MODULE 17: MEDICAID

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

For Medicare beneficiaries, Medicaid can:

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

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

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

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

What is Medicaid?
A program designed to provide health care for low-income individuals and families. Financial eligibility is defined in terms of income and resources. The rules for financial eligibility are different depending on one's age (under 65 or age 65+), whether one has a disability, or has high medical bills. The Affordable Care Act that became effective January 2014 heightened the differences between the Medicaid eligibility rules for those receiving Medicare and those who do not.

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

MEDICAID

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

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

Medicaid is administered by the states and financed jointly by the states and the federal government. Federal law requires each state to provide a minimum benefit package that includes hospital inpatient and outpatient services, physician services, skilled nursing, home care, laboratory and X-ray services, health screening follow-up services for children under 21, nurse-midwife services, family planning services, rural health clinic services and transportation for medical care for those who cannot travel by public transportation.

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

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

The New York State Department of Health (DOH) oversees the state’s Medicaid program. Each county administers its own local Medicaid program through the County Department of Social Services (DSS). Until January 1, 2014, local DSS offices determined whether every person applying for Medicaid and/or a Medicare Savings Program was eligible, and authorized coverage. In 2014, the State DOH took over the function of processing Medicaid applications and determining eligibility for certain applicants – those who do not have Medicare -- who now apply for Medicaid on the New York State of Health online Exchange or “Marketplace.” Medicare beneficiaries still apply for Medicaid and the Medicare Savings Program at their local DSS.
The DOH Medical Assistance Reference Guide, used by all local districts to explain the eligibility rules, is available online at [https://www.health.ny.gov/health_care/medicaid/reference/mrg/](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 government program that provides health insurance for individuals who are disabled, as well as for individuals who are 65 or older. Medicare is available for persons of any income level. Medicare coverage is the same in every state in the country.

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

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

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO: Health insurance for individuals age 65 and older or disabled for 2 years or end stage renal disease;</td>
<td>WHO: Health insurance for individuals of any age.</td>
</tr>
<tr>
<td>INCOME TEST? No.</td>
<td>INCOME TEST? Yes for all, and for Dual Eligibles, low resources.</td>
</tr>
<tr>
<td>Federal program: federal administration and funding, contractor implementation.</td>
<td>Cooperative program: federal, state and county funding, state administration, and county implementation.</td>
</tr>
<tr>
<td>NATIONAL? Uniform in all states.</td>
<td>Medicaid programs vary by state, with some minimum federal standards.</td>
</tr>
<tr>
<td>COST for Participants: Premiums, deductibles, and coinsurance.</td>
<td>COST: Co-payments vary by state, and a monthly “spend-down” if income exceeds the Medicaid limits.</td>
</tr>
<tr>
<td>Benefits are limited: hospital, medical, limited preventive and very limited long-term care. Generally, dental care, eyeglasses, transportation, and most long-term care are not covered.</td>
<td>Benefits are comprehensive: hospital, long-term care, dental care, transportation, additional health care services and supplies. Amount &amp; scope of benefits varies by state.</td>
</tr>
<tr>
<td>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.</td>
<td>Eligibility is based on financial need. For most people over 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.</td>
</tr>
<tr>
<td>Immigration status: U.S. citizen, or legal</td>
<td>Immigration status: In addition to citizens</td>
</tr>
</tbody>
</table>
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 for two years, may question why they would need Medicaid as well. Substantial gaps in Medicare coverage may leave an individual financially liable for medical costs they can’t afford. Medicare and Medicaid can work together to pay health care costs for low-income senior and disabled Americans. Medicare will pay first. Medicaid will then cover many, often all, of the costs not covered by Medicare. People with both Medicare and Medicaid are called “Dual Eligibles.” These Medicare gaps include:

1. **Medicare deductibles, coinsurance and premiums** - Part A hospital deductible, hospital coinsurance, the cost of days in the hospital if Medicare coverage runs out, a Medicare Part B medical deductible every year, 20 percent of Medicare’s approved amount for doctors’ services, and the monthly Medicare Part B premium. **Medicaid may pay all of these costs as “secondary 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 17-51 about the Medicare Insurance Payment Program (MIPP)).**

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

   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)(ii), as amended 2015. The provider is prohibited from balance billing the individual as a Medicaid or QMB beneficiary.

      a. **Exceptions - Medicaid/QMB will pay the full 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 only $80 or less, Medicaid would pay nothing, as it would consider the doctor fully paid.**

   2. **Medicare Advantage** – Medicaid will pay 85% of the 20% coinsurance or co-payment charged by the Medicare Advantage plan. This payment will be made regardless of the Medicaid rate for this service, unlike Original Medicare. NY Social Services Law 367-a, subd. 1(d)(iv), added 2016.
a. **Exceptions:** Medicaid/QMB will pay the full coinsurance for ambulance and psychologist. 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 provider is getting $192.50 of the $200 approved rate, provider will hopefully not be deterred from serving Mary or other QMBs/Medicaid recipients.

(2) **Services that Medicare generally does not pay for** - long-term care (home care or nursing home), eyeglasses, hearing aids, dental care, medical supplies. *Medicaid may pay for these services, if services are provided by a Medicaid provider, subject to limitations set by the State. Home care has special requirements discussed below.*

(3) **Part D - Medicaid is a pathway to Extra Help**, the subsidy that makes Part D affordable. If a Medicare beneficiary qualifies for Medicaid in just one month in an entire calendar year, s/he automatically receives Extra Help for the rest of that calendar year. And if the one-month of Medicaid eligibility is in the second half of the calendar year, Extra Help eligibility even extends to the entire following calendar year.

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

**Caution –Does Provider accept Medicaid?** If doctor is not a Medicaid provider, the 20 percent coinsurance of Medicare’s approved amount may be client’s responsibility unless the client is also a QMB Beneficiary. A Medicare provider is not required to accept Medicaid. However, if client is enrolled in the QMB Medicare Savings Program, the provider may not bill the client for the coinsurance, even though Medicaid will not pay it either if the provider does not accept Medicaid. See below at 17-14 and 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. 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 of the HIICAP Notebook.)

1 See discussion on Qualified Medicare Beneficiary balance billing below at 17-14- 17-15.
In 2017-2018, New York State moved to enforce this requirement more strictly, discontinuing Medicaid for recipients over age 65 who did not show that they had applied for Medicare. When advocates protested that many elderly Medicaid recipients were having Medicaid 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.wnyc.com/health/entry/185/.

ELIGIBILITY FOR MEDICAID

When would an individual qualify for Medicaid?

Medicaid financial eligibility rules are different for different categories of people. The rules changed significantly in 2014 when the Affordable Care Act expanded Medicaid eligibility for most people who do not have Medicare – most people under age 65 and seniors who do not have Medicare. It is important to identify which of these categories the individual is in:

1. MAGI CATEGORY – (Modified Adjusted Gross Income) – This is the eligibility category that started in 2014 under the Affordable Care Act and applies to most people under age 65 not receiving Medicare. They may be receiving Social Security early retirement benefits or disability benefits and, if disabled, be in the 2-year Medicare waiting period. Some Medicare recipients may CHOOSE to be MAGI or non-MAGI, both those under and over age 65, if they live with and take care of a child, grandchild, or other relative under age 18 (under 19 if full-time student). Also people under 65 who are disabled but not yet on Medicare may choose, as well as disabled children. See p. 17-21 for tips for making choice.

   1. MAGI Features:
      - Higher income limits – 138% Federal Poverty Level for most adults, with higher limits for pregnant women and children.
      - 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 disability. The only exception to this is if they turn age 65 during the 12 months. Then their Medicaid case is referred by the Marketplace to LDSS to redetermine eligibility under non-MAGI rules.
      - 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 or the “Marketplace” (though a small group of people, including those seeking to enroll in Managed Long Term Care or who need nursing home care, must apply at the LDSS)
2. **Essential Plan** – New plan that began in 2016 for adults between age 19 - 65 that covers the same benefits as Medicaid except for no long-term care. For individuals who would be in the MAGI category who:

- Have income that is too high -- Income above 138% FPL and below 200% FPL, or
- Are immigrants whose income is below 138% FPL but whose immigration status is either PRUCOL or subject to the 5-year bar on federal law. See more at p. 17-49.

**COSTS:** Essential plan is free for those under 150% FPL. Above that limit, $20 monthly premium and copayments charged for most services, and extra premium for dental and vision coverage. Even with the costs for those above 150% FPL, Essential Plan is much less expensive than their alternative of purchasing a private Qualified Health Plan on the Marketplace using Cost Sharing Subsidies and Advance Premium Tax Credit.

**EXAMPLE** of who could benefit for ESSENTIAL PLAN: Mary age 54 was approved for Social Security Disability of $1800/month. She will not receive Medicare for two years. She does not need home care or other long-term care benefits. Her income is above the regular MAGI limit but is below 200% FPL. Until she is 65 or becomes enrolled in Medicare, she may choose the Essential Plan with only a $20/month premium. This is much more affordable than Medicaid as she would have a high spend-down over $900/mo. Note that if she was able to work a nominal amount, she could also consider the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) discussed below. If she needed home care, she would have to choose Medicaid and use either MBI-WPD or a pooled trust.

For more info see [https://info.nystateofhealth.ny.gov/EssentialPlan](https://info.nystateofhealth.ny.gov/EssentialPlan)

2. **NON-MAGI** – “Regular Medicaid” under pre-ACA rules. Applies to everyone else, who still use the old Medicaid income and resource limits, including:

1. **“Disabled, Aged, Blind” (DAB)** – This is the main non-MAGI category, which includes all people age 65+ or under age 65 but disabled or blind. Most but not all of these people have Medicare. This is most HIICAP clients, but not all. Within this category are numerous subgroups with different budgeting rules:

   - “Regular” DAB Medicaid with low income and resource levels – see more below.
   - Medicaid Buy-In for Working People with Disabilities (under age 65 only)(subgroup with higher income and asset limits than regular “DAB” individuals)
   - 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 better than non-MAGI budgeting.

2. **Other non-MAGI** categories – a few small eligibility groups use non-MAGI if they do not qualify under MAGI rules first - Medicaid Cancer Treatment Program (MCTP) for Breast, Cervical or Prostate Cancer, adult home residents, those seeking
Medicaid subsidy for COBRA premium, Disabled Adult Children (disabled before age 22) etc.

3. NON-MAGI Features:
   - Use income limits that existed before Affordable Care Act, which for Medicare beneficiaries are much lower than the new ACA income limits. Unlike MAGI limits, DAB has “spend-down” allowing people to spend-down to the income limits if their income is over.
   - Asset test – same as existed before the ACA
   - Application filed at local DSS, not online
   - Different rules for Institutional Medicaid (nursing home) than for community, with penalties on transfers of assets solely for Nursing Home Medicaid.

