MODULE 17: MEDICAID

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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 the 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 payer to health insurance 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.

COVID-19 NOTE: Special rules made it easier to apply for and keep Medicaid during the pandemic. These are only partly covered here since they will end around the time the Public Health Emergency ends. See http://www.wnylc.com/health/news/86/ and https://www.nylag.org/covid19/ - scroll down to LATEST INFORMATION and click on:

- MEDICAID (APPLYING)
- MEDICAID (HOMECARE)
- MEDICAID (IF YOU ALREADY HAVE)

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, for some groups, financial 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. Changes that became effective in January 2023 equalize the income eligibility limits for these populations, but several differences, including resource limits, income disregards and how and where to apply for Medicaid remain in place.

What are the differences between Medicare and Medicaid?

- Medicare is a federal health insurance program for individuals age 65 and over, people under 65 who have received Social Security Disability Insurance (SSDI) for a certain period of time, and people under 65 who have been diagnosed with End-Stage Renal Disease (ESRD)
- Medicaid is a joint federal and state government program that 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.

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People eligible for Medicare are required to pay a substantial amount of money in premiums, deductibles, and coinsurance. These out-of-pocket costs have risen rapidly over the past decade. Additionally, Medicare does not cover most long-term care services, whether in a nursing home or in the community.

For those living in poverty, these costs eat up almost a quarter of their entire annual income. 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 Social Security or other income over the SSI income amount, 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.

The New York State Department of Health (DOH) oversees the state's Medicaid program. Individual states have the option to cover other medically needy people, additional services above those required, and may structure their programs to meet the special needs of their citizens. These decisions on coverage are made by the State legislature, but the details are implemented by DOH.

Managed Care vs. Fee for Service Model - In recent years, the model for delivering and paying for health care services has changed. Before, under "Fee for Service," the Medicaid recipient went to any Medicaid provider, who billed the State for each service provided. Now, most Medicaid recipients who do not receive Medicare (including those age 65+ if on SSI) are required to enroll in Medicaid "managed care" plans, sometimes called "mainstream" managed care plans. The state Medicaid program pays those insurance 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. Plan members must see only providers in the plan's network. The same model is now used to deliver home care and other long-term care services to those adults with both Medicare and Medicaid (Dual Eligibles) through *managed long term care* (MLTC) plans, which became mandatory statewide by the end of 2015. See more discussion below at p. 36.

Applications - Until January 1, 2014, the local Department of Social Services (DSS) offices in each county and HRA in NYC processed Medicaid applications, determined eligibility for Medicaid and/or a Medicare Savings Program, and authorized coverage. In 2014, the State DOH took over the function of processing Medicaid applications and determining eligibility for certain applicants – *those under 65 who do not have Medicare.* They apply for Medicaid on the New York State of Health online Exchange or "NYSoH" https://nystateofhealth.ny.gov/. Medicare beneficiaries and

everyone age 65+ still apply for Medicaid and the Medicare Savings Program at their local DSS. See more about Applications in the Q&A pp. 58-59.

The DOH Medical Assistance Reference Guide ("MARG"), used by all local districts to explain the eligibility rules, is available online at https://www.health.ny.gov/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 health insurance program for individuals who are either disabled – and have received Social Security Disability benefits for two years or have end stage renal disease-- or who are 65 or older. Medicare is available for persons of any income level with insured status. See chart below. Medicare coverage is the same in every state in the country. See Medicare chapter for more on eligibility.

Medicaid is a joint federal and state health insurance program for persons of any age 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*, and who are under age 65, there is no 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 and others who are age 65+, disabled or blind, there is a limit on the amount of their income *and* 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
WHO: Health insurance for individuals age 65 and older or disabled for 2 years or who have end stage renal disease;	**WHO**: Health insurance for individuals of any age.
INCOME TEST? No.	**INCOME TEST?** Yes, for all, and for Dual Eligibles, low resources.
Federal program: federal administration and funding, contractor implementation.	**Cooperative program**: federal, state and local funding, state administration, and local implementation.
NATIONAL? Uniform in all states.	**Medicaid programs vary by state,** with some minimum federal standards.
COST: Premiums, deductibles, and coinsurance.	**COST**: Copayments vary by state, and a monthly "spend-down" if income exceeds the Medicaid limits.
Benefits are limited: hospital, medical, prescription drugs, limited preventive and very limited long-term care. Generally, dental care, eyeglasses, transportation, and most long-term care are not covered.	**Benefits are comprehensive**: hospital, long-term care, dental care, transportation, additional health care services and supplies. Prescription drugs covered only for people not on Medicare. Amount & scope of benefits vary by state.

Medicare	Medicaid
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 most people age 65+ and others with Medicare, this means having low income and low assets. For most people under 65 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**: In addition to citizens and permanent resident aliens (those with a "green card"), NYS also includes those who do not have a green card but are "permanently residing under color of law" (PRUCOL). See http://www.wnylc.com/health/entry/33/. PRUCOL immigrants under 65 have the "Essential Plan" * instead of Medicaid, and later in 2022 this plan will for the first time include some long term care services, which have not yet been defined. Under the State budget enacted in April 2022, seniors age 65+ will be eligible for full Medicaid even if they are undocumented immigrants. This will include all long-term care in nursing homes and home care. Implementation for this change is currently delayed. Undocumented immigrants under age 65 will continue to be eligible only for "Emergency Medicaid." See p. 63.

* https://info.nystateofhealth.ny.gov/essentialplan

Why would a Medicare beneficiary need both Medicare and Medicaid?

Seniors who reach age 65 and are enrolled in Medicare, and younger people who obtain Medicare after receiving Social Security Disability Insurance benefits for two years, may question why they may need Medicaid as well. Medicaid can help pay out-of-pocket costs for Medicare. Medicare will pay first as "primary coverage." Medicaid will then cover many, often all, of the costs not covered by Medicare as "secondary payer." Medicaid will also cover some services not covered by Medicare at all. People with both Medicare and Medicaid are called "Dual Eligibles." These Medicare gaps include:

(1) Medicaid to help pay 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 payer," after Medicare pays. The beneficiary must use providers that accept Medicaid as well as Medicare. In some cases, Medicaid may pay the Part B premium, putting dollars back into the monthly Social Security check (*see Medicare Savings Programs and Question 6 page 17-56 about the Medicare Insurance Premium Payment Program (MIPP).

Since 2015, New York reduced how much of the Part B coinsurance Medicaid will subsidize.

1. Original Medicare – Medicaid will only pay the 20% Part B 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. A Medicaid provider is prohibited from balance billing an individual who has Medicaid. A Medicare provider may not bill a QMB beneficiary even if the provider does not accept Medicaid.

    a. Exceptions - Medicaid/QMB will pay the full Part A coinsurance for skilled nursing facility and hospital inpatient care, and the full Part B 20% coinsurance for 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 $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 services. In 2019, the Governor proposed to repeal the exception for ambulances, but this was rejected by the legislature.

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

(2) Medicaid to Provide Services that Medicare generally does not pay for - long-term care (home care or nursing home), eyeglasses, hearing aids, dental care, medical supplies. Some Medicare Advantage plans provide limited coverage of these services. *Medicaid may pay for these services, if services are provided by a Medicaid provider, subject to limitations set by the State. Home care, dental care and other services have limits and special requirements, some of which are 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.

[1] See discussion on Qualified Medicare Beneficiary balance billing below at 17-15.

Caution – Does Provider accept Medicaid? If a doctor is not a Medicaid provider, the 20% coinsurance of Medicare's approved amount is the client's responsibility *unless* the client is also a QMB Beneficiary. A Medicare provider is not required to accept Medicaid. However, if a 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. See below at 17-15. Also, providers themselves are sometimes confused by the Medicare/Medicaid relationship.

Must people apply for Medicare if they want Medicaid? If they do not have Medicare, can they still qualify for Medicaid?

If someone is ELIGIBLE for Medicare, they must enroll in Medicare, or they will not be eligible for Medicaid. If they are not eligible for Medicare, they may enroll in Medicaid.

People under age 65 only have Medicare if they have received Social Security Disability benefits for two years, or if they have ESRD or ALS. If they receive Social Security early retirement benefits, and are not disabled, they are not eligible for Medicare. Disabled individuals in the two-year waiting period for Medicare, or early retirees may qualify for Medicaid if financially eligible.

Medicaid recipients must enroll in Medicare when they become eligible at age 65, as a condition of Medicaid eligibility. People age 65+ who do not have Medicare because they lacked enough work quarters for Social Security may enroll in Medicare through the Part A "Buy-In," described in the Medicare Savings Program Module. (See Module 9, HIICAP Notebook; *Medicare Savings Programs*) https://aging.ny.gov/hiicap-notebook

In 2017-2018, New York State moved to enforce this requirement to enroll in Medicare more strictly, discontinuing Medicaid for recipients age 65 and over who did not show that they had applied for Medicare. When advocates protested that many elderly recipients' Medicaid was being discontinued even though they were not eligible for Medicare (often because of immigration status), the State Dept. of Health switched gears. Instead of discontinuing Medicaid, in August 2018, the State contracted with a statewide network of non-profit "Facilitated Enrollers" (FE) to conduct outreach to assist consumers in meeting the requirement to apply for Medicare as a condition of Medicaid eligibility. This was announced in 2019 LCM-01 - Outreach to Assist Medicaid Recipients with Applying for Medicare. The list of Facilitated Enrollers and other materials is posted here: https://www.health.ny.gov/health_care/medicaid/publications/pub2019lcm.htm. For more information about this initiative see http://www.wnylc.com/health/entry/185/.

Note that during the COVID-19 Public Health Emergency the requirement that Medicaid applicants who are eligible for Medicare must apply for Medicare as a condition of Medicaid eligibility has been temporary paused, in an effort to make Medicaid more accessible to a broader population. Once the Public Health Emergency and Covid easements are wound down, as expected later in 2022 or early 2023, this requirement will be reinstated.

ELIGIBILITY FOR MEDICAID

Eligibility depends on a person's category – age < 65 or 65+, disability

Medicaid financial eligibility rules are different for different categories of people. Since 2014, the Affordable Care Act (ACA) expanded Medicaid eligibility for most people under age 65 who do not have Medicare. This is the Modified Adjusted Gross Income ("MAGI") category of Medicaid. Medicaid for seniors age 65+ and younger disabled people with Medicare is under the old pre-ACA rules. This is the "Non-MAGI" Medicaid category.

1. **MAGI CATEGORY – (Modified Adjusted Gross Income) –** applies to most people under age 65 *not* receiving Medicare: children, adults < 65, including those receiving Social Security early retirement benefits or disability benefits and, if disabled, who are in the 24-month Medicare waiting period. Certain Medicare recipients may CHOOSE to be MAGI or non-MAGI, even if they are age 65+ -- but only if they live with and take care of a child, grandchild, or other relative under age 18 (under 19 if full-time student). In addition, people under 65 who are disabled but not yet on Medicare, as well as disabled children, may choose MAGI or non-MAGI Medicaid. See pp. 23-24 for tips on making choice.

    1. MAGI Features:

        - Income limits – 138% Federal Poverty Level for most adults, with higher limits for pregnant women and children. (NOTE: Previously, MAGI limits were higher but effective Jan. 2023 the same income limit applies to non-MAGI Aged, Disabled & Blind.)
        - 12-month continuous coverage – If they are eligible when they apply or are reauthorized, they remain eligible for a full 12 months, even if their income increases during that time, or even if they become enrolled in Medicare because of a disability. The only exception to this is if they turn age 65 during the 12 months. Then their Medicaid case is referred by NYSoH to LDSS to redetermine eligibility under non-MAGI rules. (But those referrals of those who turn 65 have been paused during the pandemic).
        - No asset test, though interest and dividends earned on assets count as "income."
        - Access to full Medicaid benefit package, including home care and nursing home care.
        - Simplified and fast online application process on NY State of Health Exchange (NYSoH) (Exception: some people, including those seeking to enroll in Managed Long-Term Care or who need nursing home care, must apply at the LDSS)

    2. **Essential Plan** – Health insurance for New Yorkers who are between age 19 – 65, whose income is above the MAGI Medicaid level. The NYS Budget enacted in April 2022 increases the income limit from 200% FPL to 250% FPL (though change effective April 1, 2022, this change is not on NYSOH website as of June 5, 2022). The Essential Plan covers the same benefits as Medicaid – and for the first time will include long-term care services, also due to a change enacted in April 2022. The exact scope of long-term care services is unknown.

        Additionally, immigrants whose income is *below* 138% FPL and whose immigration status is either PRUCOL or subject to the 5-year bar on federal law are in the Essential Plan instead of Medicaid. See more at pp. 53-54.

    COSTS: Essential plan is free for those under 150% FPL. Above that limit, $20 monthly premium. The additional premium for dental and vision coverage was eliminated in the NYS budget enacted in April 2021. There are copayments charged for most services, but the Essential Plan is much less expensive than the alternative of purchasing a private Qualified Health Plan on NYSoH using Cost Sharing Subsidies and Advance Premium Tax Credit. See https://info.nystateofhealth.ny.gov/EssentialPlan.

EXAMPLE of who could benefit by ESSENTIAL PLAN: Mary age 54 was approved for Social Security Disability of $3,300/month. She will not receive Medicare for two years. Her income is above the regular MAGI limit but is below 250% FPL (the new limit for the EP that will be implemented some time in 2022, increased from 200% FPL). Until she is 65 or becomes enrolled in Medicare, she may choose the Essential Plan with NO premium in 2022. This is much more affordable than Medicaid as she would have a high spend-down of about $2,300/mo. Even once she has Medicare, she may be able to avoid a spend-down if she is able to work a nominal amount to qualify for the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) (discussed below), or by enrolling in a Pooled Income Trust. New later in 2022 – she can stay in the Essential Plan and not have to switch to Medicaid even if she needs home care before she was eligible for Medicare, since some chronic care services are being added to the EP later in 2022.

For more info see https://info.nystateofhealth.ny.gov/EssentialPlan

2. **NON-MAGI –** "Regular Medicaid" under pre-ACA rules. Also referred to as Disabled, Aged, and Blind (DAB) Medicaid. DAB Medicaid includes all people age 65+ *or* under age 65 and disabled or blind. This population may have Medicare. Landmark increases took effect Jan. 1, 2023. The Medicaid income levels for non-MAGI Medicaid is now set at 138% of the federal poverty level. This is the same limit used for MAGI Medicaid.

    1. Supplemental Security Income (SSI) recipients– subgroup of the poorest "DAB" individuals who have stricter income and asset limit than others who are Disabled, Aged, or Blind.

       Some DAB individuals may CHOOSE MAGI budgeting if it is more advantageous than non-MAGI budgeting (those receiving SSD but in the 24-month waiting period for Medicare or Parent/Caretaker Relatives).

    2. Within the DAB category are numerous subgroups with different budgeting rules:

        - Medicaid Buy-In for Working People with Disabilities (under age 65 only, disabled and working): subgroup with higher income and asset limits than regular "DAB" individuals – must be working at least a minimal amount.
        - Disabled Adult Children (age 18+ and disabled before age 22 receiving SSA Disabled Adult Child benefits and remain otherwise eligible for SSI but for the increase in income; must have less than $2000 in assets).
        - Medicaid Cancer Treatment Program (MCTP) for Breast, Cervical or Prostate Cancer
        - Those seeking Medicaid subsidy for COBRA premium,
        - See other special budgeting possibilities at http://www.wnylc.com/health/entry/222/

    3. NON-MAGI Features:

        - Unlike MAGI limits, DAB has "spend-down" allowing people to spend-down to the income limits if their income is over. Countable income and income disregards differs between MAGI and non-MAGI.
        - Asset test – increased effective January 2023.

