services –FRONT DOOR CLOSED** at county DSS to apply for MOST home care, with exceptions –

Before, a person seeking personal care services applied at their local county Medicaid office for both Medicaid and personal care services.

2. Now *most* new applicants have a three-step process:

- **Apply for MEDICAID** at the local Medicaid office.

<sup>10</sup> Download the MLTC brochure and your local list of plans here - <http://nymedicaidchoice.com/program-materials> - be sure to look only at the lists of “Long Term Care” plans, not the “Health Plans.” The Health Plans are the mainstream Medicaid managed care plans that are NOT for people with Medicare or who have a spend-down.

<sup>11</sup> Direct link <https://www.nymedicaidchoice.com/sites/default/files/content-docs/MLTC%20BROCH%20r5-9-13%20v4.pdf>

- **CFEEC** - Request a Conflict-Free Eligibility Determination from the Conflict-Free Eligibility & Enrollment Center (CFEEC) run by Maximus, NY Medicaid Choice, the state's contractor. This assessment is done by a nurse in the client's home or nursing home, and makes a simple determination of whether the individual needs long-term care services so may enroll in an MLTC plan. It must be scheduled with 2 weeks of the request. Because of the delay, you may request it even before the Medicaid application is approved. However, the CFEEC determination becomes stale after 60 days if client is not enrolled in an MLTC plan. So one should not request it too early. The CFEEC determination does not determine the number of hours of care client will receive.

**To request CFEEC call 1-855-222-8350.** See <https://nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care> See NYLAG CFEEC Fact Sheet <http://www.wnyc.com/health/download/573/>.<sup>12</sup>

- **Enroll with an MLTC plan** in order to obtain home care or other long-term care services. Call various MLTC plans in your county, requests them to come to assess client in the home (or nursing home). The MLTC nurse does a comprehensive assessment and develops a plan of care, meaning the number of hours per week plan will authorize.
  - **Choosing a Plan** – If your county has choices, ask several plans to assess and pick the most favorable plan of care. Another factor in making a choice is whether preferred providers are in the plan's network - home care agency, dentist, optometrist, nursing home, physical therapy clinics. See list of services covered by MLTC above. See **TOOLS FOR CHOOSING AN MLTC PLAN**. <http://www.wnyc.com/health/entry/169/>
  - **How to enroll** - ONCE you select a plan, you sign plan's enrollment form, and plan submits the form to NY Medicaid Choice. If you are selecting a Medicaid Advantage Plus (MAP) or PACE plan, you must enroll directly with the plan. The plan must submit this form by the 18<sup>th</sup> of the month in order for enrollment to start the 1<sup>st</sup> of the following month.
  - **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 after the 18<sup>th</sup> of 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.
  - **CHANGING PLANS** – You may switch to a different MLTC plan, but the enrollment will not be effective until the 1<sup>st</sup> of the

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<sup>12</sup> State policies and FAQs on CFEEC are at [http://www.health.ny.gov/health\\_care/medicaid/redesign/mrt90/](http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/) and [MLTC Policy 15.08: Conflict-Free Evaluation and Enrollment Center Dispute Resolution](#)

next month, and in many cases not until the 1<sup>st</sup> of the second month. Since it is “voluntary” to switch plans, you may be at risk of losing services when you switch. For example, if you receive 24-hour home care in Plan A, but do not like the providers in the network, and switch to Plan B, Plan B might reduce your services to 4 hours/day. Since the change was voluntary you do not have the right to appeal.

**3. EXCEPTIONS- Who may Still Apply for Personal Care Services at the LDSS and not enroll in an MLTC plan?**

There are some populations that are excluded and not allowed to enroll in MLTC. There are others who are “exempt” and may enroll in MLTC but are not required to. There is a third exception for those who are normally required to enroll in MLTC, but may get personal care on a temporary basis through LDSS because they have an “immediate need” for services and cannot wait for MLTC enrollment. See next section below.