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

These individuals may qualify for Medicaid if their income and resources are very low. People receiving Supplemental Security Income (SSI) are automatically eligible, but people not eligible for SSI because they have higher income or resources may also be eligible. They are sometimes called “SSI-Related” because they are in the same category as SSI recipients – Age 65+, disabled or blind – but have more income or assets than SSI allows.

**RESOURCES - for Aged, Disabled or Blind (DAB)**

- **A resource** is property of any kind. A resource may be “liquid” such as bank accounts, or property that can readily be converted to cash. It may be “non-liquid,” meaning that it may not be easily or quickly converted to cash, such as stocks. Resources include both real and personal property, and tangible as well as intangible property.
- **Cash or liquid resources** include bank accounts, CDs, property, cash value of most life insurance, stocks, bonds, etc. In 2019, resource maximums increased compared to 2018-an individual may have resources that total:

**Resource (Assets) Limit**

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Age 65+, Disabled or Blind &lt; 65 Not Working</th>
<th>Disabled or Blind &lt; 65 Working (MBI-WPD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>$15,450</td>
<td>$20,000</td>
</tr>
<tr>
<td>Two (married)</td>
<td>$22,800</td>
<td>$30,000</td>
</tr>
</tbody>
</table>


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

- the value of one’s **home** and contiguous property (including multiple-family dwellings),
  - If the equity in the home is more than $878,000, client is not eligible for Medicaid home care services unless she/he lives in the home with a spouse or disabled or minor child (under age 21) (2019 limit).
Though the home is exempt, Medicaid may in some cases place a lien on the home if s/he later enters a nursing home on a permanent basis. No lien may be placed if a spouse, child under 21, a certified blind or disabled child of any age, or sibling with an equity interest in the home and who resided in the home for at least one year immediately before the date of admission to the nursing home, is lawfully residing in the home.

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 a spouse, minor or disabled child or certain other relatives lives in the home. 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;
- IRA’s – IRA’s are treated differently depending on client’s age and, if under 65, whether she is disabled and working, even a minimal amount. Generally, the client should not have to cash in the IRA to qualify for Medicaid. The three situations are:
  i. **Age 65+ OR under 65 and disabled or blind**
     The applicant or recipient does not have to cash in their IRA, as long as s/he takes regular distributions from the IRA on a periodic basis (monthly, quarterly or annually). In other words, the IRA of an applicant who is age 65+, or < 65 and disabled or blind, is exempt as a resource, as long as the IRA is in distribution status, meaning that the individual is taking distributions from the IRA according to IRS distribution tables. These distributions are counted as income, but the principal balance of the IRA is not counted as a resource.
     i. **What about the tax penalty for early withdrawals?** While the IRS only requires these distributions for people over age 70-1/2, people may take withdrawals after age 59-1/2, paying income taxes but no penalty. The IRS waives any tax penalties for distributions before age 59-1/2 if the individual is disabled.
     ii. **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; MRG p. 316. However, the spouse’s IRA may count toward the Community Spouse Resource Allowance (CSRA) if the applicant is seeking institutional Medicaid for nursing home care.
  ii. **Under age 65, disabled and working** – consider Medicaid Buy-In for Working People with Disabilities. (MBI-WPD). Since October 1, 2011, IRAs are totally exempt for this group even if the recipient is not taking distributions. Recipient not required to take distributions. See more on this program below.

i. The distributions from the IRA count as 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 it is not required 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 account from their other savings. As long as 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 on the amount. See http://wnylc.com/health/entry/36/ for guide to funeral planning for Medicaid recipients (updated June 2015). Note that funeral agreements can be set up for client’s spouse, children and some other designated relatives.

   - Holocaust reparations are not counted. See http://wnylc.com/health/entry/65/

   - ABLE accounts – see https://www.mynyable.org/. Since 2017, those who were certified disabled before age 26 may receive SSI and/or Medicaid and accumulate up to a total $100,000 in gifts from donors or their own contributions. All contributions from all sources must together be under the annual gift tax exclusion ($15,000 in 2019).

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

   - Income means any payment from any source. It includes not only payments of money, but also “payments” in goods and services. Income can be a payment made on a one-time basis or on a recurring basis. Income can be earned, such as compensation received as a

---

result of working, such as wages, tips, bonuses, and commissions. Income can also be unearned, such as dividends, interest, pension benefits, or cash gifts.

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

- **Deductions** from gross income include:
  - $20 per month per individual or couple (as shown in income chart below, this effectively raises income limit by $20/month)
  - Medical insurance premiums - Part B, Part D, Medicare Supplement (Medigap) Insurance, employment or retiree health insurance premiums. But once enrolled in Medicare Savings Program or Medicaid, since those programs will pay for the Part B premium and all or part of the Part D premium through Extra Help, may not deduct the premium to the extent subsidized.
  - Earned income deductions - If Aged/Disabled/Blind beneficiary or his/her spouse is working, the first $65 of monthly gross earned income, and half of the remaining monthly gross earned income, is disregarded. This is an incentive to work.
  - The first $90 per month of any income received from a non-family roomer or boarder is deducted.

- **Excluded income** – not counted for Medicaid includes:
  - Holocaust reparations
  - Federal energy assistance payments;
  - Food stamp coupons (SNAP)
  - VA benefits but only if for Aid & Attendance
  - **In-kind income** – If anyone other than a “legally responsible” relative pays the client’s expenses directly to the vendor, such as paying rent directly to the landlord, or paying an electric bill directly, this “in-kind” income is not counted. Children are never legally responsible for their parents. Parents are never legally responsible for children over age 21. If the money is given to the client directly, however, this is a gift of cash and is countable income.

- Retroactive benefits under the SSI program are disregarded for 9 months, and tax refunds and some other types of income have time-limited disregards, giving the client time to spend them down to the Medicaid resource limit;
  - Other less common deductions and exclusions are listed in 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.
**2019 Income Limits for Age 65+, Disabled or Blind who have Medicare (non-MAGI)**

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>$859 ($879 if age 65+, disabled, blind – after $20 disregard)</td>
</tr>
<tr>
<td>Two (married)</td>
<td>$1,267 ($1287 if age 65+, disabled, blind – after $20 disregard)</td>
</tr>
</tbody>
</table>

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

- **Consumer Tip One – Spousal Impoverishment Protections**
  
  If a married individual is applying for Medicaid because s/he needs Medicaid home care services, and if his/her spouse does NOT need Medicaid or home care, the applicant can benefit by using “spousal impoverishment protections.” 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 her own income and enough of the applicant spouse’s income to total $3,160.50/month (and up to $74,820 of individual and joint assets or half of their individual and joint assets up to $126,420)(2019). The applicant spouse also keeps an allowance of $408.00.
  
  - 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. It is “post-eligibility.” 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 Medicaid agency to revise the budget. These protections will eliminate any “spend-down” in many cases.

    - 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](https://www.health.ny.gov/health_care/medicaid/publications/pub2016adm.htm).


• For more information on Spousal Impoverishment and links to state directives see this article [http://www.wnyc.com/health/entry/165/]. The State DOH form to request spousal budgeting is at page 9 of this link - [http://www.health.ny.gov/health_care/medicaid/program/update/2014/mar14_mu.pdf]

• **Consumer Tip Two – Spousal Refusal:**
A married applicant who does not need Managed Long Term Care may not reduce excess income by using Spousal Impoverishment Protections. Spousal refusal may help. If only one spouse needs Medicaid, she/he may apply alone, and indicate that the non-applying spouse fails or refuses to contribute his/her income toward the medical bills of the applicant. Medicaid must only count the applicant’s income and resources. The county has the right to sue the “refusing spouse” for support. Find out the policy in your county for determining which spouses are likely to be sued. Form used for spousal refusal in NYC can be downloaded here -- [http://www.wnyc.com/health/download/66/].

**Note:** Not everyone may use spousal refusal. People Age 65+, Disabled or Blind may use spousal refusal, as may people under 65 who take care of and live with a child, grandchild, or other relative, 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.

• **Consumer Tip Three – Medicaid Buy-In for Working People with Disabilities (MBI-WPD):**
People over age 16 and under [age 65](#) who are disabled may qualify for Medicaid even if they have incomes higher than the limits above, if they are working. They do not have to work any minimum amount - it can be just an hour a month, as long as they are paid for their work, or self-employed. In 2019, gross income may be as high as $63,492 for an individual and over $85,572 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 $2,603 (single) and $3,523 (couple) (2019). Resource limits are $20,000 for single and $30,000 for couple. IRA’s do not count for this program and do not have to be put in pay-out status.

For more information see [www.nymakesworkpay.org](http://www.nymakesworkpay.org) and [https://www.health.ny.gov/health_care/medicaid/program/buy_in/index.htm](https://www.health.ny.gov/health_care/medicaid/program/buy_in/index.htm)

• **Consumer Tip Four – Nursing Home or Adult Home Transition Shelter Allowance**<sup>6</sup> - Reduces Spend-down

If an individual has been in a nursing home or adult home for at least 30 days, and Medicaid paid for at least part of the stay, if they enroll in or remain in an MLTC plan to be discharged back to the community, then they are allowed to keep more income, reducing or eliminating their spend-down. The chart below shows how much extra

---


<sup>7</sup> In 2018, eligibility for this special housing standard 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](https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/18ma012.pdf)
income they can keep in addition to the regular Medicaid limit ($859 for single). Please note that if the individual is married and takes advantage of “spousal impoverishment budgeting” (Consumer Tip One above), then they may not also use this extra income deduction.

<table>
<thead>
<tr>
<th>Region</th>
<th>Counties</th>
<th>Deduction$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins</td>
<td>$412</td>
</tr>
<tr>
<td>Long Island</td>
<td>Nassau, Suffolk</td>
<td>$1,269</td>
</tr>
<tr>
<td>NYC</td>
<td>Bronx, Kings, Manhattan, Queens, Richmond</td>
<td>$1,300</td>
</tr>
<tr>
<td>North Metropolitan</td>
<td>Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester</td>
<td>$930</td>
</tr>
<tr>
<td>Rochester</td>
<td>Chemung, Livingston, Monroe, Ontario, Schuylere, Seneca, Steuben, Wayne, Yates</td>
<td>$419</td>
</tr>
<tr>
<td>Western</td>
<td>Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming</td>
<td>$360</td>
</tr>
</tbody>
</table>

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

If an individual is enrolled in QMB, Medicaid will pay the Medicare deductibles, coinsurance and copayments even if the individual is not also enrolled in Medicaid, if the provider is a Medicaid provider. This is true whether Medicare is through Original Medicare or Medicare Advantage. Since QMB has higher income limits than Medicaid (Single $1,041 vs. $859 per month), and no asset test, QMB enrollment can accomplish a main goal of Medicaid for many people who would have a spend-down for Medicaid. QMB subsidizes Medicare out of pocket costs, including Part A and B deductibles and coinsurance and Part D by automatically qualifying you for Extra Help. The only benefits QMB will not help with are services only paid by Medicaid, and not Medicare, such as dental care and routine vision care, eyeglasses, hearing aids, long-term care, etc.

