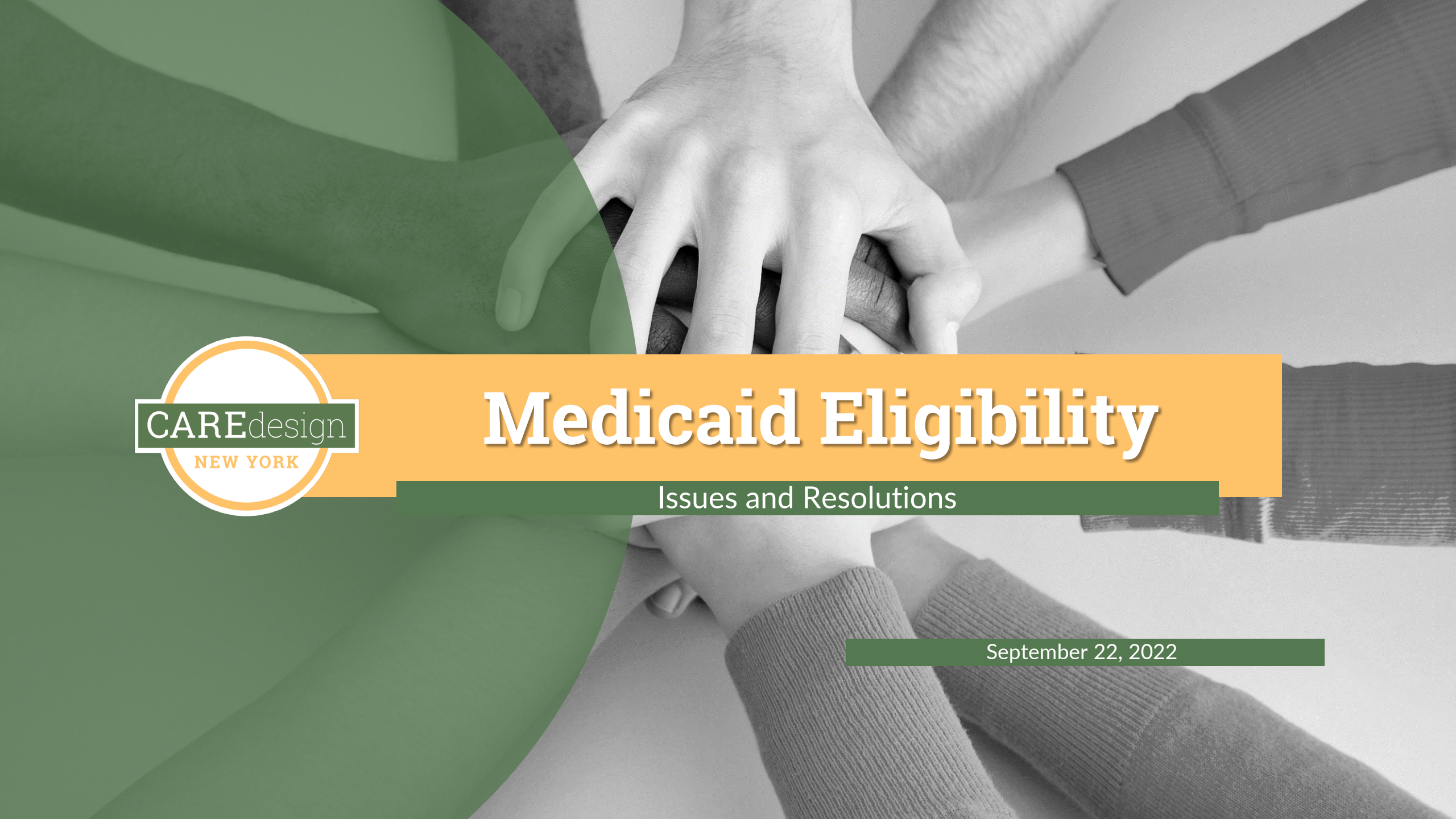

CAREdesign
NEW YORK

Medicaid Eligibility

Issues and Resolutions

September 22, 2022

Agenda

- Medicaid Overview
- Obtaining Coverage
- Medicaid Spenddowns
- OPWDD's HCBS Waiver and Medicaid
- Disabled Adult Child (DAC)
- Types of Coverage Available
- Managed Care
- Liability for Services regulations (14 NYCRR 635-12)
- Fair Hearings

Medicaid Overview

- Public health insurance
- Funded by state and federal gov't
- Overseen by NYS Department of Health
- Administered by Local Departments of Social Services (DSS) in each County in NYS, aka "Medicaid districts" or "County Medicaid Offices"
- In NYC, administered by Human Resources Administration (HRA)
- DSS/HRA offices also administer other public benefits like SNAP, TANF, HEAP, etc.