**WHO DOES NOT HAVE TO ENROLL IN MLTC? (Exemptions & Exclusions)–**

**1. Who is EXCLUDED from MLTC – may not enroll in MLTC? These groups still apply to local DSS for personal care.**

- People in Nursing Home Transition Diversion Waiver, Traumatic Brain Injury waiver, Office for People with Developmental Disabilities Waiver -
- People who need only “Housekeeping” services, also called Personal Care Level I, for which the maximum is 8 hours/week. These services are still obtained through the local Department of Social Services Medicaid program. This is for people who only need help with tasks such as shopping, cooking, cleaning, and laundry, but not with personal Activities of Daily Living (ADL) such as ambulation, toileting, dressing or bathing.
- Persons receiving hospice services (they may 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.
- Anyone under age 18

**2. Who is not eligible for any Medicaid home care – MLTC or through DSS**

- Residents of Medicaid-funded Assisted Living Programs, see [http://www.nyhealth.gov/health\\_care/medicaid/program/longterm/](http://www.nyhealth.gov/health_care/medicaid/program/longterm/)
- People who need only social model adult day care. They are excluded from MLTC enrollment unless they also need home care for assistance with ADLs.
- Adult dual eligibles who do not need any long-term care services. NOTE: MLTC plans provide some non-long term care services, such as hearing aids, dental and vision care. Adult dual eligibles who need those services but do not need home care or other long-term care services do not need to enroll in MLTC, and are even excluded from MLTC enrollment. They may use their regular Medicaid card for hearing aid, dental, vision care, medical supplies, etc.

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

- Native Americans;
- Nursing home residents who are dual eligible adults age 21+ (they became eligible to enroll in October 2015; prior to that they were *excluded* from enrolling in MLTC)
- 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:
  - Only if they require a “nursing home level of care” and either they are not yet enrolled in a mainstream Medicaid managed care program OR they need services not available from a [mainstream Medicaid managed care plan](#) such as social adult day care, environmental modifications or social or environmental supports, or home delivered meals. See [MLTC Policy 14.01: Transfers from Medicaid Managed Care to Managed Long Term Care](#).<sup>13</sup>
  - 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.)
  - *MAGI NOTE* -- Most such people are non-MAGI and applied for Medicaid on the NYS of Health Exchange. If that is the case, even though they may enroll in MLTC having MAGI Medicaid, they must still switch administration of their Medicaid case to the LDSS from the Exchange. The LDSS will use “MAGI-like” budgeting to approve or renew their Medicaid.
- 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”).

**4. Dual eligible adults with an “Immediate Need” for Personal Care or CDPAP services, who would normally be required to enroll in MLTC Plans –**

In July 2015, the NYS Dept. of Health issued a directive -- [GIS 15 MA/011 - Reminder of Expedited Authorization Process for Medicaid Recipients with Immediate Need for Personal Care Services](#). This directive makes an important change for any adult who has Medicare who needs Medicaid home care. Before this directive was issued, the "front door" was closed at the local Medicaid program to request Medicaid personal care services from the local Medicaid agency. Anyone who had Medicare had to apply for Medicaid at the local Medicaid agency, but then had to enroll in a Managed Long Term Care plan to get home care. That process could take months - even AFTER Medicaid eligibility was approved.

With this directive, the State announced that local Medicaid offices may authorize personal care services to a Medicaid recipient once Medicaid is approved. This means the individual may submit a physician's order - known as an [M11q](#) in New York City ([fill-in-able version](#)) - to the local Medicaid office, which must authorize personal care services if there is an "immediate need" for these services. Also see [Q-Tips](#) for tips on how the physician can complete the M11q.

- 4. TIP:** Though this directive says that the local Medicaid agency will only process a request for expedited home care once Medicaid is approved, you can still submit the physician's order/ [M11q](#) *along with* the Medicaid application.

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<sup>13</sup> All NYS DOH MLTC Policies are posted at [http://www.health.ny.gov/health\\_care/medicaid/redesign/mrt90/mltc\\_policies.htm](http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm).

Include a cover letter that requests that the Medicaid application be expedited and explain why individual has an immediate need for services and cannot wait to enroll in an MLTC plan.

**TWO MODELS OF MLTC with THREE TYPES OF PLANS:**

People living in mandatory MLTC counties MUST enroll in an MLTC plan, but may have a choice among two different models of plans -- the fully capitated PACE and Medicaid Advantage Plus programs and partially capitated managed long term care (MLTC) plans.

- **“Capitation”** is the fixed monthly premium payment paid by the State Medicaid program to the managed long term care plan, from which the plan pays for all services. The expectation is 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.”
  - *Full capitation* means the plan is paid to cover both MEDICARE AND MEDICAID services
  - *Partial capitation* means the plan receives payment only to cover Medicaid long-term care services, so that the individual continues to use their Medicare card separately for Medicare services and their Medicaid card for some Medicaid services not in the MLTC package.
- **Lists of 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 showing “Plan Type”);
  - <http://www.wnyc.com/health/download/371/> (List organized by County compiled by NYLAG, showing which plans are MLTC, PACE, or MAP).
  - <http://www.wnyc.com/health/download/429/> (List organized by COMPANY, showing which types of plans a company owns. Focuses on NYC).
  - <http://nymedicaidchoice.com/program-materials> - Lists by region in State on New York Medicaid Choice website (state’s contracted enrollment broker).

