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Medicaid Eligibility: Maintaining Medicaid for People with Intellectual and Developmental Disabilities in New York State

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Partnership Solutions

Housekeeping

- All participants will remain muted to ensure minimal disruptions.
- If you have a question, please submit in the Q&A feature of the Teams Webinar! We'll leave time halfway through the presentation, and at the end for questions.
- This presentation will be distributed to all attendees.
- Due to the forum and the number of providers involved, please be mindful about sharing any PHI or PII during the webinar.

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AGENDA

- Medicaid Changes
- Medicaid Updates
- Keeping Coverage
- Troubleshooting

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Medicaid Changes

- Medicaid funding basics
- Changes on the horizon
- Impacts to people with IDD
- Ways to be proactive

NYS Medicaid Funding Simplified

- **Medicaid Funding**
  - State and Federal
  - Federal Medicaid Assistance Percentage (FMAP)
  - NYS and Feds share Medicaid costs 50/50 in NYS with exceptions

- **Two ways to get Medicaid coverage in NYS**
  - Department of Social Services (DSS) or the Human Resources Administration (HRA) in NYC
  - New York State of Health (NYSoH) health insurance marketplace, aka “The Exchange”

- **People with IDD should and largely do have Medicaid via DSS/HRA rather than via NYSoH**
  - Compelling reasons for this, including avoiding some of the potential impacts of Medicaid changes

NYSoH and the Affordable Care Act

- **Affordable Care Act (ACA) passed in 2010**
  - Intent was to increase access to healthcare
  - Incentivized states with higher FMAP for expanding certain programs like Medicaid
    - NYS tends to be a leader in Medicaid expansion efforts
      - Created New York State of Health (NYSoH)
    - 90% FMAP for Medicaid expenditures for people with Medicaid via NYSoH
      - Different eligibility criteria
      - Not intended to provide Medicaid to people in the IDD service delivery system, but some have obtained coverage this way
  - This is the expanded Medicaid that is in focus for many of the changes coming
    - Important to know who “Medicaid Expansion Group” refers to

Benefits of DSS/HRA Coverage

- **Most beneficial budgeting available through DSS/HRA**
  - NYSoH Medicaid eligibility based on Modified Adjusted Gross Income (MAGI)
  - If person has more income than the MAGI limit, they lose Medicaid coverage
- **Others can more easily assist individuals in maintaining coverage or resolving coverage issues**
  - NYSoH is difficult to communicate with if you are not the person themselves
  - NYSoH staff cannot assist the person if they do not have their account information
  - Identify NYSoH coverage on ePaces as transaction district 78
- **IDD-specific benefits & entitlements trainings relate to Medicaid through DSS/HRA**
  - NYSoH eligibility rules are different and are not interchangeable with DSS/HRA rules
- **Changes that will impact NYSoH/Medicaid Expansion Group may not benefit the people we support**
  - Work requirements
  - More frequent eligibility reviews
  - Others

Medicaid and Disability Determinations

- **NYSoH is for people who are financially eligible for Medicaid and are not disabled/seeking Waiver services**
  - People can be eligible through NYSoH if they have low income
  - Eligibility for Medicaid on NYSoH does NOT involve a disability determination
- **People who receive SSI or SSDI have a disability determination from SSA because being determined disabled by SSA is a requirement for both programs**
- **People in receipt of certain special Medicaid budgeting (like MBI-WPD) have already been determined disabled by Medicaid because disability is a requirement for the program**
- **Disability determinations, whether through Medicaid or SSA have to be reviewed periodically**
  - Social Security conducts Continuing Disability Reviews (CDR) every 1-7 years
  - Medicaid disability certificates also expire and must be reviewed/renewed by Medicaid periodically (usually every 2 years)

Federal Medicaid Changes

- **Some impactful Medicaid changes may be avoided if a person is certified disabled**
  - Work requirement
    - Goes into effect January 1, 2027
    - Applies to ABAWD (Able-Bodied Adults Without Dependents)
      - “Dependents” does not include people over age 14
      - Unknown whether there will be further exemptions for disabled dependents who are over 14
  - Cost sharing
    - In effect April 1, 2025
      - Dual-eligible, HCBS Waiver enrollees and people 65+ exempt