- Note that Medicaid will pay the Part A and Part B coinsurance only if a provider is enrolled as a Medicaid provider. But even providers who only accept Medicare and not Medicaid may not bill QMB enrollees for the out-of-pocket costs.
- Since, 2017 CMS has been improving ways that QMB beneficiaries can be identified as QMB’s to providers, so the provider knows not to balance bill them. It should be on 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.

---

$Figures are for 2019 - N.Y. Dep’t of Health, General Information System Message:

Since 2017, the Medicare & You Handbook has included a discussion of QMB payment protections and directs beneficiaries to contact 1-800-MEDICARE to report problems. See pages 53 and 86 of the Medicare & You Handbook (2019) \url{https://www.medicare.gov/sites/default/files/2019-05/10050-Medicare-and-You.pdf}. The Customer Service Representatives (CSRs) 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 \url{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 \url{https://www.cms.gov/Medicare/HealthPlans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf}

In January 2017, the Consumer Finance Protection Bureau issued a guide to QMB billing, available at \url{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. If an individual’s hospital and medical bills are high enough to reduce their income or resources to the Medicaid qualifying level, they may be able to enroll in the Medicaid Spend-down Program. In 2010, the State Dept. of Health improved its online information about spend-down rules, posted at \url{https://www.health.ny.gov/health_care/medicaid/excess_income.htm}

- **The spend-down amount is the difference between their income and/or resources and the Medicaid limit.** Assuming resources are within the Medicaid limits, if a single person aged 65 has a total net monthly income, after deductions, of $929 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 $859 (2019), and there is a $20 disregard. Medical bills are applied to meet the spend-down only if they are not covered by any third party, such as private health insurance or Medicare. Also the individual has the option of choosing to “pay-in” his or her spend-down directly to the Local Department of Social Services.

- **Only Age 65+, Disabled or Blind and families living with minor children under 21 may use spenddown.** People between age 21 - 65 who have no relative under age 21 living with them and who are not disabled may not use spend-down. This is the
population that now has MAGI Medicaid (see next section) with increased income limits at 138% of the Federal Poverty Line.

- **If individuals have to spend down their resources**, their medical expenses will be applied first to their excess resources. They only need to meet the resource spend-down once. After that, they are eligible for Medicaid with no resource spend-down, but medical bills used to offset excess resources cannot also be used to meet an income spend-down. Once individuals accumulate bills equal to their spend-down amount, their Medicaid coverage will begin and Medicaid will pay for additional medical expenses to Medicaid providers. Medicaid will not cover the bills used to meet the spend-down. The individual will be responsible for those payments.

- **Important Note**: Medical bills do not have to be paid to count toward the spend-down. Bills only need to be incurred (and not covered by any other third party). The Medicaid office may not demand proof that the medical bill was paid. This does not change the fact that the client is responsible for the payments.

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

A. Medicare and private health insurance **deductibles and coinsurance** or co-payments, including Part D.

B. **Bills for medically necessary services**, including doctor, dental and therapy bills (they do not have to be Medicaid providers), lab tests, transportation to medical appointments, hearing aids, eyeglasses, medical supplies, prescription and over-the-counter medications. May use bills for services not covered by Medicaid, such as chiropractors.
   - Bills may be paid or unpaid (so long as they remain viable, which is generally for six years – the time a provider has to bring a legal collection action).

C. **The costs paid by EPIC or ADAP** for prescriptions, **plus** the EPIC copayments and deductibles paid by the EPIC member, can be used to meet the spenddown. To find out how much EPIC or ADAP have paid, call EPIC 1-800-332-3742 or ADAP 1-800-542-2437. Ask for a statement of all costs paid by EPIC and the EPIC member in the three calendar months before the month client is applying for Medicaid.

D. Bills listed above for the **spouse**, as well as the applicant, may be used.

- **Using Past Medical Bills to Meet the Spenddown**
  When one first enrolls in the Medicaid spenddown program, one may submit past medical bills to be counted toward the current spenddown amount. Once a bill is used to meet the spenddown for a particular month, the bill cannot be used again. **Past paid medical bills** may be used for medical services that were provided and paid for within the three calendar months before the month one applied for Medicaid with a spenddown. They may be used to meet the spenddown for up to six months beginning in the month one applies. (One may opt to begin the six-month maximum period retroactively, up to three months before one applied, if one wants “retroactive coverage” for Medicaid to pay recent medical bills). These rules are now explained on the State Medicaid website at [https://www.health.ny.gov/health_care/medicaid/excess_income.htm](https://www.health.ny.gov/health_care/medicaid/excess_income.htm)
  - Bills paid by **EPIC** or ADAP in the three months before the month in which you applied for Medicaid may be used to meet your spenddown.
  - **EXAMPLE 1**: Ann paid her dental bill in June for dental care provided in May. She applies for Medicaid in August. She may use the paid dental bill toward her...
spenddown in August, since the service was provided and paid for within 3 calendar months before the month in which she applied.

- **EXAMPLE 2:** EPIC paid $250 for Henry’s prescriptions, and he paid $60 in co-payments for them, between July 1st and October 1st. He applied for Medicaid in October. Since the prescription costs were incurred in the 3 calendar months before he applied for Medicaid, these costs can be applied to meet his spenddown. His monthly spenddown is $50. The total of $310 that Henry and EPIC paid for his prescriptions can meet his spenddown for six months beginning in October. If he submits 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 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 $1600/month, which exceed the limit for the Medicare Savings Programs as well as for Full and Partial Extra Help for Part D. She comes to you in September, after falling into the doughnut hole in August. Her prescriptions cost $1000/month. She is too young for EPIC, and is not eligible for MAGI Medicaid because she has Medicare (and too much income).

Her Medicaid spenddown is $721/month ($1600 - $20 - $859 = $721), which she cannot afford to pay with her rent and other living expenses. Her resources are under the Medicaid limit of $15,450 (2019). You ask her if she has any old medical bills -- she has an old hospital bill from 3 years ago of $2200, 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 $2200, 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.

**If 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, if they follow the complex rules. People over age 65 may only use a pooled trust.

**Disability Requirement:** People under age 65 who use these trusts usually have Social Security Disability income, which is sufficient proof that they are disabled. People over age 65 receive retirement benefits, rather than disability benefits, from Social Security. Medicaid requires proof that they are disabled - on specific state 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/entry2/](http://wnylc.com/health/entry2/), with
GROUP 2: MAGI Medicaid – The New Expanded Medicaid under Affordable Care Act

For individuals who are under 65 and not receiving Medicare, with exceptions that they may be MAGI even if over 65 and even if receiving Medicare at any age if they live with and care for a minor child or relative under age 18, or under age 19 if in school. In MAGI they have:

A. NO RESOURCE LIMIT

There is no limit on resources for MAGI Medicaid. If their resources generate interest and dividends, this interest counts as income. For this category, there is no spenddown permitted - either they meet the income limits or they don’t. So, as a practical matter, there is a limit on resources if one’s savings generate too much interest or dividends.

B. INCOME

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

2019 MAGI Income Limits

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

<table>
<thead>
<tr>
<th>Household Size</th>
<th>Monthly income Gross= 138% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>$1,437</td>
</tr>
<tr>
<td>Two</td>
<td>$1,945</td>
</tr>
</tbody>
</table>

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

- NO $20/month deduction from income.
- NO deduction for health insurance premiums
- NO deduction from earned income, in contrast to disregard of over HALF of all earned income for Disabled, Aged, Blind Medicaid.

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

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

MAGI uses a tax filing unit, with limited exceptions. Household income is redefined for the MAGI group to include the income of all members of the tax filing household, with some exceptions for members who are not required to file tax returns. These rules are very complicated, and not fully explained here. As an example of how the rules impact people over age 60, Uncle Matt, age 63 and not receiving Medicare, lives with his niece, Mary, and her husband and 2 children. Mary and her husband claim Uncle Matt as a tax dependent because he is the type of relative who can be counted as a dependent under the tax law, he lives with them, his income is under $3900/year, and they provide more than half of his support. As their dependent, when Mary and her husband apply for Medicaid for their family, they must include Uncle Matt’s income in their household income, but also benefit from the increased family size. However, Matt is allowed to apply for MAGI Medicaid on his own as a Household of One, even though he is counted as their dependent. This is a special Multi-Generation Household Size rule. This allows Matt to qualify for Medicaid without having to count the income of his niece and her husband. For a full explanation of these complicated rules see: NYS DOH 13ADM-03 - Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010 –download at http://www.health.ny.gov/health_care/medicaid/publications/pub2013ad.htm and see more info at 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/

WHAT INCOME IS COUNTED?

Gross income counted for MAGI includes:

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

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

- Veteran’s benefits – NOT COUNTED – both disability and pension
- Child support received
- Gifts, inheritances, and lump sums (lawsuit settlements that are not taxable are not counted as income, whether lump sums or structured settlements)(Note some lawsuit settlements ARE taxable)
- American Indian income
- Worker’s Compensation
DEDUCTIONS from income:

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

SPECIAL MAGI FEATURES –

- are eligible for ALL Medicaid benefits including long term care – both home care and nursing home care. Note, however, that for a MAGI Medicaid recipient seeking nursing home care or to enroll in an MLTC plan or waiver program, the administration of the Medicaid case will be transferred from the NYS of Health to the local district. However, eligibility is still based on MAGI eligibility.

- have 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 based on increased income. Exception to continuous eligibility: If the MAGI recipient reaches age 65 during the 12 months, then MAGI ends at age 65. Continuous 12-month eligibility continues even if disabled person becomes enrolled in Medicare.

- apply for Medicaid on the online Exchange NYS of Health, not at Medicaid offices (with exception of people needing managed long term care or nursing home care).

SOME PEOPLE MAY CHOOSE MAGI or NON-MAGI BUDGETING:

- If individual is disabled under age 65, she may choose MAGI or non-MAGI budgeting, but only if she is not yet receiving Medicare. Once she receives Medicare, she may not use MAGI budgeting UNLESS she lives with and cares for her child, grandchild or other relative under age 18 (19 if student). EXCEPTION: If she is still within 12-month continuous eligibility period when she enrolls in Medicare, the continuous eligibility continues until the end of the 12 months.

