Module 14: Medicaid

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MODULE 14 LEARNING OBJECTIVES

1. Review Medicaid coverage and eligibility.
2. Explain different Medicaid programs.
3. Understand.

MEDICAID BASICS

Medicaid is a federal and state program that covers medical care for certain people with limited income and assets. Unlike Medicare, Medicaid is a means-tested program, meaning individuals must show that they have limited income and assets in order to qualify.

The federal government establishes broad guidelines, including minimum standards, for the Medicaid program, and states determine specifics. Although each state uses financial eligibility rules, the income eligibility levels vary from state to state above a federally established floor. States also determine the type, amount, duration, and scope of Medicaid-covered services, within federal requirements, and decide how much providers get paid for those services.

States run various Medicaid-funded programs for different groups of people, known as eligibility categories. These categories include children, pregnant people, parents and/or caretakers of children, older adults, people with disabilities, and, in many states, individual adults who don't fit any of these categories. Medicaid first determines if an individual fits one of these categories, and then assesses their financial eligibility. Categories may have different income and asset eligibility levels as well as benefits.

There are also Medicaid options for people with limited incomes and assets who need nursing home care or community-based long-term care services such as personal care services (e.g. bathing, dressing, toileting, personal hygiene, ambulation, housekeeping and meal preparation).

An individual is eligible for Medicaid if they meet income and asset requirements **and** are in one of the eligibility categories mentioned above.

All state Medicaid programs are required to cover the following benefits at a minimum:

1. Inpatient and outpatient hospital services
2. Nursing facility services
3. Home health services
4. Physicians' services, laboratory services, and x-rays
5. Rural health clinic services
6. Transportation to medical services
7. Family planning services, nurse midwife services, tobacco cessation counseling for pregnant people, state-licensed freestanding birth centers
8. Pediatric and certified family nurse practitioner services

Note that services such as inpatient and outpatient hospital services, home health care, and physician services are also covered by Medicare. Please refer to next section on Medicare and Medicaid.

In New York, the Medicaid program is overseen by NYS Department of Health (DOH). MAGI Medicaid applications are handled by New York State of Health (NYSoH) exchange. Non-MAGI Medicaid applications are handled by an individual's local Department of Social Services (DSS) or, for New York City residents, the Human Resources Administration (HRA).

For more information about Medicaid, refer to the Medicaid Reference Guide (MRG), which is used to assist districts in determining Medicaid eligibility for applicants/recipients. https://www.health.ny.gov/health_care/medicaid/reference/mrg/

MEDICARE AND MEDICAID

If an individual qualifies for Medicare and Medicaid, the two programs work together to cover an individual's health care needs. These individuals are known as dually eligible individuals, dual eligible, or duals. These individuals can have Medicaid and Original Medicare or a Medicare Advantage Plan.

There are also partial dual eligibles—individuals who get assistance with Medicare premiums from a Medicare Savings Program (MSP) but do not have full Medicaid. MSPs help pay some Medicare costs. For more information, see HIICAP Notebook Module 9: Medicare Savings Programs.

When an individual has Medicare and Medicaid, Medicare pays first for all health care claims and Medicaid is the payer of last resort. This means that Medicaid pays after all other health insurance has paid. For those with just Medicare and Medicaid, Medicare will pay first, and Medicaid will pay second. Note that an individual who has Medicare and Medicaid should keep their Medicare Part D prescription drug coverage. They need Medicare drug coverage, even if they have Medicaid.

A full dual eligible will not usually have to pay Medicare Part A (if applicable) and Part B premiums or cost-sharing such as deductibles and coinsurances. For example, if an individual receives outpatient hospital services, which are covered by both Medicare and Medicaid, then

Medicare pays first and Medicaid pays up to its approved cost for the service. If this cost is less than Medicare's approved cost, then Medicaid pays nothing. This means that the provider does not get paid for the coinsurance or copayment.

Medicaid can also provide coverage for items and services that Medicare does not cover, such as routine dental services. States determine what additional services—beyond the federal minimum—are covered by their Medicaid program. For example, New York Medicaid covers dental care. Even though Medicare generally does not cover dental care, duals could receive covered dental services in accordance with New York's Medicaid coverage rules. In this case, as long as an individual has no other coverage, Medicaid would pay first for the services received.

Dually eligible individuals should see providers who accept Medicare and Medicaid in order to have the best coverage of their services with the lowest out-of-pocket cost. However, be aware that many physicians do not accept patients enrolled in Medicaid, which creates significant problems with a beneficiary's access to care.

Remember: Medicaid is the payer of last resort. If an individual is eligible for Medicare, they should enroll in Medicare. Generally, Medicaid is only responsible for paying after Medicare.

Why take Medicaid as secondary?

Clients may question why they need Medicaid as well as Medicare. Medicaid can help pay out-of-pocket costs for Medicare. Also, Medicaid will cover some services that Medicare does not. Reference the list below for some of the important ways that Medicaid can fill in the gaps for Medicare:

1. **Medicaid may help pay Medicare cost-sharing:** Medicaid helps with a variety of costs, including Part A hospital deductible and coinsurance, additional days in the hospital for those who have run out of Medicare-covered days, Part B annual deductible, and the Part B coinsurance for outpatient services.
    a. Original Medicare Part B coinsurance: Medicaid will only pay the 20% Part B coinsurance if the Medicaid rate is higher than the Medicare rate for the service (NY Social Services Law 367-a, subd. 1(d)(iii), as amended 2015). A Medicaid provider is prohibited from balance billing an individual who has Medicaid. A Medicare provider may not bill a Qualified Medicare Beneficiary (QMB) recipient even if the provider does not accept Medicaid. (For more information, see HIICAP Notebook Module 9: Medicare Savings Programs.)
        i. Example: The Medicare rate for a doctor's visit is $100, so the 20% coinsurance would be $20. If the Medicaid rate for the same service is $80 or less, Medicaid would pay nothing, as it would consider the doctor fully paid.
        ii. 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. Medicare Advantage copayment/coinsurance: 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.

    i. Exceptions: Medicaid/QMB will pay the full coinsurance for ambulance and psychologist services. In 2019, the Governor proposed to repeal the exception for ambulances, but this was rejected by the legislature.
    ii. 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.

2. Medicaid may cover services that Medicare does not usually pay for: Long-term care, vision, hearing, dental, and other services excluded from Medicare coverage may be available through Medicaid. The beneficiary should receive these services from a Medicaid provider. Services are subject to limitations set by the state. Certain services, like long-term care, may also have additional eligibility requirements.
3. Medicaid beneficiaries receive Extra Help: This federal program works with Part D to lower prescription drug costs. Medicare beneficiaries who qualify for Medicaid automatically receive Extra Help. More specifically, a beneficiary who qualifies for Medicaid for one month within a calendar year receives Extra Help for the remainder of the year. If the month an individual qualifies for Medicaid is in the second half of the calendar year, the beneficiary is also eligible for Extra Help for the entirety of the next calendar year. For more information, see HIICAP Notebook Module 10: Extra Help.

Note: Medicaid acts as secondary only if the provider accepts Medicare and Medicaid. If a dually eligible individual goes to a Medicare-only provider for services, they are responsible for the cost-sharing after Medicare pays, unless they are a QMB beneficiary. For more information, see the balance billing rules in HIICAP Notebook Module 9: Medicare Savings Programs.

Medicaid and Medigaps

Low-income Medicare who need help paying for cost-sharing often Medicaid or the Qualified Medicare Beneficiary (QMB) program to cover the costs Medicare does not. However, Medicaid and QMB will only pay coinsurance and deductibles to doctors and other providers who accept Medicaid. And even when a provider accepts Medicaid, New York Medicaid may not pay the entire Part B coinsurance. So, some low-income beneficiaries prefer to have a medigap policy. A medigap assures providers, who might otherwise not want to see a Medicaid recipient, that they will receive full payment.

Medigap insurance premiums are an allowable deduction from income for disabled, aged, and blind Medicaid budgeting. Medigap premiums can also be used towards a Medicaid spend-down. However, know that many seniors eligible for Medicaid cannot afford Medigap premiums.

Remember that providers may not bill QMB recipients for the Part B coinsurance: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf.

Note that Medigap policies may not be sold to individuals with full Medicaid, meaning that they have Medicaid without a spend-down. 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.

Suspending Medigap coverage: 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, they 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.

MEDICAID FEE FOR SERVICE AND MANAGED CARE

Medicaid beneficiaries typically either receive their benefits through fee-for-service (FFS) Medicaid or via a Medicaid Managed Care (MMC) plan.

- FFS: the plan offered by the state. Beneficiaries can go to any doctor that accepts Medicaid.
- MMC: a private plan that provides Medicaid benefits. Enrollees usually must use in-network providers or receive prior authorization from their plan before getting certain kinds of care. Beneficiary may need primary care doctor's referral before seeing a specialist.

With FFS, Medicaid services are paid on a per-service basis (similar to Original Medicare). In managed care, plans are paid a capitated rate (flat monthly fee) for the care their enrollees require. Contracted network providers are paid by the plan for services received by enrollees.