- A paper application and annual renewals that must be filed at local DSS (via mail, fax, or in-person), cannot be completed online or submitted electronically
- A "lookback" and other different rules for Institutional Medicaid (nursing home) and, no earlier than October 2022, for community-based long-term care, with penalties on transfers of assets. See below pp. 29-32.

Group 1: NON-MAGI: Disabled, Age 65+, or Blind (DAB) – Resource and Income rules

These individuals may qualify for Medicaid if their income and resources are very low. People receiving Supplemental Security Income (SSI) are automatically eligible. The "SSI-Related" or "DAB" category includes people who are in the same category as SSI recipients – Age 65+, disabled or blind – but have more income or assets than SSI allows.

- ***See FACT SHEET on DAB rules***: http://www.wnylc.com/health/entry/144/

RESOURCES - for Aged, Disabled or Blind (DAB)

- **A resource is an asset or** property of any kind. A resource may be "liquid," meaning cash, or property that can readily be converted to cash, such as bank accounts, stocks, bonds, CDs, and the cash value of "whole" life insurance policies. It may be "non-liquid," meaning that it may not be easily or quickly converted to cash, such as real property or collectibles.
- **Countable resources must be under the Medicaid resource limit. See below for exempt resources.** The **2023 DAB** resource limits are:

Resource (Assets) Limit - 2023

Household Size	Age 65+, Disabled or Blind < 65 Not Working	Disabled or Blind < 65 Working (MBI-WPD)
	2023	2023
One	$30,182	$30,182
Two (married)	$40,821	$40,821

Check for updates at http://www.wnylc.com/health/download/314/ or http://www.health.ny.gov/health_care/medicaid/#income**.**

EXEMPT RESOURCES – Certain resources do not count toward the above limits. The following lists 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), as long as it is their primary residence. The applicant's **home** has an equity limit ***only*** if the applicant is seeking home and community-based services (Managed long term care (MLTC), adult day care, personal care or consumer-directed assistance through the local Medicaid agency, waiver programs).
  - The **equity limit** is $1,033,000 for the primary residence (2023 limit). The equity limit does not apply if the applicant lives in the home with a spouse or disabled or minor child (under age 21), or to receive Medicaid for primary and acute care services.

- **LIENS -** Medicaid may place a lien on the home only if the home is no longer the primary residence (such as when the client enters a nursing home on a permanent basis), but no lien may be placed if any of these relatives are residing in the home:
  - A spouse, child under 21, a certified blind or disabled child of any age, or
  - A sibling with an equity interest in the home and who resided in the home for at least one year immediately before the admission to the nursing home
- **ESTATE CLAIM -**If client dies with the home in her name, it will be part of her Estate and subject to a Medicaid claim for the cost of services provided after age 55 – whether in the community or in a nursing home.
- **There are exceptions to both the nursing home lien and Estate claim** if there is a surviving spouse, minor or disabled child or certain other relatives. Rules are complicated. Clients who own homes should be referred to elder law attorneys for advice on Medicaid and estate planning. Find referrals at 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.
- **Qualified Retirement Accounts (including IRA's, 401(k)'s and 403(b)'s)** – Qualified retirement accounts such as IRA's are treated differently depending on client's age and, if under 65, whether the client is disabled and working, even a minimal amount. The three situations each with different rules about IRA's are:

  i. **Age 65+ *OR* under 65 and disabled or blind (Non-MAGI)**
  The applicant or recipient does not have to cash in their IRA, and the principal of the IRA will not be counted as a resource, 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+, or < 65 and disabled or blind, is exempt as a resource, as long as the individual is taking regular distributions from the IRA according to IRS distribution tables. These distributions are counted as income, but the principal of the IRA is not counted as a resource.

  i. **Since the IRS only requires me to take "Regular Minimum Distributions" (RMD) at age 72, can't I wait until then to start taking distributions if I want Medicaid?** No. Medicaid does not follow IRS rules and requires DAB Medicaid recipients to take periodic distributions before the IRS requires them. Otherwise, the entire principal of your IRA will be counted as a resource. In 2020, under the SECURE Act, the age the IRS requires you to take the RMD increased from 70½ to age 72 for those reaching age 70½ in 2020 or later. But this does not affect Medicaid applicants or recipients. If you want Medicaid, you must start taking the RMD or regular IRA distributions, unless you are under 65, disabled, working and enrolled in the **Medicaid Buy-In for Working People with Disabilities. (MBI-WPD).**

  ii. **What about the tax penalty for early withdrawals**? Under IRS rules, people may take withdrawals with no penalty after age 59½, and before age 59½ if one is disabled. You must pay income taxes on the withdrawal but there is no tax penalty. If you are under age 59½ and not "disabled," then you are not likely to be in the DAB Non-MAGI category at all.

  iii. **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;[2] MRG p. 316. However, the spouse's IRA counts toward the Community Spouse Resource Allowance (CSRA) if the applicant is seeking institutional Medicaid for nursing home care and if the spouse is not taking periodic distributions.

ii. **Under age 65, disabled and working – consider Medicaid Buy-In for Working People with Disabilities (MBI-WPD).** IRAs are totally exempt for this group -- so the recipient is not required to take periodic distributions while enrolled in MBI-WPD. See more on this program below.

If periodic distributions are being taken, then the distributions from the IRA count as additional income. This income may be placed in a supplemental needs trust or pooled trust, as discussed elsewhere.

iii. **Under age 65, not disabled – (MAGI) -** There is no asset limit for this category, so the IRA principal is exempt and there is no specific requirement to take distributions. However, if distributions are taken, they count as *income*. Income must be below 138% FPL (higher for pregnant women and children)

- **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 or financial institution account from their other savings. As long as the amount is under $1500 at time of Medicaid application, interest accrued later does not count – fund is still exempt.
  - 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 may purchase a non-refundable **irrevocable funeral agreement**. There is no dollar limit on the amount, but it must be reasonable, and since it is irrevocable, the client cannot change her mind later. See http://wnylc.com/health/entry/36/ for guide to funeral planning for Medicaid recipients. Note that funeral agreements can be set up for client's spouse, children and some other designated relatives, with more limited coverage.
- **Holocaust reparations** are not counted. See http://wnylc.com/health/entry/65/
- **ABLE accounts** – see https://www.mynyable.org/. Since 2017, those who were certified ***disabled before age 26*** may receive SSI and/or Medicaid while sheltering their own contributions and contributions from other sources. All contributions from all sources must *together* be under the annual gift tax exclusion ($16,000 in 2022), but higher if beneficiary is working.[3] The maximum balance may not exceed the maximum account balance for the 529

[2] Available at http://www.health.ny.gov/health_care/medicaid/publications/, direct link https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/06ma004.pdf .

[3] Article 84 of Mental Hygiene Law enacted 2015 but not implemented until 2017. NYS DOH GIS 18 MA/002 - Treatment of New York Achieving a Better Life Experience (ABLE) Accounts available at https://www.health.ny.gov/health_care/medicaid/publications/pub2018gis.htm; Neighborhood Legal Services ABLE Fact Sheet 2021 at https://nls.org/wp-content/uploads/2021/03/ABLE-Accounts-Hotline-Letter.pdf; GIS 18 MA/002 at https://www.health.ny.gov/health_care/medicaid/publications/gis/18ma002.htm; GIS 17 TA/DC-033: "Supplementary Nature of New York ABLE Savings Accounts" available at http://otda.ny.gov/policy/gis/2017/17DC033.pdf)

College Savings Program which is currently $520,000 (increased from $100,000 by 2019 state law). SSI recipients must keep the ABLE account balance at a lower level.

- A **transfer of excess assets** by the applicant or spouse may disqualify an applicant from having Medicaid pay for nursing home care if either spouse needs it within five years after making a transfer, but elder law attorneys have legal strategies to minimize the financial burden during the penalty period and reduce the penalty period. A 30-month lookback and transfer penalty will apply to new applicants applying for Medicaid for managed long term care, other home care services or the Assisted Living Program if applicant or spouse transferred assets since Oct. 1, 2020. This new lookback has been delayed because of the pandemic. It may begin no earlier than applications filed after Oct. 1, 2022. See more below pp. 29-32. Consumers should consult an elder law attorney about transfers of assets.
- **Excess resources may also be offset by unpaid medical bills** that are outstanding at application.
- Someone with excess resources might also consider a Medicare Savings Program and EPIC, instead of Medicaid, since these programs have no resource limits.

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

- **Income** means any payment from any source. Income can be a one-time payment or a recurring one. Income can be earned, such as wages, tips, bonuses and commissions, self-employment and rental income. Also included is unearned income, such as dividends, interest, pensions, Social Security, unemployment compensation, worker's compensation, IRA distributions, or cash gifts.
- **Gross income** is always counted, though some deductions are taken, described below.
  - The **spouse's** income is also counted (but may be disregarded with a "spousal refusal" – see below).
  - Generally, the income of children, siblings, and other household members is not counted, even if they are related.
  - **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 the amount of Social Security. See http://www.wnylc.com/health/entry/185/.
- **Deductions** from gross income include:
  - Unearned income disregard: $20 per month per individual or couple (as shown in income chart below, this effectively raises income limit by $20/month)
  - Medical insurance premiums: Medicare Part B, Medicare Part D, Medicare Supplement (Medigap) Insurance, employment or retiree health insurance premiums. But once enrolled in Medicare Savings Program, since this program will pay for the Part B premium and all or part of the Part D premium through Extra Help, you may not deduct the premiums to the extent subsidized.
  - Earned income disregard: 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.
  - Rental expenses: expenses of renting an apartment in a building owned by applicant alone or jointly.
- **Excluded income** – not counted for DAB Medicaid includes:

- Holocaust reparations
- Interest and dividends (generated by savings or investment accounts)
- Federal energy assistance payments.
- Food stamp coupons (SNAP)
- VA benefits for Aid & Attendance (all other VA benefits DO count)
- **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 to the electric company, this "in-kind" income is not counted. Children are never legally responsible for their parents, and parents are never legally responsible for children over age 21 – so if bills are paid by those relatives, it does not count as "income" to the applicant. If the money is given to the client directly, however, this is a gift of cash and is countable income.

- **Time-limited disregards --** 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 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.

2023 Income Limits for Age 65+, Disabled or Blind who have Medicare (non-MAGI)

Household Size	Monthly Income 2023
One	**$1,677** ($1,697– after $20 disregard)
Two (married)	**$2,268** ($2,288 – after $20 disregard)

Effective of January 2023, the DAB income limits are 138% FPL. Though DAB income limits match MAGI limits, all the rules above about what income is disregarded and what income is counted for non-MAGI still applies.
Note about Household Size: Even if the Medicaid Applicant/Recipient and her spouse, if any, have children or other relatives living with them, the household size is always either ONE or TWO. See this chart to figure out whether it is ONE of TWO - http://www.wnylc.com/health/download/96/. If using Spousal Refusal, always use size of ONE.

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

NEW: Online checklist of these strategies at http://www.wnylc.com/health/entry/222/.

- **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." Spousal impoverishment budgeting, previously only for nursing home and waiver programs such as Lombardi, is now available to married couples where (1) one spouse is in a Managed Long-Term Care (MLTC) plan OR (2) one spouse is receiving Personal Care or Consumer Directed Personal Assistance Program (CDPAP) services through the "Immediate Need" process (described below).[4]

  - If applicant has a "**community spouse**," meaning a spouse who is not on Medicaid, the community spouse may keep their own income and enough of the applicant spouse's income to total $3,435.50/month (and up to $74,820 of individual and joint assets or half of their individual and joint assets up to $137,400)(2022). The applicant spouse also keeps an allowance of $433.00.
  - It works almost the same as for nursing home, but with some minor variations.
  - WARNING – WHEN CAN YOU REQUEST SPOUSAL IMPOVERISHMENT BUDGETING?
    - If you enroll in MLTC directly after applying for and being approved for Medicaid – you may NOT request Spousal Impoverishment budgeting in the application for Medicaid to obtain MLTC. You may only request it once enrolled in the MLTC plan. So initially, when applying for Medicaid, the spouse needs to file a "spousal refusal" for excess income and/or assets. As soon as enrolled in the MLTC plan, ask the local DSS to revise the budget using Spousal Impoverishment rules. These protections will eliminate or at least reduce the "spend-down."
    - BUT if you file the Medicaid application along with a request for personal care or CDPAP services based on an "Immediate Need" for home care services, then you MAY request Spousal Impoverishment budgeting as part of the application. See 16ADM-02 - Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services[5]
  - For more information on Spousal Impoverishment and links to state directives see this article http://www.wnylc.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

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

  A married applicant who does not need Managed Long-Term Care or Immediate Need home care services may not reduce excess income by using Spousal Impoverishment Protections. Spousal refusal may help. If only one spouse needs Medicaid, she/he may

[4] 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/

[5] Available at https://www.health.ny.gov/health_care/medicaid/publications/pub2016adm.htm. Also see http://www.wnylc.com/health/entry/203/

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 at http://www.wnylc.com/health/download/66/.

Not everyone may use spousal refusal. People Age 65+, Disabled or Blind may use spousal refusal, as may people under 65 who take care of and live with a child, grandchild, or other relative, 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. Spousal refusal cannot be used in MAGI budgeting.

Heads Up – with the increases in Income and Asset limits coming in 2023, fewer people may need to 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 are self-employed. In 2022, gross income may be as high as $68,988 for an individual and $92,950 for a couple (assuming all earned income and no unearned income). Net monthly income, after deducting more than *half* of gross earned income, must be under $2832 (single) and $3,815 (couple) (2022).

  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.

  See https://www.health.ny.gov/health_care/medicaid/program/buy_in/index.htm

- **Consumer Tip Four – Nursing Home or Adult Home Transition Housing Disregard[6] - 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 or remain in[7] 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 ($934 for single). A married individual may not use both "spousal impoverishment budgeting" (Consumer Tip One above), and this income deduction.

[6] 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

[7] In 2018, eligibility was expanded to include people who were already in an MLTC plan before they entered the nursing home. https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/18ma012.pdf

Special Income Standard for Housing Expenses after Discharged from Nursing Home		
Region	**Counties**	**2022 Deduction[8]**
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	$466
Long Island	Nassau, Suffolk	$1414
NYC	Bronx, Kings, Manhattan, Queens, Richmond	$1497 (down from $1535 in 2021)
Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	$537
North Metropolitan	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	$1032
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	$464
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	$414

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

  If an individual is enrolled in QMB, Medicaid will pay the Medicare Part A and Part B premiums, deductibles, coinsurance and copayments even if the individual is not also enrolled in Medicaid, as long as the provider is a Medicaid provider.

  - **QMB Eligibility** – Effective January 2023, QMB and DAB Medicaid have the same income limits (138% FPL). However, because QMB has no asset test, it can be useful for those who need a reduction in their Medicare out of pocket costs but are over the asset limits for Medicaid.
  - **QMB subsidizes Part D by automatically qualifying you for Extra Help**.
  - QMB does not provide access to Medicaid services not covered by Medicare, such as dental and routine vision care, eyeglasses, hearing aids, long-term care, etc.
  - **Medicaid will pay the Part A and Part B coinsurance and deductibles only if a provider is enrolled as a Medicaid provider**. This is true whether Medicare is through Original Medicare or Medicare Advantage.
  - **BALANCE BILLING PROTECTIONS** -- Even providers who only accept Medicare and not Medicaid may not "balance bill" QMB enrollees for Medicare out-of-pocket costs.[9]
    - CMS has been improving ways that beneficiaries can be identified as QMB's to providers, so the provider knows not to balance bill them. It should be on

[8] 2022 rates published in Attachment I to GIS 20 MA/13 -- 2022 Medicaid Levels and Other Updates available at https://www.health.ny.gov/health_care/medicaid/publications/pub2020gis.htm

[9] See CMS Information Bulletin, *Billing for Services Provided to Qualified Medicare Beneficiarie*s, Jan. 6, 2012, at http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf ; CMS Medicare Learning Network Bulletin SE1128, *Prohibition on Balance Billing Qualified Medicare Beneficiaries*, revised June 26, 2018, available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf ; see also http://www.wnylc.com/health/entry/99/#QMB.

the Medicare Summary Notice for those in Original Medicare. For those in Medicare Advantage, CMS is now giving the plans monthly data files identifying QMB status, and plans are supposed to share that with network providers.