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

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

- TIPS FOR MAKING CHOICE -- PRO’s of MAGI BUDGETING--

  - Higher income limit - 138% FPL vs. 87% FPL = $1437 vs. $859/month

---

Workers comp, VA benefits, child support, inheritances, gifts not counted

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 $15,450 (2019).

• CON’s FOR MAGI -
  
  If disabled person is working at any age even 65+, traditional “DAB” 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)

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

  Can’t use MAGI if you have Medicare, unless you live with your child/relative <18 or < 19 if in school

• NEW CHOICES in 2016 FOR PEOPLE UNDER AGE 65 with income > 138% FPL so not eligible for non-MAGI Medicaid, and client is disabled but does not have Medicare – Choose between:

  1. If does not need long term care, eligible for the ESSENTIAL PLAN if income < 200% FPL.

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

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

  4. Qualified Health Plan on Marketplace with premium and cost-sharing subsidies – but no long-term care on Exchange

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

When an individual who is enrolled in MAGI Medicaid through the Marketplace becomes eligible for Medicare due to turning age 65 or receiving SS disability for 2 years, they should expect their Medicaid through the Marketplace to end and their case to be transferred from the Marketplace to their Local Department of Social Services (LDSS), which re-determines eligibility for NON-MAGI Medicaid. In addition to 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 onto Medicare at age 65, or became enrolled in Medicare after 24 months on Social Security Disability.

- **MAGI Medicaid Enrollee Turning 65**
  In the month that a MAGI Medicaid enrollee turns 65, they should expect to be disenrolled from their Medicaid Managed Care plan and the Marketplace 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. This transitional period of Fee for Service coverage will last up to four months (outside NYC) or five months (in NYC), counting the month of transition as the first month. It could be shorter if your Local DSS specifies an earlier date on the application. To determine when Fee for Service coverage ends, call your Local DSS. Note that the 12 months of continuous MAGI eligibility is cut off when the individual turns 65. NYS DOH GIS 15 MA/022 - Continuous Coverage for MAGI Individuals (12/2015). During this transition individuals can call the Marketplace 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).

When the LDSS determines eligibility for non-MAGI Medicaid, it should also determine eligibility for a Medicare Savings Program.

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

When an individual enrolled in MAGI Medicaid starts to receive Medicare due to their Social Security disability payments, they should expect to be disenrolled from their Medicaid Managed Care plan. Unlike those turning 65, they will continue to have Fee for Service MAGI Medicaid in the Marketplace through the end of their 12 month continuous care period. They can call the Marketplace 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).

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

The LDSS should also determine eligibility for a Medicare Savings Program. Until that determination is made, the NYS DOH should continue reimbursing them for their Part B premiums.
• **Extra Transition Issue for MAGI Medicaid recipients who received Medicaid personal care or other home care services from their “mainstream” Medicaid managed care plan.** As said above, they will be disenrolled from their mainstream managed care plan once they start receiving Medicare. Once they are disenrolled, the plan would stop providing home care services. To prevent that from happening, these individuals should be assigned to an MLTC plan if they do not select one after being given notice of the opportunity to do so. See [MLTC Policy 15.02: Transition of Medicaid Managed Care to MLTC](https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf). This should ensure a seamless transition to an MLTC plan to continue the home care services. While people who “disable” onto Medicare should also be transitioned to an MLTC plan, the procedure does not work well for them, and requires pro-active advocacy.

  o These cases require troubleshooting. If an individual is becoming eligible for Medicare and was receiving home care from a managed care plan, be proactive and ensure that they enroll in an MLTC plan immediately. Make sure the new MLTC plan continues the same services provided before by the mainstream plan.

  o If there is a problem, call ICAN. (Independent Consumer Advocacy Network) 1-844-614-8800

---

**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** can wrap around Medicare coverage and pay many of the costs Medicare does not pay. However, Medicaid 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. 17-04 and 17-05 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. See [http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf](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-1, and QDWI programs are part of the public safety net.**

---

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

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

**Eligibility for community-based services, 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, described above, makes it possible for many seniors and people with disabilities to qualify for Medicaid coverage of long-term care needs.

- **No transfer penalty for community-based services.** If an individual’s resources/assets exceed the Medicaid limits, there is no penalty for transferring these excess assets if one only seeks community-based Medicaid, including home care services. Someone may transfer assets in one month, and apply for Medicaid for community-based services, including home care, the first of the following month. However, that individual or his/her spouse may be disqualified from having Medicaid pay for nursing home care should she/he need it any time during the five years after the transfer. This “transfer penalty” is explained below. For this reason, legal advice from an elder lawyer is recommended before transferring assets, even for community-based services which have no transfer penalty.

- **Home equity limit of $878,000 (2019 rate).** Beginning January 1, 2006, a Medicaid applicant/recipient of institutional and non-institutional long-term care services is
subject to a home equity limit. If the value of your equity interest in your home exceeds $878,000 (as of January 1, 2019), and no spouse, child under 21 or certified blind or certified disabled child resides in the home, you are not eligible for Medicaid coverage for long-term care services. For married couples, the home is protected for the spouse who continues to live there regardless of the equity amount. Note that the limit is on equity value, not market value; the equity value can be reduced by taking out a mortgage. This equity limit only applies to long-term care services such as home care, not eligibility for primary and acute care Medicaid services.

- **Married couples - Spousal Impoverishment protections and Spousal Refusal** can lower or even eliminate excess income or resources or spend-down. See above.

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

All of a Medicaid recipient’s income, except for a small monthly allowance for personal needs (generally $50/month) and enough to pay Medigap or other health insurance premiums, 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 if one is determined to be Medicaid eligible. There are “spousal impoverishment provisions” that mandate additional financial protection for the spouse in the community and other dependent relatives, discussed below. NOTE that if a new nursing home resident reasonably expects to return home, he or she can request “community budgeting,” which allows him/her to keep the regular Medicaid allowance ($859/mo in 2019 including $20 disregard) rather than $50/month. The purpose of this is to have money to pay rent to maintain an apartment. This is usually authorized for six months subject to renewal. A five-year lookback of assets is still required, described below. See more at [http://www.wnyc.org/health/entry/117/](http://www.wnyc.org/health/entry/117/).

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

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

**LOOKBACK PERIOD** - Applicants must disclose every statement for all assets owned by applicant and the spouse, even if the spouse is not seeking Medicaid. This includes bank accounts, investment accounts, etc. - back five years before filing the Medicaid application. This is called the **lookback period**.

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

The length of the transfer penalty is the amount of money transferred divided by a regional penalty transfer rate that is set each year. The 2019 rates are in GIS 19 MA/01 - Medicaid Regional Rates for Calculating Transfer Penalty Periods for 2019 at [https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/19ma01.pdf](https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/19ma01.pdf)
For transfers made on or after February 8, 2006, the period of ineligibility for nursing facility services (transfer penalty) generally begins the first month of institutionalization and in which a completed application for Medicaid is filed, if the applicant would otherwise be eligible for Medicaid coverage of nursing facility services. In other words, the applicant must at the time have resources within the Medicaid resource limits ($15,450 in 2019 plus the exempt assets such as a pre-paid funeral agreement and IRA in pay-out status).

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

Example: Susan lives in Rochester and transferred $100,730 to her daughter in March 2015, and applied for Medicaid to receive certified home health agency services in April 2015. These services were approved because there is no transfer penalty for community-based services. In March 2019, Susan had a stroke, was hospitalized and then was placed in a nursing home. Other than the money she transferred in March 2015, her assets were within the 2019 Medicaid limit for a single person - $15,450. She applies for Nursing Home Medicaid in June 2019, after her rehab care covered by Medicare and her Medigap policy ends. Assuming that there are no exemptions from the transfer penalty (discussed below), the penalty runs for 10 months -- $100,730 divided by $12,342.

Since she is institutionalized, is applying for and is otherwise eligible for Medicaid, the transfer penalty begins in June 2019. Medicaid will not pay for her nursing home care for the next 10 months beginning June 2019. One option around this penalty is for her to return home from the nursing home after the penalty starts “running” any time between July 2019 and March 2020. 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.

Exceptions to the transfer penalty may apply if money or property is transferred to certain members of your family or to a person with a disability under age 65, or under the following circumstances:

- You transfer assets to your *spouse*;
- 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;
- your brother or sister who already has an equity interest in part of your home and who lived in the home for at least one year immediately before you became institutionalized.
- your child of any age if your child was living in your home for at least two years immediately before you became institutionalized and your child took care of you so that you could stay home rather than enter a nursing home.

You intended to sell the asset for what it was worth or to get something else of equal value in exchange;

The asset was transferred exclusively for some reason other than to qualify for Medicaid coverage of nursing facility services, or

Despite all your attempts, you cannot get the money or property back or get something of equal value, and you cannot get the medical care you need without Medicaid, or the transfer penalty would deprive you of food, clothing, shelter, or other necessities of life.

You must work with the LDSS in trying to get the money or property back.

All of the transferred assets have been returned.

**Consumer Tip** - Transfer rules are complicated. Refer to an experienced elder law attorney if the person seeking long-term care, whether in the community or in a nursing home, or his or her spouse, owns a home, has assets exceeding the Medicaid limits, or transferred assets in the past five years and now needs nursing home care. Referrals at [www.naela.org](http://www.naela.org).

**New York State’s Spousal Impoverishment Provisions for Couples where One is in a Nursing Home, or in a Community-Based “Waiver” Program or Managed Long Term Care (MLTC) Plan**

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

This law allows each state to decide on a dollar figure up to a maximum dollar amount that the community spouse can keep. New York State allows the community spouse to retain the highest amount of 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 $126,420.

Here’s how the law works. When one spouse enters a nursing home – or enrolls in a Managed Long Term Care plan or a “waiver” program -- a “snapshot” is taken of the couple’s total countable resources. The couple’s home, car, household possessions, and certain funds established for burial expenses are not counted as resources. IRA’s are also exempt, as long as distributions are being taken, under the same rules that apply for community Medicaid.

**Income Protections for Spouse.** In 2019, the community spouse of an institutionalized Medicaid recipient is permitted to retain up to $3,160.50 of monthly income. If the
community spouse has personal income in excess of this amount, he or she will not receive any allowance from the institutionalized spouse, and will be asked to contribute 25 percent of his or her income that exceeds this amount toward the cost of care of the institutionalized spouse. If the community spouse’s income is below that figure, s/he will receive the institutionalized spouse’s income up to the amount needed to bring her total income up to $3,160.50.

**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 or a waiver program in the community, she is entitled to keep an allowance of $408 of monthly income. 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.** 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 $126,420 (2019) or
- an amount established by fair hearing, or;
- an amount transferred to the community spouse by court order

In addition, the institutionalized spouse can retain up to $15,450 in countable resources, can place any amount of money in a nonrefundable irrevocable funeral agreement, and in some cases, may also have a burial fund.