Keep in mind that there are different types of managed care plans. Mainstream managed care plans cover all Medicaid services, including primary, acute, and long-term care. Health & Recovery Plans (HARP) are only available to individuals with behavioral health needs. Managed long-term care (MLTC) plans only cover an individual's long-term care. Some dually eligible clients may be in Medicare and an MMC, HARP, or MLTC. Also remember that beneficiaries may have their Medicaid coverage paired with a Dual-eligible Special Needs Plan (D-SNP) for their Medicare coverage. We will discuss this further in later sections.

There are groups of people who are excluded or exempt from Medicaid managed care. For more information, see: GIS 15 MA/012 - Medicaid Managed Care Exemptions and Exclusions -- PDF Attachment 1 (Exclusions) - Attachment 2 (Exemptions) - download at http://www.health.ny.gov/health_care/medicaid/publications/pub2015gis.htm

Note that certain populations previously excluded from managed care must now enroll, including SSI recipients, people with HIV/AIDS, homeless individuals, adults with serious and persistent mental illness (SPMI), children with serious emotional disturbances (SED), working people under 65 with disabilities in MBI-WPD program, and hospice recipients. Dually eligible individuals, who previously were also excluded, now are, in certain cases, also eligible to enroll in a managed care plan.

MEDICAID ELIGIBILITY

Medicaid financial eligibility rules are different for different categories of people. Modified Adjusted Gross Income (MAGI) Medicaid provides Medicaid eligibility for people under age 65 who do not have Medicare. The disabled, aged, blind (DAB) category of Medicaid is for seniors age 65+ and disabled people under 65. Also known as the non-MAGI category. Most Medicare beneficiaries have this type of Medicaid.

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

    1. MAGI details:

        - Income limits – 138% federal poverty level (FPL) for most adults, with higher limits for pregnant women and children.
        - 12-month continuous coverage – If an applicant is eligible when they apply or are reauthorized, they remain eligible for a full 12 months, even if their income increases during that time, or even if they become enrolled in Medicare because of a disability. The only exception to this is if they turn age 65 during the 12 months. Then their Medicaid case is referred by NYSoH to LDSS to redetermine eligibility under non-MAGI rules.
        - 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 NYSoH. However, certain groups of people, such as individuals who need to enroll in a managed long-term care plan or who need nursing home care, must apply through the LDSS.

    2. **Essential Plan** – Health insurance for New Yorkers who are between age 19 – 65, whose income is above the MAGI Medicaid level. Essential Plan benefits individuals who are above the income limit for Medicaid and not yet eligible for Medicare but still have limited income and resources.

        - Income limits – 250% FPL The NYS Budget enacted in April 2022 increases the income limit from 200% FPL to 250% FPL
        - Access to same benefits as Medicaid
        - Immigrants whose income is below 138% FPL and whose immigration status is either PRUCOL or subject to the 5-year bar on federal law are in the Essential Plan instead of Medicaid.
        - Costs – Essential Plan is free for those under 150% FPL. Above that limit, $20 monthly premium. The additional premium for dental and vision coverage was eliminated (April 2021). There are copayments charged for most services, but the Essential Plan is much less expensive than the alternative of purchasing a private Qualified Health Plan on NYSoH using cost sharing subsidies and advance premium tax credit. See https://info.nystateofhealth.ny.gov/EssentialPlan.

2. **NON-MAGI –** DAB Medicaid includes all people age 65+ *or* under age 65 and disabled or blind. This population may have Medicare. Landmark increases took effect Jan. 1, 2023. The Medicaid income levels for non-MAGI Medicaid is now set at 138% of the federal poverty level. This is the same limit used for MAGI Medicaid.

1. Non-MAGI details:
    - Income limits – 138% FPL. Note that while income limits for MAGI and non-MAGI are the same, rules for what income is counted and what income is disregarded are different.
    - Asset test – unlike MAGI, non-MAGI applicants must also meet an asset test.
    - DAB Medicaid offers a spend-down program, allowing people over income to use medical expenses to reduce their income to the Medicaid limit.
    - Paper application must be mailed or faxed to LDSS. Cannot be completed online or submitted electronically.
    - Supplemental Security Income (SSI) – Provides cash assistance to the needy elderly, certified blind, and certified disabled who qualify based on having low income and limited resources. Recipients automatically qualify for Medicaid.
    - Certain groups may choose MAGI budgeting if it is more advantageous than non-MAGI budgeting (example: those receiving Social Security Disability Insurance but in the 24-month waiting period for Medicare, or parent/caretaker relatives).
    - There is a lookback period as well as other separate rules for Institutional Medicaid (nursing home) and community-based long-term care, with penalties on transfers of assets.
2. Within the DAB category are numerous subgroups with different budgeting rules:
    - Medicaid Buy-In for Working People with Disabilities (under age 65 only, disabled and working): subgroup with higher income and asset limits than regular DAB individuals – must be working at least a minimal amount.
    - Disabled Adult Children (age 18+ and disabled before age 22 receiving SSA Disabled Adult Child benefits and remain otherwise eligible for SSI but for the increase in income; must have less than $2000 in assets).
    - Medicaid Cancer Treatment Program (MCTP) for Breast, Cervical or Prostate Cancer
    - Those seeking Medicaid subsidy for COBRA premium
    - See other special budgeting possibilities at http://www.wnylc.com/health/entry/222/

DAB MEDICAID ELIGIBILITY

Fact sheet on DAB rules: http://health.wnylc.com/health/entry/144/

2024 Income Limits for DAB Medicaid

Household Size	Monthly Income 2024
One	**$1,732** ($1,752– after $20 disregard)
Two (married)	**$2,391** (**$2,371** – after $20 disregard)

Resource (Assets) Limit - 2024

Household Size	Age 65+, Disabled or Blind < 65 Not Working	Disabled or Blind < 65 Working (MBI-WPD)
	2024	2024
One	$31,175	$31,175
Two (married)	$42,312	$42,312

Figures also updated at http://health.wnylc.com/health/download/314/ and https://www.health.ny.gov/health_care/medicaid/#income.

A. INCOME

- Refers to any payment from any source. Income can be a one-time payment or a recurring one. Income can be earned, such as wages, tips, bonuses and commissions, self-employment and rental income. Also included is unearned income, such as dividends, interest, pensions, Social Security, unemployment compensation, worker's compensation, IRA distributions, or cash gifts.
- Gross income is always counted, subject to certain deductions.
  - The spouse's income is also counted (but may be disregarded via spousal refusal).
  - Generally, the income of children, siblings, and other household members is not counted, even if they are related.
  - Applicants **must** apply for Social Security as a condition of eligibility for Medicaid or the Medicare Savings Program, with income counted even if it causes a spend-down. One may not defer applying in order to maximize the amount of Social Security. See http://www.wnylc.com/health/entry/185/.
- **Deductions** from gross income include:
  - Unearned income disregard: $20 per month per individual or couple (as shown in income chart below, this effectively raises income limit by $20/month)
  - Medical insurance premiums: Medicare Part B, Medicare Part D, Medicare Supplement (Medigap) Insurance, employment or retiree health insurance premiums. But once enrolled in Medicare Savings Program, since this program will pay for the Part B premium and all or part of the Part D premium through Extra Help, you may not deduct the premiums to the extent subsidized.
  - Earned income disregard: If Aged/Disabled/Blind beneficiary or his/her spouse is working, the first $65 of monthly gross earned income, and ***half*** of the remaining monthly gross earned income, is disregarded. This is an incentive to work.
  - The first $90 per month of any income received from a non-family roomer or boarder is deducted.
  - Rental expenses: expenses of renting an apartment in a building owned by applicant alone or jointly.
- **Excluded income** – not counted for DAB Medicaid includes:
  - Holocaust reparations
  - Interest and dividends (generated by savings or investment accounts)
  - Federal energy assistance payments.
  - Food stamp coupons (SNAP)
  - VA benefits for Aid & Attendance (all other VA benefits do count)

    - **In-kind income** – If anyone other than a "legally responsible" relative pays the client's expenses directly to the vendor, such as paying rent directly to the landlord, or paying an electric bill to the electric company, this "in-kind" income is not counted. Children are never legally responsible for their parents, and parents are never legally responsible for children over age 21 – so if bills are paid by those relatives, it does not count as "income" to the applicant. If the money is given to the client directly, however, this is a gift of cash and is countable income.
  - **Time-limited disregards --** Retroactive benefits under the SSI program are disregarded for 9 months, and tax refunds and some other types of income have time-limited disregards, giving the client time to spend them down to the Medicaid resource limit.
    - Other less common deductions and exclusions are listed in the Department of Social Services regulations at 18 NYCRR §§ 360-4.6, 360-4.7. Once the above deductions are taken from gross income, one is eligible if the remaining net income is under the following limits.

Remember, though DAB income limits match MAGI limits, the rules above for what income is disregarded and what income is counted for non-MAGI still applies.

Note: Even if a Medicaid Applicant/Recipient and their spouse, if any, have children or other relatives living with them, the household size is always either ONE or TWO. See this chart to figure out whether it is ONE of TWO - http://www.wnylc.com/health/download/96/. If using Spousal Refusal, always use size of ONE.

B. RESOURCES

A resource is an asset or property of any kind. Resources may be liquid, meaning cash, or property that can readily be converted into cash, such as bank accounts, stocks, bonds, CDs, and the cash value of whole life insurance policies. Resources may also be non-liquid, meaning that it may not be easily or quickly converted into cash, such as real property or collectibles.