**1. Fully capitated plans – PACE, Medicaid Advantage Plus (MAP), and FIDA (FIDA only in NYC and Nassau County as of June 2015, scheduled to expand to Suffolk & Westchester only in mid-2016)**

In a fully capitated plan, the member essentially gives up her Medicare and Medicaid cards and agrees to enroll in a special Medicare Advantage Plan that covers both Medicare and all 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. There are 3 types of fully capitated plans:

1. *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. All Medicare and Medicaid services are covered.
  - 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 team is responsible for directly providing or arranging all primary, inpatient hospital and long-term care services required by a PACE member.

- 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.
2. *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.
  - *Warning:* These Medicaid Advantage Plus plans are different than Medicaid Advantage plans with no “Plus.” Both types of plans are Medicare Advantage Plans, and both include some Medicaid services. The different is that the “PLUS” plans include all Medicaid services, including all long term care services. The plans with no “plus” include only Medicaid primary and acute care but no long-term home care services.
3. **Fully Integrated Dual Advantage (FIDA)**(Only in NYC & Nassau as of 5/16)(Scheduled to expand to Westchester and Suffolk in mid-2016)
- FIDA is a demonstration program that is hoped to reduce costs and inefficiency and improve outcomes. It is designed solely for adult dual eligibles who need long-term care.
  - Enrollment began in April 2015 in Nassau County and NYC only. Over 100,000 MLTC members in those counties received notices giving them 90 days to either voluntarily enroll in a FIDA plan, or “opt out” of FIDA altogether. If they did neither, they would be “passively enrolled” into the FIDA plan connected to their own MLTC plan. Most of the MLTC plans in this region offered a sister FIDA plan. As of February 2016, 6,252 people are enrolled in FIDA. At least 57,000 of these individuals opted out of FIDA.
  - As of early 2016, the state stopped “passive enrollment” of MLTC members into FIDA. Future enrollment in FIDA is voluntary.
  - FIDA has the potential to offer better care management and coordination, and has a unique unified appeal system.

For all 3 fully capitated types of plans, the downside for the individual is that they must only use providers in their plan’s network, so that they lose some access to other doctors, hospitals and other providers. Also, since all of these plans include prescription drugs, one must look carefully at the drug formulary to be sure one’s prescriptions are covered.

## 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 – 154,333 in NYS as of April 2016, 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, supplemented by regular Medicaid card for primary care, inpatient hospital, 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)

Enrolling in one of these plans is mandatory for adults age 21+ who need Medicaid home care and other community-based long-term care services if the county has become mandatory, with option of choosing a PACE or MAP plan instead, or FIDA in NYC or Nassau County.

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 (became mandatory part of MLTC downstate in February 2015, and rest of state by July 2015 – see more below)

### **Member Rights when Plan Reduces Services or Denies Increased Services**

MLTC members have the right to appeal any adverse determination by the MLTC plan regarding denial, reduction, or termination of services.

- 1. Denials.** If a member is denied an increase in services, or a request for a new type of service, the plan must provide a written notice approving or denying the request. That notice must be provided within two weeks, and sometimes within only three days in urgent requests that must be expedited. The notice must explain the reason for the denial and how the member may appeal. See time limits here and the criteria for expediting requests. <http://www.wnyc.com/health/entry/114/#new%20service%20requests>,  
 How to appeal: The member may choose whether to first request an “internal appeal” within the plan, or to go directly to a Fair Hearing. If she requests an internal appeal and loses, she will receive notice of that denial, and then has the right to request a fair hearing. Since July 2015, it is the member’s choice whether to request an internal appeal

before requesting a fair hearing.<sup>14</sup> Request a hearing online, by phone or by fax – see <http://otda.ny.gov/hearings/request/>.

**2. Reductions or Terminations of Services.** When a plan proposes to reduce or terminate a service, and the member requests a fair hearing before the “effective date” of the reduction, the plan must continue services unchanged during the internal appeal and until a hearing is decided. This is known as “Aid Continuing.” State MLTC Directive 13.01<sup>15</sup> states, “... 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.”