**Spousal Protections Now Apply to Managed Long Term Care and “Immediate Need” Personal Care or Consumer Directed Personal Care Services**

The spousal impoverishment protections described above have been expanded. They now apply to couples with:

- one spouse in a nursing home,
- one spouse enrolled in a Managed Long Term Care (MLTC) plan and
- one spouse receiving personal care or CDPAP services through their local Dept. of Social Services based on “Immediate Need” for such services.
- One spouse in the Traumatic Brain Injury Waiver Program (TBI) or Nursing Home Transition and Diversion (NHTD) waiver programs. It used to include the Lombardi program (long term home health care program), but this program was closed down when MLTC started. See [http://wnylc.com/health/news/32/](http://wnylc.com/health/news/32/); [http://www.wnylc.com/health/entry/165/](http://www.wnylc.com/health/entry/165/).

**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 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 payor for any Medicare services, and Medicaid is secondary payor.

- **Hospital** inpatient and outpatient services
- **Laboratory** and X-ray services
- **Nursing home** care - short-term rehabilitation as well as long-term care
- **Outpatient or clinic** treatment and preventive health and **dental and vision** care (doctors, dentists, optometry). Note that 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/](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**
- **Medicine (prescription and over-the-counter) and supplies** - HOWEVER 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. Now if the Part D plan does not cover a drug in these classes, or any drug, the dual eligible’s only recourse is to appeal the denial of the drug to the plan or change drugs.

Medicare beneficiaries newly approved for Medicaid who are already in a Part D plan 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 Services are not 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](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/](http://www.wnylc.com/health/entry/182/).

- **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](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/](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. People in Managed Long Term Care (MLTC) plans must request and schedule medical transportation through their MLTC plan. Everyone else – including those enrolled in “mainstream” Medicaid managed care plans and those in “fee for service” Medicaid -- must use a State contractor. On April 23, 2017, the New York City contractor was switched from LogistiCare to Medical Answering Services LLC (MAS) – the same contractor that serves most counties outside NYC -- for approval for and scheduling this transportation.

  **MAS CONTACT INFO:**
  - Telephone: 1-844-666-6270 (NYC specific)
  - Fax: 1-315-299-2786
  - Website: [https://www.medanswering.com/](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. People with higher incomes (over $1465/month) do not receive SSI, but must pay the facility $1445/month. Medicaid pays the rest, and their Medicaid “spend-down” is the amount of their income exceeding $1445/month. Both SSI recipients and other ALP residents may keep a personal needs allowance of $204/mo. For a statewide list of ALPs see [https://health.data.ny.gov/Health/Adult-Care-Facility-Directory/wssx-idhx](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/](http://www.wnylc.com/health/entry/150/).

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

- **CAUTION:** In every county in NYS, most Medicaid recipients who do not have Medicare or other third party health insurance, and who do not have a spend-down, are required to enroll in a Medicaid managed care insurance plan (“mainstream” plan) and to receive most of the services listed above from providers in the plan’s network and using the authorization procedures in that plan. More on this later.
**Managed Long Term Care -- Medicaid Community-based long-term care**

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

- Home Care, including:
  - Personal Care (Home attendant or Housekeeping)
  - Certified Home Health Agency Services (home health aide, visiting nurse, visiting physical or occupational therapist)
  - Private Duty Nursing
  - Consumer Directed Personal Assistance Program, 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, and aides may perform skilled tasks that normally can only be performed by nurses or family. See more at [http://www.wnylc.com/health/entry/40/](http://www.wnylc.com/health/entry/40/).
- 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
- Hearing Aids and Eyeglasses
- Four Medical Specialties:
  - Podiatry
  - Audiology + hearing aids and batteries
  - Dental. (Note that a lawsuit settled in 2018 will expand 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/](http://www.wnylc.com/health/entry/210/)).
  - Optometry + eyeglasses
- Non-emergency medical transportation to doctor offices, clinics (ambulette)
- Nursing home care (permanent nursing home care became a mandatory part of MLTC in 2015, but may be limited to include only temporary nursing home care (3 months or less) in 2019 or later see more below)

**What is not included in the MLTC package described above?** Note that 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 have a choice about whether to keep their regular Medicare separately, through Original Medicare or Medicare Advantage, or to join a special kind of Medicare separately. See more below.
Choice of TYPES OF MLTC PLANS:

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 payment paid to the managed long term care plan, from which the plan pays for all services. The expectation is that the plan will save money on clients who need few services, and spend more on high-need individuals. This is known as “spreading the risk.”

There are two capitation models in MLTC:

- **Partial capitation** plans receive payment only to cover Medicaid long-term care services. Their members keep their preferred Medicare coverage separately – whether Original Medicare (+Part D plan) or Medicare Advantage. These are sometimes known as “regular” MLTC plans. Most New Yorkers prefer the partially capitated MLTC plans – in April 2019 there were 229,711 in MLTC partial capitation plans and only 24,037 in the 3 types of fully capitated plans combined.

- **Full capitation** plans are paid to cover both MEDICARE AND MEDICAID services. These plans are a combination of 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 only long term care but also primary and acute and emergency medical care. Also, 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 3 types of Fully Capitated plans.
  1. **Program for All-Inclusive Care for the Elderly (PACE)**
     - Must be age 55 and older who are 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.
  2. **Medicaid Advantage Plus (MAP)**
     - Unlike PACE, this is more of a pure insurance model, not based on any particular provider setting, but must use in-network providers. The individual joins a “Medicare Advantage Plan” and then joins the connected Medicaid Advantage Plus plan operated by the same company, thus combining both Medicare and Medicaid services.
     - **Warning:** These Medicaid Advantage Plus plans are different than Medicaid Advantage plans with no “Plus.” Both types of plans are Medicare Advantage Plans, and both include some Medicaid services. The different is that the “PLUS” plans include all Medicaid services, including all long term care services. The plans with no “plus” include only Medicaid primary and acute care but no long-term home care services.
  3. **Fully Integrated Dual Advantage (FIDA)** (Demonstration program only in NYC, Nassau, Suffolk, & Westchester that will END Dec. 31, 2019)
Since this program is being phased out at end of 2019, it will not be discussed in this manual. In short, FIDA plans are a variation on the Medicaid Advantage Plus (MAP) plans described above, wrapping into one plan all Medicare, Medicaid and MLTC services.

State has indicated that FIDA enrollees will be given opportunity to transfer to a Medicaid Advantage Plus plan in their county effective Jan. 1, 2020. If they do not pick one, they will be assigned to one. If they prefer to transfer to a regular MLTC plan, they must remember to select and enroll in a stand-alone Medicare Part D plan, or they will be randomly assigned to one that may not cover all of their prescription drugs.

Lists of plans:

- [http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm](http://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm) (official DOH list showing “Plan Type”);
- [http://nymedicaidchoice.com/program-materials](http://nymedicaidchoice.com/program-materials) - Scroll down to plan lists for Long Term Care plans - by region - on New York Medicaid Choice website (state’s contracted enrollment broker).

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 -- Who are receiving or are applying for CERTAIN SPECIFIED Medicaid home care and other community-based long term care services. “Long-term” means you need home care or other long-term care services for more than 120 days. Must need more than mere “housekeeping” assistance, which means assistance with meal prep, shopping, cleaning, laundry, etc. To be eligible for MLTC client must also need assistance with personal activities like toileting, bathing and dressing. If they need only housekeeping, they apply at local DSS and limited to 8 hours/week. NYS has designated the NY Medicaid Choice (Maximus) Conflict-Free Eligibility & Enrollment Center (CFEEC) to conduct this assessment to determine the need for long-term care. See [https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care](https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care)

- **Who is EXCLUDED from and may not enroll in MLTC? These groups still apply to local DSS for personal care.** (Note that having a spend-down is NOT an exemption or exclusion from MLTC).
  - In Nursing Home Transition Diversion Waiver or Traumatic Brain Injury waiver (but MLTC will be mandatory for them in January 2022).
  - 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://opwd.ny.gov/opwd_services_supports/people_first_waiver/home](https://opwd.ny.gov/opwd_services_supports/people_first_waiver/home)
  - People who need only “Housekeeping” services, also called Personal Care Level I, for which the maximum is 8 hours/week. These services are still obtained through the local Department of Social Services Medicaid program. This is for people who only need help with tasks such as shopping, cooking, cleaning, and laundry, but not with personal Activities of Daily Living (ADL) such as ambulation, toileting, dressing or bathing. If they need
Housekeeping along with ADL assistance, the MLTC plan provides both, and the 8-hour limit does not apply.

- Persons receiving hospice services at time of enrollment (they may apply to CASA/DSS for personal care services to supplement hospice) (An MLTC member, however, may remain in the MLTC plan if they later become enrolled in a hospice program);
- 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, and Medicaid Assisted Living Program (ALP)
- Anyone under age 18
- Undocumented immigrants solely eligible for “Emergency Medicaid”
- 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 they must meet an extra eligibility criterion – they must require a “nursing home level of care,” meaning they could be admitted to a nursing home based on their medical and functional condition. This is determined by NY Medicaid Choice in the Conflict Free Eligibility & Enrollment assessment (CFECC);
- 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 authorizing and providing most long-term care services including personal care, CDPAP, CHHA, and nursing home care. Some people may prefer an MLTC plan, but may only do so in the circumstances below.
  - If they have just applied for Medicaid, and have not yet enrolled in a mainstream Medicaid managed care plan, and they have had a “conflict free” evaluation by NY Medicaid Choice finding they require a “nursing home level of care,” they may enroll in an MLTC plan. 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 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 All NYS DOH MLTC Policies are posted at http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm.
If they enroll in an MLTC, they would receive other Medicaid services that are not covered by the MLTC plan on a fee-for-service basis, not through managed care (such as hospital care, primary medical care, prescriptions, etc.)

**NOTE re Shifting Medicaid from NYS of Health to LDSS** -- Most people in mainstream Medicaid plans applied for Medicaid on the NYS of Health Exchange. If that is the case, even though they may sometimes enroll in MLTC having MAGI Medicaid, as described above, they must still switch administration of their Medicaid case to the LDSS from the Exchange. The LDSS will use “MAGI-like” budgeting to approve or renew their Medicaid.

### 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/](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.
- Adult dual eligibles who do not need any long-term care services. NOTE: MLTC plans provide some non-long term care services, such as hearing aids, dental and vision care. Adult dual eligibles who need those services but do not need home care or other long-term care services do not need to enroll in MLTC, and are even excluded from MLTC enrollment. They may use their regular Medicaid card for hearing aid, dental, vision care, medical supplies, etc. These services are accessed through Fee for Service Medicaid.

### 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 2 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 verifies resources/assets and documentation of the amount of assets. Otherwise will not qualify for either MLTC or other home care.