Federal Medicaid Changes

- **Medicaid eligibility review twice a year**
  - In effect October 1, 2027
    - For Medicaid Expansion Group (NYSoH)
    - Requires data matching and review by Medicaid program but does not necessarily require person to do anything (not a traditional “recert” process)
    - Redeterminations on NYSoH are based on Modified Adjusted Gross Income (MAGI) reported on individual tax returns, conducted via IRS data matches

- **Retroactive coverage changes**
  - In effect October 1, 2027
    - Changes from 3-month retroactive eligibility to 2 months for disabled
    - Increases the importance of timely recertifications to avoid gaps in coverage

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Stay Tuned!

Questions?

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Foundational Medicaid Information

From this point forward, all references to Medicaid refer to coverage obtained via DSS/HRA

- **Medicaid eligibility income and resource limits change every year with the FPL changes**
  - OPWDD posts these on their website

- **Medicaid recertifications generally occur annually – some longer eligibility periods allowed**
  - Recertification packets are sent to Medicaid beneficiaries to complete and return by a specified deadline (may be earlier than the Medicaid expiration date)
    - HRA prefills recertification forms and beneficiary only indicates any changes
    - DSS does not prefill recertification forms and beneficiary must provide all info

- **People who receive Supplemental Security Income (SSI) are categorically eligible for Medicaid**
  - Recertifications are not required for people who have SSI and Medicaid
  - Resource limit is $2,000 for SSI recipients (differs from standard Medicaid resource limit)
  - SSI recipients cannot have a spenddown

Foundational Medicaid Information

- **There may be special budgeting available for people to help obtain/retain coverage – some examples:**
  - Medicaid Buy-In for Working People with Disabilities (MBI-WPD)
    - Allows disabled people who work to have higher income and resource limits
  - Disabled Adult Child (DAC)
    - Allows an adult in receipt of Social Security Disability Insurance (SSDI) payments based on a parent's work record to avoid a spenddown if they received SSI just prior to SSDI
    - Resource limit is $2,000 - because it is based on prior receipt of SSI payments, follows the SSI resource limit requirement
  - Pickle
    - Allows someone whose SSDI COLA puts them above the income limit for Medicaid to maintain their coverage without paying a spenddown

Calculating Income

- **NOT ALL INCOME "COUNTS"**
  - Financial eligibility for Medicaid is based on "countable" income
  - Some income is not included for Medicaid budgeting purposes (not "countable")
    - The amount that is not included is called an "income disregard" or "income exemption"
    - **Total income <u>minus</u> applicable income disregards/exemptions = countable income**

- **Total Income includes Earned and Unearned Income**
  - Earned Income
    - from wages, tips, work performed whether for an employer or self-employed, whether legal employment or otherwise
  - Unearned Income
    - from sources not related to currently performing work, such as Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), State Supplementary Payment (SSP), and retirement benefits (and more)

Calculating Countable Earned Income

- **Countable Earned Income = half of the remainder of gross earned income after the first $65 is excluded (remember this…less than half of earned income "counts")**
  - Take gross monthly income amount and subtract $65 (the first $65 of earned income is disregarded)
  - Divide the remainder in half (half of earned income after the $65 is subtracted is disregarded)
  - Result is total countable earned income

- **Example – gross wages of $500/month**
  - ($500 – $65)/2 = countable earned income
  - $435/2 = **$217.50 in countable earned income**
  - If this person's only income is earned income, total countable income = $217.50

Calculating Countable Unearned Income

- **Countable Unearned Income = total gross unearned income from all sources minus $20 unearned income disregard**
  - Note – if a person's only source of income is SSI, they do not receive the $20 disregard
  - If unearned income amount is less than the $20 disregard, it is first applied to unearned income and the amount of the unearned income disregard that exceeds the person's unearned income amount is applied to earned income prior to the earned income exemption
  - What does that mean in plain language??!