- The Medicare & You Handbook now includes QMB protections and directs beneficiaries to contact 1-800-MEDICARE to report problems.
- The Customer Service Representatives (CSRs) at 1-800-MEDICARE now can verify QMB status in their database and will instruct beneficiaries to tell their provider that they may not be billed. If a beneficiary does not successfully resolve the billing problem with the provider, the CSRs will refer the issue to the Medicare Administrative Contractor (MAC) for the region where the beneficiary lives. The Medicare contractor will send a letter to the provider instructing the provider to return any payments received from the QMB and to cease any current billing or collection effort. Importantly, the MAC will also send a letter to the beneficiary with a copy of the provider communication and with instructions not to pay the bill. A provider bulletin explains the process and includes the model letters that are used, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf (rev'd July 2017). 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/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf
- In January 2017, the Consumer Finance Protection Bureau issued a guide to QMB billing, available at https://www.consumerfinance.gov/about-us/blog/what-do-if-youre-wrongfully-billed-medicare-costs/. A consumer who has a problem with debt collection, may also submit a complaint online or call the CFPB at 1-855-411-2372. TTY/TDD users can call 1-855-729-2372.
- *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. An individual's hospital and medical bills can offset excess income or resources to qualify them for Medicaid. This is the Medicaid Spend-down Program. *See* State Dept. of Health website about spend-down rules, posted at https://www.health.ny.gov/health_care/medicaid/excess_income.htm
  - **The spend-down amount is the difference between countable income and/or resources and the Medicaid limit.** Assuming resources are within the Medicaid limits, if a single person aged 65 has a total countable monthly income of $1,727, after deducting $20/month and other deductions, 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 $1677 (2023). 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.
  - The individual has the option of choosing to "**pay-in**" his or her spend-down directly to the Local Department of Social Services, instead of submitting medical bills that meet the spend-down.

- **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 138% of the Federal Poverty Line. If income of someone in the MAGI group is above the MAGI limit, they cannot spend down to qualify for Medicaid. They may be eligible for the Essential plan or can enroll in a Qualified Health Plan with cost-sharing subsidies.
- **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 copayments, 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 or dependent minor children**, as well as the applicant, may be used.

- **Using Past Medical Bills to Meet the Spenddown – Special Rules for New Applicants Only**

  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 of the Medicaid application. 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 explained at https://www.health.ny.gov/health_care/medicaid/excess_income.htm and in NYS Directive 96 ADM 15.

- 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, and Henry paid $60 in copays for his prescriptions between July 1st and October 1st. He applied for Medicaid in October. Since the prescription costs were incurred in the 3 calendar months before the month in which he applied for Medicaid, these costs can be applied to meet his spend-down. 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 the 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 up to 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.

- **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.

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 $1900/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 coverage gap 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 $203/month ($1900 - $20 - $1,677 = $203), which she cannot afford to pay with her rent and other living expenses. Her resources are under the Medicaid limit of $30,182 (2023). You ask her if she has any old medical bills -- she has an old hospital bill from 3 years ago of $700, 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 $700, 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. They reduce the bill to the Extra Help copays.
- 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 (SNT) 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.

  Person Age 65+ Must Use a Pooled Trust -- not an individual SNT. 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 clients enroll by signing a "joinder agreement" that sets up their own account within the trust. People with disabilities under age 65 have a choice and can use either. People over age 65 may only use a pooled trust.

Since March 2020, a Power of Attorney used to enroll a Medicaid recipient in a pooled trust need not include a separate "Statutory Gift Rider." See NYS DOH GIS 20 MA/03 at https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/20ma03.pdf. Note that NYS Power of Attorneys executed after June 13, 2021, no longer include Statutory Gift Riders anyway.

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 age 65 and over receive Social Security Retirement benefits, rather than Disability benefits. Medicaid requires that they request and receive a disability determination by the New York State Disability Review Team as proof that they are disabled - on specific NYS Department of Health forms -- 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. The disability forms required by the state change frequently, so be sure to check the website for the most recently updated list. See more at http://www.wnylc.com/health/14/.

GROUP 2: MAGI Medicaid & Essential Plan – under the Affordable Care Act

Individuals who are *under 65* and *not receiving* Medicare are generally MAGI. Also, even people age 65+ and receiving Medicare at any age may be MAGI -- if they live with and care for a minor child or relative under age 18, or under age 19 if in school.

The rules are complicated! This background will help you identify who might be MAGI, but REFER them for expert counseling by navigators:
https://info.nystateofhealth.ny.gov/IPANavigatorSiteLocations or to Community Health Advocates at 1-888-614-5400.

A. MAGI HAS NO RESOURCE LIMIT (Both MAGI Medicaid & Essential Plan)

There is no limit on resources for MAGI Medicaid. Interest and dividends generated by an asset do count as income. For this category, there is no spend-down permitted -- either they meet the MAGI income limits, or they don't. As a practical matter, there is a limit on resources if one's savings generate too much interest or dividends.

B. HIGHER INCOME LIMITS (but they will be the same beginning 2023)

The income limit for most adults is 138% of the Federal Poverty Line. The 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.

If income is over the MAGI Medicaid limits, the individual can qualify for the Essential Plan up to 250% of the FPL (will increase from 200% in 2023), even if they need long-term care (a change enacted in April 2022 not yet implemented as of April 2023).
https://info.nystateofhealth.ny.gov/essentialplan

2023 MAGI Monthly Income Limits

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

Household Size	Medicaid 138% FPL	Essential Plan 200% FPL	Essential Plan 250% FPL (later in 2023)
One	$1,677	$2,430	$3,038
Two	$2,268	$3,287	$4,108

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

- NO $20/month deduction from unearned 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.
- NO Spousal refusal. If married couple lives together, must include both spouses' income, unless one spouse receives SSI or cash public assistance.
- NO Spenddown -- People under age 65 who do not have Medicare may NOT qualify for MAGI Medicaid if their income exceeds the limits in the MAGI Income Table above by using "spenddown." However, they may be eligible for the Essential Plan, or 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.

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

Who is in a MAGI HOUSEHOLD (in order to determine whose income counts)?

MAGI budgeting 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 http://www.health.ny.gov/health_care/medicaid/publications/pub2013adm.htm and see http://www.wnylc.com/health/entry/195/. See also National Health Law Program Guide to

MAGI at https://healthlaw.org/resource/advocates-guide-to-magi-updated-guide-for-2018/.

See the MAGI REFERRALS pp. 20-21.

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 childcare)
- Social Security income – includes ALL SS income, even the part that is not taxable
- Interest and dividends – even if non-taxable
- Unemployment benefits (certain *federal* unemployment benefits authorized under the COVID-19 stimulus bills, as opposed to state unemployment, do NOT count for MAGI Medicaid).
- 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 – neither disability nor pension
- Child support received
- Gifts, inheritances, non-taxable lawsuit settlements (lawsuit settlements that are not taxable are not counted as taxable income, whether lump sums or structured settlements) (Note that some lawsuit settlements ARE taxable so are countable as income)
- American Indian income
- Worker's Compensation
- Lump sums generally don't count because of 12-month continuous eligibility – see below

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 flex spending cafeteria plan for health care or childcare pre-tax

SPECIAL MAGI MEDICAID FEATURES –

- **Includes full Medicaid benefits including long term care** – both home care and nursing home care. Note, however, that for a MAGI Medicaid recipient to be approved for nursing home care or enrollment in an MLTC plan or waiver program, the administration of the Medicaid case must be transferred from NYSofHealth portal to the local district. However, financial eligibility is still based on MAGI eligibility rules. Note that most MAGI recipients are required to enroll in "mainstream" Medicaid managed care insurance plans, which must authorize and provide personal care or Consumer-Directed Personal Assistance program services (CDPAP) or private duty nursing services. The Medicaid case does not need to be transferred from NYSofHealth to the local DSS for a mainstream managed care member to receive these long-term care services. Note that sometime in 2022, the Essential Plan for the first time will begin to cover long term care. So those whose incomes are above the MAGI level who need long term care will no longer need to switch to non-MAGI Medicaid if they need long term care services (if otherwise eligible for the Essential Plan, i.e., not yet on Medicare).

- **Continuous eligibility for 12 months**, despite increases in income during that period. At the next renewal at the end of the 12 months, Medicaid would be discontinued if income remains above the MAGI limit. Continuous 12-month eligibility continues if a disabled person becomes enrolled in Medicare. However, if the MAGI recipient reaches age 65 during the 12 months, then MAGI normally ends at age 65.[10] (However, this is not the case under COVID rules - those who reach age 65 or become eligible for Medicare based on disability continue under MAGI Medicaid). Note that the Essential Plan does NOT have 12-month continuous eligibility.

- **Apply for Medicaid and Essential Plan on online through the Exchange (NYSoH)**, not at Medicaid offices (unless need managed long-term care or nursing home care).

SOME PEOPLE MAY CHOOSE MAGI or NON-MAGI BUDGETING:

- **Disabled under age 65, in 2-year waiting period for Medicare** - may choose MAGI or non-MAGI budgeting. Once someone receives Medicare, they may not use MAGI budgeting UNLESS they live with and care for their child, grandchild or other relative under age 18 (19 if student). EXCEPTION: If they are still within 12-month continuous eligibility period when they enroll in Medicare, the continuous eligibility continues until the end of the 12 months.

- **Parent/caretaker relatives who are disabled or over 65 who live with and care for a child** under age 18 (19 if a student) may choose MAGI or Non-MAGI, *even if they receive Medicare.*

- Disabled children may choose MAGI or NON-MAGI, *unless they are in a waiver program (e.g. Katie Beckett program).*

- **TIPS FOR MAKING CHOICE -- PROs of MAGI BUDGETING**–

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

- Is client receiving income that is exempt for MAGI, but counts for non-MAGI -- Workers Comp, VA benefits, child support, inheritance or gifts?

- No asset test!

  - EX. Alice receives $1200/mo. SS Disability and is not yet on Medicare. She has savings of $50,000. Her income is under 138% FPL. With MAGI she will have Medicaid with no spend-down and no asset test. She must plan now to bring her assets within the non-MAGI limits before she becomes enrolled in Medicare. She might put the assets into an individual or pooled SNT because she is under age 65, and keep the Medicaid allowed limit in the bank of $30,182 (2023).

- **CON's FOR MAGI** -

  - If disabled person is **working:**

    - "DAB" non-MAGI Medicaid has better income disregards for earned income (first $65 of monthly gross income and half of remainder of monthly gross earned income is not counted – even if age 65+)

    - If working **and under age 65**, higher income limits apply in Medicaid Buy-In for Working People with Disabilities under age 65 – income limit **250% FPL**.

  - Can't use MAGI if you have Medicare, at any age, unless you live with your child/relative <18 or < 19 if in school

- **OPTIONS for PEOPLE UNDER AGE 65 with income > 138% FPL** so are not eligible for MAGI Medicaid, including people who are disabled but do not yet have Medicare – Choose between:

  1. **ESSENTIAL PLAN** if income < 200% FPL (Increasing to **250% FPL** later in 2023 and will also cover long term care for the first time, though package still undefined) see https://info.nystateofhealth.ny.gov/essentialplan.

  2. Medicaid spend-down – if needs home care or long-term care or

  3. Medicaid-Buy-In for Working People with Disabilities under age 65

  4. Qualified Health Plan on NYSoH with premium and cost-sharing subsidies – but no long-term care available in these health plans

  5. Other special budgeting methods – see Consumer Tips pp. 14-20 http://www.wnylc.com/health/entry/222/

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

When an individual who is enrolled in MAGI Medicaid through NYS of Health becomes eligible for Medicare due to turning age 65 or receiving SS disability for 2 years, their Medicaid through the NYSoH normally will end and their case will be transferred from NYSoH to their Local Department

of Social Services (LDSS), which re-determines eligibility for NON-MAGI Medicaid. In addition to the transfer of administration of their Medicaid case to the local DSS when they obtain Medicare, the individual is also disenrolled from their Medicaid Managed Care plan. The timing of both the transfer to the LDSS and disenrollment from the Medicaid Managed Care plan is different 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. These rules are paused during COVID-19, as described below.

- *Managed Care change for Medicaid recipients new to Medicare.*
    - **Before** COVID-19, people with MAGI Medicaid on NYSoH who become enrolled in Medicare, whether based on age or disability, were disenrolled from their Medicaid managed care plan. They were automatically transitioned to Fee-for-Service Medicaid, as secondary coverage to their Medicare. Their managed care plans were allowed to inform these members of their options to join the same company's Medicare Advantage or Medicaid Advantage plans, but it was voluntary.
    - **During** the COVID-19 Public Health Emergency, MAGI Medicaid recipients stay in their Medicaid managed care plans even though they become enrolled in Medicare.
    - ***Default Enrollment of Medicaid Recipients who Newly Enroll in Medicare.*** In 2021, changes began for new Medicare beneficiaries who previously had Medicaid and were enrolled in a "mainstream" Medicaid managed care plan. Starting with those newly enrolling in Medicare in April 2021, they are "default enrolled" into a Dual-SNP.
        - If they *DID NOT* receive personal care or CDPAP services from their mainstream plan, some are also default enrolled into an "**IB-DUAL" plan** (Integrated Benefit – Dual) plan. This is basically a new name for a mainstream Medicaid managed care plan that wraps around the Dual-SNP Medicare coverage. The default enrollment is always to an IB-DUAL plan operated by the same insurance company that operates the Dual-SNP. This is what makes it an "integrated" benefit.
        - If they *DID* receive personal care, CDPAP, or private duty nursing services from their mainstream managed care plan, they are default enrolled into a Medicaid Advantage Plus (MAP) plan, which is a hybrid of a Dual-SNP, MLTC and mainstream Medicaid managed care plan all in one.
        - Under "default enrollment," the Medicaid recipient receives a notice that they will be automatically enrolled in the Dual-SNP and "IB-DUAL" plan or MAP plan, with the right to "opt out" and select their preferred Medicare and Medicaid coverage. Those who received home care services from their managed care plan may opt out of MAP and select an MLTC plan instead.
        - Default enrollment is only being used for some plans in some counties. A list is posted on DOH's new website on integrated care for dual eligibles. https://www.health.ny.gov/health_care/medicaid/redesign/duals/index.htm. Under the dropdown for "IB-DUAL" is a chart identifying which plans have been approved for default enrollment in each county. In Jan. 2023 DOH announced some new approved plans that are not yet on this website. The NYHealthAccess website will soon be updated with the updated plan lists - http://www.wnylc.com/health/entry/226/.

- See also the MRC Default Enrollment Fact Sheet at https://medicareinteractive.org/pdf/default-enrollment-NYS.pdf.
- Beware that MAP plans members do not have a special right in fair hearings to Varshavsky increases in hours while the hearing is pending. See article at http://www.wnylc.com/health/entry/228/.

- **MIPP in 2023 (Reimbursement of Part B)** – Effective February 2023, Medicare-eligible individuals with MAGI Medicaid are automatically enrolled in the QMB MSP to pay their Part B premium. These individuals no longer receive MIPP checks to reimburse payment of the Part B premium (as was previously the case, GIS 18 MA/001 Medicaid Managed Care Transition for Enrollees Gaining Medicare). Member should call NYSofHealth if issues arise.