**B. CFEEC** - Request a Conflict-Free Eligibility Determination from the Conflict-Free Evaluation & Enrollment Center (CFEEC) run by Maximus, NY Medicaid Choice, the state’s contractor. See [https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care](https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care). This assessment is done by a nurse in the client’s home or nursing home, and makes a simple determination of whether the individual needs long-term care services so may enroll in an MLTC plan. It must be scheduled within 2 weeks of the request. Because of the delay, you may request it even before the Medicaid application is approved. However, the CFEEC determination becomes stale after 75 days if client is not enrolled in an MLTC plan. (This was increased from 60 days in December 2016. DOH MLTC Policy 16.08). So one should not request it too early. The CFEEC determination does not determine the number of hours of care client will receive.

C. **Choose and enroll with an MLTC plan.** Choose TYPE Of plan (“regular” partially capitated or fully capitated plan – see above). Call various MLTC plans in your county, requests them to come to assess client in the home (or nursing home). The MLTC nurse does a comprehensive assessment and develops a plan of care, meaning the number of hours per week plan will authorize.

- 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 are in the plan’s network - - home care agency, dentist, optometrist, nursing home, physical therapy clinics? See list of services covered by MLTC above. See TOOLS FOR CHOOSING AN MLTC PLAN. http://www.wnylc.com/health/entry/169/

- How to enroll - ONCE you select a plan, you sign plan’s enrollment form, and plan submits the form to NY Medicaid Choice. If you are selecting a Medicaid Advantage Plus (MAP) or PACE plan, you must enroll directly with the plan. The plan must submit this form by the 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.

- **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 not only for MEDICAID but also for 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.

---

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
Since July 2016, dual eligibles may use a Fast-Track procedure to apply to the local DSS not only for MEDICAID but also personal care or CDPAP. The applicant must have an "Immediate Need" for either personal care or Consumer Directed Personal Assistance services. 

16 ADM-02 - Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services (CDPAP). A 2015 state law requires local Medicaid offices to process and approve a 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 re-opens the "front door" that was closed at the local DSS Medicaid program to request Medicaid personal care services. That door was closed when enrollment in a Managed Long Term Care plan became mandatory.

This procedure addresses the long delays encountered in the three-step process described above for applying for Medicaid, then doing the Conflict Free assessment, then enrolling in a Managed Long Term Care plan to get home care. That process could take months - even AFTER Medicaid eligibility was approved.

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" (DOH-4495A in New York City, in all other counties use Form DOH-5178A) (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.
   2. If an application was already submitted and is pending, submit a copy of it along with all documentation, and proof of when and where it was filed.

ii. **Physician’s order for personal care/**

   1. [Form M11q in NYC](#) - Must be current, seen by and signed by doctor within last 30 days. See tips at [Q-Tips](#) (designed for NYC form but can be adapted for any county)
   2. [Form DOH-4359](#) – use statewide unless county has had its own form approved by the State. Some forms outside NYC available [here](#).

iii. **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.

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.
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/

WHAT HAPPENS AFTER “IMMEDIATE NEED” SERVICES BEGIN?
After the consumer has received the services for 120 days, she will receive a letter from New York Medicaid Choice giving her 60 days to select an MLTC plan. If she does not select one, she 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
- 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 plan must provide the same services and the same number of hours as DSS had authorized under “Immediate Need” for the first 90 days after enrollment. This time period was lengthened from 60-90 days by a May 2013 State directive -- MLTC Policy 13.10: Communication with Recipients Seeking Enrollment and Continuity of Care, available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/policy_13_10_guidance.pdf. During this 90-day period, the plan must assess the new member’s needs in her home. The plan’s nurse will decide how much care the plan will approve after the 90-day transition period.

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

NAVIGATING MLTC PLANS ONCE ENROLLED

CHANGING PLANS and LOCK-IN – The current rule in effect as of May 16, 2019 is that enrollees may switch to a different MLTC plan in any month, with the change effective the 1st of the next month. WARNING: Since it is “voluntary” to switch plans, however, you may be at risk of having services reduced when you switch. For example, if you receive 24-hour home care in Plan A, but do not like the providers in the network, and switch to Plan B, Plan B might reduce your

services to 4 hours/day 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.

**WARNING: NEW LOCK-IN RULE MAY GO INTO EFFECT ANY TIME.** The State is awaiting permission from CMS to prevent MLTC members from changing plans at certain times. If and when CMS approves this change, a new MLTC member will have a grace period of 90 days after the initial 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 is defined by state law to include poor quality of care, lack of access to covered services or to providers experienced in dealing with the enrollee’s care needs. It will be further defined by the State Department of Health.

WATCH for alerts on possible CMS approval of this change here http://www.wnyci.com/health/news/78/.

Members May Request Plan to Increase Services or Authorize New Services

MLTC members may request their plan to 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 is that a delay "would seriously jeopardize the enrollee’s life or health or ability to attain, maintain, or regain maximum function." It 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.wnyci.com/health/entry/114/#new%20service%20requests. For more info on how the plan assesses need see http://www.wnyci.com/health/entry/114/#HOW%20plans%20asseses%20needs.

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

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

1) **Denials.** If a member is denied an increase in services, or a request for a new type of service, the plan must 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) must explain the reason for the denial and how the member may appeal.

2) **How to appeal:** Beginning May 1, 2018, 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 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.wnyci.com/health/entry/184/.
3) **Reductions or Terminations of Services.** When a plan proposes to reduce or terminate a service, it must mail notice 10 days in advance of the “effective date” of the reduction. 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.” 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. Again, the member may request a Fair Hearing with aid continuing. State MLTC Directive 13.01\(^\text{14}\) 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.”

- **Advance Notice** – Both the Initial Adverse Determination (IAD) Notice of the proposed reduction or termination, and the Final Adverse Determination (FAD) notices must be given ten (10) days before the effective date of the reduction. The forms must use new templates required by NYS DOH, posted at [https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm](https://www.health.ny.gov/health_care/managed_care/plans/appeals/index.htm). (Scroll down to DOH Model Notices…)

- The plan must state in the written notice a reason why the individual no longer needs the amount of services previously authorized - an improvement in her medical condition, a change in social circumstances (a daughter moved in with her), or other change. For the last few years, 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.](https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm) 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](https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/mltc_policies.htm).

- **How to Appeal.** In order to get AID CONTINUING – continuation of the prior higher level of service - a Plan Appeal must be requested very quickly. The Notice of Initial Adverse Determination must be sent at least 10 days before the effective date of the adverse action, and the appeal must be requested before that effective date. Beginning May 1, 2018, the member MUST first request an Internal Plan Appeal from the plan following an Initial Adverse Determination. Only after a decision on that internal appeal is made by the plan, called a "Final Adverse Determination" or "FAD," may the member request a FAIR HEARING. Member should then make sure to request AID CONTINUING on the subsequent FAIR HEARING request. If member has already gone through an internal appeal and received a Final Adverse Determination, you can request a hearing online, by phone or by fax – see [http://otda.ny.gov/hearings/request/](http://otda.ny.gov/hearings/request/).

\(^{14}\) All state policy directives, model contracts etc. on MLTC are posted here [https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm](https://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm).
• **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 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. [www.icannys.org](http://www.icannys.org)

• **See this article regarding Appeals and Grievances in Managed Long Term Care --** [http://www.wnylc.com/health/entry/184/](http://www.wnylc.com/health/entry/184/) - for more information on your right to appeal.

• **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

**WHAT IF AN MEMBER NEEDS NURSING HOME CARE – TEMPORARILY OR PERMANENTLY?  CHANGES in 2015 and again expected in 2019-20**

The law has been rapidly changing regarding what happens when dual eligibles need permanent nursing home placement. Watch for more changes expected this year or next, described below.

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

**Since 2015 and currently** (as of May 2019) -- any MLTC or mainstream Medicaid managed care member who enters a nursing home remains in their MLTC or mainstream plan. Since most MLTC members have Medicare, Medicare pays for most of rehab days. The MLTC plan must allow a member to choose an out-of-network nursing home for temporary rehab covered by Medicare. If the member does not have a Medigap policy that includes the skilled nursing facility coinsurance, the MLTC plan must pay the coinsurance, even for an out-of-network nursing home. If the MLTC member is only temporarily in the nursing home, then they return home and resume MLTC home care services. Even if the nursing home placement became permanent, the individual still remains in the MLTC plan, and the MLTC plan becomes responsible for paying the nursing home. In that case, if the nursing home was not in the MLTC plan’s network, the individual needs to change MLTC plans to cover their nursing home.

Though the MLTC member has “community” Medicaid, she is still required to apply for “institutional” Medicaid once in the nursing home after Medicare coverage ends. This means doing the five-year lookback of assets. An individual who transferred assets during the lookback period and has a transfer penalty will not be eligible for Medicaid to pay for the nursing home care, and will be disenrolled from the MLTC plan.

Even a Medicare beneficiary who was **NOT** in an MLTC plan in the community, but who is admitted to a nursing home for permanent placement, must enroll in an MLTC plan once accepted for institutional Medicaid. This new rule also became effective in 2015 for new people admitted to nursing homes. Longtime residents were “grandfathered in” and not required to join plans; Medicaid continued to pay for their nursing home care fee for service. However, they will be required to enroll in a plan if they are hospitalized and lose “bed hold” status. Once they return to the facility, they will be notified that they have 60 days to select an MLTC plan or will be automatically enrolled in a plan.
WHAT MAY CHANGE in 2019-20?

The NYS Budget enacted April 2018 proposes to reverse the 2015 changes—so that MLTC members will be disenrolled from an MLTC plan after they are permanently placed in a nursing home for three months. The permanent nursing home care after 3 months would be paid by Medicaid fee for service and not by the MLTC plan. As of this writing, May 22, 2018, the change is still awaiting approval from CMS. If it is not approved, the current system will continue. If it is approved, then a date of implementation will be set. Also, new nursing home residents who were not previously in an MLTC plan prior to being admitted to the nursing home will no longer be required to enroll in an MLTC plan, as has been true since 2015.