- Advance Notice -- Notice of the proposed reduction or termination must be given ten (10) days before the effective date of the reduction.
- The notice must be in writing and provide a specific reason for the reduction. Only certain reasons are permitted, such as a change in medical or social circumstances or a mistake in the prior authorization.<sup>16</sup> If the plan simply changes its mind or uses a new assessment tool, this is not a sufficient reason.
- FORM OF NOTICE –The NYS DOH has required MLTC plans to implement mandatory model notice templates, which must include specific facts and reasons justifying a proposed reduction.<sup>17</sup>
- How to Appeal. Though the member has the option to request an internal appeal as well as a fair hearing, the member will only get AID CONTINUING – continuation of the prior higher level of service – if she immediately requests a FAIR HEARING and not an internal appeal. The hearing must be requested before the effective date of the adverse action, which should be at least 10 days after the date of the written Notice from the plan. After the hearing is requested, while it is being scheduled, the member may still request an internal appeal with hopes of resolving the issue. If it is resolved, the member can withdraw the hearing request. Request a hearing online, by phone or by fax – see <http://otda.ny.gov/hearings/request/>.
- **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.**

**3. Contact ICAN – Independent Consumer Advocacy Network.** Members with appeals can contact ICAN for assistance. Phone: 844-614-8800

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<sup>14</sup> [MLTC Policy 15.03](#): End of Exhaustion Requirement for MLTC Partial Plan Enrollees

<sup>15</sup> All state policy directives, model contracts etc. on MLTC are posted here [https://www.health.ny.gov/health\\_care/medicaid/redesign/mrt\\_90.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm) .

<sup>16</sup> See 18 NYCRR § 505.14(b)(5)(v)(c)(2).

<sup>17</sup> See *Dear Health Plan Administrator* Letter, dated March 2, 2015, from Mark L. Kissinger, Director, NYS DOH Division of Long Term Care, available with notice templates at <http://www.wnyc.com/health/download/579/> and announced in a NYS DOH webinar on April 29, 2015, available at [http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/2015-04-29\\_new\\_model\\_initial\\_determination\\_and\\_model\\_action\\_notices.wmv](http://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-04-29_new_model_initial_determination_and_model_action_notices.wmv) (last accessed March 9, 2016).

TTY Relay Service: 711 Website: [icannys.org](http://icannys.org) E-mail: [ican@cssny.org](mailto:ican@cssny.org)

## NURSING HOME CARE and MLTC – CHANGES in 2015

- Until 2015, MLTC was mandatory only for dual eligibles who need Medicaid home care or other COMMUNITY-BASED Long Term Care (LTC) services.
  - Those without Medicare, who have long been required to join “mainstream” managed care [MMC] plans, were disenrolled from the plans if in a NH more than 60 days.
- In NYS move to “managed care for all,” all adult Medicaid recipients age 21+ who become permanent nursing home residents will be required to enroll in a managed care plan: MLTC plans (for dual eligibles age 21+) and Mainstream Medicaid managed care plan (for those without Medicare)
- **WHEN** –Those who *first* become PERMANENT nursing home residents, meaning they have already been found eligible for institutional Medicaid with no transfer penalty--
  - After February 1, 2015 (NYC)
  - After April 1, 2015 (Nassau, Suffolk and Westchester )
  - After July 1, 2015 (rest of state)
- **People who were NOT in an MLTC or Mainstream managed care [MMC] plan and now need nursing home care –**
  - May select nursing home of their choice willing to accept them
  - Once in nursing home, they apply for Institutional Medicaid (includes 5-year look-back and transfer penalties)
    - If they have a Medicaid transfer penalty, they are not eligible for Medicaid to pay for the NH care at all. They must either private pay OR advocate to be discharged home with MLTC services, since there is no transfer penalty in the community.
  - If approved, they will receive notice giving 60 days to pick a plan (should pick one that includes their nursing home in the network)
  - If they don’t pick a plan, will be auto-assigned to a plan that has that NH in network (MLTC for duals, MMC for non-duals).
- **Those without Medicare who were already in a MAINSTREAM MMC plan** before NH admission must enter a NH in that plan’s NETWORK or Medicaid will not pay for it.
  - **MMC plan no longer will disenroll** someone because they need long term nursing home placement. Plan must pay for NH.
  - Plans should assess members who are NH residents for possible discharge home and provide home care services on discharge
- **Dual Eligibles** being admitted to a nursing home –
  - If they are leaving the hospital to enter a nursing home TEMPORARILY for rehabilitation, the **MLTC plan MAY NOT restrict them to nursing homes in the plans’ networks**. MLTC plan must pay the Medicare coinsurance for the rehab even if NH is not in plan’s network, if not paid by a Medigap policy.
- Once Medicare ends, if NH is not in the plan’s network, it is not clear whether the MLTC plan must pay. DOH has said that the plan must pay for a reasonable time to allow the

individual to change to a plan that does cover the NH, but it is not clear. Individual may change MLTC plans but not effective until 1<sup>st</sup> of the next month.