- *Medicaid Changes –Turning 65 vs. enrolling in Medicare based on disability*

1. MAGI Medicaid Enrollee Turning 65

During the pandemic – The process described below - of transferring Medicaid from NYSoH to the local DSS and redetermining eligibility under non-MAGI rules - is NOT HAPPENING during the Public Health Emergency. Recipients keep MAGI Medicaid on NYSoH even though they become enrolled in Medicare. See GIS 20 MA/04 – COVID-19) – Medicaid Eligibility Processes During Emergency Period and https://health.ny.gov/health_care/medicaid/covid19/factsheets/eng_guide_med_cons_enrolled_thru_ldss.htm. Once the pandemic ends, the procedures described below will be reinstated.

Before the pandemic – and presumably again once the pandemic ends -- In the month that a MAGI Medicaid enrollee turns 65, NYSoH will transfer their Medicaid case to the Local DSS, which will put up temporary Fee-for-Service Coverage while the LDSS processes a redetermination of eligibility. The LDSS should send the client a notice with either a re-certification form and Supplement A, or a new Medicaid application. See 2014 LCM-02. 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.

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). However, if this individual has a child, grandchild or other relative under 18 living with them (under 19 in school), MAGI can continue.

As of January 2023, the MAGI and non-MAGI income limits are aligned at 138% of the federal poverty level. However, there will still be an asset test for non-MAGI Medicaid. For this reason, some individuals may lose full Medicaid eligibility when they begin receiving Medicare if their resources are over the expanded 2023 resource limit.

Part B Premiums - Since MSP has NO ASSET limit, some individuals may be enrolled in the MSP even if they lose Medicaid because of assets, or if they now

have a Medicaid spend-down. If a Medicare/Medicaid recipient reports income that exceeds the Medicaid level, districts must evaluate the person's eligibility for MSP. 08 OHIP/ADM-4 In 2023, the income limit for the QI-1 MSP program will increase to 186% FPL, so many people not eligible for Medicaid may be eligible for the MSP.

2. MAGI Medicaid Enrollee Obtaining Medicare after Receiving 24 Months of Social Security Disability Insurance Payments

An individual enrolled in MAGI Medicaid who starts to receive Medicare due to Social Security disability, unlike those turning 65, will continue to have MAGI Medicaid through NYSoH through the end of their 12-month continuous care period. At the end of their 12-month period, *before the pandemic and again once the pandemic is over,* their case will be transferred to the Local DSS and go through the same process as above for those turning 65. *During the COVID public health emergency, their Medicaid remains on NYSoH.* 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.

Part B. They can call NYSoH to request Part B premium reimbursement, but they should receive it automatically in the form of a check from the Computer Science Corporation. These reimbursements are called the Medicare Insurance Premium Payment (or MIPP under 87 ADM-40). The LDSS should also determine eligibility for a Medicare Savings Program. Until that determination is made, NYS DOH should reimburse them for their Part B premiums. See more about MIPP at http://www.wnylc.com/health/entry/229/.

EXAMPLE: Sam, age 60, was last authorized for Medicaid on the NYSoH in June 2019. He became enrolled in Medicare based on disability in August 2021 and started receiving Social Security in the same month (he won a hearing approving Social Security disability benefits retroactively, after first being denied disability). Even though his Social Security is too high, he can keep Medicaid for 12 months beginning August 2021(and likely longer because of COVID-19 rules).

Sam has to pay for his Part B premium - it is deducted from his Social Security check. He may call the NYSoH and request a refund under MIPP. This will continue until the end of his 12 months of continuous MAGI Medicaid eligibility. He will be reimbursed regardless of whether he is in a Medicaid managed care plan. See, GIS 18 MA/001 Medicaid Managed Care Transition for Enrollees Gaining Medicare (PDF). When that ends (or later after the Public Health Emergency ends), he will renew Medicaid as non-MAGI and apply for MSP with his local district.

"Unwinding" the Public Health Emergency (PHE) -- Medicaid and MSP Renewals Re-Start in March 2023. Those who do not request rebudgeting from their local Medicaid offices will be rebudgeted using the 2023 levels at some point when they go through the renewal process starting in March 2023. All 8+ million Medicaid recipients in NYS will go through these renewals over the course of the year. All local Medicaid agencies start sending out renewals to all Medicaid recipients over the year starting March 2023 (NYC) or April 2023 (rest of state and NYSofHealth). This year-long round of renewals is called the UNWINDING of the Public Health Emergency (PHE) because since March 2020, the federal "Maintenance of Effort" protections forbade states from discontinuing Medicaid or increasing the spend-down. In most of the state, renewals were not even sent to recipients since March 2020. NYC recipients received renewals but HRA did not process the renewals that were returned.

Recipients should receive the renewal at the same time of year they used to receive them before the COVID PHE emergency (or in NYC continuing through the PHE). If they know that their renewal is expected earlier in the year starting March 2023, they might hold off on requesting "rebudgeting" from their local Medicaid office now. If they know their renewal won't be until later in the 12-month cycle, then they might want to request rebudgeting now to reduce or eliminate their spend-down.

WARNING: If they fail to return the renewals on time, do not provide adequate documentation with the renewals, or are no longer eligible, Medicaid and MSP will be DISCONTINUED. The first discontinuance notices will be sent around June 20, 2023 to cut off Medicaid or MSP on **July 1, 2023**. This first round will include those who received the first round of renewals starting in March in NYC and April outside of NYC, if they do not return them on time or with all required documents.

- They must **request a Fair Hearing right away** before the effective date of July 1, 2023 (or later if in a later round of renewals) in order to receive **Aid Continuing** and have their Medicaid continue until the Fair Hearing is resolved. See how to request a hearing at https://otda.ny.gov/hearings/request/.

HIICAP COUNSELORS can help clients by:

- reminding them to **look for the renewals in the mail and help them respond** on time.
- help clients **report any change of address** to their local Medicaid office if they moved since 2019 and never reported this change.
- Help people upgrade to full Medicaid from MSP-only or upgrade to QMB – see below.
- **Requesting a Fair Hearing** if they receive a notice discontinuing Medicaid or MSP (see above), and try to resolve the case with the local Medicaid office. **Contact one of the MCCAP programs for help**.

For those who had MSP only and not Medicaid – and now are eligible for Medicaid under the new 2023 income limits: Those who want Medicaid must submit an entire Medicaid application and Supplement A to their local Medicaid office. They cannot simply request "rebudgeting." Until July 1, 2023, they can still "attest" to most eligibility factors rather than verify them with documents (except for citizenship and identity). Those who had QI-1 or SLIMB and now want to upgrade to QMB must submit the one-page MSP application DOH-4328 and may not simply request rebudgeting.

NYS has been approved for waivers, which allow for certain flexibilities during the PHE unwind period. These waivers may also help beneficiaries retain Medicaid coverage.

- **Automated renewals for SNAP recipients:** ABD Medicaid beneficiaries who are also recipients of the Supplemental Nutrition Assistance Program (SNAP) will be automatically renewed for ABD Medicaid. This waiver does not apply to MAGI cases, MSP-only cases, MBI-WPD, chronic care budgeting, NYSOH referrals, or individuals turning age 65.
- **Asset test waived for Medicaid renewals:** Medicaid asset test waived at renewal for anyone in non-MAGI category. If an individual does submit asset information during renewal, it will be ignored. Keep in mind that this waiver is for renewals. It does not apply to new ABD Medicaid applicants (but does include individuals referred to LDSS from NYSOH)
- **Medicaid enrollees retained on NYSOH:** Medicaid recipients on NYSOH who are eligible for Medicare will not have their cases transferred to the LDSS. They will remain on NYSOH throughout the waiver period.

These waivers apply until May 2024.

Stay tuned for more about this roll-out and the unwinding at http://www.wnylc.com/health/news/90/.

MEDIGAP -- 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 or QMB** can wrap around Medicare coverage and pay many of the costs Medicare does not pay. However, Medicaid and QMB will only pay coinsurance and deductibles to doctors and other providers who accept Medicaid. Since many doctors do not accept Medicaid, the recipient may prefer to have a Medigap policy. Even when the provider does accept Medicaid, New York Medicaid may not pay the entire Part B coinsurance, whether the recipient has Original Medicare and Medicare Advantage. See pp. 5-6 above.

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.

Caution: Can the senior afford Medigap? Is it necessary for a dual eligible with Medicaid to supplement Medicare? What if they drop Medigap and then want it back? 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.

- 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. http://www.medicaid.gov/Federal-

Policy-Guidance/downloads/CIB-01-06-12.pdf and QMB discussion above. 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.

- **WARNING**: A Medigap policy may not be sold to someone who has "full" Medicaid, meaning that they have Medicaid without a spend-down. This means that if a Medicaid recipient drops their Medigap policy, thinking they do not need it anymore because they have Medicaid, then decides to buy a policy again, they may not be able to buy a policy if they have full Medicaid.
- **Solution --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, and QDWI programs are part of the public safety net**.

SPECIAL ELIGIBILITY RULES TO RECEIVE MEDICAID LONG-TERM CARE SERVICES – NURSING HOME & IN THE COMMUNITY

Medicaid covers 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 financial eligibility rules that apply to receiving long-term care.

Eligibility for community-based long-term care services, including home care and Assisted Living Program 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, along with spousal refusal and pooled trusts, described above, makes it possible for many seniors and people with disabilities to qualify for Medicaid coverage of long-term care needs. Here are unique rules for community-based long-term care services:

Home equity limit of $955,00 (2022 rate). 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 this amount, 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 who live together, or individuals with a minor disabled child living with them, there is no home equity limit. Note that the limit is on equity value, not market value; the equity value can be reduced by taking out a mortgage. This equity limit only applies to long-term care services such as home care, not eligibility for primary and acute care Medicaid services.

If I sell or give away resources, or transfer any money, can I still get Medicaid to pay for nursing home care or community-based long-term care?

Until now, in New York State, an individual could give away or "transfer assets" in one month and apply for Medicaid for community-based long term care the next month. A "transfer penalty" was imposed solely for nursing home care.

NEW LOOKBACK! A change in NYS law enacted in 2020 will, when implemented, require a **lookback and transfer penalty** for applications for Medicaid to obtain **home care or other community-based long-term care service**. For an application filed after the date the change becomes effective, if a "non-exempt" transfer was made after October 1, 2020, Medicaid will not pay for community-based long-term care services for the penalty period. See more below.

- **When will the new lookback start?** Because the lookback was enacted during the Public Health Emergency, it cannot be implemented until this emergency is over. For this reason, it keeps being postponed**.** As of the date this chapter is being edited (May 31, 2022), the earliest the lookback can start is for new Medicaid applications filed after October 1, 2022, but more likely not until Jan. 1, 2023, unless further delayed.
- **Which services will lookback apply to?** Managed Long Term Care (MLTC), personal care or consumer-directed personal assistance programs from the local Dept. of Social Services (through "Immediate Need" or for those who are excluded or exempt from MLTC enrollment such as those in hospice – see more below), private duty nursing, and the Assisted Living Program.
- **The lookback will NOT be required for** Medicaid for primary or acute medical care, or for these waiver programs – Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion Waiver (NHTDW), and OPWDD waivers.
- Stay tuned – many details are not yet fleshed out.

Because the lookback and transfer penalty are virtually the same for nursing home care and for community-based long-term care, they are discussed together below, with differences indicated.

What is a "transfer of assets?" A transfer occurs when money or property that would have been an "excess" asset for Medicaid is given away or sold for less than it is worth. This includes transfers to individuals (gifts), charities, or to a trust. Transfer of an exempt asset is allowed, such as Holocaust reparations, or transfer of assets below the resource limit.

What is a LOOKBACK PERIOD? - Applicants must disclose every statement for all assets owned by applicant and the spouse, whether owned jointly or individually, or owned jointly with anyone else. The spouse's financial records are required even if the spouse is not seeking Medicaid, or even if using "spousal refusal." Spousal refusal is still in effect, but a spouse's assets must still be documented for the lookback period; if the spouse made a non-exempt transfer, there is a transfer penalty for the consumer.

How long is the Lookback Period?

- For Nursing Home Care, it is FIVE years or 60 months.
- For Community-Based Long-Term Care, it will be 30 months after it is phased-in, starting no earlier than Oct. 1, 2022, but more likely in January 2023 or later. The lookback will always look back to transfers made on or after 10/1/2020. If the lookback implementation starts Oct. 1, 2022, the lookback period will be 24 months, back to 10/1/20. It will add one month every month until it is 30 months in April 2023

What is a Transfer Penalty? - If either spouse has transferred money or property within the lookback period for the particular service, the consumer may be ineligible for Medicaid coverage of nursing home facility services – or for community-based long term care services, once that lookback starts. The period of ineligibility is called a "penalty period."

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

The length of the transfer penalty is the total amount of money transferred divided by a regional penalty transfer rate that is set each year. The 2022 rates are on the next page. Every year NYS DOH publishes them in a GIS directive, and HRA also includes them in the chart of Medicaid income and resource levels at http://www.wnylc.com/health/entry/15/ (See Box 9). The same transfer penalty rates will be used for nursing home care and community-based long-term care.

When will the transfer penalty begin for MLTC, Assisted Living Program, or other home care? DOH has indicated that if a physician indicates that the applicant has the functional need for home care, the penalty will begin from the time of application. This policy is not yet finalized.

Exceptions to the transfer penalty: No penalty is applied for the following transfers:

- You transfer assets to your **spouse** (who then can use "spousal refusal").
- You transfer assets or property to your **child of any age 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; or
  - 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, or
  - your child of any age who was living in your home for at least two years immediately before you became institutionalized and who 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
- *Undue Hardship* - Despite 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.

Transfer Penalty Rates 2022		
Central $11,328		
Broome	Jefferson	Oswego
Cayuga	Lewis	St. Lawrence
Chenango	Madison	Tioga
Cortland	Oneida	Tompkins
Herkimer	Onondaga	
Northern Metropolitan $13,399		
Dutchess	Orange	Putnam
Rockland	Sullivan	Ulster
Westchester		
Northeastern $12,560		
Albany	Fulton	Saratoga
Clinton	Greene	Schenectady
Columbia	Hamilton	Schoharie
Delaware	Montgomery	Warren
Essex	Otsego	Washington
New York City $13,415		
Long Island $14,012		
Nassau	Suffolk	
Western $11,884		
Allegany	Cattaraugus	Chautauqua
Erie	Genesee	Niagara
Orleans	Wyoming	
Rochester $13,376		
Chemung	Livingston	Monroe
Ontario	Schuyler	Seneca
Steuben	Wayne	Yates

The transfer penalty for nursing facility services generally begins the first month of institutionalization and in which a completed application for nursing home Medicaid is filed, as long as the applicant was otherwise eligible for Medicaid coverage of nursing facility services. In other words, the applicant must at the time have resources within the Medicaid resource limits ($16,800 in 2022 plus the exempt assets such as a pre-paid funeral agreement and IRA in pay-out status). The penalty period does not begin until you are actually in a nursing home, even if it as much as 5 years after the transfer.

Example: Susan lives in Rochester and transferred $124,600 to her daughter in March 2019 and applied for Medicaid to receive MLTC services in April 2019. In March 2022, Susan had a stroke, was hospitalized, and then placed in a nursing home. Other than the money she transferred in March 2019; her assets were within the 2022 Medicaid limit for a single person - $16,800. She applies for Nursing Home Medicaid in June 2022, 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 -- $124,600 divided by $13,376.

Since she is institutionalized, is applying for (and is otherwise eligible for) Medicaid, the transfer penalty begins in June 2022. Medicaid will not pay for her nursing home care for the next 10 months beginning June 2022. One option around this penalty is for her to return home from the nursing home after the penalty starts "running" in June 2022. Once it starts, the ten-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 – until applications filed in Jan. 2023.

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 if his or her spouse owns a home, has assets exceeding the Medicaid limits, or transferred assets in the lookback period and now needs nursing home or home care. Referrals at www.naela.org.

Treatment of Income in a Nursing home - Single Person

All of a single 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, must

be used to help pay for the cost of care. This is called the NAMI or Net Available Monthly Income. Medicaid will pay the balance up to the Medicaid rate.