Consumer advocates are concerned that with these changes will make it more difficult to leave a nursing home for someone who has been disenrolled from their MLTC plan. Now they need to 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 New 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


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 -
DOH FIDA website http://www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm

NYHEALTHACCESS.org http://wnylc.com/health/entry/169/ (tools to select a plan)
http://wnylc.com/health/entry/114/ (about MLTC)
http://wnylc.com/health/entry/176/ (new procedures for applying for home care)
http://www.wnylc.com/health/entry/184/ - Grievances & Appeals in MLTC

DOH MRT website about adding Nursing Home benefit to MLTC and mainstream managed care -
http://www.health.ny.gov/health_care/medicaid/redesign/mrt_1458.htm

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

- PowerPoint: http://www.wnylc.com/health/download/474/
State DOH Complaint Number for MLTC Problems - 1-866-712-7197

- e-mail mlctac@health.state.ny.us and put "COMPLAINT" in subject line

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

Email ican@cssny.org. Statewide network – call to find out your regional organization.
DELIVERY OF MEDICAID SERVICES – FEE FOR SERVICE CARE vs. MANAGED CARE

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

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

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

What services must be obtained through the Medicaid managed care plan? Most people without Medicare must be in a Medicaid managed care plan and use their plan’s membership card instead of their regular Medicaid card for most medical services. But they must keep their regular Medicaid card to obtain some important benefits that are not covered (“carved out”) by their Medicaid managed care plan. However, since 2011, some services that were formerly “carved out” are now covered by the Medicaid managed care plan:

- prescription drugs and over the counter medications,
- personal care and Consumer-Directed Personal Assistance Program (CDPAP),
- adult day 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.
- As described above, nursing home services are part of the package as of 2015 (but may be phased out in 2019-20).

Where is Medicaid Managed Care mandatory?

Medicaid recipients in all counties and New York City are generally required to join a managed care plan, unless they are excluded or exempt.
In New York City and at least 31 upstate counties, recipients receive mandatory enrollment packets from **New York Medicaid Choice**, a private company contracted to handle managed care enrollments and disenrollments.


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

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


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

**Does everyone in New York State who does not have Medicare have to join a managed care plan?**

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

The types of Beneficiaries that are **excluded** were significantly cut in recent years. As of May 2017 the only people **EXCLUDED** are those who:

- Are in the Medicaid Spenddown or Excess Income program;
- Are under 65 and were determined eligible by the Breast Cancer Screening & Treatment Program (for Breast, Cervical, Colorectal and Prostate Cancer);
- Have **Medicare (dual eligibles)**, though they *may* enroll in **Medicaid Advantage**, which is a type of managed care that combines Medicare Advantage with Medicaid managed care to cover all Medicare and Medicaid services
- Are enrolled in a managed long term care plan
- Receive family planning services only, who are not otherwise eligible for Medicaid and whose net available income is 200% or less of the federal poverty level,
- Get Medicaid for less than 6 months – unless pregnant (for example, they get Emergency Medicaid as an undocumented immigrant);
- only use Medicaid for tuberculosis (T.B.) related services;
- Infants living with a mother in jail
- Are covered by other comprehensive private insurance as primary payer, such as an employee group health policy, or could have this insurance, if cost-effective;
- Live in certain institutions: resident of State-operated psychiatric facilities, resident of state certified or voluntary operated OMH treatment facilities for children, residents of 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)
- Foster care children placed in voluntary agencies
- Receiving hospice services at the time of enrollment
- NOTE: NO LONGER EXCLUDED (though most excluded because have Medicare):
  Individuals under 65 and working and eligible for Medicaid Buy-in for Working People with Disabilities (MBI-WPD)

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

- They are **Native American**; or
- they have a **chronic medical condition and** are being treated by a specialist who does not participate with *any* Medicaid managed care plans -- they may defer enrollment into the HMO but only for **six months** or until the course of treatment is complete, whichever occurs first. This is a one-time exclusion – once in a lifetime;
- Individuals **already scheduled for a major surgical procedure** (within 30 days of scheduled enrollment) with a provider who is not a participant in the network of any Medicaid MCO in the service area. Exemption is limited to six months
- Residents of Intermediate Care Facilities for the Developmentally Disabled
- Participants in certain **Waiver** programs -- Developmentally or physically disabled individuals receiving services through a OPWDD waiver, Children in Care-at-Home Waivers, Bridges to Health (B2H) waivers for children in Foster Care, OMH waivers, Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion Medicaid Waiver (NHTD) (Note that participants in the Lombardi program are no longer exempt and are required to transition to managed care, which will take over their home care)
- Residents of **Chemical Dependence** Long Term Residential Program
- Nursing home resident at time of enrollment (before Oct. 2015 they were excluded from managed care, now are exempt)

See  [NYSDOH Charts of Exclusions and Exemptions, attachments to GIS 15 MA/012 - Medicaid Managed Care Exemptions and Exclusions](http://www.health.ny.gov/health_care/medicaid/publications/pub2015gis.htm) -- PDF

- **Attachment 1** - **Attachment 2** - download at

**Many exemptions have been eliminated** - Many people who used to be exempt or excluded from Medicaid managed care must now enroll, including SSI recipients, people with HIV/AIDS, homeless individuals, and adults with serious and persistent mental illness (SPMI) and children with serious emotional disturbances (SED), working people under 65 with disabilities in MBI-WPD program and hospice recipients

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

- **Information by The Legal Aid Society** -- [http://wnylc.com/health/entry/160/](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)
QUESTIONS AND ANSWERS ON MEDICAID

1. How does someone apply for Medicaid?

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

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

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

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. (DOH-4495A in NYC, Form DOH-5178A in all other counties)

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

In New York City, there are different types of Medicaid offices:

- 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 – eg. 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
109 East 16th Street, 5th Floor,
New York, NY 10003 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 Enrollee Program for Aged, Blind and Disabled - https://www1.nyc.gov/site/ochia/about/other-initiatives.page

- If a client is a patient of one of the following, she/he should contact the office listed after the name of the facility:
  New York State Office of Mental Health Facility - Patient Resource Office
  New York State Office of People With Developmental Disabilities Facility - Revenue Support Field Office

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

Medicaid does not require one to be a citizen or a lawful permanent resident (also known as having a “green card”). Medicaid also is available to other immigrants who are Permanently Residing Under Color of Law (PRUCOL), meaning they are in the U.S. with the knowledge and acquiescence of the US Center for Immigration Services. A Desk Guide for identifying immigrants who are PRUCOL as well as for documenting citizenship is at 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).


**NEW in 2016 – Essential Plan for certain immigrants under age 65 who do not have Medicare.** Until January 2016, “PRUCOL” immigrants received regular Medicaid as long as they met the other requirements for Medicaid – income, resources, proof of identity, residency, etc. That is still true for the non-MAGI “DAB” category (Disabled, Aged 65+ or Blind). However, certain immigrants under age 65 who do not have Medicare are being transitioned from MAGI Medicaid to a new health insurance program called the Essential Plan. Affected immigrants are PRUCOL and “Qualified Aliens” in their five year bar, meaning that while they have been covered under New York law under a court decision called **Aliessa**, they were not covered under federal Medicaid. When they move to the Essential plan, the federal government will now pay for part of the cost of services, instead of only the State.
• **Essential Plan ends at age 65** -- Individuals cannot remain on the Essential Plan when they turn 65, no matter what their Medicare eligibility is. If a client is ineligible for Medicare and the Medicare Savings Programs, or cannot afford to buy-in to Medicare, they can enroll in a Qualified Health Plan (QHP) with Advance Premium Tax Credits (APTCs) and Cost-Sharing Reductions (CSRs). There are cost sharing reductions in place for individuals over 65 who purchase plans through the Marketplace between 139-200% FPL.

• **Transitioning from the Essential Plan to Medicare** - Transitions from the Essential Plan to Medicare are explained in GIS 16 MA/004.15 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 or MSP. Those EP enrollees who are **Aliessa** immigrants will be transferred to the LDSS with Fee for Service Medicaid. The Fee for Service Medicaid coverage should continue until they submit their re-certification at the LDSS, or until the date listed on the LDSS notice.

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

   The number of times Medicaid will pay for visits to doctors or clinics, labs, and drug stores may be limited. This limit is called Medicaid Utilization Thresholds. See more info including how to request an override of these limits at [http://wnylc.com/health/entry/89/](http://wnylc.com/health/entry/89/).

   **Occupational Therapy, Physical Therapy and Speech Therapy.** Effective 4/12/18, Physical therapy visits are limited to 40 visits per year, increased from 20 visits per year. However, occupational and speech therapy are still each limited to 20 visits per year. These limits are flat limits on services – the physician may not request an override on an individual basis. The limits do not apply to people with developmental disabilities or a Traumatic Brain Injury.

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

   Medicaid may pay for care given during the three calendar months before the month in which the client applied for Medicaid. These three months are called retroactive coverage. For non-Medicare recipients (MAGI) people applying on the Exchange, there are new procedures to obtain retroactive coverage. Non-MAGI applicants (mostly those with Medicare or a spend-down), should flag on the application and in a cover letter that they have paid or unpaid medical bills and want retroactive coverage. At the client’s option, some bills may be used to meet her spenddown, discussed above, and once the spenddown is met, may be reimbursed. See more information at [http://wnylc.com/health/entry/18/](http://wnylc.com/health/entry/18/).

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

   Maybe. Medicaid will pay for medical care someone gets out of state if:
   - People from a border county usually get medical care in that state.
   - The Local Department of Social Services placed the individual in a nursing home or foster care in another state.
   - The provider (such as a doctor) has received prior approval for the individual to get medical care out-of-state.

---

- The individual needs emergency medical care while traveling in another state and the out-of-state provider is enrolled (or is willing to enroll) in the New York State Medicaid program.

6. Can Medicaid pay for the Medicare premiums?

Yes, aside from the Medicare Savings Programs, there are two types of circumstances where Medicaid will 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 may get Part B premium paid or reimbursed until they are enrolled in an MSP program

Those who, prior to becoming enrolled in Medicare, had Medicaid through the Affordable Care Act are eligible to have their Part B premiums paid by Medicaid (or the cost reimbursed) during the time it takes for them to transition to a Medicare Savings Program. In 2018, DOH clarified that reimbursement of the Part B premium will be made regardless of whether the individual is still in a Medicaid managed care (MMC) plan. GIS 18 MA/001 Medicaid Managed Care Transition for Enrollees Gaining Medicare (PDF) provides, "Due to efforts to transition individuals who gain Medicare eligibility and who require LTSS, individuals may not be disenrolled from MMC upon receipt of Medicare. To facilitate the transition and not disadvantage the recipient, the Medicaid program is approving reimbursement of Part B premiums for enrollees in MMC."

The procedure for getting the Part B premium paid is different for those whose Medicaid was administered by the NYS of Health Exchange (Marketplace), as opposed to their local social services district. The procedure is also different for those who obtain Medicare because they turn 65, as opposed to obtaining Medicare based on disability. These differences are described below.

Either way, Medicaid recipients who transition onto Medicare should be automatically evaluated for MSP eligibility at their next Medicaid recertification. NYS DOH 2000-ADM-7. Individuals can also affirmatively ask to be enrolled in MSP in between recertification periods.