- **Example: gross SSDI payment of $900/month**
  - $900 – $20 = countable unearned income
  - $880 = countable unearned income

Calculating Total Countable Income

- **Total countable income = total countable unearned income + total countable earned income**

- **Example: $500/month in wages AND SSDI payment of $900/month**
  - Calculate countable earned income by applying earned income disregards
    - ($500 - $65)/2 = $217.50
  - Calculate countable unearned income by applying unearned income disregard
    - $900 - $20 = $880
  - Add countable earned income and countable unearned income together
    - $217.50 + $880 = $1097.50/month in total countable income

Countable Income and Medicaid Eligibility

- **To determine financial eligibility for Medicaid, compare total countable income to applicable Medicaid income limit**
  - If countable income is equal to or less than the Medicaid income limit, person is financially eligible for Medicaid (assuming resources are under the applicable limit for the person)
  - If countable income is greater than the Medicaid income limit, the amount over the limit is called “excess income” and is the basis for a spenddown
    - Spenddowns must be satisfied for any month for which a person needs coverage
      - Pay directly to DSS/HRA (for up to 6 months at a time)
      - Present paid or unpaid bills for things that would be covered by Medicaid
        - Certain supplies/OTC items and others you may not immediately think of

Countable Income and Medicaid Eligibility

- **If countable income is higher than the Medicaid income limit**
  - This is where special budgeting may come into play to avoid a spenddown
    - Is the person working?
    - Do they have any qualifying expenses that could be used to meet the requirement?
    - If they receive SSDI benefits on a parent's work record, did they previously receive SSI?
    - Do they have a disability determination?
    - Would an income trust be a possibility for the person?

  - The questions above help to determine whether special budgeting may be available to the person to help protect their income
    - Work incentives
    - DAC budgeting
    - Qualifying income trust

Medicaid Recertifications

- **It is critical to understand recertification requirements**
  - Failure to recertify is one of the biggest issues in maintaining continuous coverage
    - Important to know when Medicaid expires and when a recert packet should be expected
    - Non-receipt of a recert packet can easily lead to case closure
    - If expecting a recert packet and have not received one, contact Medicaid to request
  - Deadlines are given on recert packets and must be adhered to
    - If a deadline cannot be met for good reason, an extension can be requested – do not just miss the deadline!
    - This allows a little more time for the recert to be submitted without impacting coverage

People Under 18 in the HCBS Waiver

- **Children enrolled in the HCBS Waiver – NOTE!**
  - Recertifications for HCBS Waiver-enrolled children (under 18) should include Supplement A, which is detail around income – in this case, the parent's income
    - This is being requested regularly by DSS/HRA, even though the parents' income is excluded from the child's budget if they are in the HCBS Waiver
    - Medicaid districts are required to apply the "most beneficial budgeting" available for the person; for children, this means they make 2 determinations:
      - As a member of the household, counting the parents' income
        - If the child is eligible for Medicaid at this point, Medicaid is approved on that basis. If they are NOT eligible for Medicaid with the parents' income included, a second determination is made with the parental income excluded
      - Second determination is as a "household of one"
        - These are "waiver kids" – children that qualify for Medicaid based on their documented need for HCBS Waiver services that they can only access if their parents' income is not counted toward the child's eligibility for Medicaid

Medicaid Best Practices to Avoid Disruption

- **ALWAYS make sure the person's mailing address in ePaces matches where they actually receive mail**
  - In recent months, we have become aware of individuals losing Medicaid because the recertification packet or other critical communications from Medicaid have been sent to an old address
  - Risks of not ensuring addresses are accurate and current can result in:
    - Notice being received by a person other than the intended recipient, making them vulnerable to fraud
    - Notice being returned to the post office
  - If a Medicaid recert or any other Medicaid-related correspondence is returned to the post office, it will NOT be forwarded – it will be returned to the Medicaid office that sent it
    - This will result in a closure of the case and loss of coverage

Medicaid Best Practices to Avoid Disruption

- **Report any changes that could impact eligibility (income, living arrangement, change of address, third-party health insurance coverage, etc.)**
  - Requirement is to notify the appropriate Medicaid district within 10 days of the change
  - Timely notification is critical to ensure coverage continues
  - People receiving SSI benefits must notify their SSA office for the change to be made
  - Changes can impact which Medicaid district is responsible for providing coverage, availability of special budgeting, changes to Medicaid income limits that could impact eligibility or whether someone has a spenddown, etc.