- When client can go home, MLTC must arrange and provide home care services.
- **No LOCK-IN** –In both MLTC and MMC, member may change in any month to a plan that has a preferred NH in its network.
  - This is true anyway in MLTC, but in MMC there IS LOCK-IN generally, but no lock-in for nursing home residents.
  - Changing plans takes time. Enrollment in the new plan is only effective the 1<sup>st</sup> of the next month or later. It is unclear if current plan must pay for out of network NH while changing plans.
- **CONTINUITY GUARANTEED – NO ONE WILL BE FORCED TO MOVE** - People already in nursing homes as permanent residents in NYC on 2/1/2015 (4/1/2015 in Long Island and Westchester and 7/1/2015 upstate) are grandfathered in – don’t have to enroll in MLTC or mainstream MMC plan - can stay in their nursing home with Medicaid paying Fee-for-Service as before.
  - But in October 2015, “voluntary enrollment” in MLTC began for these NH residents, when they MAY enroll in MLTC plans.
  - BEWARE OF marketing by plans to enroll residents into FULLY CAPITATED Plans that control MEDICARE services. MLTC plans in NYC and Nassau County may market their linked FIDA plans.
  - *Nursing home care was ALREADY part of the MLTC benefit package.* But MLTC plans were disenrolling members who needed NH care. This will stop because new NH residents must join an MLTC plan.
- **NETWORK SIZE** – The number of nursing homes that must be in a plan’s network varies by county. See table next page.

**Table. Minimum number of Nursing Homes in Networks of MLTC plans and Mainstream Medicaid Managed Care plans.**

County/BoroughCounty	# of NHs in county	Network minimum Number of NHs
Manhattan	18	5
Brooklyn	42	8
Queens	59	8
Bronx	46	8
Staten Island	10	5
Nassau	36	8
Suffolk	42	8
Westchester	43	8
Monroe, Erie	Various – see <a href="http://nursinghomes.nyhealth.gov/">http://nursinghomes.nyhealth.gov/</a> for list by county	5
Oneida, Dutchess, Onondaga, Albany		4
Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster		3
All other counties		2 unless only 1 exists
Specialty NHs (AIDS/ vent/ behavior)		2 unless fewer exist

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

See Consumer Spend-down Tip No. Four – p. 17-11.

**For more information on MLTC and DOH Complaint contact numbers:**

**STATE DOH MLTC POLICIES** - All policy directives, model contracts for MLTC, etc.

[http://www.health.ny.gov/health\\_care/medicaid/redesign/mrt\\_90.htm](http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm)

**Model MLTC Contract -**

[http://www.health.ny.gov/health\\_care/medicaid/redesign/docs/mrt90\\_partial\\_capitation\\_contract.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt90_partial_capitation_contract.pdf)

**DOH FIDA website** [http://www.health.ny.gov/health\\_care/medicaid/redesign/mrt\\_101.htm](http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm)

**NYHEALTHACCESS.org** <http://wnylc.com/health/entry/169/> (tools to select a plan)

<http://wnylc.com/health/entry/114/> (about MLTC)

<http://wnylc.com/health/entry/176/> (new procedures for applying for home care)

<http://www.wnyc.com/health/news/41/> - News on MLTC updated monthly

<http://www.wnyc.com/health/news/33/> - News about FIDA

<http://www.wnyc.com/health/entry/184/> - Grievances & Appeals in MLTC

<http://www.wnyc.com/health/entry/169/> - Tools for selecting an MLTC Plan

<http://www.wnyc.com/health/news/39/> - advocacy concerns

**DOH MRT website about adding Nursing Home benefit to MLTC and mainstream managed care -** [http://www.health.ny.gov/health\\_care/medicaid/redesign/mrt\\_1458.htm](http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm)

Scroll down to bottom -- **June 1, 2014 Population Transition – Nursing Home**

Free webinar on MLTC conducted May 2014 for HIICAPs - view at <https://attendee.gotowebinar.com/recording/1348252302283983105> (2.25 hours) with:

- PowerPoint: <http://www.wnylc.com/health/download/474/>
- Appendix: <http://www.wnylc.com/health/download/473/>

