Medicaid Eligibility

Updates

August 22, 2023

Agenda

- Medicaid During the PHE
- PHE Unwinding
- Changes to Medicaid
- Recertification Requirements
- Be on the Lookout
- Resolving Issues
- Fair Hearings

Medicaid During the PHE

- Public health emergency (PHE) began 3/18/2020
- Coverage could not be ended or downgraded
- Automatic recertifications through 6/30/2023 (wow!)
- DOH suspended reports to DSS/HRA of Medicare eligibility
- DOH suspended requirement to report TPHI coverage

- Not without hiccups
  - Cases automatically recertified with no LTC (coverage code 20)
  - Spenddown cases closed for failure to pay
  - Documents/applications faxed to HRA lost, not received, incomplete
  - Short-staffing at DSS/HRA offices
  - Poor coordination between SSA (SSI) and Medicaid when someone lost SSI

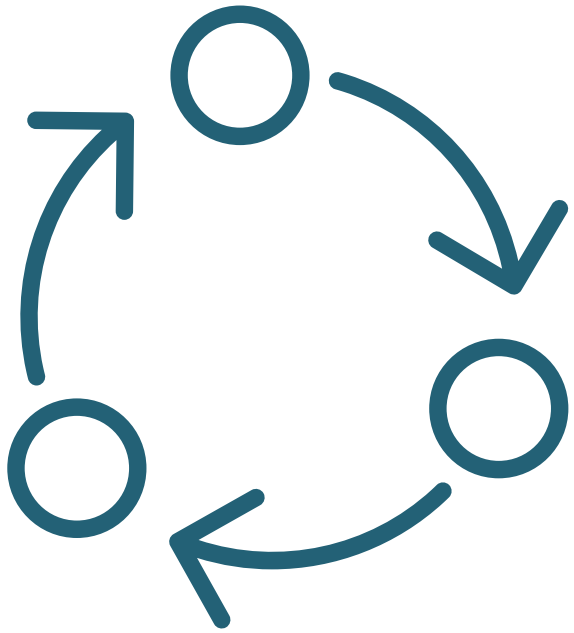
PHE Unwinding

- States have an extended period to re-institute processes and programs that were suspended during COVID
- Medicaid recertifications are underway for many
- Automatic recertifications are being completed for recipients who meet certain, specific requirements
- Complex process for DSS/HRA due to the number of exceptions and criteria
- Exceptions are based on coding in the WMS (we have no access)

2023 Changes to Medicaid

- Increases to income and resource limits (see chart)
  - Income limit: 138% FPL
  - Resource limit: $30,182, OR
  - SSI recipient/DAC resource limit: $2,000 (yes, still!)
  - Rebudgeting done by request or at recert
    - Could be beneficial for those with spenddowns
- Auto renewals for SOME began July, 2023
  - Picked up after PHE relief ended

Auto renewals for SOME (not all!)



- CMS approved a waiver allowing NYS to implement autorenewal process for certain situations during the unwind period
- DSS/HRA will automatically (manually until programming is completed) renew Medicaid cases for CERTAIN recipients:
  - SNAP recipients who receive notice that MCD will be extended unchanged (started late June for September expirations)
  - People without SNAP but who are coded as aged/blind/disabled (SSI-related) who have net pension or SSDI payments less than 138% FPL
  - People who have SSI with open-ended Medicaid coverage or an end-date of 12/31/9999 (just a reminder…this always applies)

Auto Renewal Exceptions

- Some Medicaid cases will not be automatically renewed
  - People with spenddowns
  - People in MBI-WPD
  - People who do not meet the criteria in the previous slide
  - MAGI cases (coverage through the Exchange)
- Recerts must be completed for anyone that does not meet the criteria for auto renewals
  - May be difficult to determine whether a case should be auto-renewed
  - Complete any recerts received to be safe
  - If recert is received, this is the time for case rebudgeting
  - Could potentially lower or eliminate a spenddown

Disabled Adult Child (DAC)

- May be able to avoid a spenddown
- Person must
  - Have been in receipt of SSI and lost eligibility due to initial receipt of or increase (not due to COLA) of SSDI benefit on a parent's work record
  - Be otherwise eligible for SSI (resources under $2,000)
- Can document eligibility for DAC budgeting with notice from SSA about SSI eligibility being terminated and the award letter from SSA about SSDI benefit eligibility starting
  - If verification is needed, can ask SSA for Benefit Summary – it shows history of benefits received by the person (can also request via online account)
- Can lose eligibility for DAC budgeting due to resources, but can be re-budgeted as DAC when resources are below limit again