EXEMPT RESOURCES – Certain resources do not count toward the above limits. The following lists exempt resources -- ***if client has "excess resources" consider using them to purchase these things:***

- The value of one's **home** and contiguous property (including multiple-family dwellings), as long as it is their primary residence. The applicant's **home** has an equity limit ***only*** if the applicant is seeking home and community-based services (Managed long term care (MLTC), adult day care, personal care or consumer-directed assistance through the local Medicaid agency, waiver programs).
  - The **equity limit** is $1,071,000 for the primary residence (2024 limit). The equity limit does not apply if the applicant lives in the home with a spouse or disabled or minor child (under age 21), or to receive Medicaid for primary and acute care services.
  - **LIENS** - Medicaid may place a lien on the home only if the home is no longer the primary residence (such as when the client enters a nursing home on a permanent basis), but no lien may be placed if any of these relatives are residing in the home:
    - A spouse, child under 21, a certified blind or disabled child of any age, or
    - A sibling with an equity interest in the home and who resided in the home for at least one year immediately before the admission to the nursing home

- **ESTATE CLAIM -**If client dies with the home in her name, it will be part of her Estate and subject to a Medicaid claim for the cost of services provided after age 55 – whether in the community or in a nursing home.
- **There are exceptions to both the nursing home lien and Estate claim** if there is a surviving spouse, minor or disabled child or certain other relatives. Rules are complicated. Clients who own homes should be referred to elder law attorneys for advice on Medicaid and estate planning. Find referrals at www.naela.org. Transfers of a home may have serious tax consequences and raise other legal issues, for which professional legal advice is necessary.

- An automobile, clothing, furniture, appliances and personal belongings.
- Tools and equipment necessary for the applicant's trade or business.
- **Qualified Retirement Accounts (including IRA's, 401(k)'s and 403(b)'s)** – Qualified retirement accounts such as IRA's are treated differently depending on client's age and, if under 65, whether the client is disabled and working, even a minimal amount. The three situations each with different rules about IRA's are:

i. **Age 65+ *OR* under 65 and disabled or blind (Non-MAGI)**
The applicant or recipient does not have to cash in their IRA, and the principal of the IRA will not be counted as a resource, as long as s/he takes regular distributions from the IRA on a periodic basis (monthly, quarterly or annually). In other words, the IRA of an applicant who is age 65+, or < 65 and disabled or blind, is exempt as a resource, as long as the individual is taking regular distributions from the IRA according to IRS distribution tables. These distributions are counted as income, but the principal of the IRA is not counted as a resource.

  i. **Since the IRS only requires me to take "Regular Minimum Distributions" (RMD) at age 72, can't I wait until then to start taking distributions if I want Medicaid?** No. Medicaid does not follow IRS rules and requires DAB Medicaid recipients to take periodic distributions before the IRS requires them. Otherwise, the entire principal of your IRA will be counted as a resource. In 2020, under the SECURE Act, the age the IRS requires you to take the RMD increased from 70½ to age 72 for those reaching age 70½ in 2020 or later and age 73 for those who turn 72 after December 31, 2022. But this does not affect Medicaid applicants or recipients. If you want Medicaid, you must start taking the RMD or regular IRA distributions, unless you are under 65, disabled, working and enrolled in the **Medicaid Buy-In for Working People with Disabilities. (MBI-WPD).**
  ii. **What about the tax penalty for early withdrawals**? Under IRS rules, people may take withdrawals with no penalty after age 59½, and before age 59½ if one is disabled. You must pay income taxes on the withdrawal but there is no tax penalty. If you are under age 59½ and not "disabled," then you are not likely to be in the DAB Non-MAGI category at all.
  iii. **SPOUSE of aged, disabled or blind applicant –** If the spouse is not also seeking Medicaid, the spouse does not have to take distributions from his/her IRA. The IRA is exempt for community Medicaid for applicant. DOH GIS 06 MA/004 - Treatment of Community Spouses' Retirement Funds;[1] MRG p. 316. However, the spouse's IRA counts toward the Community Spouse

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

Resource Allowance (CSRA) if the applicant is seeking institutional Medicaid for nursing home care and if the spouse is not taking periodic distributions.

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

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

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

- **Money set aside for burial and life insurance:**
  - The applicant and his/her spouse may each have a **$1500 burial fund**, if kept in a separate bank or financial institution account from their other savings. As long as the amount is under $1500 at time of Medicaid application, interest accrued later does not count – fund is still exempt.
  - Up to $1500 of the cash value of a **life insurance policy** may count as the burial fund, in lieu of a cash burial fund. If the cash value of the policy exceeds $1500, the remaining cash value is counted as a resource
  - In addition, all Medicaid applicants and recipients may purchase a non-refundable **irrevocable funeral agreement**. There is no dollar limit on the amount, but it must be reasonable, and since it is irrevocable, the client cannot change her mind later. See http://wnylc.com/health/entry/36/ for guide to funeral planning for Medicaid recipients. Note that funeral agreements can be set up for client's spouse, children and some other designated relatives, with more limited coverage.
- **Holocaust reparations** are not counted. See http://wnylc.com/health/entry/65/
- **ABLE accounts** – see https://www.mynyable.org/. Since 2017, those who were certified ***disabled before age 26*** may receive SSI and/or Medicaid while sheltering their own contributions and contributions from other sources. All contributions from all sources must *together* be under the annual gift tax exclusion ($18,000 in 2024), but higher if beneficiary is working.[2] The maximum balance may not exceed the maximum account balance for the 529 College Savings Program which is currently $520,000 (increased from $100,000 by 2019 state law). SSI recipients must keep the ABLE account balance at a lower level.
- A **transfer of excess assets** by the applicant or spouse may disqualify an applicant from having Medicaid pay for nursing home care if either spouse needs it within five years after making a transfer, but elder law attorneys have legal strategies to minimize the financial burden during the penalty period and reduce the penalty period. A 30-month lookback and

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

transfer penalty will apply to new applicants applying for Medicaid for managed long term care, other home care services or the Assisted Living Program if applicant or spouse transferred assets since Oct. 1, 2020. This new lookback has been delayed because of the pandemic. It may begin no earlier than applications filed after Oct. 1, 2022. Consumers should consult an elder law attorney about transfers of assets.

- **Excess resources may also be offset by unpaid medical bills** that are outstanding at application.
- Someone with excess resources might also consider a Medicare Savings Program and EPIC, instead of Medicaid, since these programs have no resource limits.

CONSUMER TIPS

These strategies can help people with higher incomes access Medicaid. Also check the online list of these strategies at: http://www.wnylc.com/health/entry/222/.

- **Consumer Tip One – Spousal Impoverishment Protections**

  If a married individual is applying for Medicaid because s/he needs Medicaid home care services, and if his/her spouse does NOT need Medicaid or home care, the applicant can benefit by using "spousal impoverishment protections." Spousal impoverishment budgeting, previously only for nursing home and waiver programs such as Lombardi, is now available to married couples where (1) one spouse is in a Managed Long-Term Care (MLTC) plan OR (2) one spouse is receiving Personal Care or Consumer Directed Personal Assistance Program (CDPAP) services through the "Immediate Need" process (described below).[3]

  - If applicant has a "**community spouse**," meaning a spouse who is not on Medicaid, the community spouse may keep their own income and enough of the applicant spouse's income to total $3,853.50/month (and up to $74,820 of individual and joint assets or half of their individual and joint assets up to $154,140)(2024). The applicant spouse also keeps an allowance of $852.00
  - It works almost the same as for nursing home, but with some minor variations.
  - WARNING – WHEN CAN YOU REQUEST SPOUSAL IMPOVERISHMENT BUDGETING?
    - If you enroll in MLTC directly after applying for and being approved for Medicaid – you may NOT request Spousal Impoverishment budgeting in the application for Medicaid to obtain MLTC. You may only request it once enrolled in the MLTC plan. So initially, when applying for Medicaid, the spouse needs to file a "spousal refusal" for excess income and/or assets. As soon as enrolled in the MLTC plan, ask the local DSS to revise the budget using Spousal Impoverishment rules. These protections will eliminate or at least reduce the "spend-down."
    - BUT if you file the Medicaid application along with a request for personal care or CDPAP services based on an "Immediate Need" for home care services, then you MAY request Spousal Impoverishment budgeting as part of

[3] N.Y. Dep't of Health, General Information System Message: Spousal Impoverishment and Transfer of Assets Rules for Certain Individuals Enrolled in Managed Long-Term Care, GIS 13 MA/018 (September 24, 2013). Available at http://www.health.ny.gov/health_care/medicaid/publications/

the application. See 16ADM-02 - Immediate Need for Personal Care Services and Consumer Directed Personal Assistance Services[4]

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

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

  Not everyone may use spousal refusal. People Age 65+, Disabled or Blind may use spousal refusal, as may people under 65 who take care of and live with a child, grandchild, or other relative, whose income exceeds the MAGI limits. People between age 21 – 65, who have no relative under age 21 living with them and who are not disabled, whose income exceeds the MAGI limits, may not use spousal refusal. Spousal refusal cannot be used in MAGI budgeting.