Medicaid Overview

Medicaid Provides:

- Medical coverage
- Payment for medical supplies and medications
- The basis for HCBS Waiver enrollment (must have Medicaid)
- Payment for OPWDD services
- Additional coverage for people with other health insurance
- Reimbursement of other health insurance premiums if Medicaid determines it is cost-effective
- Payment for Care Management services provided by CCOs

New York State of Health (NYSoH)

- NYS' Health Insurance Exchange
- General population uses to:
  - Obtain health insurance
  - Obtain subsidized (advance income credits) health insurance
  - Obtain Child Health Plus (does NOT pay for OPWDD services)
  - **Obtain Medicaid**
    - **MAGI eligibility**
    - No resource test
    - Data matches

NYSoH Coverage

- Must be financially eligible with MAGI budgeting
  - No special budgeting
  - No spenddowns allowed
  - Coverage based on financial factors, not disability
- Disabled individuals and people in/applying for OPWDD Waiver should be handled via DSS, but may obtain coverage on NYSoH first if financially eligible
  - Adults – not mandatory to change to DSS
  - Children – mandatory to change to DSS
- Transition processes

Departments of Social Services (DSS)

- Non-MAGI eligibility
- Most individuals with I/DD have Medicaid via DSS
  - County Medicaid offices
    - DAC and other special budgeting
    - Spenddowns are allowed
    - Work incentives available
    - Medicare Savings Program (MSP)
- Receives cases from NYSoH that NYSoH determines belong with DSS and those actively transitioned by a person or someone assisting them

Supplemental Security Income (SSI) Recipients

- SSI recipients are automatically eligible for Medicaid
- Case is opened as result of approved SSI application
  - If applying for SSI, always advisable to apply for Medicaid anyway
  - Protective filing dates
- Medicaid is administered by DSS
- Report changes to SSA and Medicaid
- No recertification is needed
- Continuing Disability Review (CDR)

Medicaid Excess Income (Spenddown)

Medicaid Coverage Codes indicating spenddown, or possible spenddown

- **06** (provisional coverage) – person has a spenddown and has not paid it
- **09** (Medicare Savings Program) – person gets help paying for Medicare premiums but does not have Medicaid coverage (possible unpaid spenddown or other situation)
- **21** (outpatient coverage with community-based long-term care) – person has a spenddown and has paid it
    - Or, some Medicaid districts will give 01 (full coverage) or 19 (community coverage with community-based long-term care) when spenddown is paid – that's fine
- **Be on the alert for 06 and 09 coverage** – no OPWDD providers can bill/be paid, including doctors, pharmacies, etc., and may deny services
    - Work with people to help them understand reason for and importance of paying spenddown/keeping coverage active
    - People who refuse to pay can be billed by OPWDD providers for the full cost of services provided

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)***

OPWDD's HCBS Waiver

Allows certain Medicaid rules to be "waived"

- Katie Beckett
- Parents' income does not count for the child's Medicaid budget
- Specialized services can be provided in the community instead of an institutional setting

Most OPWDD services are Waiver services

- Require the right type of Medicaid coverage
- Must access a Waiver service regularly to stay in the Waiver
- Children whose parents' income is too high to qualify for Medicaid need the Waiver to access Medicaid
    - Cannot keep Medicaid coverage if not enrolled in the Waiver

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 lose eligibility for DAC budgeting due to resources, but can be re-budgeted as DAC when resources are below limit again

Medicaid Coverage Codes

- 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)

Mainstream Managed Care (MMC)

- Some people are not allowed to enroll in MMC (excluded)
  - People with spenddowns
  - People who also have Medicare
  - People who have TPHI
  - People who reside in DC/ICF
  - People receiving hospice care
- If someone is enrolled in MMC and then meets one of the above criteria for exclusion, they will have to disenroll from MMC but will still be eligible for Medicaid
- Can enroll in Partial LTC plans BUT cannot get Waiver services

Maintaining Medicaid Eligibility

- SSI recipients do not have to recertify their Medicaid
- Other Medicaid recipients must recertify their coverage annually
  - Return recertification form promptly to avoid lapse in coverage (even if person gets SSI and should not have to!)
  - Must submit forms to Medicaid district before coverage expires
    - Recerts due back prior to expiration date – cases closed if not received by the deadline given in the recert packet
    - If not submitted by recert deadline given, but before expiration would have occurred, case can be reactivated; otherwise, whole new app is needed
- Report all changes timely
  - Change in address, change in income or resources that would impact eligibility, loss of job, change in household size, etc.
- If any issues arise, contact Care Manager or residential agency right away!

COVID-19 and Medicaid Coverage

- March 18, 2020
  - No loss of coverage
  - No downgrade of coverage
  - No need to recertify
- Federal Public Health Emergency (PHE)
  - Expires 10/15/2022
  - Feds will give 60 days notice to states
  - States will have some flexibility in re-implementing regular processing rules for programs like Medicaid
  - Important to stay informed!!

Be Prepared when PHE Ends

- Make sure addresses are up to date
  - Medicaid mail will not be forwarded – returned mail will result in case closings
  - If there is an issue with an address, take care of that now to avoid disruption of coverage
  - Keep an eye on any notices or correspondence from Medicaid and respond timely
    - Recerts not required, but can still be done if recert packet is received
    - Once recerts are again required, this must be done whether or not packet is received

Barriers to Medicaid

- Failure to recertify/incomplete information or documentation
- 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
  - Return all needed docs timely
  - If recert packet not received, contact Medicaid or CM for assistance
- Find ways of helping person meet spenddown/keep resources under the limits
- Check coverage on Medicaid notice when Medicaid opens or 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

Fair Hearings

- 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)

Liability for Services, 14 NYCRR 635-12

- Requires providers to bill individuals for the cost of their services if Medicaid lapses
- Billing for services provided in a given month must be billed no later than 30 days after the last day of the month in which the service was provided
  - For example, for services provided in May, must bill by June 30
- Service providers can refuse services to someone who does not have Medicaid coverage in many cases
- Physicians and pharmacies can refuse services or require payment from the person if they do not have Medicaid coverage

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/

- Work incentives information:

  https://www.ssa.gov