- EXCEPTION: If a nursing home resident reasonably expects to return home, he or she can request "community budgeting," which allows him/her to use the same budgeting used in the community. They may keep the regular Medicaid allowance ($934/mo in 2022) rather than $50/month, or more if they used a pooled trust or other special budgeting in the community. The purpose of this is to have money to pay rent to maintain an apartment. This is usually authorized for six months at a time. A five-year lookback of assets is still required, described below. See FACT SHEET at http://www.wnylc.com/health/download/711/ and http://www.wnylc.com/health/entry/117/.

- SSI RECIPIENTS – may keep their SSI for 3 months if hospitalized or in a nursing home, if they expect to return home, but a form signed by the hospital or nursing home must be submitted to the SSA. For form and more info see FACT SHEET at http://www.wnylc.com/health/download/594/.

Married Persons in a Nursing Home or in Managed Long-Term Care (MLTC) Plan or other Waiver - Spousal Impoverishment Provisions

When one spouse enters a nursing home or enrolls in an MLTC plan or obtains "Immediate Need" home care, the other spouse (the "community spouse") is protected from becoming impoverished by the federal spousal impoverishment provisions. They allow the "community spouse" to keep a certain amount of the couple's total countable resources and also may keep some of the institutionalized spouse's income, if her own income is below a specified threshold called a Minimum Monthly Maintenance Needs Allowance (MMMNA).

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 monthly income allowed by federal law, which usually gets an annual cost of living increase. However, New York State has not opted for the highest resource allowance for a spouse. This allowance has been frozen in New York at $74,820 since 1995, while the highest allowed under federal law has increased to $137,400 (2022).

Spousal Protections Now Apply to Managed Long-Term Care and "Immediate Need" Personal Care or Consumer Directed Personal Care Services

The spousal impoverishment protections described below now apply not only to couples with one spouse in a nursing home, but also couples with:

- one spouse enrolled in a Managed Long-Term Care (MLTC) plan, or

- one spouse receiving personal care or CDPAP services through their local Dept. of Social Services based on "Immediate Need" for such services, or

- One spouse in the Traumatic Brain Injury Waiver Program (TBI) or Nursing Home Transition and Diversion (NHTD) waiver programs. See http://wnylc.com/health/news/32/; http://www.wnylc.com/health/entry/165/.

Here's how the law works.

Income Protections for Spouse. An "institutionalized spouse" is defined as a spouse who is in a nursing home, enrolled in an MLTC plan or other waiver, or receiving "Immediate Need" home care. In 2022, the community spouse of an "institutionalized spouse" is permitted to retain up to $3,435 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 $3,435.

Income Allowance for Applicant. If residing in a nursing home on a permanent basis, the nursing home spouse may keep only $50/month. If the applicant spouse is in an MLTC plan, other waiver program, or Immediate Need home care, she is entitled to keep an allowance of $433 of monthly income (2022). The balance of the applicant's income after these allocations, and after paying for health insurance premiums, is the "Net Available Monthly Income" or NAMI. This is the amount required to be paid for the cost of care.

Resource Protections for Spouse. When one spouse enters a nursing home – or enrolls in a Managed Long-Term Care plan, "immediate need" home care or a "waiver" program -- a "snapshot" is taken of the couple's total countable resources. Exempt resources described above are not counted. See pp. 10-12. 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 $137,400 (2022) or
- an amount established by fair hearing or court order

In addition, the institutionalized spouse (or spouse enrolled in MLTC or receiving Immediate Need home care) can retain up to $16,800 in countable resources, can purchase a nonrefundable irrevocable funeral agreement, and in some cases, may also have a burial fund. Note the $16,800 allowance will increase significantly in 2023.

SERVICES COVERED BY MEDICAID

Medicaid covers a broad package of services, described below. However, the way that these services are authorized and obtained is changing. Most Medicaid recipients who do not have Medicare or other primary insurance 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 now are required to enroll in "managed long-term care" plans if they need Medicaid home care or other 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 payer for any Medicare services, and Medicaid is secondary payer.

NEWS 2022 – annual limits on the number of lab tests, mental health, dental, & other clinic visits, etc. were lifted effective July 1, 2022. These were called Utilization Thresholds, requiring a cumbersome override process. See http://www.wnylc.com/health/entry/89/.

- **Hospital** inpatient and outpatient services, physician's clinic services
- **Laboratory** and X-ray services –
- **Outpatient or clinic** treatment and preventive health and **dental and vision** care (doctors, dentists, optometry). A lawsuit settled in 2018 will expand New York's coverage of dental implants when medically necessary and change the rules for replacement dentures. See more here - http://www.wnylc.com/health/entry/210/.
- **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**
- **Prescription and over-the-counter drugs and supplies** - Medicare beneficiaries must enroll in a Part D plan. Medicaid will no longer pay for their prescriptions, except for 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. If the Part D plan does not cover a drug in these classes, or any drug, the dual eligible must appeal the denial of the drug to the plan, change drugs, or change plans during the annual enrollment period or in a Special Enrollment Period.

  Medicare beneficiaries newly approved for Medicaid who are already in a Part D plan are eligible for Extra Help to subsidize the Part D costs. Until they are officially enrolled in Extra Help, they should present the Medicaid notice or card to the pharmacy, which will submit it to the plan. The plan should accept the notice as "Best Available Evidence" that they qualify for Extra Help. Those who are not yet in Part D should also provide the Medicaid notice to the pharmacy, who will submit the claim through "LINET," charging the Extra Help copayments. They will later be auto enrolled into a Part D plan and Extra Help.
- **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.wnylc.com/health/entry/190/.

- **Physical, Occupational and Speech Therapy -** Annual caps on the amount of PT, OT, and ST services were lifted effective Jan. 1, 2021. Previously, the annual limits ranged from 20 to 40 visits per year, with some exceptions. However, the managed care plan must still grant "prior approval" for these services based on medical necessity, which can still be a barrier. See http://www.wnylc.com/health/entry/158/.
- **Orthotics, inserts and compression stockings** – Severe restrictions of these items under a 2011 state budget have been lifted by litigation. Prostheses are no longer limited to amputees or when needed as part of a diabetic treatment plan, or to children with development problems. The final policy is posted at https://www.emedny.org/ProviderManuals/communications/Prescription_Footwear_Benefit_Update_Provider_communication_Final_Version.pdf. See more information at http://www.wnylc.com/health/entry/182/
- **Emergency ambulance** transportation to a hospital

- **Transportation to non-emergency medical** appointments, including bus fare, ambulettes and car mileage. In the state budget enacted April 1, 2020, transportation will no longer be managed by MLTC plans, but will be delegated to a state contractor to be decided. On March 23, 2022, CMS notified DOH that it does not need CMS permission to approve this change, which need only be incorporated in the state's contracts with the MLTC plans. (https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/docs/2022-03-23_cms_1115_ext_app.pdf). As of June 5, 2022, this change is not yet implemented. Once approved, it will likely be rolled out and use Medical Answering Services LLC (MAS), which already handles transportation for mainstream Medicaid managed care members and those not in managed care plans.

  Until then, MLTC member continues to request and schedule medical transportation through their MLTC plan.

  MAS CONTACT INFO:

  Telephone: 1-844-666-6270 (NYC specific) Contact info by borough or county see:
  Fax: 1-315-299-2786 Website: https://www.medanswering.com/
  Mailing Address: Medical Answering Services, LLC
  PO Box 12000, Syracuse, NY 13218

- **Assisted Living Program (ALP**) – Medicaid covers the cost of assisted living only in a limited number of facilities. These are not the private assisted living facilities 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. SSI pays a higher "Congregate Care III" rate for residents of ALPs, with a chart updated each year. People with incomes under $1535/month (2022) receive SSI in an amount that brings their income up to $1535/mo. They may keep a personal needs allowance of $222/mo. (2022), and the rest must be paid for room and board to the facility. If income is above $1535/mo., they must pay the facility $1535/month and Medicaid pays the rest. For a statewide list of ALPs see https://health.data.ny.gov/Health/Adult-Care-Facility-Directory/wssx-idhx (Look for Assisted Living Program beds, not "ALR" beds). For more information see http://www.wnylc.com/health/entry/150/#payment.

  - **The lookback and transfer penalty will apply to ALP services** for Medicaid applications filed after the date the lookback starts for community-based long term care services, which can be no earlier than Oct. 1, 2022. See above.

- **Nursing home** care - short-term rehabilitation as well as long-term care
- **Medicaid home care and other community-based long-term care** – personal care, consumer-directed personal assistance program (CDPAP), home health aides, private duty nursing, adult day care, Personal Emergency Response System – NY has a rich array of these services, but the model for providing them has changed radically. See section in Managed Long-Term Care below.

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

After an application is approved, most persons will get a plastic card called a Common Benefit Identification Card, which is their Medicaid insurance card. Whether they can use this card to see any Medicaid provider, or only certain providers within a network, depends on whether they are enrolled in a Medicaid Managed Care plan or receive Medicaid fee-for-service.

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

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 who must give referrals 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.

New York State has different types of "managed care." "Mainstream" Medicaid managed care plans cover all Medicaid services, including primary, acute, and long-term care. HARP plans are a type of mainstream plan that is solely open to people with behavioral health impairments. Most HIICAP clients are *not* in mainstream or HARP plans because they exclude Medicare beneficiaries and anyone with a spenddown. Other types of "managed care" cover only long-term care services – primarily Managed Long Term Care (MLTC) plans. "Mainstream" plans will be discussed first, followed by MLTC plans.

Does everyone in New York State have to join a "mainstream" Medicaid managed care plan?

No. **Medicare beneficiaries and some other groups are EXCLUDED** from Medicaid Managed Care, meaning they cannot join a Medicaid managed care plan even if they would like to. Some people are EXEMPT from managed care, meaning they may request an exemption from enrollment

in a managed care plan that must be approved. See https://nymedicaidchoice.com/ask/who-does-not-have-join-health-plan

People who are **excluded** from mainstream Medicaid managed care are those who:

- Have a **Medicaid Spenddown** or Excess Income.
- 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 covered by other comprehensive third-party health insurance (TPHI), such as an employee group health policy, or could have this insurance, if cost-effective.
- Are under 65 and eligible for the Cancer Screening & Treatment Program (for Breast, Cervical, Colorectal and Prostate Cancer),
- Are enrolled in a managed long term care plan
- 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 – see pp. 51-55).
- only use Medicaid for tuberculosis (T.B.) related services.
- Infants living with a mother in jail
- Children and adults living in State-operated or certified psychiatric or treatment facilities, OPWDD facilities, 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)
- Receiving hospice services at the time of enrollment

EXEMPTIONS - The following beneficiaries may request an **exemption** from managed care – if they don't request an exemption they are auto-assigned to a plan:

- **Native American**; or
- have a **chronic medical condition and** being treated by a specialist who does not participate with *any* Medicaid managed care plans, including people scheduled for surgery within 30 days of enrollment, with a surgeon not participating in any plan -- 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.
- Residents of Intermediate Care Facilities for the Developmentally Disabled
- Adults in certain **Waiver** programs -- OPWDD waiver, Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion Medicaid Waiver (NHTD)
- Residents of **Chemical Dependence** Long Term Residential Program

See NYSDOH Charts of Exclusions and Exemptions, attachments to GIS 15 MA/012 - Medicaid Managed Care Exemptions and Exclusions -- PDF Attachment 1 (Exclusions) - Attachment 2 (Exemptions) - download at 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.

What services must be obtained through the Medicaid managed care plan? Medicaid managed care plans cover most medical services. But members 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,*** fewer services are "carved out" of the benefit package. These plans now cover services including:

- prescription drugs and over the counter medications,
- personal care and Consumer-Directed Personal Assistance Program (CDPAP),
- adult day health care, dental and orthodontia care, and hospice care (since 2013)
- chemical dependence outpatient treatment, mental health treatment, and other behavioral health and substance abuse services used to be carved out and obtained on a fee for service basis, until the new "HARP" plans were implemented in 2016.
- Physical, speech and occupational therapy – but the annual caps on the number of visits was lifted April 1, 2021. The plans may still deny "prior approval" of visits, however, which may be appealed.

However, transportation is carved out and not accessed through these plans (since 2013). See http://www.wnylc.com/health/entry/143/. See pp. 35.

How does a new Medicaid recipient enroll in Medicaid Managed Care – and can they change plans?

New Medicaid recipients may designate their plan choice when they apply for Medicaid on NYSoH or at the LDSS. If they do not choose a plan then, they receive mandatory enrollment packets from **New York Medicaid Choice**, a private company contracted to handle managed care enrollments and disenrollment's. They will be randomly assigned into a Medicaid managed care plan if they do not choose a plan within 30 days.

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

A list of managed care plans available by county is at http://www.health.ny.gov/health_care/managed_care/mcplans.htm

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.

For more information about Medicaid managed care:

- **NYHealthAccess.org** 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 - Download the Model Member Handbook, model contracts, and links to statewide online map showing status of managed care in each county- https://www.health.ny.gov/publications/1109.pdf (Consumer booklet about managed care)

Managed Long Term Care -- Medicaid Community-based long-term care

From 2012-2015, NYS phased in the requirement that all adult Dual Eligibles (age 21+) who need Medicaid home care or other long-term care services for more than 120 days, with very few exceptions, enroll in a Managed Long-Term Care (MLTC) plan in order to receive these services. The MLTC plan controls access to, approves, and pays for all Medicaid home care services and other long-term care services in the MLTC service package, including:

- Home Care, including:
  - Personal Care **-NEW limits on this service coming – see below**
  - Certified Home Health Agency Services (home health aide, visiting nurse, visiting physical or occupational therapist)
  - Private Duty Nursing
  - Consumer Directed Personal Assistance Program, a variation of personal care services in which consumers may hire their own aides, including family members other than a spouse or a parent of a minor child. The personal assistants may perform skilled tasks that normally can only be performed by nurses or family. See more at http://www.wnylc.com/health/entry/40/. **NEW limits on this service – see below**
- 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, orthopedic shoes, compression stockings)
- Physical, speech, and occupational therapy outside the home (Note the annual cap on the number of visits was lifted April 1, 2021)
- Hearing Aids and Eyeglasses
- Four Medical Specialties:
  - Podiatry
  - Audiology + hearing aids and batteries
  - Dental (Note that a lawsuit settled in 2018 expands New York's coverage of dental implants when medically necessary and change the rule for replacement dentures. See more at http://www.wnylc.com/health/entry/210/).
  - Optometry + eyeglasses
- **2020 CHANGE: Non-emergency medical transportation** to doctor offices, clinics (ambulette, taxi) – Not yet implemented as of 6/5/2022 but coming -- MLTC plans will no longer be in charge of authorizing and contracting for this service. It will be centralized with a state contractor and authorized outside of MLTC. See p. 35.
- **2020 CHANGE: Long-term nursing home care** became a mandatory part of MLTC in 2015, but as of April 2020, is limited to include only temporary nursing home care (3 months or less). After 3 months, an individual will be disenrolled from the MLTC plan. See more below on this change.

What is not included in the MLTC package? Regular MLTC plans do not include services covered by Medicare – primary and specialist medical care, hospital inpatient and outpatient care, prescription drugs, lab test, etc. MLTC members use their Medicare coverage for these services, with options described below. Beginning in 2020, MLTC plans no longer include long-term nursing home care, and later in 2022 or 2023, will no longer include non-emergency medical transportation.

Choice of TYPES OF MLTC PLANS -- Full Capitation vs. Partial Capitation:

People required to enroll in MLTC have a choice among two different models of plans. All of these plans are "managed care" plans, meaning that all covered services must be accessed through the plan, using providers in the plan's network.