- **Consumer Tip Three – Medicaid Buy-In for Working People with Disabilities (MBI-WPD):**
  People over age 16 and **under age 65** who are disabled may qualify for Medicaid even if they have incomes higher than the limits above, if they are working. They do not have to work any minimum amount - it can be just an hour a month, as long as they are paid for their work, or are self-employed. In 2024, gross income may be as high as $75,385 for an individual and $102,285 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 $3,138 (single) and $4,259 (couple) (2024).

  Resource limits are $31,175 for single and $342,312 for couple. IRA's do not count for this program and do not have to be put in pay-out status.

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

- **Consumer Tip Four – Nursing Home or Adult Home Transition Housing Disregard[5] - 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[6] an MLTC plan to

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

[5] N.Y. Dep't of Health, Administrative Directive: Special Income Standard for Housing Expenses for Individuals Discharged from a Nursing Facility who Enroll into the Managed Long Term Care (MLTC) Program, 12 OHIP/ADM-5 at 2-4 (October 1, 2012), at http://www.health.ny.gov/health_care/medicaid/publications/index.htm

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

be discharged back to the community, then they are allowed to keep more income, reducing or eliminating their spend-down. The chart below shows how much extra income they can keep in addition to the regular Medicaid limit ($1,732 for single). A married individual may not use both "spousal impoverishment budgeting" (Consumer Tip One above), and this income deduction.

Special Income Standard for Housing Expenses after Discharged from Nursing Home		
Region	**Counties**	**2024 Deduction[7]**
Central	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	$365
Long Island	Nassau, Suffolk	$1,624
NYC	Bronx, Kings, Manhattan, Queens, Richmond	$1931 (up from $1701 in 2023)
Northeastern	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	$433
North Metropolitan	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	$1,180
Rochester	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates	$392
Western	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	$320

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

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

  - **QMB Eligibility** – Effective January 2023, QMB and DAB Medicaid have the same income limits (138% FPL). However, because QMB has no asset test, it can be useful for those who need a reduction in their Medicare out of pocket costs but are over the asset limits for Medicaid.
  - **QMB subsidizes Part D by automatically qualifying you for Extra Help**.
  - QMB does not provide access to Medicaid services not covered by Medicare, such as dental and routine vision care, eyeglasses, hearing aids, long-term care, etc.
  - **Medicaid will pay the Part A and Part B coinsurance and deductibles only if a provider is enrolled as a Medicaid provider**. This is true whether Medicare is through Original Medicare or Medicare Advantage.

[7] 2024 rates published in Attachment I to GIS 24 MA/01 -- 2024 Federal Poverty Levels available at https://www.health.ny.gov/health_care/medicaid/publications/search_by_year.htm

- **BALANCE BILLING PROTECTIONS** -- Even providers who only accept Medicare and not Medicaid may not "balance bill" QMB enrollees for Medicare out-of-pocket costs.[8]
    - CMS has been improving ways that beneficiaries can be identified as QMB's to providers, so the provider knows not to balance bill them. It should be on the Medicare Summary Notice for those in Original Medicare. For those in Medicare Advantage, CMS is now giving the plans monthly data files identifying QMB status, and plans are supposed to share that with network providers.
    - The Medicare & You Handbook now includes QMB protections and directs beneficiaries to contact 1-800-MEDICARE to report problems.
    - The Customer Service Representatives (CSRs) at 1-800-MEDICARE now can verify QMB status in their database and will instruct beneficiaries to tell their provider that they may not be billed. If a beneficiary does not successfully resolve the billing problem with the provider, the CSRs will refer the issue to the Medicare Administrative Contractor (MAC) for the region where the beneficiary lives. The Medicare contractor will send a letter to the provider instructing the provider to return any payments received from the QMB and to cease any current billing or collection effort. Importantly, the MAC will also send a letter to the beneficiary with a copy of the provider communication and with instructions not to pay the bill. A provider bulletin explains the process and includes the model letters that are used, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9817.pdf (rev'd July 2017). CMS reminded Medicare Advantage plans of the rule against Balance Billing in the 2017 Call Letter for plan renewals, available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf
    - In January 2017, the Consumer Finance Protection Bureau issued a guide to QMB billing, available at https://www.consumerfinance.gov/about-us/blog/what-do-if-youre-wrongfully-billed-medicare-costs/. A consumer who has a problem with debt collection, may also submit a complaint online or call the CFPB at 1-855-411-2372. TTY/TDD users can call 1-855-729-2372.
    - *See* pages 17-4 to 17-5 above regarding 2015 and 2016 changes that reduce how much Part B cost-sharing assistance Medicaid pays for QMB recipients.

- **Consumer Tip Six - Medicaid Spend-down:**
Some individuals may qualify for Medicaid with income or resources higher than Medicaid's specific limits. An individual's hospital and medical bills can offset excess income or resources to qualify them for Medicaid. This is the Medicaid Spend-down Program. *See* State Dept. of Health website about spend-down rules, posted at https://www.health.ny.gov/health_care/medicaid/excess_income.htm

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

- **The spend-down amount is the difference between countable income and/or resources and the Medicaid limit.** Assuming resources are within the Medicaid limits, if a single person aged 65 has a total countable monthly income of $1,802, after deducting $20/month and other deductions, she/he would need to spend or incur monthly medical bills of $50 a month in order to become Medicaid eligible because Medicaid's monthly income limit for a household of one is $1732 (2024). Medical bills are applied to meet the spend-down only if they are not covered by any third party, such as private health insurance or Medicare.
- The individual has the option of choosing to "**pay-in**" his or her spend-down directly to the Local Department of Social Services, instead of submitting medical bills that meet the spend-down.
- **Only Age 65+, Disabled or Blind and families living with minor children under 21 may use spenddown.** People between age 21 - 65 who have no relative under age 21 living with them and who are not disabled may not use spend-down. This is the population that now has MAGI Medicaid (see next section) with increased income limits at 138% of the Federal Poverty Line. If income of someone in the MAGI group is above the MAGI limit, they cannot spend down to qualify for Medicaid. They may be eligible for the Essential plan or can enroll in a Qualified Health Plan with cost-sharing subsidies.
- **If individuals have to spend down their resources,** their medical expenses will be applied first to their excess resources. They only need to meet the resource spend-down once. After that, they are eligible for Medicaid with no resource spend-down, but medical bills used to offset excess resources cannot also be used to meet an income spend-down. Once individuals accumulate bills equal to their spend-down amount, their Medicaid coverage will begin, and Medicaid will pay for additional medical expenses to Medicaid providers. Medicaid will not cover the bills used to meet the spend-down. The individual will be responsible for those payments.
- **Important Note: Medical bills do not have to be *paid* to count toward the spend-down.** Bills only need to be incurred (and not covered by any other third party). The Medicaid office may not demand proof that the medical bill was paid. This does not change the fact that the client is responsible for the payments.
- **Medical expenses that can be used to meet the spenddown are:**

  A. Medicare and private health insurance **deductibles and coinsurance** or copayments, including Part D.

  B. **Bills for medically necessary services**, including doctor, dental and therapy bills (they do not have to be Medicaid providers), lab tests, transportation to medical appointments, hearing aids, eyeglasses, medical supplies, prescription and over-the-counter medications. May use bills for services not covered by Medicaid, such as chiropractors.

     - Bills may be paid or unpaid (so long as they remain viable, which is generally for six years – the time a provider has to bring a legal collection action).

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

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

- **Using Past Medical Bills to Meet the Spenddown – Special Rules for New Applicants Only**
  When one first enrolls in the Medicaid spenddown program, one may submit *past* medical bills to be counted toward the *current* spenddown amount. Once a bill is used to meet the spenddown for a particular month, the bill cannot be used again.

  Past *paid* medical bills may be used for medical services that were provided and paid for within the **three calendar months** before the month of the Medicaid application. They may be used to meet the spenddown for up to six months beginning in the month one applies. (One may opt to begin the six-month maximum period retroactively, up to three months before one applied, if one wants "retroactive coverage" for Medicaid to pay recent medical bills). These rules are explained at https://www.health.ny.gov/health_care/medicaid/excess_income.htm and in NYS Directive 96 ADM 15.

  - Bills paid by **EPIC or ADAP** in the three months before the month in which you applied for Medicaid may be used to meet your spenddown.
  - **EXAMPLE 1:** Ann paid her dental bill in June for dental care provided in May. She applies for Medicaid in August. She may use the paid dental bill toward her spenddown in August, since the service was provided and paid for within 3 calendar months before the month in which she applied.
  - **EXAMPLE 2:** EPIC paid $250, and Henry paid $60 in copays for his prescriptions between July 1st and October 1st. He applied for Medicaid in October. Since the prescription costs were incurred in the 3 calendar months before the month in which he applied for Medicaid, these costs can be applied to meet his spend-down. His monthly spenddown is $50. The total of $310 that Henry and EPIC paid for his prescriptions can meet his spenddown for six months beginning in October. If he submits the bills with his application, he can activate Medicaid for six months.

  Past *unpaid* medical bills may be used to meet one's spenddown amount even if they are old, as long as they are still viable, meaning that the medical provider is still able to bring a legal action to collect them. Generally, this means the bills can be up to six years old. These bills may be applied to meet one's spenddown *indefinitely* into the future. Medicaid is certified in periods of up to six months, but unpaid bills can be carried forward to subsequent periods.