**State DOH Complaint Number for MLTC Problems - 1-866-712-7197**

- e-mail [mltctac@health.state.ny.us](mailto:mltctac@health.state.ny.us) and put "COMPLAINT" in subject line
- **For enrollment complaints - call NY Medicaid Choice -**  
**1-855-886-0570** (Advocates line) **1-888-401-6582** (Consumers line)

**NEW: Statewide Ombudsprogram for Members of MLTC, FIDA, and Managed care plans who receive Long Term Care Services. “Independent Consumer Advocacy Network” or ICAN. <http://icannys.org/> Call 844-614-8800 TTY Relay Service 711**

**Email [ican@cssny.org](mailto:ican@cssny.org). Statewide network – call to find out your regional organization.**

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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.

**What services must be obtained through the Medicaid managed care plan?** 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, since 2011*, some services that were formerly “carved out” are now covered by the Medicaid managed care plan. This includes prescription drugs (see <http://pbic.nysdoh.suny.edu/>), over the counter medications, personal care and Consumer-Directed Personal Assistance Program (CDPAP), chemical dependence outpatient treatment, mental health treatment, adult day care, dental and orthodontia care, and hospice care (new in October 2013) and some other services. Behavioral health services used to be carved out and obtained on a fee for service basis, until the new “HARP” plans are now being implemented in 2016. As described above, nursing home services are part of the package as of 2015.

### Where is Medicaid Managed Care mandatory?

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 and at least 31 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.** See local sites at <http://nymedicaidchoice.com/node/41>.

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 State 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. Timeline continually changing – posted at [https://www.health.ny.gov/health\\_care/medicaid/redesign/docs/mrt1458\\_timeline.xls](https://www.health.ny.gov/health_care/medicaid/redesign/docs/mrt1458_timeline.xls) - see [https://www.health.ny.gov/health\\_care/medicaid/redesign/mrt\\_1458.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm).

The types of Beneficiaries that are **excluded** were significantly cut in recent years. As of May 2016 the only people **EXCLUDED** are those who:

- Are in the Medicaid Spenddown or Excess Income program;
- 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 or could be covered by other comprehensive private insurance as primary payor, such as an employee group health policy, if cost-effective;
- Live in certain institutions: resident of State-operated psychiatric facilities, resident of state certified or voluntary operated OMH treatment facilities for children, or nursing home residents under age 21
- Blind or disabled children living separate or expected to be living separately 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.

- Receiving hospice services at the time of enrollment
- NOTE: NO LONGER EXCLUDED:

Individuals under 65 and working and eligible for Medicaid Buy-in for Working People with Disabilities (MBI-WPD)

**EXEMPTIONS** - As of April 1, 2012, the following beneficiaries not in one of the above excluded categories may request and be granted an **exemption** from managed care – if they don't request an exemption they are auto-assigned to a plan:

- 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. This is a one-time exclusion – once in a lifetime;
- Individuals **already scheduled for a major surgical procedure** (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area. Exemption is limited to six months
- Residents of Intermediate Care Facilities for the Developmentally Disabled
- Participants in certain **Waiver** programs -- Developmentally or physically disabled individuals receiving services through a OPWDD waiver, Children in Care-at-Home Waivers, Bridges to Health (B2H) waivers for children in Foster Care, OMH waivers, Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion Medicaid Waiver (NHTD) (Note that participants in the Lombardi program are no longer exempt and are required to transition to managed care, which will take over their home care)
- Residents of **Chemical Dependence** Long Term Residential Program
- Infants living with a mother in jail
- Nursing home resident at time of enrollment (before Oct. 2015 they were excluded from managed care, now are exempt)

See NYSDOH Charts of Exclusions and Exemptions, attachments to [GIS 15 MA/012 - Medicaid Managed Care Exemptions and Exclusions](#) -- PDF

- [Attachment 1](#) - [Attachment 2](#) - download at

[http://www.health.ny.gov/health\\_care/medicaid/publications/pub2015gis.htm](http://www.health.ny.gov/health_care/medicaid/publications/pub2015gis.htm)

**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), working people under 65 with disabilities in MBI-WPD program and hospice recipients

**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?

**SSI** - When someone is applying for or getting Supplemental Security Income, they do not have to fill out a separate application for Medicaid. Medicaid enrollment is automatic.

**MAGI Medicaid on the Exchange** -- Beginning January 1, 2014, most people who do not have Medicare apply for Medicaid online on the NYS Health Exchange at <http://healthbenefitexchange.ny.gov/>. This includes those receiving Social Security, if they do not also have Medicare. This includes spouses of Medicare beneficiaries if they do not have Medicare.