"**Capitation**" is the fixed monthly premium paid to the managed long term care plan "Per Member Per Month" (PMPM), 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." There are two capitation models in MLTC:

1. *Partial capitation* MLTC plans cover only Medicaid long-term care services and other limited Medicaid services like dental care listed above. Their members keep their preferred Medicare coverage separately – whether Original Medicare (+ Part D plan) or Medicare Advantage.
    - Most New Yorkers prefer the partially capitated MLTC plans – in February 2022 there were 243,131 members of MLTC partial capitation plans and only 37,834 in the 2 types of fully capitated plans combined (MAP and PACE).
2. *Full capitation* plans are paid to cover both MEDICARE AND MEDICAID services. These plans combine in one plan a MEDICARE ADVANTAGE plan with an MLTC plan. All Medicaid and Medicare services must be accessed through the plan from in-network providers. The plans cover not only Medicaid long term care, but also primary and acute and emergency medical care paid for by Medicare. Since all of these plans include a Part D prescription drug benefit, one must look carefully at the drug formulary to be sure one's prescriptions are covered. There are 2 types of Fully Capitated plans. (A third type called "FIDA" was discontinued at the end of 2019, and operated only in NYC, Long Island and Westchester).
    - *Program for All-Inclusive Care for the Elderly (PACE)*
        - Must be age 55+ and otherwise eligible for nursing home admission.
        - 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.
        - 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.
    - *Medicaid Advantage Plus (MAP)*
        - Unlike PACE, MAP plans are more of a pure insurance model, not based on any particular provider setting. The member must use in-network providers for all Medicare and Medicaid services. The individual first joins a "Medicare Advantage Dual-SNP Plan" and then joins the aligned Medicaid Advantage Plus plan operated by the same company, thus combining both Medicare and Medicaid services.
        - ***NEW IN 2020-21 –*** Medicaid recipients newly enrolling in Medicare who received personal care, CDPAP or private duty nursing services through their Medicaid managed care plan are default enrolled in the "aligned" MAP plan sponsored by the same company that operates their Medicaid managed care plan. See more about default enrollment above and http://www.wnylc.com/health/entry/226/.

Lists of plans:

- http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm
- http://nymedicaidchoice.com/program-materials - Scroll down to plan lists for Long Term Care plans - by region

Who Must Enroll in MLTC, and who is EXEMPT or EXCLUDED from MLTC?

- **Adult Dual-Eligible Medicaid recipients MUST ENROLL IN MLTC 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 – **NEW coming in 2022/23** – exact date after Oct. 1, 2022, *to be announced* - eligibility criteria will be more restrictive. Until now, it was enough to need assistance with any "**Activity of Daily Living" (ADL)** for more than 120 days.

    ADLs include eating, bathing, personal hygiene, dressing, walking, locomotion/transfer, toilet use and bed mobility (turning & positioning in bed).

    New applicants following the effective date must need *physical maneuvering* with at least *three ADLs*, or for persons with dementia or Alzheimer's diagnosis, need at least supervision with *two ADLs*. People already in MLTC plans or receiving home care before the effective date will be grandfathered in. The NY Independent Assessor (NY Medicaid Choice or Maximus) will do the assessment to determine the need for long-term care. See https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care.

- **Who is EXCLUDED from, and may not enroll in, MLTC? Some of these groups still apply to local DSS for personal care, but others no longer qualify for personal care.** (Having a spend-down is NOT an exemption or exclusion from MLTC).
  - **NEW EXCLUSION starting 2020: Long-term Nursing Home Stay ("LTNHS") residents –**MLTC plans no longer cover long-term nursing home care. From 2015 - 2020, new nursing home residents were required to enroll in an MLTC plan, which paid the nursing home for their care. Or if they were already in an MLTC plan, they remained in the plan while in a nursing home, even if it was long-term. Now, MLTC members who have been in a nursing home for more than 3 months, and who have been approved for Institutional Medicaid, are disenrolled from the MLTC plans. They should receive notices with the right to request an assessment to return home, and to request a hearing, before being disenrolled. See http://www.wnylc.com/health/entry/199/. Anyone in a nursing home for more than 3 months may request an assessment by the NY Independent Assessor to determine if they may enroll in an MLTC plan to return home. Call ICAN for problems.
  - **NEW EXCLUSION to begin on or after Oct. 1, 2022) - People who do not meet the new 2- or 3-ADL requirement are excluded** -- if they do not need physical maneuvering with three or more ADLs, or for persons with dementia or Alzheimer's diagnosis, if they do not need supervision with two or more ADLs." ***They are not only excluded from enrolling in MLTC but are not eligible for any Medicaid personal care or CDPAP***.

    Until this change, those who needed *only* "Housekeeping" services (shopping, cooking, cleaning, and laundry) (also called "Instrumental ADLs"), but no ADL assistance, were excluded from MLTC enrollment, but could still apply for a maximum of 8 hours/week of these Personal Care "Level I" services through the local DSS Medicaid program. Now, the new state law eliminates stand-alone Level I personal care "housekeeping" services altogether for those who do not meet the new minimum ADL requirement.

    MLTC plans still cover "Housekeeping" services if the member meets the 2- or 3-ADL minimum, and the 8-hour/week limit does not apply.

- In Nursing Home Transition Diversion Waiver or Traumatic Brain Injury waiver (but MLTC may be mandatory for them in January 2023).
- In Office for People with Developmental Disabilities (OPWDD) Waiver. Some people don't realize they are in this waiver. A code of "95" signifies this exclusion. People First waiver also in process – https://www.health.ny.gov/health_care/medicaid/program/longterm/omrdd.htm
- Receiving hospice services at time of enrollment - They may apply to Local DSS/HRA for personal care services to supplement hospice. An MLTC member, however, may remain in the MLTC plan if they later enroll in a hospice program -- MLTC Policy 13.18: *MLTC Guidance on Hospice Coverage*
- Residents of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Alcohol & Substance Abuse Long Term Care Residential Program, adult Foster Care Home, psychiatric facilities
- Live in Medicaid Assisted Living Program (ALP)
- Anyone under age 18
- Undocumented immigrants solely eligible for "Emergency Medicaid" – but in 2022, undocumented immigrants age 65+ will be eligible for long term care services from a mainstream Medicaid managed care plan (not MLTC).
- People expected to be eligible for Medicaid for less than 6 months (If person eligible for Medicaid with a spend-down, they should request DSS for eligibility code 06 – which codes them as having ongoing active Medicaid even though they haven't met the spend-down for six months. Having an approved pooled trust also solves this 6-month problem. In some counties, using the Pay-In program for spend-down could also work, but Pay-In is NOT recommended in NYC – it causes more problems. Be sure to ask your DSS what is best in your county).

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

- Native Americans.
- Dual eligible individuals age 18- 21, but only if they require a "nursing home level of care." This is determined by NY Independent Assessor (new name for the Conflict Free Eligibility & Enrollment assessor (CFEEC)).
- 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").
- Non-dual eligible adults over age 21 who have Medicaid but not Medicare:
  - Normally, these individuals must enroll in "mainstream" Medicaid managed care plans, which are responsible for providing most long-term care services, including personal care, CDPAP, CHHA, private duty nursing, and nursing home care.
  - Non-duals who prefer an MLTC plan may only enroll in one in these circumstances:
    - If they have just applied for Medicaid, have not yet enrolled in a mainstream Medicaid managed care plan, and the NY Independent Assessor determines they require a "nursing home level of care (run by NY Medicaid Choice). See https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care.
    - If they are already in a mainstream Medicaid managed care plan, they may switch to an MLTC plan only if NY Medicaid Choice has determined that

they require a "nursing home level of care" AND that they need services not available from a mainstream Medicaid managed care plan such as social adult day care, environmental modifications, social or environmental supports, or home delivered meals. See MLTC Policy 14.01: *Transfers from Medicaid Managed Care to Managed Long Term Care*.[11]

- If they enroll in an MLTC, they would receive those 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.)
- *Shift Medicaid Administration from NYSoH to LDSS* -- Most people in mainstream Medicaid plans applied for Medicaid on the NYS of Health Exchange. In order to enroll in MLTC, they must transfer administration of their Medicaid case to the LDSS from NYSoH. The LDSS will use "MAGI-like" budgeting to approve or renew their Medicaid.

4. 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/. Since the ALP is required to provide some personal care services, it is considered a duplication of services.
- 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.
- **NEW 2022/23**: People applying after a date to be announced – which cannot be before 10/1/22 -- must need physical maneuvering with three ADLs, or for persons with dementia or Alzheimer's diagnosis, need supervision with two ADLs. This is a new limitation for eligibility for any personal care or Consumer-Directed (CDPAP) services, whether through MLTC or the LDSS. People already in MLTC plans or receiving home care from their LDSS or in a waiver before the effective date will be grandfathered in.

Two Pathways for Applying for Medicaid and Home Care/MLTC

Adult dual-eligibles newly applying for home care have these options for applying for Medicaid to receive home care. There are TWO general pathways, both of which begin with filing a Medicaid application with the local DSS.

Pathway One – Apply for Medicaid and then Enroll in MLTC plan

WHO? Dual Eligible Adults > 21 who are *required* to or who *may* enroll in an MLTC plan. This means those for whom MLTC is MANDATORY or who are *exempt* from MLTC (they *may* enroll), not those who are EXCLUDED from MLTC. See above for description of these different groups. Note that even those for whom MLTC is MANDATORY may also choose Pathway TWO if they have an "immediate" need for home care, because it is a faster process.

A. Apply for MEDICAID at the local DSS Medicaid office. Must include the "Supplement A" that lists resources/assets and document the amount of assets. Otherwise, will not qualify for either MLTC or other home care. NOTE – NEW Supplement A form statewide - (DOH-5178A). Before, NYC used a different form.

B. NY Independent Assessor (NYIA)– NEW starting May 16, 2022 – replaces the Conflict-Free Evaluation & Enrollment Center (CFEEC) but is also run by Maximus, NY Medicaid Choice, the state's contractor. See https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care. This assessment is in two parts:

[11] All NYS DOH MLTC Policies are posted at http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm.

i. **Community Health Assessment (CHA) -** nurse assessment in the client's home or nursing home or by telehealth (same as former conflict-free assessment), PLUS

ii. **Clinical Assessment (CA) –** a medical assessment by an Independent Practitioner Panel (IPP) composed of a physician, osteopath, nurse practitioner, and/or physician assistant, who determines whether medical condition is stable and whether consumer is self-directing. May be in person at consumer's request or by telehealth.

iii. **Based on these 2 assessments, NYIA** determines eligibility to enroll in MLTC. Once the new ADL requirements become effective, this assessment will also determine if that threshold is met.

WARNING: Both of the 2 assessments should be scheduled within 2 weeks of the request, but delays expected. Unclear whether you may request it even before the Medicaid application is approved, unlike the CFEECs. A NYIA eligibility determination is good for one year, and does become stale after 75 days, unlike the CFEEC. NYIA does not determine the number of hours of care client will receive.

To request NYIA call 1-855-222-8350. See https://nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care

See more info on NYIA at http://www.wnylc.com/health/news/85/ and state NYIA website at https://www.health.ny.gov/health_care/medicaid/redesign/nyia/index.htm. NYLAG tips for CFEEC's still useful -- see Fact Sheet http://www.wnylc.com/health/download/573/.[12]

C. **Choose and enroll with an MLTC plan**. Choose TYPE of plan ("regular" partially capitated or fully capitated plan – see above pp. 39-40). Call various MLTC plans in your county to assess client in the home (or nursing home). The plan must use the new NYIA assessments (CHA and CA) described above) to determine a plan of care but will probably send a nurse to do a "mini-assessment" of the consumer.

- Lists of plans by region available at https://nymedicaidchoice.com/program-materials (scroll down to LIST OF PLANS then to LONG TERM CARE plans in your region). Ask several plans to assess and pick the most favorable plan of care – Do they give enough hours? Are preferred providers 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.wnylc.com/health/entry/169/
- **How to enroll** - ONCE you select a plan, you sign the 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 18th of the month in order for enrollment to start the 1st of the following month. If you want your enrollment to be effective as soon as possible, be sure to SIGN the enrollment form at the enrollment visit and ask for a copy.
  - **What if the plan determines it will give more than 12 hours/day of home care?** the plan determines that more than 12 hours are needed, it must refer the case again to NY Independent Assessor for a high needs review to determine if home care can maintain health and safety at home. This is called the I**NDEPENDENT REVIEW PANEL (IRP).** This referral can be made and

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

completed before or after the enrollment forms are signed and submitted. The enrollment should not be delayed in order for the plan to make this referral. See info on how plan assesses need, including standards for authorizing 24/7 care, at http://www.wnylc.com/health/entry/114/#HOw%20plan%20assesses%20needs.

- **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 signed the enrollment agreement and plan submitted it after the 18th 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. If the plan delayed submitting the enrollment form, even though client signed it before the 18th, call ICAN and/or file a complaint with the NYS Dept. of Health MLTC Complaint line. 1-866-712-7197 or e-mail mltctac@health.ny.gov

Pathway TWO - Apply to LDSS for Medicaid AND Personal Care or CDPAP services at the same time

WHO:

1. Dual eligible adults with an "**Immediate Need**" for Personal Care or CDPAP services, who would normally be required to enroll in MLTC Plans – procedures explained below.

2. People excluded or exempt from MLTC (see categories above) who are not enrolled in mainstream Medicaid managed care plans - Note that they *do not* use all the "immediate need procedures" below. They use (i) and (ii) of the steps outlined below on the next page. The fast-track timelines do not apply to these applications.

1. IMMEDIATE NEED PROCEDURES – FAST TRACK for PERSONAL CARE OR CDPAP.

Dual eligibles may use a Fast-Track procedure to apply to the local DSS for both MEDICAID and also for personal care or CDPAP. The applicant must have an "Immediate Need" for either personal care or CDPAP services. 16 ADM-02 - Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services (CDPAP). The DSS must process and approve the Medicaid application in SEVEN DAYS and authorize personal care or CDPAP services in TWELVE DAYS, if there is an immediate need for these services.

This procedure addresses the long delays encountered in enrolling in a Managed Long Term Care plan to get home care. That process could take months - even AFTER Medicaid eligibility has been approved. *However, beginning July 1, 2022, the Immediate Need process will also have more delays* because it must use the NY Independent Assessor also used for MLTC.

PROCEDURE TO APPLY FOR IMMEDIATE NEED – Individual may apply from home, a hospital, or rehab. Submit to local DSS:

i. **Medicaid application** with all required documents. This must include "Supplement A" (NEW: use Form DOH-5178A statewide – NYC no longer uses a separate form). (Alternate languages and formats of forms posted at this link). See more about Medicaid eligibility here.

1. If you already have Medicaid, submit the approval notice and the CIN number. No need to submit application.
2. If an application was already submitted and is pending, submit a copy along with all documentation, and proof of when and where it was filed.
3. **LOOKBACK—**This new requirement has been postponed, but after 10/1/2022, unless postponed further because the Public Health Emergency is extended, applications must include financial records of the applicant and spouse back to Oct. 1, 2020. Initially this would be 24 months of records. Eventually it will be phased in to be 30 months of records. See above pp. 29-32.

ii. **Attestation of Immediate Need (OHIP 0103) --** Consumer must sign this form to attest to immediate need. The form requires you to attest that:

1. You have no informal caregivers available, able and willing to provide or continue to provide *needed* assistance.
2. You are not receiving *needed* help from a home care services agency.
3. You have no adaptive or specialized equipment or supplies in use to meet your needs; and
4. You have no third-party insurance or Medicare benefits available to pay for *needed* help.

iii. **New – After July 1, 2022, unless postponed further, a Physician's order for personal care will no longer be required.** This is Form M11q in NYC and Form DOH-4359 – use outside NYC. Instead**,** the local DSS will refer the consumer to the **NY Independent Assessor** (**NYIA),** which is run by NY Medicaid Choice, to do the same two assessments described above used for MLTC enrollment. These are the Community Health Assessment (nurse) and Clinical Assessment (medical assessment). NYIA will determine if the applicant is eligible for personal care or CDPAP based on these 2 assessments.