  - **EXAMPLE:** Eric has a $2000 hospital bill from four years ago and received a collection notice from the hospital last year. His spenddown is $200. He may submit this bill with his application to meet his spenddown for ten consecutive months. The initial Medicaid coverage will be for six months, using up $1200 of the hospital bill. Eric will then be recertified for a period of four more months, using the balance of $800 of the hospital bill.

- **Consumer Tip Seven – Spenddown as Pathway to Extra Help:**
  Even when one has a high spenddown, it is worth gathering past medical bills, even very old unpaid bills. If the bills meet the spenddown for just one month in Year One, an individual will qualify for Medicaid for that month, and in turn, will qualify for Part D Extra Help for that entire calendar year (Year One), and for the entire next year (Year Two) if the Medicaid eligibility occurs in the last half of Year One. This

helps people whose income is above the limit for Extra Help or a Medicare Savings Program.

Example of Using Past Bills to Obtain Part D Extra Help

Mary is 63 years old, single, disabled and has Medicare. Her Social Security Disability benefits after Part B deduction are $2000/month, which exceed the limit for the Medicare Savings Programs as well as for Full and Partial Extra Help for Part D. She comes to you in September, after falling into the coverage gap in August. Her prescriptions cost $1000/month. She is too young for EPIC and is not eligible for MAGI Medicaid because she has Medicare (and too much income).

Her Medicaid spenddown is $/month ($2000 - $20 - $1,732 = $248), which she cannot afford to pay with her rent and other living expenses. Her resources are under the Medicaid limit of $31,175 (2024). You ask her if she has any old medical bills -- she has an old hospital bill from 3 years ago of $750, 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 $750, which meets her spenddown for three months. Medicaid approves her with retroactive coverage for August, September and October. You ask her pharmacy to fill her prescriptions, billing her only for the Extra Help copayments, by providing the Medicaid notice as "Best Available Evidence" of her eligibility for Extra Help.
- You also mail back the Part D plan's bill for the August prescriptions, enclosing a copy of the Medicaid notice, and explaining that they may only bill her for the Extra Help copayments, citing the notice as Best Available Evidence of her eligibility. They reduce the bill to the Extra Help copays.
- She will have Extra Help for the remainder of the current calendar year, and the entire subsequent year, even though she will no longer meet the Medicaid spenddown after October.

Special Six-Month Spenddown Rule for Inpatient Hospital Coverage -- If the amount of one's past paid and unpaid medical bills meets the spenddown for a full six months, then she/he is certified eligible for inpatient as well as outpatient Medicaid coverage (i.e., including inpatient care in a hospital) for a six-month period. If the amount of past bills meets the spenddown for only two months, then the individual is eligible for only two months of Medicaid outpatient coverage and Medicaid will not pay for inpatient care during that period. If, after the initial six-month certification period, the individual has additional unpaid bills, she/he may use the remaining unpaid bills to be authorized for another certification period of up to six months. Remaining paid bills cannot be carried forward past the initial six months.

Month-to-Month Spenddown Coverage -- After an individual has used up all of his/her past paid and unpaid medical bills to meet the spenddown, she/he must meet the spenddown each month solely with medical bills for services provided in that month. She/he must submit medical bills for these services -- paid or unpaid -- to the social services district Medicaid office one month at a time. Some Medicaid offices accept bills by fax. She/he can also enroll in the Pay-In program, in which she/he pays the spenddown amount to the district, up to six months at a time. There will be a gap in coverage each month while the Medicaid office processes the medical bills.

- **Consumer Tip Eight - Eliminating Spenddown Using a Supplemental Needs Trust:** Under special federal rules, if a Medicaid recipient who is disabled, of any age including

seniors, deposits his or her spenddown into a Supplemental Needs Trust (SNT) each month, and the trust is approved by the Medicaid program, the local district must re-budget the income and disregard the amount paid into the Trust. In essence, this procedure makes the spenddown vanish. Since this policy was approved in 2005, thousands of New Yorkers who would otherwise have a high spenddown have accessed Medicaid this way. There are many rules and requirements to use this procedure.

Person Age 65+ Must Use a Pooled Trust -- not an individual SNT. There are two types of Supplemental Needs Trusts -- individual trusts drafted for the individual client, and "pooled trusts" run by non-profit organizations, in which clients enroll by signing a "joinder agreement" that sets up their own account within the trust. People with disabilities under age 65 have a choice and can use either. People over age 65 may only use a pooled trust.

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

Disability Requirement: People under age 65 who use these trusts usually have Social Security Disability income, which is sufficient proof that they are disabled. People age 65 and over receive Social Security Retirement benefits, rather than Disability benefits. Medicaid requires that they request and receive a disability determination by the New York State Disability Review Team as proof that they are disabled - on specific NYS Department of Health forms -- in order to enroll in these trusts.

For Forms and More Information: See NYLAG Evelyn Frank Legal Resources Program's guide to supplemental needs trusts at http://wnylc.com/health/entry/2/, with links to a step-by-step guide to enrolling in a pooled trust, links to the disability forms, and a link to a list of pooled trusts in New York State. The disability forms required by the state change frequently, so be sure to check the website for the most recently updated list. See more at http://www.wnylc.com/health/14/.

MAGI MEDICAID ELIGIBILITY

2024 MAGI Monthly Income Limits

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

Household Size	Medicaid 138% FPL	Essential Plan 250% FPL
One	$1,732	$3,038
Two	$2,268	$4,108

Note: MAGI has no resource limit. Interests and dividends generated by an asset count as income.

Note: Pregnant women and children have higher income limits (223% FPL and 154% FPL respectively).

Clients who are identified as having MAGI Medicaid should be referred to receive expert counseling by a navigator at https://info.nystateofhealth.ny.gov/NavigatorDirectory or to Community Health Advocates (CHA) at 1-888-614-5400.

The deductions from gross income are also different for MAGI. Unlike with DAB Medicaid, there is:

- NO $20/month deduction from unearned income.
- NO deduction for health insurance premiums
- NO deduction from earned income, in contrast to disregard of over HALF of all earned income for Disabled, Aged, Blind Medicaid.
- NO Spousal refusal. If married couple lives together, must include both spouses' income, unless one spouse receives SSI or cash public assistance.
- NO Spenddown **--** People under age 65 who do not have Medicare may NOT qualify for MAGI Medicaid if their income exceeds the limits. However, they may be eligible for the Essential Plan or for Advance Premium Tax Credits and coinsurance subsidies if they purchase a Qualified Health Plan on the Exchange. Note: children under 21 or their parents/caretaker relatives as well as people with disabilities and seniors who do not have Medicare have the option of using DAB budgeting and the spend-down.

Some income counts for DAB category that does not count for MAGI category, e.g. Worker's compensation, VA benefits, cash gifts.

A. INCOME

Gross income counted for MAGI includes:

- Wages (but excludes amount contributed to a pre-tax cafeteria flex spending plan for health care or childcare)
- Social Security income – includes ALL SS income, even the part that is not taxable
- Interest and dividends – even if non-taxable
- Unemployment benefits (certain *federal* unemployment benefits authorized under the COVID-19 stimulus bills, as opposed to state unemployment, do NOT count for MAGI Medicaid).
- Pensions
- IRA distributions
- Alimony
- Income from self-employment - Only net income after expenses – use Schedule C
- Rental income – net income after expenses

EXCLUSIONS – The following income does not count for MAGI budgeting:

- Veteran's benefits – neither disability nor pension
- Child support received
- Gifts, inheritances, non-taxable lawsuit settlements (lawsuit settlements that are not taxable are not counted as taxable income, whether lump sums or structured settlements) (Note that some lawsuit settlements ARE taxable so are countable as income)
- American Indian income
- Worker's Compensation

- Lump sums generally don't count because of 12-month continuous eligibility – see below

DEDUCTIONS from income:

- Alimony paid
- Certain moving expenses
- Student loan interest
- Self-employed health insurance contributions and self-employment tax
- IRA deduction
- Income contributed to flex spending cafeteria plan for health care or childcare pre-tax

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

When an individual who is enrolled in MAGI Medicaid through NYS of Health becomes eligible for Medicare due to turning age 65 or receiving SS disability for 2 years, their Medicaid through the NYSoH normally will end and their case will be transferred from NYSoH to their Local Department of Social Services (LDSS), which re-determines eligibility for NON-MAGI Medicaid. In addition to the transfer of administration of their Medicaid case to the local DSS when they obtain Medicare, the individual is also disenrolled from their Medicaid Managed Care plan. The timing of both the transfer to the LDSS and disenrollment from the Medicaid Managed Care plan is different depending on whether the client is aging on to Medicare at age 65 or became enrolled in Medicare after 24 months on Social Security Disability. These rules are paused during COVID-19, as described below.