IF CLIENT HAD MEDICAID ON THE MARKETPLACE (NYS of Health Exchange) before obtaining Medicare:

IF they obtain Medicare because they turn age 65, they will receive a letter from their local district asking them to "renew" Medicaid through their local district. See 2014 LCM-02. Now, their Medicaid income limit will be lower than the MAGI limits ($859/month reduced from $1437/month in 2019) and they now will have an asset test. For this reason, some individuals may lose full Medicaid eligibility when they begin receiving Medicare. People over age 65 who obtain Medicare do NOT keep "Marketplace Medicaid" for 12 months (continuous eligibility) See GIS 15 MA/022 - Continuous Coverage for MAGI Individuals. Since MSP has NO ASSET limit, some individuals may be enrolled in the MSP even if they lose Medicaid, 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

If client became eligible for Medicare based on disability and is UNDER AGE 65:
Client is entitled to keep MAGI Medicaid for 12 months from the month it was last authorized, even if she now has income normally above the MAGI limit, and even though you now have Medicare. This is called Continuous Eligibility. EXAMPLE: Sam, age 60, was last authorized for Medicaid on the Marketplace in June 2016. He became enrolled in Medicare based on disability in August 2016, 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 June 2016.

Sam has to pay for his Part B premium - it is deducted from his Social Security check. He may call the Marketplace and request a refund. 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, he will renew Medicaid and apply for MSP with his local district.

B. Medicare Insurance Premium Payment (MIPP) Program – Pays for Part B premium for people in MBI-WPD and others if cost-effective

The NYS Medicaid program will pay for the Part B premiums of MBI-WPD enrollees with a net income above the SLIMB level through the Medicare Insurance Premium Payment (MIPP) program. Consumers receiving MIPP payments have their Part B premium deducted from their Social Security award, but receive a separate payment from a NYS Medicaid vendor via check.

The other populations eligible for MIPP, besides those enrolled in MBI-WPD, are:

- Caretaker relatives with MAGI budgeting and an MSP budget above SLIMB level (GIS 18 MA/001)
- Consumers paying the Part B premiums and the payment reduces the net income to below the Medicaid level. The consumer should be paid the difference to bring her up to the Medicaid level. (Note that these individuals could have QMB, but would then have a small spend down).

The legal authority for this program is found in the SSA POMS here https://secure.ssa.gov/poms.nsf/lnx/0600815001; NYS DOH GIS 15 MA/004, GIS 15 MA/014, 02 02MA019.

To enroll your MBI-WPD 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 SLIMB level or QMB level (this disqualifies them for MIPP and the application for MSP must go through HRA/DSS).

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

Generally, no. Medicaid is the insurer of last resort, and pays as secondary coverage. Medicaid pays after any other “primary” health coverage the consumer has, including Medicare, employer group health insurance and Medigap. As discussed above, an individual who has Medigap may decide s/he no longer needs that coverage because Medicaid will fill the gaps in Medicare. Wait and ask this question at the interview. As an incentive to retain other primary health coverage, Medicaid allows the cost of all health insurance premiums to be deducted from income in
determining eligibility -- for people age 65, disabled, or blind. Once someone drops his or her Medigap policy, they may not be able to get it back because insurers are not permitted to sell these policies to Medicaid recipients, since it is duplicative coverage. An exception is made if the individual has a “spend-down.” Also, individuals can temporarily suspend their Medigap coverage.

If someone is paying a high premium for private health coverage, s/he may be eligible to have Medicaid pay for that premium -- if it is cost-effective for Medicaid to help him/her keep their private coverage. COBRA policies are an example - continued health coverage after losing a job. However, this benefit has been sharply cut back since May 2013. Medicaid will only reimburse if the COBRA premium is less than the capitation rate paid to a Medicaid managed care plan, 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

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

People permanently placed in a nursing home can keep a small amount for your personal use. The allowance is $50/month generally ($55 if you receive SSI). Additionally, if there is a reasonable expectation that you will return home, you may request permission to keep income up to the community Medicaid level, which in 2019 is $859 per month. With that budgeting called “community budgeting,” the income deductions or disregards that are used in the community would be used to calculate the spenddown just as in the community. Refer to sections above for information about nursing home Medicaid and “community budgeting” during temporary nursing home admissions at http://wnylc.com/health/entry/96/ . However, this generally is authorized for six months, and may be extended for another 6 months or more. You need to affirmatively ask the nursing home to request this budgeting from the Medicaid program. It requires that a doctor certify that you are reasonably expected to return home.

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

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

Many people think that Medicaid puts a lien on your home when you apply for Medicaid. This is not true. There are instances when Medicaid may place a lien on your home or make a claim against your Estate after you die, which may include your home.

First, if you are a permanent resident in a nursing home, an intermediate care facility or a residential treatment facility and not expected to return home, and 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 available at http://www.health.ny.gov/health_care/medicaid/publications/pub2015gis.htm. 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 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/.

10. What if I have emergency medical needs?

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

Someone who already has Medicaid, or who is applying for Medicaid, may request that personal care services be authorized by the LDSS if they have an “immediate need” for the services, and cannot wait to enroll in an MLTC plan. See above at pp. 17-37.
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/Legal Services for the Elderly, Disabled of Western New York 1-800-635-0355
- The Legal Aid Society - Statewide Hotline 1-888-500-2455
- The Legal Aid Society - NYC Hotline 1-212-577-3575
- Medicare Rights Center HIICAP Hotline 1-800-480-2060
- Evelyn Frank Legal Resources Program at NYLAG eflrp@nylag.org 1-212-613-7310

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

- Statewide Hotline 1-844-614-8800
  TTY Relay Service: 711 Website: icannys.org ican@cssny.org
  Has regional specialists – call statewide hotline to be directed to local organization

Check for news items and information on http://nyhealthaccess.org - a joint project of Empire Justice Center, Legal Aid Society, and NYLAG.
STUDY GUIDE MODULE 9: Medicaid

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

Read your HIICAP Notebook for information on Medicaid

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

1. DIFFERENCES BETWEEN MEDICARE AND MEDICAID

Group Activity

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

a. What each program provides

b. Who may participate in each program

c. How each program is administered

d. Services each program covers

2. HOW MEDICARE AND MEDICAID WORK TOGETHER

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

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

3. MEDICAID COVERAGE OF LONG-TERM CARE

Mark each of the following statements True or False

a. Medicaid can pay for the cost of your long-term care in a nursing home or at home when you have spent your assets down to a very low level and can no longer pay for your own care, if you are otherwise eligible. T_____F_____

b. Medicaid includes the value of your automobile when calculating your total resources. T_____F_____

c. A federal law protects couples from having to spend any of their resources (savings, CDs, stocks and bonds, etc.) when one of them must receive long-term care. T_____F_____
d. HIICAP counselors may give a Medicare beneficiary the general qualification guidelines for Medicaid. Applications for Medicaid, however, are taken at Local Departments of Social Services. T_____ F_____

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

T _____ F _____

Review and explain your answers with your group.

In Summary: Review these basic concepts of Medicaid.

- If an individual’s income is low, he/she may qualify for Medicaid.
- Medicaid will pay the Medicare deductibles and coinsurance, and some of the health care costs that Medicare does not pay.
- Spousal impoverishment provisions protect some of the income and resources of the spouse who is married to an institutionalized spouse but is not an institutionalized spouse himself/herself. These provisions help to ensure that the community spouse will not have to spend all of his/her monthly income and resources on the cost of care of the institutionalized spouse. The same spousal impoverishment provisions protect income and resources of a couple where one spouse is in an MLTC plan and one is not receiving Medicaid.
ANSWER KEY MODULE 9: Medicaid

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

Read your HIICAP Notebook for information on Medicaid.

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

1. DIFFERENCES BETWEEN MEDICARE AND MEDICAID

Group Activity

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

- What each program provides
- Who may participate in each program
- How each program is administered
- Services each program covers

Answer chart appears at the end of the test.

2. HOW MEDICARE AND MEDICAID WORK TOGETHER

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

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

3. MEDICAID COVERAGE OF LONG-TERM CARE

Mark each of the following statements True or False

- Medicaid can pay for the cost of your long-term care in a nursing home or at home when you have spent your assets down to a very low level, and can no longer pay for your own care, if you are otherwise eligible. True
- Medicaid includes the value of your automobile when calculating your total resources. False
- A federal law protects couples from having to spend any of their resources (savings, CDs, stocks and bonds, etc.) when one of them must receive long-term care. False
- HIICAP counselors may give a Medicare beneficiary the general qualification guidelines for Medicaid. Applications for Medicaid, however, are taken at local Departments of Social Services. True
- Someone who wants Medicaid or the Medicare Savings Program can wait until age 70 to apply for Social Security in order to maximize the amount of their benefit. They can apply for Medicaid or the MSP at age 65 with their eligibility based on their other income. False
In Summary: Review these basic concepts of Medicaid and the Medicare Savings Programs.

- If an individual’s income is low, he/she may qualify for Medicaid.
- Medicaid will pay the Medicare deductibles and coinsurance, and some of the health care costs that Medicare does not pay.
- Spousal impoverishment provisions protect some of the income and resources of the spouse who is married to an institutionalized spouse but is not an institutionalized spouse himself/herself. These provisions help to ensure that the community spouse will not have to spend all of his/her monthly income and resources on the cost of care of the institutionalized spouse. The same spousal impoverishment provisions protect income and resources of a couple where one spouse is in an MLTC plan and one is not receiving Medicaid.

Answer chart for Group Activity Question 1:

<table>
<thead>
<tr>
<th>Provides:</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health insurance</td>
<td>Health assistance</td>
</tr>
<tr>
<td>Participants:</td>
<td>People of any income level, age 65 and over, and some people with disabilities under age 65</td>
<td>People of any age with low income and resources</td>
</tr>
<tr>
<td>Administration:</td>
<td>Federal; program is uniform in all states</td>
<td>Federal/state/county partnership in NYS; programs vary by state</td>
</tr>
<tr>
<td>Services Covered:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic hospital</td>
<td>Basic hospital</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>Physician</td>
<td></td>
</tr>
<tr>
<td>Therapy</td>
<td>Therapy (limits on PT – 40 visits/year; OT &amp; ST - 20 visits/year)</td>
<td>Therapy (limits on PT – 40 visits/year; OT &amp; ST - 20 visits/year)</td>
</tr>
<tr>
<td>Limited skilled nursing facility services and home health care</td>
<td>Nursing home care</td>
<td></td>
</tr>
<tr>
<td>Limited prevention-oriented</td>
<td>Physical exams</td>
<td></td>
</tr>
<tr>
<td>Dental care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglasses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory and x-ray services</td>
<td>Laboratory and x-ray services</td>
<td></td>
</tr>
<tr>
<td>Transportation to medical appointments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private insurance premiums for some people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home/community-based care for frail elderly and people with disabilities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>