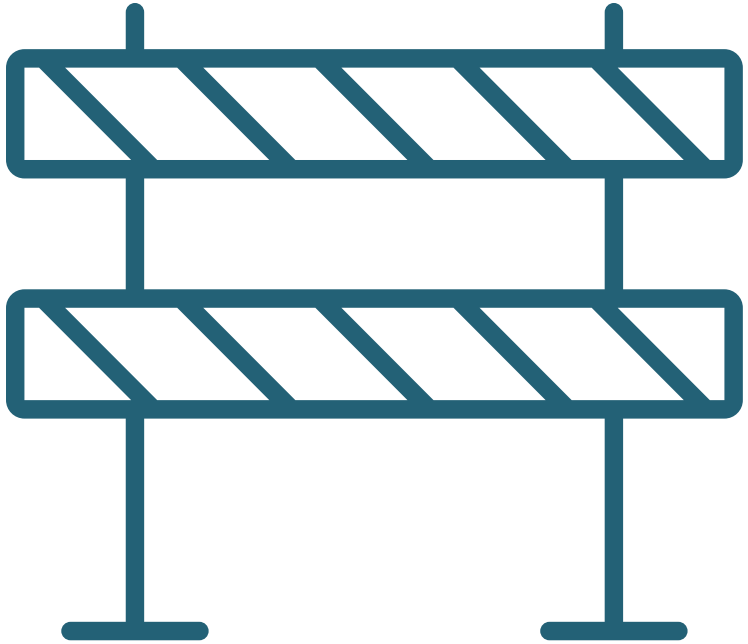
Meeting a Spenddown

- Payment (or incurred expenses) for a number of services/supplies can be used to meet a spenddown requirement
- If already paid, payments for the following can be used toward the spenddown if paid by the person (not someone else)
  - Physicians, dental and clinic visits, eye exams, lab tests and prescriptions/OTC drugs ordered by doctor
  - Therapists, nurses, chiropractics, personal care and home care aides as ordered by doctor
  - Durable medical equipment (DME) like medical/surgical supplies/equipment, hearing aids, eyeglasses and prosthetics ordered by doctor
- Expenses that do not qualify for meeting a spenddown include
  - Bills paid by Medicare or other TPHI
  - Bills used for a prior spenddown period

NOTE – CCO services cannot be used to meet a spenddown (not allowable by Medicaid)

Barriers to Medicaid

- Failure to recertify/incomplete information or documentation
- Auto renewal (if applicable) not completed by DSS/HRA
- Spenddown not paid
- Wrong coverage given
- Retroactive coverage not given
- Reluctance to apply for Medicaid
- Misunderstanding of importance of Medicaid coverage
- Immigration-related barriers



Best Practices

- Know when recertification is due and act timely
- Always ensure address on record with Medicaid is correct
- Report all changes that could potentially affect eligibility timely
- Pay attention to ALL notices and correspondence from Medicaid
- Find ways of helping person meet spenddown/ keep resources under the limits – request rebudgeting if needed; assist with DAC budgeting if needed
- Check coverage on Medicaid notice when Medicaid opens/is recertified – if wrong coverage is given (very common), follow up right away
- Ensure coverage for 3 months prior to Medicaid application date is given if needed and appropriate – if not, follow up right away
- Discuss openly with Care Manager and other service providers so when there is an issue, everyone can work together to address
- If you disagree with an action taken on a Medicaid case, file for a FH promptly

Be on the Lookout for…

Recertification packets

- Due back to DSS one month prior to expiration
- Due back to HRA two months prior to expiration
- Make sure to check the due date and submit timely
- If one is not received but you think it should have been, contact Medicaid district
- If one is received but should be auto-renewed
  - complete the recertification anyway
  - include cover letter stating the person belongs in one of the categories for auto-renewal
  - include any relevant documentation

NYSoH cases – not auto renewed!

Medicaid Coverage for OPWDD Services

Full Coverage (01)

- Pays for all Medicaid covered services/supplies
- Must document resources for last 5 years

Community Coverage with Community-Based Long-Term Care (19 or 21)

- Pays for OPWDD and HCBS Waiver services
- Must document current resources at application; attest at renewal

Community Coverage without Long-Term Care (20 or 22)

- Does NOT pay for HCBS Waiver services
- Does pay for Care Management services
- Can attest to resources at application and renewal

PCP Full Coverage – Managed Care (30)

- MMC okay, but not MLTC plans like PACE, MAP, HARP
- Attest unless requesting long-term care (Waiver services)

Fair Hearing Rights

- Aid to Continue (A/C or AC)
  - Request within 10 days of notice
  - Maintains current coverage until hearing is held and decision is made
- After 10 days, can request Fair Hearing (no AC) up to 60 days after notice is received
- Always request a Fair Hearing if needed, even after 60 days or no notice received

Office of Temporary and Disability Assistance (OTDA)

- Can request online, by phone, by fax, or in Albany/NYC, can do in person
- Request Hearing | Fair Hearings | OTDA (ny.gov)

Available Resources

OPWDD's Benefit Development Resource Toolkit:
Benefit Development Resource Toolkit | Office for People With Developmental Disabilities (ny.gov)

NYS Medicaid Information:
https://www.health.ny.gov/health_care/medicaid/

Medicaid program information:
https://www.medicaid.gov/

Set up Online Account for SSA:
https://www.ssa.gov

Questions?