Medicaid Best Practices to Avoid Disruption

- **Review ALL notices, coverage decisions, and type of coverage given after recertification is submitted**
  - Medicaid is required to notify individuals of any changes to their coverage/case
  - Notification of negative action is required 10 days prior to the change
    - Spenddown determination
    - Increase in spenddown amount
    - Downgrade in coverage
    - Case closure
  - This is the best way to get ahead of any issues
    - It is easier to address issues before they happen, which is why the notice comes out in advance of the changes
    - Notices are issued to the person/advocate, not to the Care Managers
    - Share any info you know about the person's Medicaid eligibility or status based on communications from DSS/HRA that the Care Manager may not know about

Medicaid Best Practices to Avoid Disruption

- **File for Fair Hearings to protect coverage or appeal a decision**
  - Within 10 days of the notice
    - Can request Aid to Continue (AC) when filing for the FH
    - This allows all coverage and services to continue unchanged until a hearing is held and a decision has been made on the appeal
      - Medicaid remains open
      - Spenddown situation does not change
      - Medicaid coverage type remains the same
  - Within 60 days of the notice
    - Aid to Continue (AC) not available because change has already occurred (request anyway – worth a try!)
    - Fair Hearings take a while to get scheduled – process is:
      - Request a FH
      - Notice is issued to acknowledge the FH request
      - Notice is issued with the scheduled date/time and location for the FH
      - FH is held (if a person cannot make the appointment, or cannot appear in person, they can request a different date/time/location – no shows are NOT advisable!)
      - FH decision is made and notice of decision is sent
      - Monitor to ensure decision is upheld and if not, can file for another hearing for the decision to be enforced (not typically needed, but sometimes!)

Concerns and Current Issues

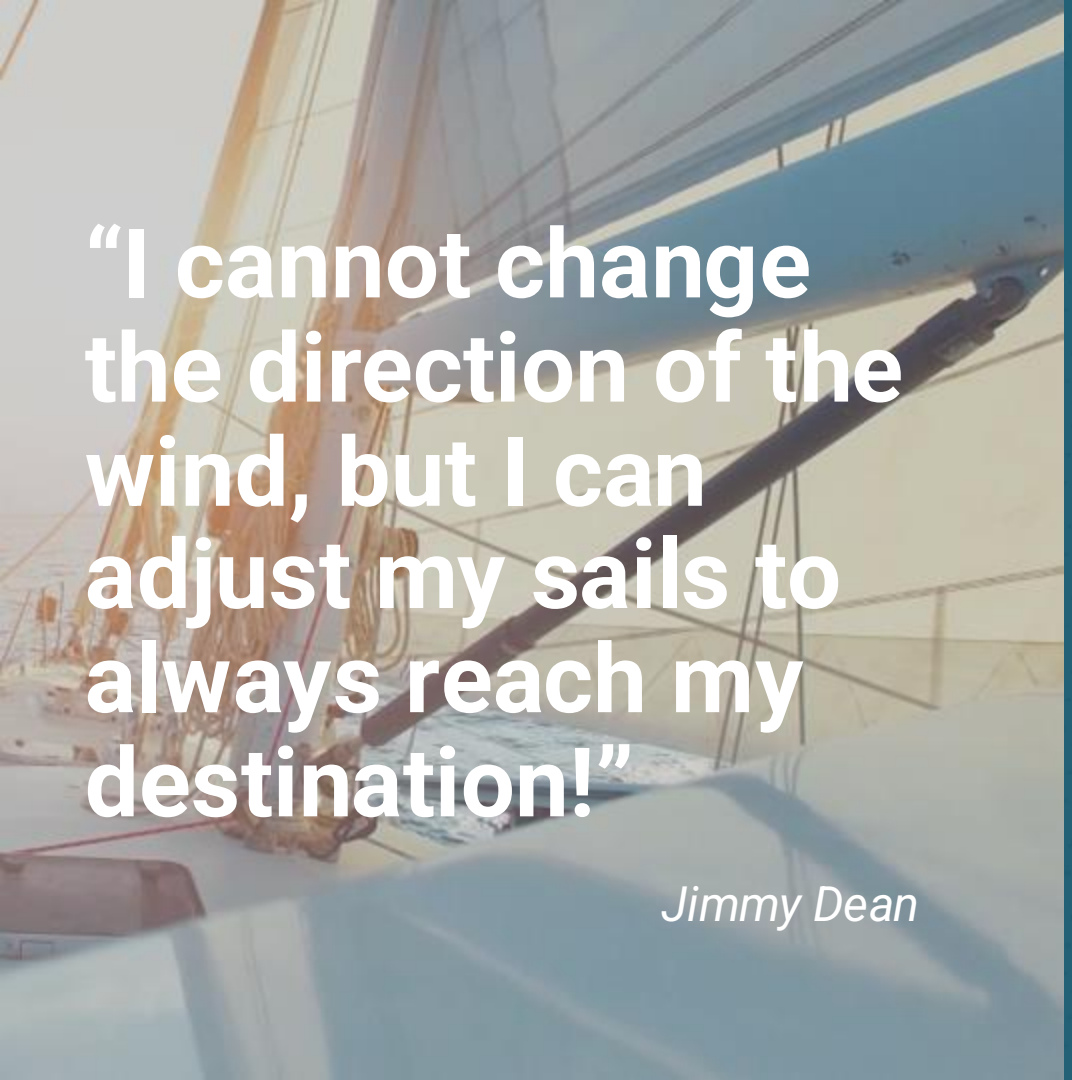
- **What we are hearing**
  - Medicaid being closed without notice
    - Notices are sent in most situations but may not be received for a variety of reasons
    - If this happens, contact the Medicaid district immediately for a copy of the notice
    - File for a Fair Hearing
  - Medicaid being closed for no reason
    - There is usually a reason, but it may not be readily apparent (and it may not be a good/valid reason!)
    - Review the notice and File for a Fair Hearing
  - Documentation being requested that does not seem like it should be needed
    - Common request is parental income – must be provided even if it will be waived
    - Other requests must also be responded to – disagreeing with what is being asked will delay the process further
    - Medicaid has requirements around many things that may not be evident to recipients and advocates, and if they request information, they need to get it to move forward
    - While a CM can assist in understanding what is being requested, they cannot convince Medicaid to not require it
      - If something is requested that is unusual and cannot be provided for a valid reason, Medicaid should be contacted in that situation to discuss if there is an alternative