1. Until July 1, 2022, or if NYIA postponed further, you should STILL include a Physician's Order signed within the last 30 days with the application. Note that this form may now be signed by a Nurse practitioner or Physician's Assistant (change since Nov. 8, 2021).

iv. **Cover letter** that explains the particular nature of the "immediate need" for services, and status of the Medicaid application if previously approved or filed, whether there are other services or informal supports available, or if they were available explains they are no longer available.

Include in the cover letter - if applicant is married to spouse who does not need Medicaid, applicant may request "spousal impoverishment" protections." These allow couple to keep more assets and income than normally allowed, without doing a spousal refusal.

The Local District uses the two NYIA nurse and medical assessments to determine the plan of care, meaning the number of hours. If the LDSS determines that more than 12 hours are needed, it refers the case again to NYIA for a "high needs review" by an Independent Review Panel to determine if home care can maintain health and safety at home. The LDSS makes the final decision and assigns a home care agency to provide services. See info on standards for assessing need for care at http://www.wnylc.com/health/entry/7/#5%20how%20much%20care?.

For more information on Immediate Need, see: NYS website - https://www.health.ny.gov/health_care/medicaid/#need and more links in this article -

http://www.wnylc.com/health/entry/203/ and
Fact Sheet at http://www.wnylc.com/health/download/637/ with copies of forms.
See more on NY Independent Assessor at http://www.wnylc.com/health/news/85/.

WHAT HAPPENS AFTER "IMMEDIATE NEED" SERVICES BEGIN?

After the consumer has received the services for 120 days, they will receive a letter from New York Medicaid Choice giving them 60 days to select an MLTC plan. If the consumer does not select a plan, they will be auto assigned after the 60 days to a partial capitation MLTC plan. See above for choices between types of plans and tips for selecting a 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[13]
- 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

90- Day Transition Period after Immediate Need recipient enrolls in an MLTC plan:

MLTC plans must provide the same services and the same number of hours as the LDSS had authorized under "Immediate Need" for the first 90 days after enrollment (increased from 60 days). 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, During this 90-day period, the plan must assess the new member's needs.

If, after the 90-day transition period, the plan decides to reduce services, it must send advance written notice at least 10 days before the effective date of the reduction, so that the member may appeal and obtain Aid Continuing if they appeal *right away* before the "effective date" of the reduction.

However, effective Nov. 8, 2021, new regulations allow MLTC plans to reduce hours after the Transition Period if the Plan determines that the previous plan or local Medicaid agency gave you "more services than are medically necessary," without proving any change. The Plan's notice proposing to reduce your services need only "indicate a clinical rationale that shows review of the client's specific clinical data and medical condition." However, advocates believe that plans should still only be allowed to reduce hours if the member's condition or circumstances changed in a way that requires less care than was authorized by the LDSS. These are the only reasons why plans may generally reduce a member's hours. NYS DOH MLTC Policy 16.06. The new regulation creates an exception to this rule for members who transitioned to a new MLTC plan.

TIP: Always request a plan appeal or fair hearing RIGHT AWAY as provided in the adverse notice and refer the consumer for representation if a reduction in hours is proposed.

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

Contact ICAN at 1-844-614-8800 or organizations listed at http://www.wnylc.com/health/index.php?View=entry&EntryID=232#Get%20Help.

See more on changes in transition rights at http://www.wnylc.com/health/entry/232/.

NAVIGATING MLTC PLANS ONCE ENROLLED

CHANGING PLANS and LOCK-IN – Beginning December 1, 2020, a new MLTC member has a grace period of 90 days after enrollment to change plans for any reason. For the rest of a 12-month period starting with the date of enrollment, they may change plans only for **good cause**.

Good cause includes:

- Enrollee is moving from the plan's service area
- Member did not consent to the enrollment
- The plan failed to furnish accessible and appropriate medical care, services, or supplies to which the enrollee is entitled as per the plan of care, or the State determines that the plan failed to meet its contractual obligations with the State, which directly impacts enrollees
- Current home care provider does not have a contract with the enrollee's plan (i.e. home care agency no longer contracts with plan)
- Plan and enrollee agree that the transfer is appropriate

WARNING: Even during the 90-day grace period, if there is good cause to switch plans, since these changes are considered "voluntary," DOH policy allows the new plan to reduce your hours. 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 upon your enrollment. Since the change was voluntary, the State's view is that this is not a "reduction" and you do not have the right to appeal. You only have the right to request an increase, and appeal if that request is denied. ***See more here*** http://www.wnylc.com/health/entry/114/#LOCK-IN

Annual Reassessments and Assessments after a Hospital or Nursing Home Stay– Plans must reassess each member annually. This change began Nov. 8, 2021. Before that, reassessments were every six months. Also, plans should assess members after a temporary hospital or nursing home stay. Eventually, the NY Independent Assessor will conduct all of these reassessments, using the same two assessments described above used for MLTC enrollment – the CHA nurse assessment and the CA clinical or medical assessment – plus the third high-need assessment if the plan determines that 24/7 care is needed (or other plan of care more than 12 hours/day). As of June 5, 2022, DOH has not yet set a start date for using the NYIA for these annual reassessments or assessments after a hospital or rehab stay. Until then, plan nurses still conduct these assessments.

Members May Request Plan to Increase Services or Authorize New Services

In between the annual reassessments, MLTC members may request that their plan increase hours of existing personal care or CDPAP services, or authorize new services, such as Private Duty Nursing services. It is recommended that these requests be made in writing – by certified mail or fax – so that there is proof that the request was made and when. It may also be made in person, such as to a nurse at a 6-month assessment. In that case, the written request should be given to the nurse. Ask the nurse to sign and date your copy of the request to show it was received.

If the need is urgent, ask for the request to be EXPEDITED. The standard for requesting an expedited request is that a delay "would seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function." The case is stronger if the member's physician puts the request in writing for the increase and for it to be expedited and explains in detail why the change is needed urgently. The plan must decide an expedited request more quickly. See for more

info http://www.wnylc.com/health/entry/114/#new%20service%20requests.
For more info on how the plan assesses need see
http://www.wnylc.com/health/entry/114/#HOw%20plan%20assesses%20needs.

See Fact Sheet on requesting services at http://www.wnylc.com/health/download/723/ .

Eventually, MLTC plans will be required to refer all requests for increases to the NY Independent Assessor, which will conduct the same two assessments described above used for MLTC enrollment – the CHA nurse assessment and the CA clinical or medical assessment – plus the third high-need assessment if the plan determines that 24/7 care is needed (or other plan of care more than 12 hours/day). As of June 5, 2022, DOH has not yet set a start date for using the NYIA for these assessments. Until then, plan nurses still conduct these assessments.

Member Rights when Plan Reduces or Denies Request for Increased Services -MLTC

MLTC members have the right to appeal any adverse determination by the MLTC plan regarding denial, reduction, or termination of services. In 2020, the appeal system for Medicaid Advantage Plus (MAP) plans was changed, integrating Medicare and Medicaid appeals into one system. Below, the partially capitated MLTC appeals are discussed first.

1) **Denials**. If a member is denied an increase in services or a request for a new service, the plan must send a written notice approving or denying the request within 14 calendar days for standard requests, or within three calendar days for expedited requests, where a delay would seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The plan may extend its time to decide either standard or expedited requests for up to 14 days if it is in the enrollee's interest.

   The denial notice, called an *Initial Adverse Determination* (IAD) https://www.health.ny.gov/health_care/managed_care/plans/appeals/guidance/final_iad.htm -- must explain the reason for the denial and how the member may appeal.

   - **How to appeal:** The member MUST first request an internal Plan Appeal from the plan following an Initial Adverse Determination by the plan. Only after the plan issues its decision on that internal plan appeal, called a "*Final Adverse Determination*" or "FAD," may the member request a FAIR HEARING. If the member has already gone through an internal appeal and received a Final Adverse Determination, you can request a Fair Hearing online, by phone or by fax –see http://otda.ny.gov/hearings/request/. For more about the new requirement that you "exhaust" the plan appeal before requesting a fair hearing, see this article http://www.wnylc.com/health/entry/184/.

2) **Reductions or Terminations of Services**. When a plan proposes to reduce or terminate a service, it must mail an *Initial Adverse Determination* notice 10 days in advance of the "effective date" of the reduction. The forms must use DOH template https://www.health.ny.gov/health_care/managed_care/plans/appeals/guidance/final_iad_ac.htm (See unofficial sample - http://www.wnylc.com/health/download/644/). The written notice must specify a reason why the individual no longer needs the services previously authorized - an improvement in medical condition, a change in social circumstances (a daughter moved in with her), or other change. After plans were claiming they made a "mistake" in originally approving too much service, in 2016, the State Dept. of Health issued a policy directive limiting when a "mistake" could be claimed, and explaining what changes justify a reduction. See *MLTC Policy 16.06: Guidance on Notices Proposing to Reduce or Discontinue Personal Care Services or Consumer Directed Personal Assistance Services*. If the plan simply changes its mind or

uses a new assessment tool, this is not a sufficient reason. All policies posted at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm.

- **WARNING**: If the reduction is at the end of a Transition Period, after the consumer enrolled in the MLTC plan after receiving Immediate Need services, or after their previous plan closed, a change in state regulations allows the plan to reduce hours even without a reason required by *MLTC Policy 16.06.* See more on this above and at http://www.wnylc.com/health/entry/232/ -- and refer consumer for representation if this happens. See referrals at http://www.wnylc.com/health/entry/232/#Get%20Help.
- **How to Appeal**. If the member requests an internal Plan Appeal before the "effective date" of the reduction, the plan must continue services *unchanged* at the old level until the appeal is decided. This is known as "Aid Continuing." In order to get AID CONTINUING, a Plan Appeal must be requested very quickly, before the "effective date" of the reduction.
- If the member loses the appeal – she will receive a *Final Adverse Determination* notice, which again gives her 10 days to request a Fair Hearing before the new effective date of the reduction. Template at https://www.health.ny.gov/health_care/managed_care/plans/appeals/guidance/final_fad_ac.htm

  The member is entitled to request a Fair Hearing with aid continuing, even if she did not get Aid Continuing on the initial plan appeal. She can request a hearing online, by phone or by fax – see http://otda.ny.gov/hearings/request/. State MLTC Directive 13.01[14] 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."
- WARNING: Some plans discourage people from requesting Aid Continuing, telling them they will have to pay for the cost of the services if they lose the appeal. Members are understandably concerned about being charged with this cost. But - the chance of them losing their appeal is only about FIVE PERCENT. This figure is from a study that examined the number of fair hearings challenging MLTC reductions in hours. To maximize their chance of winning the appeal, refer the member to ICAN for representation. See below.
- **See this article regarding Appeals and Grievances in Managed Long-Term Care --** http://www.wnylc.com/health/entry/184/ - for more information on your right to appeal.
- **See Fact Sheet on MLTC appeals at** http://www.wnylc.com/health/download/654/
- **Contact ICAN – Independent Consumer Advocacy Network.** Members with appeals can contact ICAN for assistance. Phone: 844-614-8800

  TTY Relay Service: 711 Website: icannys.org E-mail: ican@cssny.org

  Also see list at http://www.wnylc.com/health/entry/232/#Get%20Help.

[14] All state policy directives, model contracts etc. on MLTC are posted here https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm .

NEW 2020- "FIDE" Integrated Appeals System for Medicaid Advantage Plus (MAP) Plans – for appeals of both Medicare and Medicaid denials and reductions

Nearly ten percent of all MLTC members belong to Medicaid Advantage Plus (MAP) plans, which combine a Medicare Advantage Dual-SNP with an MLTC plan and add all other Medicaid services into one "fully capitated" plan. The State is encouraging enrollment in these plans, so the numbers will grow. The plans are also called "FIDE" or "FIDE SNP" plans (Fully Integrated Dual Eligible SNP).

Most MAP plans are in NYC, Long Island and Westchester – replacing FIDA. Fidelis and other plans are launching MAP upstate. Look for "MAP" in "plan type" column in this list - https://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm. Also see lists at https://nymedicaidchoice.com/program-materials - scroll down to Long Term Care plans – lists are by region.

NEW FIDE INTEGRATED APPEAL PROCESS for MAP. This process is used for all home care and other services normally in the MLTC benefit package plus many Medicare services, but NOT for these Medicare services – Part D drugs, hospital, home health, Skilled Nursing Facility.

MAP FIDE notices have different TITLES than MLTC notices.

1. "***Coverage Determination Notice*"** of initial denial instead of an "Initial Adverse Determination" notice use by MLTC, though initially the denial might be verbal. The notice should have instructions for how to appeal. If the plan is reducing services, you have only 10 days to appeal to receive "Aid Continuing." Otherwise, you have 60 days. Include medical documentation to support your appeal. You or your provider can ask for this appeal to be expedited if delay would cause serious risk to your health.
    a. **WARNING**: MAP plans sometimes use the wrong notice – MLTC instead of the new MAP notices. This may not be obvious! Call ICAN for problems.
2. "***Appeal Decision Notice***" if appeal is denied, instead of MLTC "Final Adverse Determination" notice. But you *do **not** have to appeal this notice*! The plan must **auto-forward** this notice to the next level of appeal, the Integrated Administrative Hearing Office (IAHO), which, like fair hearings, is run by the NYS OTDA. The IAHO should contact you about the appeal. You can ask for this to be expedited if delay would cause serious risk to your health. This hearing can be by phone or in person (during the pandemic all appeals are by phone). You can ask for a copy of your case file and submit evidence to support your appeal in advance. If the appeal is about a reduction in services, and you had Aid Continuing at the initial level of appeal, Aid Continuing should continue until the hearing is decided.
    a. **WARNING**: in 2021, Healthfirst MAP failed to refer almost 800 appeals for hearings. The State ordered the plan to provide temporary increase in hours to these members, until the next reauthorization or assessment. Read more about this here. http://www.wnylc.com/health/entry/225/. Such mistakes may continue. If a MAP member is not contacted to schedule a hearing after an adverse appeal decision, contact ICAN.
3. Additional Appeals possible – to Appeals Council and Federal Court.
4. Services not covered by FIDE Appeals Process –
    a. Hospital, Skilled Nursing Facility or Home Health Discharges – should receive notices to appeal denial of Medicare coverage to Quality Improvement Organization (QIO) but may be eligible to continue same services under

Medicaid – also from MAP plan. See http://medicarerights.org/fliers/Rights-and-Appeals/MA-Ending-Care-Appeals-Packet.pdf

b. Part D drugs – appeal process same as in MA-PD plans. See http://medicarerights.org/fliers/Rights-and-Appeals/Part-D-Appeals-Packet.pdf.

5. See more about MAP and FIDE appeals at http://www.wnylc.com/health/entry/225/.

WHAT IF A MEMBER NEEDS NURSING HOME CARE – TEMPORARILY OR PERMANENTLY? CHANGES in 2020

The law has been rapidly changing regarding what happens when adult dual eligibles need permanent nursing home placement.

Before 2015, an MLTC member was disenrolled from the MLTC plan once a temporary rehab stay became permanent.

From 2015 through 2020 – any MLTC or mainstream Medicaid managed care member who entered a nursing home remained in their MLTC or mainstream plan. The MLTC plan paid the nursing home to the extent that Medicare did not pay. If the MLTC member was only temporarily in the nursing home, then they returned home and resumed MLTC home care services. Even if the nursing home placement became permanent, the individual still remained in the MLTC plan, and the MLTC plan became responsible for paying the nursing home.