- Exception – some people in the MAGI category must apply for Medicaid at the local DSS. This includes people who wish to enroll in an MLTC plan, if they meet the strict requirements.

**WHERE to apply – Those who have Medicare** apply for Medicaid at their local county Medicaid office. Some families may have to file two applications – one for a spouse and other family members who are “MAGI” and file online on the Exchange, and one for a spouse and other family members who have Medicare and file at their local county Medicaid office.

- All counties must use the Access New York application Form DOH-4220, which can be found at <http://www.wnyc.com/health/entry/119/>. Those Age 65+, Blind or Disabled must be sure to complete the Supplement A and verify their current assets.
- In New York City, dual eligible seeking Medicaid home care services apply at a different office than those not seeking long term care. See <http://www.wnyc.com/health/entry/79/> for more information for NYC.

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. Also see for New York City -

<http://www.wnyc.com/health/entry/79/>.

- 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), meaning they are in the U.S. with the knowledge and acquiescence of the US Center for Immigration Services. 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/>.

- **NEW in 2016 – Essential Plan for certain immigrants under age 65 who do not have Medicare.** Until January 2016, “PRUCOL” immigrants received regular Medicaid as long as they met the other requirements for Medicaid – income, resources, proof of identity, residency, etc. That is still true for the non-MAGI “DAB” category (Disabled, Aged 65+ or Blind). However, certain immigrants under age 65 who do not have Medicare are being transitioned from MAGI Medicaid to a new health insurance program called the Essential Plan. Affected immigrants are PRUCOL and “Qualified Aliens” in their five year bar, meaning that while they have been covered under New York law under a court decision called *Aliessa*, they were not covered under federal Medicaid. When they move to the Essential plan, the federal government will now pay for part of the cost of services, instead of only the State.
- **Essential Plan ends at age 65 --** Individuals cannot remain on the Essential Plan when they turn 65, no matter what their Medicare eligibility is. If a client is ineligible for Medicare and the Medicare Savings Programs, or cannot afford to buy-in to Medicare, they can enroll in a Qualified Health Plan (QHP) with Advance Premium Tax Credits (APTCs) and Cost-Sharing Reductions (CSRs). There are cost sharing reductions in place for individuals over 65 who purchase plans through the Marketplace between 139-200% FPL.
- **Transitioning from the Essential Plan to Medicare -** Transitions from the Essential Plan to Medicare are explained in GIS 16 MA/004.<sup>18</sup> All individuals who are enrolled in the Essential Plan should expect their coverage to end at the end of the month they turn 65. Their case will be referred to the LDSS to determine if they are eligible for non-MAGI Medicaid or MSP. Those EP enrollees who are *Aliessa* immigrants will be transferred to the LDSS with Fee for Service Medicaid. The Fee for Service Medicaid coverage should continue until they submit their re-certification at the LDSS, or until the date listed on the LDSS notice.

### 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 limits do not apply to people with developmental disabilities or a Traumatic Brain Injury.

### 4. Can Medicaid pay for past medical bills? What is retroactive coverage?

Medicaid may pay for care given during the three calendar months before the month in which the client applied for help. These three months are called retroactive coverage. For non-Medicare recipients (MAGI) people applying on the Exchange, there are new procedures to

<sup>18</sup> Available at [http://www.health.ny.gov/health\\_care/medicaid/publications/index.htm](http://www.health.ny.gov/health_care/medicaid/publications/index.htm)

obtain retroactive coverage. Non-MAGI applicants (mostly those with Medicare or a spend-down), should flag on the application and in a cover letter that they have paid or unpaid medical bills and want retroactive coverage. 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://wnylc.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 for one of the Medicare Savings Programs. Medicaid will not pay for a Medigap premium.

**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 as secondary coverage. Medicaid 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. 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. An exception is made if the individual has a "spend-down." Also, individuals can temporarily suspend their Medigap 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. However, this benefit has been sharply cut back since May 2013. Medicaid will only reimburse if the COBRA premium is less than the capitation rate paid to a Medicaid managed care plan. See GIS 13 MA/012: Changes to the Criteria Used For Determining The Cost Benefit of Paying Health Insurance Premiums, posted at [http://www.health.ny.gov/health\\_care/medicaid/publications/gis/13ma012.htm](http://www.health.ny.gov/health_care/medicaid/publications/gis/13ma012.htm)

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

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 may request permission to keep income up to the community Medicaid level, which in 2016 is \$825 per month. With that budgeting called “community budgeting,” 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 need to affirmatively ask the nursing home to request this budgeting from the Medicaid program. It requires that a doctor certify that you are reasonably expected to return home.