- *Managed Care change for Medicaid recipients new to Medicare.*
    - **Before** COVID-19, people with MAGI Medicaid on NYSoH who become enrolled in Medicare, whether based on age or disability, were disenrolled from their Medicaid managed care plan. They were automatically transitioned to Fee-for-Service Medicaid, as secondary coverage to their Medicare. Their managed care plans were allowed to inform these members of their options to join the same company's Medicare Advantage or Medicaid Advantage plans, but it was voluntary.
    - **During** the COVID-19 Public Health Emergency, MAGI Medicaid recipients stay in their Medicaid managed care plans even though they become enrolled in Medicare.
    - ***Default Enrollment of Medicaid Recipients who Newly Enroll in Medicare.*** In 2021, changes began for new Medicare beneficiaries who previously had Medicaid and were enrolled in a "mainstream" Medicaid managed care plan. Starting with those newly enrolling in Medicare in April 2021, they are "default enrolled" into a Dual-SNP.
        - If they *DID NOT* receive personal care or CDPAP services from their mainstream plan, some are also default enrolled into an "**IB-DUAL" plan** (Integrated Benefit – Dual) plan. This is basically a new name for a mainstream Medicaid managed care plan that wraps around the Dual-SNP Medicare coverage. The default enrollment is always to an IB-DUAL plan operated by the same insurance company that operates the Dual-SNP. This is what makes it an "integrated" benefit.

- If they *DID* receive personal care, CDPAP, or private duty nursing services from their mainstream managed care plan, they are default enrolled into a Medicaid Advantage Plus (MAP) plan, which is a hybrid of a Dual-SNP, MLTC and mainstream Medicaid managed care plan all in one.
- Under "default enrollment," the Medicaid recipient receives a notice that they will be automatically enrolled in the Dual-SNP and "IB-DUAL" plan or MAP plan, with the right to "opt out" and select their preferred Medicare and Medicaid coverage. Those who received home care services from their managed care plan may opt out of MAP and select an MLTC plan instead.
- Default enrollment is only being used for some plans in some counties. A list is posted on DOH's new website on integrated care for dual eligibles. https://www.health.ny.gov/health_care/medicaid/redesign/duals/index.htm. Under the dropdown for "IB-DUAL" is a chart identifying which plans have been approved for default enrollment in each county. In Jan. 2023 DOH announced some new approved plans that are not yet on this website. The NYHealthAccess website will soon be updated with the updated plan lists - http://www.wnylc.com/health/entry/226/.
- See also the MRC Default Enrollment Fact Sheet at https://medicareinteractive.org/pdf/default-enrollment-NYS.pdf.
- Beware that MAP plans members do not have a special right in fair hearings to Varshavsky increases in hours while the hearing is pending. See article at http://www.wnylc.com/health/entry/228/.

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

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

  1. MAGI Medicaid Enrollee Turning 65

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

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

of Fee-for-Service coverage will last up to four months (outside NYC) or five months (in NYC), counting the month of transition as the first month. It could be shorter if your Local DSS specifies an earlier date on the application. To determine when Fee-for-Service coverage ends, call your Local DSS.

The 12 months of continuous MAGI eligibility is cut off when the individual turns 65. NYS DOH GIS 15 MA/022 - Continuous Coverage for MAGI Individuals (12/2015). However, if this individual has a child, grandchild or other relative under 18 living with them (under 19 in school), MAGI can continue.

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

Part B Premiums - Since MSP has NO ASSET limit, some individuals may be enrolled in the MSP even if they lose Medicaid because of assets, or if they now have a Medicaid spend-down. If a Medicare/Medicaid recipient reports income that exceeds the Medicaid level, districts must evaluate the person's eligibility for MSP. 08 OHIP/ADM-4 In 2023, the income limit for the QI-1 MSP program will increase to 186% FPL, so many people not eligible for Medicaid may be eligible for the MSP.

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

An individual enrolled in MAGI Medicaid who starts to receive Medicare due to Social Security disability, unlike those turning 65, will continue to have MAGI Medicaid through NYSoH through the end of their 12-month continuous care period. At the end of their 12-month period, *before the pandemic and again once the pandemic is over,* their case will be transferred to the Local DSS and go through the same process as above for those turning 65. *During the COVID public health emergency, their Medicaid remains on NYSoH.* Once the case is sent to the Local DSS, the client should receive a notice from their LDSS with either a re-certification form and Supplement A, or a new Medicaid application. This transitional period of Fee-for-Service coverage will last up to four months (outside NYC) or five months (in NYC), counting the month of transition as the first month. It could be shorter if your Local Department of Social Services specifies an earlier date on the application. To determine when Fee-for-Service coverage ends, call your Local Department of Social Services.

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

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

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

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

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

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

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

HIICAP COUNSELORS can help clients by:

- reminding them to **look for the renewals in the mail and help them respond** on time.

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

For those who had MSP only and not Medicaid – and now are eligible for Medicaid under the new income limits: Those who want Medicaid must submit an entire Medicaid application and Supplement A to their local Medicaid office. They cannot simply request rebudgeting.

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

MEDICAID AND IMMIGRATION STATUS

New York State Medicaid does not require an individual to be a citizen or lawful permanent resident (green card status). NYS Medicaid also is available to 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. For more information on identifying immigrants who are PRUCOL as well as for documenting citizenship:

- http://www.health.ny.gov/health_care/medicaid/publications/docs/gis/08ma009att.pdf
- https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/19ma02_attachment.pdf
- https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/19ma02.pdf

In 2022, NYS expanded Medicaid to cover undocumented immigrants age 65+ for all services.Implementation began in January 2024. Undocumented immigrants who receive nursing home Medicaid may need to consult an immigration attorney concerning public charge. http://health.wnylc.com/health/entry/251

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

Referrals on Immigration Issues

- New York State New Americans Hotline 212-419-3737 Toll-free 1-800-566-7636 Monday-Friday, from 9:00 a.m. to 8:00 p.m. Saturday-Sunday, 9:00 a.m. to 5:00 p.m.
- New York Immigration Coalition state-wide list of legal resources, https://www.nyic.org/providers/

Essential Plan for certain immigrants under age 65 who do not have Medicare

Until January 2016, “PRUCOL” immigrants received regular Medicaid as long as they met the other requirements for Medicaid – income, resources, proof of identity, residency, etc. That is still true for the non-MAGI category. However, certain immigrants under age 65 who do not have Medicare are instead enrolled in the Essential Plan. Affected immigrants are PRUCOL and “Qualified Aliens” in their five-year bar, meaning that while they have been covered under New York law under a court

decision called *Aliessa*, they were not covered under federal Medicaid. When they move to the Essential Plan, the federal government will now pay for part of the cost of services, instead of only the State.

MANAGED LONG-TERM CARE (MLTC)

MLTC plans are available throughout New York for dually eligible individuals who require long-term care. MLTC does not affect Medicare coverage. An enrollee's primary payer remains Original Medicare or their Medicare Advantage Plan. MLTC only covers Medicaid community-based long-term care benefits. Services covered include:

- Home Care, including:
  - Personal care
  - Certified Home Health Agency Services (home health aide, visiting nurse, visiting physical or occupational therapist)
  - Private Duty Nursing
  - Consumer Directed Personal Assistance Program, a variation of personal care services in which consumers may hire their own aides, including family members other than a spouse or a parent of a minor child. The personal assistants may perform skilled tasks that normally can only be performed by nurses or family. See more at http://www.wnylc.com/health/entry/40/.
- 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 expands New York's coverage of dental implants when medically necessary and change the rule for replacement dentures. See more at http://www.wnylc.com/health/entry/210/).
  - Optometry + eyeglasses
- Non-emergency medical transportation
- Nursing home care

MLTC is mandatory for individuals who meet the following:

- Are age 21 or older
- Are dually eligible
- Require long-term care services and supports for more than 120 days
  - These individuals must need help with activities of daily living (ADL), e.g. eating bathing, personal hygiene, dressing, walking, locomotion/transfer, toliett use, and bed mobility (turning and positioning in bed).

Note: The requirement that new applicants need help with 2-3 ADLs has been postponed. This requirement states that new applicants following the effective date must need physical maneuvering with at least *three ADLs*, or for persons with dementia or Alzheimer's diagnosis, need at least

supervision with *two ADLs*. People already in MLTC plans or receiving home care before the effective date will be grandfathered in.

What is not included in the MLTC package? MLTC plans do not include services covered by Medicare, such as primary and specialist medical care, hospital inpatient and outpatient care, and prescription drugs. MLTC members use their Medicare coverage for these services.

Individuals in need of long-term care may alternatively be eligible for the Program of All-Inclusive Care for the Elderly (PACE) or Medicaid Advantage Plus (MAP).

- **PACE:** a program that provides Medicare, Medicaid, and long-term care services under one plan. PACE is available in select New York counties. Enrollees receive their care at PACE centers, which are responsible for arranging primary care, inpatient hospital care, and long-term care.
- **MAP:** a type of integrated Dual-eligible Special Needs Plan (D-SNP). MAP plans are offered in certain New York counties and provide managed care to dually eligible individuals in need of long-term care. Enrollees also receive behavioral health benefits and utilize an integrated appeals process for Medicare and Medicaid denials.

Unlike MLTC, PACE and MAP do affect an individual's Medicare coverage. These plans are considered full capitation plans as a single plan covers all Medicare, Medicaid, and LTC benefits (unlike MLTC, which is a partial capitation plan).