- A Medicare beneficiary who was NOT in an MLTC plan in the community and was admitted to a nursing home for permanent placement, was required to enroll in an MLTC plan once accepted for Institutional Medicaid. Longtime residents were "grandfathered in" and not required to join MLTC plans -- Medicaid continued to pay for their nursing home care fee for service.

WHAT CHANGED in 2020 regarding Nursing Home Care and MLTC?

In late 2019, CMS approved the State's request to remove the long-term Nursing Home benefit from the MLTC service package. It has taken effect in several stages.

1. Early in 2020, nursing home residents who had not previously been enrolled in MLTC plans were no longer assigned to MLTC plans once they were approved for Institutional Medicaid. Their nursing home care was billed Fee for Service.

2. Effective August 1, 2020, 15,561 MLTC members were disenrolled from their MLTC plan if they were in a nursing home for three months *and* were approved for institutional Medicaid. Since then, about 5,000 more MLTC members have been disenrolled in batches. They all received a 10-day notice giving them the right to request a Fair Hearing if they do not want to be disenrolled from the MLTC plan, and to request an assessment to be evaluated for potential return to the community. See the notice posted at http://www.wnylc.com/health/download/722/. If they did not appeal, they were disenrolled from the MLTC plan and their nursing home care is paid by Medicaid fee for service and not by the MLTC plan.

3. Starting in October 2021, responding to consumer advocacy, plans began sending members 30-day advance notice that they would be disenrolled from the plan if they did not request an assessment to return to the community, and giving a heads-up about the 10-day notice with fair hearing rights. Notice at http://www.wnylc.com/download/793/.

4. Going forward, if an MLTC member is placed in a nursing home, whether for temporary rehab or for permanent placement, after 3 months, they will receive a similar 30-day and then 10-day notice that they will be disenrolled from the MLTC plan, if they have been approved for nursing home Medicaid by the local DSS.

5. A member who was disenrolled has the right to re-enroll within 6 months.

Consumer advocates are concerned that these changes will make it more difficult to leave a nursing home for someone who has been disenrolled from their MLTC plan. Now they must go through the NY Independent Assessor and must convince a new MLTC plan to accept them and provide enough hours of care to return home. Also, there is concern that some MLTC plans may steer their higher need members into nursing homes, where they will no longer be responsible to pay the cost of care, instead of paying the cost of high-hour home care at home. Stay tuned for further information, which is expected to be posted as an update to this article - http://www.wnylc.com/health/entry/199/.

The MLTC Housing Disregard - Higher Income Allowed for Nursing Home Residents to Leave the Nursing Home or Adult Home by Enrolling in or Remaining in an MLTC

See Consumer Spend-down Tip No. Four above – pp.15-16.

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

Model MLTC Contract – posted at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/hlth_plans_prov_prof.htm - click on Model Contracts and see partial capitation contract.

NYHEALTHACCESS.org http://wnylc.com/health/entry/114/ (about MLTC)

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

http://www.wnylc.com/health/news/41/ - News on MLTC updated monthly

http://www.wnylc.com/health/entry/184/ - Grievances & Appeals in MLTC

http://www.wnylc.com/health/entry/202/ - Fact Sheets & Webinars on MLTC

State DOH Complaints for MLTC Problems - 1-866-712-7197 or mltctac@health.state.ny.us

Statewide ICAN Ombudsprogram for MLTC and Managed care plans who receive Long Term Care Services. "Independent Consumer Advocacy Network" or ICAN.
http://icannys.org/ 844-614-8800 TTY Relay Service 711 Email ican@cssny.org.

QUESTIONS AND ANSWERS ON MEDICAID

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

   SSI - When someone receives Supplemental Security Income, they do not have to fill out a separate application for Medicaid. Medicaid enrollment is automatic. If SSI is cut off, the recipient should receive a notice asking them to submit a Medicaid renewal form. If they submit the form within the time requested, Medicaid will continue without interruption. This is called the Stenson process. See http://www.wnylc.com/health/entry/85/.

   MAGI Medicaid on the Exchange -- Beginning January 1, 2014, most people who do not have Medicare apply for Medicaid online on the NYS of Health https://nystateofhealth.ny.gov/. This includes those under age 65 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 or a waiver program, or who need Medicaid to cover nursing home care, if they are not in a mainstream Medicaid managed care plan.

   Non-MAGI – Those with Medicare and age 65+ --

- **Application**: All counties must use the Access New York application Form DOH-4220, which can be found at http://www.wnylc.com/health/entry/119/. Those Age 65+, Blind or Disabled must be sure to complete the Supplement A and verify their current assets. (Form DOH-5178A now used statewide – NYC no longer uses a separate form)

  The application form DOH-4220 allows the applicant to designate someone as their representative for the application, renewals and generally to discuss the case with the district. If the applicant cannot sign the application, and it is signed by a representative, though the applicant is required to separately authorize the representative, unless there is a power of attorney or guardianship. If no one was designated as representative in the application, or if the individual wants to change the representative, she signs and submits Form DOH-5247. See GIS 17 MA/017: Introduction to Form DOH-5247 - Medicaid Authorized Representative Designation/Change Request. Form DOH-5247 can be downloaded at http://www.wnylc.com/health/download/655/.

- **WHERE do non-MAGI applicants 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" on NYSoH, and one for a spouse and other family members who have Medicare at their local county Medicaid office.

  DURING THE COVID PANDEMIC: NYC prefers that applications be faxed.

  - 917-639-0732 – e-Fax for Applications generally
  - 917-639-0731 – e-Fax for "authorized submitters" (not for general public)
  - 917-639-0665 – e-Fax for Immediate Need personal care/CDPAP applications

  OUTSIDE OF THE PANDEMIC: In New York City, there are different types of Medicaid offices – but do NOT apply in person at these offices during the pandemic:

  - Dual eligibles applying for Medicaid in order to enroll in MLTC or those seeking "Immediate Need" home care apply at: HCSP Central Medicaid Unit, 785 Atlantic Avenue, 7th Floor, Brooklyn, NY 11238. (File at 1st floor Window 16). "Immediate Need" applications, described fully above, should be e-faxed to **1-917-639-0665**

  - Those EXCLUDED from Managed Long Term Care and seeking "regular" personal care or housekeeping services – (See above – e.g. those who need only Housekeeping services, or those in the Nursing Home Transition, OPWDD or TBI Waivers, or those who do NOT have Medicare and are not in a "mainstream" Medicaid managed care plan, so are not required to enroll in an MLTC plan, or those under age 21, or in hospice care – file Medicaid application and M11q at

    CENTRAL INTAKE -NYC HRA Home Care Services Program
    132 West 125th Street, 5th Floor
    New York, NY 10027 TEL 929-221-8851 FAX 212-666-1747

  - Those not seeking home care apply at these offices https://www1.nyc.gov/site/hra/locations/medicaid-locations.page See http://www.wnylc.com/health/entry/79/ for more information for NYC. New York City residents may call the Human Resources Administration Info line at 311 or (718) 557-1399 for information about how and where to apply for Medicaid. See info on Facilitated Enroller Program for Aged, Blind and Disabled - https://www1.nyc.gov/site/ochia/about/other-initiatives.page

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

NYS Medicaid does not require one to be a citizen or a lawful permanent resident (also known as having a "green card"). NYS 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 http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/08ma009att.pdf (note there is a new page 12 of the Desk Guide – see https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/19ma02_attachment.pdf (the GIS directive explaining this new page is at https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/19ma02.pdf)

NEWS: The "Public Charge" changes announced by the Trump Administration were permanently blocked in March 2021, after extensive litigation. This means that receipt of Medicaid for community-based care will not be evidence that an individual applying to adjust status (apply for a green card) would be a public charge, which could disqualify them for adjusting their status. Medicaid for nursing home care, however, has always been and continues to be a basis for finding an immigrant to be a "public charge." See more at https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge/public-charge-resources and https://protectingimmigrantfamilies.org/.

In 2022, NYS expanded Medicaid to cover undocumented immigrants age 65+ for all services. Undocumented immigrants who receive nursing home Medicaid may need to consult an immigration attorney concerning public charge.

See Immigrant Eligibility Chart by Empire Justice Center and NY Immigration Coalition (11/2021) https://www.nyic.org/our-work/supporting-immigration-services/immigrant-eligibility-for-public-benefits-chart/ and http://wnylc.com/health/entry/33/ and http://www.wnylc.com/health/entry/25/.

Referrals on Immigration Issues–

- New York State New Americans Hotline 212-419-3737 Toll-free 1-800-566-7636 Monday-Friday, from 9:00 a.m. to 8:00 p.m. Saturday-Sunday, 9:00 a.m. to 5:00 p.m.

- New York Immigration Coalition state-wide list of legal resources, https://www.nyic.org/providers/

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 instead enrolled in 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, regardless of whether or not they are Medicare-eligible.

- **Transitioning from the Essential Plan to Medicare -** Transitions from the Essential Plan to Medicare are explained in GIS 16 MA/004.[15] 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 and/or MSP. Those Essential Plan enrollees who are *Aliessa* immigrants (PRUCOL or Qualified Aliens) will be transferred to the LDSS with Fee for Service Medicaid in place while their eligibility for Medicaid is being redetermined. If they are found ineligible, they should receive a notice with the right to appeal and request Aid Continuing pending the hearing.
- If a client age 65+ is ineligible for Medicare, 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 NYSoH between 139-200% FPL.
- Note that Essential Plan income limits will increase from 200 to **250% FP**L later in 2022. Also, Essential Plan will begin covering some long-term care services, so, once this expansion is implemented, adults who need these services will not have to transfer from the Essential Plan to Medicaid.

3. 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 Medicaid. These three months are called retroactive coverage. If bills are due to Medicaid providers for services provided during these 3 months, once Medicaid is approved with a retroactive effective date, give those providers your Medicaid number and they can bill Medicaid. If you paid providers during that period, you can request Medicaid to reimburse you. If you have a spend-down, some of the past bills may be used to meet the spenddown, discussed above, and once the spenddown is met, may be reimbursed. See more information at http://wnylc.com/health/entry/18/.

How to request 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. In Section G of the Medicaid application DOH-4220, answer YES to Question 1, which asks, "Does anyone applying have paid or unpaid medical or prescription bills for this month or the three months before this month?" The form reminds you to send proof of income for the three retroactive months, and also you should send proof of assets for this period as well. Include the bills if you have them. In NYC, HRA will not reimburse you automatically even if you submit the bills with the application. Submission of the bills qualifies you for retroactive coverage. Once Medicaid is approved, then you must submit a request for reimbursement separately. See http://www.wnylc.com/health/entry/18/. This procedure may vary in other districts.

4. 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:

- You live in a border county where residents 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.

[15] Available at http://www.health.ny.gov/health_care/medicaid/publications/index.htm

- 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 (see https://www.emedny.org/info/ProviderEnrollment/index.aspx).

5. Can Medicaid pay for the Medicare premiums for those not in a Medicare Savings Program?

Yes, for people who may not be eligible for the Medicare Savings Programs, the **Medicare Insurance Premium Payment (MIPP) Program may** pay or reimburse the client for the Part B premium. Medicaid will not pay for a Medigap premium.

A. Medicaid Recipients Newly Enrolled in Medicare who are not yet enrolled in an MSP program – see above pp. 25-29. Because of the pandemic, those who have Medicaid on NYSofHealth are not being transitioned to the local districts for redeterminations for non-MAGI Medicaid and MSP. They get Part B premium reimbursed. Even outside of the pandemic, they get Part B premium reimbursed until they are enroll in the MSP.

B. People who have **Medicaid through special budgeting categories** such as **MBI-WPD** – even though their net income above the SLMB level so they would not normally be eligible for MSP. The NYS Medicaid program will reimburse them for the Part B premiums.

Another example in this group are **caretaker relatives with MAGI budgeting**, whose income is above SLMB level (GIS 18 MA/001). If their Medicaid is on NYSOH, they call NYSOH to enroll in MIPP.

C. Consumers whose income is in between the Medicaid limit and the QMB limit. Paying the Part B premium reduces the net income to below the Medicaid level, but with QMB, they would have a small spend down. The consumer should be paid the difference to bring her up to the Medicaid level. See SSA POMS https://secure.ssa.gov/poms.nsf/lnx/0600815001; NYS DOH GIS 15 MA/004, GIS 15 MA/014, GIS 02-MA-019.

To enroll your MBI-WPD or MAGI client in the MIPP program, contact MSP@health.ny.gov with a HIPAA release for the Department of Health, proof of Medicare enrollment, and proof of Medicaid enrollment. Be sure that your client is not eligible for MSP at the SLMB level or QMB level (this disqualifies them for MIPP and the application for MSP must go through HRA/DSS).

See article about MIPP http://www.wnylc.com/health/entry/229/.

6. Should a Medicaid applicant or recipient cancel other health insurance 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 they no longer need 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 people with full Medicaid, since it is duplicate 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, they may be eligible for Medicaid to pay for that premium -- if it is cost-effective for Medicaid to help them 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, which is generally under $400/mo. 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

7. 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 only if you are in the non-MAGI (Disabled, Aged Blind) category, a lien may be put on your real property. However, no lien may be placed if a spouse, a minor or disabled child or certain other relatives reside in the home. However, if you are MAGI, no lien may be placed in this circumstance. NYS DOH GIS 14 MA/16. There are also limits on circumstances under which a validly placed lien may be executed. See an elder law attorney for more information.

Second, Medicaid may recover against your Estate after you die for the cost of medical services paid for by Medicaid on or after your 55th birthday, whether while you were 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, since it will be part of your estate when you die, subject to estate recovery. 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. The rules are complicated, and in some instances a sibling who resided in the home with an equity interest, and a caretaker adult child, may also be protected. See an elder law attorney. See more information at http://wnylc.com/health/entry/96/.

8. What if I have emergency medical needs?

The term “emergency Medicaid” is often misunderstood. “Emergency Medicaid” is the term for the limited Medicaid services for which undocumented immigrants are eligible, if they do not qualify for full Medicaid based on PRUCOL status. This is discussed above at 17-51 - 17-52. And see articles at http://www.wnylc.com/health/entry/70/ (emergency Medicaid) and http://www.wnylc.com/health/entry/33/ (PRUCOL).

Unfortunately, other than the limited “emergency” services for undocumented immigrants, there is no “emergency Medicaid” for general health care services. Someone who already has Medicaid, or who is applying for Medicaid, may request that personal care or CDPAP services be authorized relatively quickly 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. 45.

Apart from Medicaid, New York State and federal law require anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay. See Fact Sheet at https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/. If an emergency patient is uninsured, the hospital will generally screen patient for Medicaid eligibility and submit a Medicaid application if you appear to be eligible.

If you have applied for Medicaid but it has not yet been approved, if a Medicaid provider is willing to treat you while your Medicaid application is pending, the provider can bill Medicaid later, retroactively, for the care s/he provided while the Medicaid application is pending and during the three months before the month in which you applied for Medicaid. You must request this retroactive eligibility when you apply. See Question 4 above for how to request retroactive eligibility.

Sources of Assistance

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

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

Medicare Hotline **1-800-MEDICAR(E)**
1-800-633-4227

NY Connects **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 Health@empirejustice.org or 1-800-724-0490 x 5822
- The Legal Aid Society – Benefits Hotline 1-888-663-6880
- Medicare Rights Center HIICAP Hotline 1-800-480-2060
- NYLAG Evelyn Frank Legal Resources Program eflrp@nylag.org or 1-212-613-7310
- New York StateWide Senior Action Council www.nysenior.org 1-800-333-4374

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

Statewide Hotline **1-844-614-8800**
TTY Relay Service: 711 Website: icannys.org ican@cssny.org

Facilitated Enrollment Program for the Aged, Blind or Disabled

- https://www.cssny.org/programs/entry/fe-abd - contacts in **38 upstate counties**
- https://www.healthsolutions.org/community-work/health-insurance/aged-blind-disabled/ - **All New York City** **1-800-544 8269**

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