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?

Many people think that Medicaid puts a lien on your home when you apply for Medicaid. This is not true. There are instances when Medicaid may place a lien on your home or make a claim against your Estate after you die, which may include your home. First, 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, and if you are in the non-MAGI (Disabled, Aged Blind) category, a lien may be put on your real property unless a spouse or certain relatives reside in the home. However, if you are MAGI, no lien may be placed in this circumstance. NYS DOH [GIS 14 MA/16](#) available at [http://www.health.ny.gov/health\\_care/medicaid/publications/pub2015gis.htm](http://www.health.ny.gov/health_care/medicaid/publications/pub2015gis.htm).

Second, Medicaid may recover against your Estate after you die for the cost of medical services paid for by Medicaid on or after your 55<sup>th</sup> birthday, whether at home or in a nursing home, unless 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. If your eligibility was based on MAGI for services received after age 55, the Medicaid claim against your Estate is limited to the cost of any nursing home care or other home and community-based services, and related hospital and prescription drug services received on or after the MAGI individual's 55th birthday. The same family exceptions apply for MAGI as for Non-MAGI – with no Estate claim if the deceased has a surviving spouse, disabled or minor child. NY Social Services Law § 369, NYS DOH GIS 14-MA/016, [15 OHIP/INF-1 Q. 12](#). Directives available at [http://www.health.ny.gov/health\\_care/medicaid/publications/index.htm](http://www.health.ny.gov/health_care/medicaid/publications/index.htm).

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 during three months before the month in which you applied for Medicaid.

A lawsuit is pending that claims that people should be able to get Medicaid approved in an emergency, even before the Medicaid application has been accepted. This is still in litigation without any relief. In April 2015, the law was amended to require that local Medicaid programs process Medicaid applications within seven days if there is an immediate need for personal care services. As of May 2016, this law has not yet been implemented. NY Social Services Law Sec 366-a, subd. 12. However, if someone already has Medicaid, they may request that emergency personal care services be authorized by the LDSS if they have an “immediate need” for the services, and cannot wait to enroll in an MLTC plan. See above at pp. 17-30.

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**
- Evelyn Frank Legal Resources Program at NYLAG  
[eflrp@nylag.org](mailto:eflrp@nylag.org) **1-212-613-7310**

**ICAN – Independent Consumer Advocacy Network – Statewide Ombudsprogram for MLTC, FIDA, and Medicaid Managed Care members with problems concerning Long Term Care**

- **Statewide Hotline** **1-844-614-8800**  
**TTY Relay Service: 711 Website: [icannys.org](http://icannys.org) [ican@cssny.org](mailto:ican@cssny.org)**
- **Has regional specialists – call statewide hotline to be directed to local organization**

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

**STUDY GUIDE MODULE 9: Medicaid**

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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. Medicaid can help pay costs not covered by Medicare.



Read your *HIICAP Notebook* for information on Medicaid

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



**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. 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.  
T \_\_\_\_\_ F \_\_\_\_\_
- e. Someone who wants Medicaid or the Medicare Savings Program can wait until age 70 to apply for Social Security in order to maximize the amount of their benefit. They can apply for Medicaid or the MSP at age 65 with their eligibility based on their other income.  
T \_\_\_\_\_ F \_\_\_\_\_



**Review and explain your answers with your group.**



**In Summary: Review these basic concepts of Medicaid.**

- If an individual's income is low, he/she may qualify for Medicaid.
- Medicaid will pay the Medicare deductibles and coinsurance, and some of the health care costs that Medicare does not pay.
- 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. The same spousal impoverishment provisions protect income and resources of a couple where one spouse is in an MLTC plan and one is not receiving Medicaid.

**ANSWER KEY MODULE 9: Medicaid**

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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. Medicaid can help pay costs not covered by Medicare.



Read your *HIICAP Notebook* for information on Medicaid.

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



**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. 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. **True**
- e. Someone who wants Medicaid or the Medicare Savings Program can wait until age 70 to apply for Social Security in order to maximize the amount of their benefit. They can apply for Medicaid or the MSP at age 65 with their eligibility based on their other income. **False**



**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.
- Medicaid will pay the Medicare deductibles and coinsurance, and some of the health care costs that Medicare does not pay.
- 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. The same spousal impoverishment provisions protect income and resources of a couple where one spouse is in an MLTC plan and one is not receiving Medicaid.

**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