For more information about plans, see:

- https://www.health.ny.gov/health_care/managed_care/mltc/mltcplans.htm
- https://nymedicaidchoice.com/program-materials

MLTC exclusions

While some of these groups still apply to their LDSS for personal care, others no longer qualify for personal care. (Note: having a spend-down is not an exemption or exclusion from MLTC).

- **Long-term Nursing Home Stay ("LTNHS") residents** –MLTC plans no longer cover long-term nursing home care. From 2015 - 2020, new nursing home residents were required to enroll in an MLTC plan, which paid the nursing home for their care. Or if they were already in an MLTC plan, they remained in the plan while in a nursing home, even if it was long-term. Now, MLTC members who have been in a nursing home for more than 3 months, and who have been approved for Institutional Medicaid, are disenrolled from the MLTC plans. They should receive notices with the right to request an assessment to return home, and to request a hearing, before being disenrolled. See http://www.wnylc.com/health/entry/199/. Anyone in a nursing home for more than 3 months may request an assessment by the NY Independent Assessor to determine if they may enroll in an MLTC plan to return home. Call ICAN for problems.
- In Nursing Home Transition Diversion Waiver or Traumatic Brain Injury waiver (but MLTC may be mandatory for them in January 2023).
- In Office for People with Developmental Disabilities (OPWDD) Waiver. Some people don't realize they are in this waiver. A code of "95" signifies this exclusion. People First waiver also in process – https://www.health.ny.gov/health_care/medicaid/program/longterm/omrdd.htm

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

MLTC exemptions

- Native Americans.
- Dual eligible individuals age 18- 21, but only if they require a "nursing home level of care." This is determined by NY Independent Assessor.
- 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 MMC plans, which are responsible for providing most long-term care services, including personal care, CDPAP, CHHA, private duty nursing, and nursing home care.
  - Non-duals who prefer an MLTC plan may only enroll in one in these circumstances:
    - If they have just applied for Medicaid, have not yet enrolled in a mainstream Medicaid managed care plan, and the NY Independent Assessor determines they require a "nursing home level of care (run by NY Medicaid Choice). See https://www.nymedicaidchoice.com/ask/do-i-qualify-managed-long-term-care.
    - If they are already in a mainstream Medicaid managed care plan, they may switch to an MLTC plan only if NY Medicaid Choice has determined that they require a "nursing home level of care" AND that they need services not available from a mainstream Medicaid managed care plan such as social adult day care, environmental modifications, social or environmental supports, or home delivered meals. See MLTC Policy 14.01: *Transfers from Medicaid Managed Care to Managed Long Term Care*.[9]

[9] 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 those Medicaid services that are not covered by the MLTC plan on a fee-for-service basis, not through managed care (such as hospital care, primary medical care, prescriptions, etc.)
- *Shift Medicaid Administration from NYSoH to LDSS* -- Most people in mainstream Medicaid plans applied for Medicaid on the NYS of Health Exchange. In order to enroll in MLTC, they must transfer administration of their Medicaid case to the LDSS from NYSoH. The LDSS will use "MAGI-like" budgeting to approve or renew their Medicaid.

Individuals ineligible for any Medicaid home care (MLTC or through DSS)

- Residents of Medicaid-funded Assisted Living Programs, see http://www.nyhealth.gov/health_care/medicaid/program/longterm/. Since the ALP is required to provide some personal care services, it is considered a duplication of services.
- People who need only social model adult day care. They are excluded from MLTC enrollment unless they also need home care for assistance with ADLs.

MORE INFORMATION ON MLTC

State DOH MLTC policies - Policy directives, model contracts for MLTC: http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

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

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

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

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

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

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

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

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

SPECIAL ELIGIBILITY RULES FOR MEDICAID LONG-TERM CARE

Medicaid covers long-term care, both in the community and in nursing homes. The services Here, we will discuss some special financial eligibility rules that apply to individuals receiving long-term care.

Eligibility for community-based long-term care services, including home care and Assisted Living Program The rules for resources and income for people age 65+, blind, or disabled, set forth above, apply for all community-based home care and other non-institutional services, with a few exceptions and caveats below. The spend-down program, along with spousal refusal and pooled trusts, described above, makes it possible for many seniors and people with disabilities to qualify for

Medicaid coverage of long-term care needs. Here are unique rules for community-based long-term care services:

> **Home equity limit of $955,00 (2022 rate).** A Medicaid applicant/recipient of institutional and non-institutional long-term care services is subject to a home equity limit. If the value of your equity interest in your home exceeds this amount, and no spouse, child under 21 or certified blind or certified disabled child resides in the home, you are not eligible for Medicaid coverage for long-term care services. For married couples who live together, or individuals with a minor disabled child living with them, there is no home equity limit. Note that the limit is on equity value, not market value; the equity value can be reduced by taking out a mortgage. This equity limit only applies to long-term care services such as home care, not eligibility for primary and acute care Medicaid services.

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

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

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

- **When will the new lookback start?** Because the lookback was enacted during the Public Health Emergency, it cannot be implemented until this emergency is over. For this reason, it keeps being postponed**.** As of the date this chapter is being edited (June 17, 2024), the earliest the lookback can start is for new Medicaid applications filed after October 1, 2022, but more likely not until Jan. 1, 2023, unless further delayed.
- **Which services will lookback apply to?** Managed Long Term Care (MLTC), personal care or consumer-directed personal assistance programs from the local Dept. of Social Services (through "Immediate Need" or for those who are excluded or exempt from MLTC enrollment such as those in hospice – see more below), private duty nursing, and the Assisted Living Program.
- **The lookback will NOT be required for** Medicaid for primary or acute medical care, or for these waiver programs – Traumatic Brain Injury (TBI), Nursing Home Transition & Diversion Waiver (NHTDW), and OPWDD waivers.
- Stay tuned – many details are not yet fleshed out.

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

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

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

be documented for the lookback period; if the spouse made a non-exempt transfer, there is a transfer penalty for the consumer.

How long is the Lookback Period?

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

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

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

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

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

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

- You transfer assets to your **spouse** (who then can use "spousal refusal").
- You transfer assets or property to your **child of any age who is certified blind or certified disabled**, or to a trust established solely for the benefit of such child.
- You transfer assets to a **trust established solely for the benefit of any individual under age 65 who is certified disabled** - including a trust for yourself if you are under age 65.
- The property transferred was your **home**, and it was transferred to:
    - your spouse, child under age 21, or child of any age who is certified blind or certified disabled; or
    - your brother or sister who already has an equity interest in part of your home and who lived in the home for at least one year immediately before you became institutionalized, or
    - your child of any age who was living in your home for at least two years immediately before you became institutionalized and who took care of you so that you could stay home rather than enter a nursing home.
- You intended to sell the asset for what it was worth or to get something else of equal value in exchange.
- The asset was transferred exclusively for some reason other than to qualify for Medicaid coverage of nursing facility services, or
- *Undue Hardship* - Despite your attempts, you cannot get the money or property back or get something of equal value, and you cannot get the medical care you need without Medicaid,

or the transfer penalty would deprive you of food, clothing, shelter, or other necessities of life. You must work with the LDSS in trying to get the money or property back.

- All of the transferred assets have been returned.

Transfer Penalty Rates 2024		
Central $12,196		
Broome	Jefferson	Oswego
Cayuga	Lewis	St. Lawrence
Chenango	Madison	Tioga
Cortland	Oneida	Tompkins
Herkimer	Onondaga	
Northern Metropolitan $14,165		
Dutchess	Orange	Putnam
Rockland	Sullivan	Ulster
Westchester		
Northeastern $13,235		
Albany	Fulton	Saratoga
Clinton	Greene	Schenectady
Columbia	Hamilton	Schoharie
Delaware	Montgomery	Warren
Essex	Otsego	Washington
New York City $14,273		
Long Island $14,668		
Nassau	Suffolk	
Western $12,241		
Allegany	Cattaraugus	Chautauqua
Erie	Genesee	Niagara
Orleans	Wyoming	
Rochester $14,419		
Chemung	Livingston	Monroe
Ontario	Schuyler	Seneca
Steuben	Wayne	Yates

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

Example: Susan lives in Rochester and transferred $124,600 to her daughter in March 2019 and applied for Medicaid to receive MLTC services in April 2019. In March 2022, Susan had a stroke, was hospitalized, and then placed in a nursing home. Other than the money she transferred in March 2019; her assets were within the 2022 Medicaid limit for a single person - $16,800. She applies for Nursing Home Medicaid in June 2022, after her rehab care covered by Medicare and her Medigap policy ends. Assuming that there are no exemptions from the transfer penalty (discussed below), the penalty runs for 10 months -- $124,600 divided by $13,376.

Since she is institutionalized, is applying for (and is otherwise eligible for) Medicaid, the transfer penalty begins in June 2022. Medicaid will not pay for her nursing home care for the next 10 months beginning June 2022. One option around this penalty is for her to return home from the nursing home after the penalty starts "running" in June 2022. Once it starts, the ten-month penalty would continue to run out while she was at home, and Medicaid would pay for community-based home care and other medical care, which has no transfer penalty – until applications filed in Jan. 2023.

Consumer Tip - Transfer rules are complicated. Refer to an experienced elder law attorney if the person seeking long-term care, whether in the community or in a nursing home, or if his or her spouse owns a home, has assets exceeding the Medicaid limits, or transferred assets in thelookback period and now needs nursing home or home care. Referrals at www.naela.org.