Children Losing Medicaid

- **Medicaid being discontinued at recert for children – file for a FH immediately**
  - Children under 18 whose parents have income that exceeds the Medicaid income limit can have their parents' income "waived" when applying for Medicaid to be able to access Waiver services (not just to access Medicaid for other reasons)
    - A basic requirement for parental income to be waived is that the child must have a disability determination completed when they apply for Medicaid
    - During COVID, some disability determinations may not have been completed by the State as part of the PHE, which is causing issues for continued Medicaid coverage for these kiddos
- **During recert time, if a person does not have a disability determination, their case may be transferred to NYSoH (this is an example of the importance of disability determinations as we move forward)**
  - NYSoH does not have any special budgeting (i.e., waiving parental income is not possible), so children in these situations will have their cases closed
  - DOH and OPWDD are aware of this issue and are working together to try to get the affected children back to DSS/HRA for disability determinations

In Conclusion

- **Medicaid is complicated and nuanced and seems to get more so every day**
- **Individuals, providers, advocates all need to work together to ensure uninterrupted coverage**
- **There is a lot of concern and anxiety out there around impending Medicaid changes**
    - There is also a lot of advocacy overall for Medicaid funding to avoid some of the indirect impacts to people with IDD and other vulnerable populations
    - Overall advocacy needs to be balanced with factual, reliable information about how the changes may impact people
- **Educating ourselves about the changes and impacts allows us to best support the people relying on all of us**
    - Individuals/families may be uninformed/ill-informed and feel very helpless and scared
    - We all need to be able to identify the areas where there may be impacts and the areas where there are protections/exemptions for people with IDD and help people navigate how to access those protections/exemptions (like obtaining a disability determination, for example)
    - There is a tremendous amount of advocacy going on around the things we cannot control, but we have a handle on the things that we can and we stay focused on that and being proactive while we continue to monitor the state and federal implementation of changes.



“I cannot change the direction of the wind, but I can adjust my sails to always reach my destination!”

Jimmy Dean

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Questions?

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