Treatment of Income in a Nursing home - Single Person

All of a single Medicaid recipient's income, except for a small monthly allowance for personal needs (generally $50/month) and enough to pay Medigap or other health insurance premiums, must be used to help pay for the cost of care. This is called the NAMI or Net Available Monthly Income. Medicaid will pay the balance up to the Medicaid rate.

- EXCEPTION: If a nursing home resident reasonably expects to return home, he or she can request "community budgeting," which allows him/her to use the same budgeting used in the community. They may keep the regular Medicaid allowance ($1,732 in 2024) rather than $50/month, or more if they used a pooled trust or other special budgeting in the community. The purpose of this is to have money to pay rent to maintain an apartment. This is usually authorized for six months at a time. A five-year lookback of assets is still required, described below. See FACT SHEET at http://www.wnylc.com/health/download/711/ and http://www.wnylc.com/health/entry/117/.

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

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

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

This law allows each state to decide on a dollar figure up to a maximum dollar amount that the community spouse can keep. New York State allows the community spouse to retain the highest amount of monthly income allowed by federal law, which usually gets an annual cost of living increase. However, New York State has not opted for the highest resource allowance for a spouse. This allowance has been frozen in New York at $74,820 since 1995, while the highest allowed under federal law has increased to $154,140 (2024).

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

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

- one spouse enrolled in a Managed Long-Term Care (MLTC) plan, or
- one spouse receiving personal care or CDPAP services through their local Dept. of Social Services based on "Immediate Need" for such services, or
- One spouse in the Traumatic Brain Injury Waiver Program (TBI) or Nursing Home Transition and Diversion (NHTD) waiver programs. See http://wnylc.com/health/news/32/; http://www.wnylc.com/health/entry/165/.

Here's how the law works.

Income Protections for Spouse. An "institutionalized spouse" is defined as a spouse who is in a nursing home, enrolled in an MLTC plan or other waiver, or receiving "Immediate Need" home care. In 2024, the community spouse of an "institutionalized spouse" is permitted to retain up to $3,853.50 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 $3,853.50.

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, other waiver program, or Immediate Need home care, she is entitled to keep an allowance of $619 of monthly income (2024). The balance of the applicant's income after these allocations, and after paying for health insurance premiums, is the "Net Available Monthly Income" or NAMI. This is the amount required to be paid for the cost of care.

Resource Protections for Spouse. When one spouse enters a nursing home – or enrolls in a Managed Long-Term Care plan, "immediate need" home care or a "waiver" program -- a "snapshot" is taken of the couple's total countable resources. Exempt resources described above are not counted. See pp. 10-12. The community spouse is permitted to retain resources, called the Community Spouse Resource Allowance (CSRA), equal to the *greater* of the following:

- $74,820, or
- the "spousal share," which is 1/2 of the total value of the countable combined resources of the couple up to $154,140 (2024) or
- an amount established by fair hearing or court order

In addition, the institutionalized spouse (or spouse enrolled in MLTC or receiving Immediate Need home care) can retain up to $31,175 in countable resources, can purchase a nonrefundable irrevocable funeral agreement, and in some cases, may also have a burial fund.

COMMON QUESTIONS

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

   SSI - When someone receives Supplemental Security Income, they do not have to fill out a separate application for Medicaid. Medicaid enrollment is automatic. Individuals who lose SSI should receive a notice asking them to submit a Medicaid renewal form. If they submit the form within the time requested, Medicaid will continue without interruption. For more information, see: http://www.wnylc.com/health/entry/85/.

   MAGI – Individuals applying for MAGI Medicaid utilize an online application process available on the NYSoH website: https://nystateofhealth.ny.gov/.

   Non-MAGI

   - **Application**: All counties must use the Access New York application Form DOH-5178A, which can be found at http://www.wnylc.com/health/entry/119/. DAB applicants must

complete Supplement A and verify their current assets. (DOH-5178A is now used statewide – NYC no longer uses a separate form.)

The application form 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, they sign and submit 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/.

- Applications should be submitted to the LDSS (also known as their local Medicaid office). Some families may have to file two applications – one for a spouse and other family members who use MAGI budgeting, and one for a spouse and other family members who use DAB budgeting.
  - Dual eligibles applying for Medicaid in order to enroll in MLTC or those seeking "Immediate Need" home care apply at: HCSP Central Medicaid Unit, 785 Atlantic Avenue, 7th Floor, Brooklyn, NY 11238. (File at 1st floor Window 16). "Immediate Need" applications, described fully above, should be e-faxed to **1-917-639-0665**
  - Those EXCLUDED from Managed Long Term Care and seeking "regular" personal care or housekeeping services – (See above – e.g. those who need only Housekeeping services, or those in the Nursing Home Transition, OPWDD or TBI Waivers, or those who do NOT have Medicare and are not in a "mainstream" Medicaid managed care plan, so are not required to enroll in an MLTC plan, or those under age 21, or in hospice care – file Medicaid application and M11q at

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

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

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

Medicaid may pay for care given during the three calendar months before the month in which the client applied for Medicaid. These three months are called retroactive coverage. If bills are due to Medicaid providers for services provided during these three months, once Medicaid is approved with a retroactive effective date, the client should give those providers their Medicaid number and they can bill Medicaid. If the cleint paid providers during that period, they can request Medicaid reimbursement. If the client has a spend-down, some of the past bills may be used to meet the spenddown, discussed above, and once the spenddown is met, may be reimbursed. For more information or to request retroactive coverage: http://wnylc.com/health/entry/18/.

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

Maybe. Medicaid will pay for medical care someone gets out of state if:

- You live in a border county where residents usually get medical care in that state.
- The Local Department of Social Services placed the individual in a nursing home or foster care in another state.
- The provider (such as a doctor) has received prior approval for the individual to get medical care out-of-state.
- The individual needs emergency medical care while traveling in another state and the out of-state provider is enrolled (or is willing to enroll) in the New York State Medicaid program (see https://www.emedny.org/info/ProviderEnrollment/index.aspx).

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

Many people think that Medicaid puts a lien on your home when you apply for Medicaid. This is not true. There are instances when Medicaid may place a lien on your home or make a claim against your Estate after you die, which may include your home.
First, if you are a permanent resident in a nursing home, an intermediate care facility or a residential treatment facility and not expected to return home, and only if you are in the non-MAGI (Disabled, Aged Blind) category, a lien may be put on your real property. However, no lien may be placed if a spouse, a minor or disabled child or certain other relatives reside in the home. However, if you are MAGI, no lien may be placed in this circumstance. NYS DOH GIS 14 MA/16. There are also limits on circumstances under which a validly placed lien may be executed. See an elder law attorney for more information.

Second, Medicaid may recover against your Estate after you die for the cost of medical services paid for by Medicaid on or after your 55th birthday, whether while you were at home or in a nursing home, unless you have a surviving spouse or a disabled or minor child. If you own a home, you should see an experienced Elder Law attorney for advice and planning regarding your home, since it will be part of your estate when you die, subject to estate recovery. If your eligibility was based on MAGI for services received after age 55, the Medicaid claim against your Estate is limited to the cost of any nursing home care or other home and community-based services, and related hospital and prescription drug services received on or after the MAGI individual's 55th birthday. The same family exceptions apply for MAGI as for Non-MAGI – with no Estate claim if the deceased has a surviving spouse, disabled or minor child. NY Social Services Law § 369, NYS DOH GIS 14-MA/016, 15 OHIP/INF-1 Q. 12. The rules are complicated, and in some instances a sibling who resided in the home with an equity interest, and a caretaker adult child, may also be protected. See an elder law attorney. See more information at http://wnylc.com/health/entry/96/.

5. **What if I have emergency medical needs?**

The term emergency Medicaid refers to the limited Medicaid services program which previously existed for undocumented immigrants, if they did not qualify for full Medicaid based on PRUCOL status. This is discussed at http://www.wnylc.com/health/entry/70/ (emergency Medicaid) and http://www.wnylc.com/health/entry/33/ (PRUCOL).

There is no emergency Medicaid for general health care services. Someone who already has Medicaid, or who is applying for Medicaid, may request that personal care or CDPAP services be authorized relatively quickly by the LDSS if they have an **immediate need** for the services, and cannot wait to enroll in an MLTC plan.

For more information on immediate need:

- https://www.health.ny.gov/health_care/medicaid/#need
- http://www.wnylc.com/health/entry/203/
- http://www.wnylc.com/health/download/637/

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

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

Sources of Assistance

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

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

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

NY Connects **1-800-342-9871**

Managed Care Consumer Assistance Program (MCCAP) Technical Assistance Hotlines:

- Community Services Society Community Health Advocates 1-888-614-5400
- Empire Justice Center Health@empirejustice.org or 1-800-724-0490 x 5822
- The Legal Aid Society – Benefits Hotline 1-888-663-6880
- Medicare Rights Center HIICAP Hotline 1-800-480-2060
- NYLAG Evelyn Frank Legal Resources Program eflrp@nylag.org or 1-212-613-7310
- New York StateWide Senior Action Council www.nysenior.org 1-800-333-4374

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

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

Facilitated Enrollment Program for the Aged, Blind or Disabled

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

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