PHP PARTNERS HEALTH PLAN

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

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Partnership Solutions

Housekeeping

- Everyone will be muted to limit background noise – we will unmute participants as needed.
- If you have a question, please type it in the chat – we will pause to take questions and will try to answer them then.
- This presentation will be distributed to all attendees.
- Please do not share any personally-identifying or private health information during the webinar.

Partnership Solutions

AGENDA

- NYS Medicaid Review
- Medicaid Changes
- Keeping Coverage
- If Help is Needed

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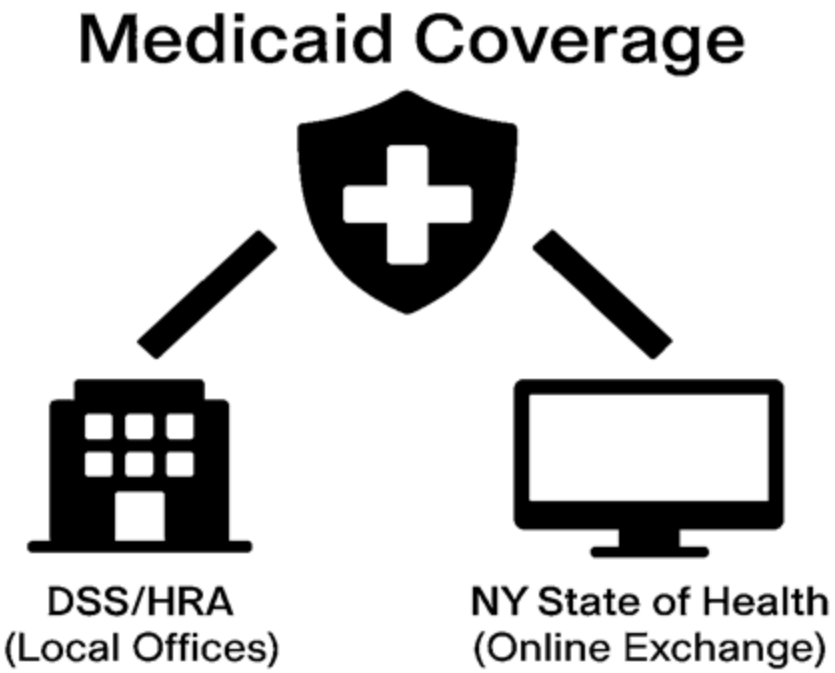
New York State Medicaid Review

- **Medicaid is health insurance**
  - Pays for OPWDD services (only payer for these services)
  - Pays for doctors' visits, medical tests, hospitals, etc.
  - People can have Medicaid and other types of health insurance at the same time
    - From a job/employer ("third party health insurance")
    - From Medicare
      - Part A (hospital)
      - Part B (doctors, lab tests)
      - Part D (prescription drug)
      - Part C (Medicare Advantage)
- **Two ways to apply for Medicaid in NYS**
    - Department of Social Services (DSS)/Human Resources Administration (HRA) in NYC
    - New York State of Health (NYSoH)

Same Coverage – Different Eligibility Rules



Differences Between DSS/HRA and NYSoH

- **Medicaid through DSS/HRA**
  - Most people getting OPWDD services have Medicaid from DSS/HRA (local departments of social services/county Medicaid offices)
  - Can access Aged, Blind or Disabled benefits
    - Requires disability determination by NYS Medicaid or Social Security Administration (SSA)
    - Some income does not count toward Medicaid eligibility
    - Special programs may help people keep Medicaid even with higher incomes
      - Excess Income (spenddowns)
      - Disabled Adult Child (DAC)
      - Medicaid Buy-In for Working People with Disabilities (MBI-WPD)
      - And more…
- **Medicaid through NYSoH (Affordable Care Act)**
  - Expanded Medicaid to cover more people – different eligibility rules based on IRS tax returns
    - Modified Adjusted Gross Income (MAGI)
    - Intended for non-disabled people and people not seeking HCBS Waiver services
  - ***Medicaid Expansion Group*** *– the group that Medicaid changes will affect most directly*

Why do the differences matter?

- **No special budgeting available on NYSoH**
  - If someone has more income than the MAGI limit, they lose Medicaid coverage
    - If income is over the MAGI limit, offers a subsidized health insurance plan
    - If under 18 and parents' income is over the MAGI limit, enrolls child in Child Health Plus
  - ***IMPORTANT*** *– subsidized health insurance plans/Child Health Plus* ***DO NOT*** *pay for OPWDD/HCBS Waiver services*

- **NYSoH makes it harder for someone else, like a CM or advocate, to help the person obtain/maintain coverage**
  - NYSoH only speaks to the person, and person must have their account information available
  - DSS/HRA will speak with others who are assisting a person with their Medicaid coverage/recognizes authorizations to release information to allow assistance

- **Changes that will affect the Medicaid Expansion Group (NYSoH) may not benefit the people we support**
  - Work requirements
  - More frequent eligibility reviews
  - Less retroactive eligibility
  - Cost-sharing

What does this mean to me?

- **Everyone should have and maintain Medicaid coverage to protect the services and supports they receive/want to receive**
  - People with Medicaid through NYSoH (the Exchange) will be subject to the changes that will impact the Medicaid Eligibility Group
  - If a person is determined “disabled” by Medicaid or the Social Security Administration (SSA), Medicaid should be through DSS/HRA
  - Children (under 18) should not have Medicaid coverage through NYSoH if receiving OPWDD services

If you or someone you love has Medicaid through NYSoH and you have concerns about how this will affect you or them, please reach out to your Care Manager for assistance.

Your Care Manager has a **Benefits & Entitlements team available** to them for support in these areas.

You do not have to navigate any of this alone – we are here to help!

Federal Medicaid Changes and NYS

- Work requirement
- Cost-sharing
- Eligibility redeterminations twice a year
- Retroactive coverage changes

Medicaid Work Requirement

- Goes into effect January 1, 2027
- Requires Medicaid applicant/recipient to:
  - Work at least 80 hours/month
  - Complete at least 80 hours of community service
  - Participate in a work program for at least 80 hours
  - Be enrolled at least half-time in an educational program
  - Engage in any combination of these for at least 80 hours
- ONLY applies to ABAWD (Able-Bodied Adults Without Dependents)
  - Exemptions for
    - Blind
    - Living with physical, intellectual, or developmental disabilities
    - Diagnosed with mental illness or substance abuse disorder
    - Living with serious or complex medical conditions
    - Disabled veterans
    - Parents or caregivers of people 13 and younger
    - Parents or caregivers of people with disabilities
- Proof that a person qualifies for an exemption likely to be required – states have until June, 2026 to figure out how to do this

Cost-Sharing Requirements

- Cost sharing (co-pays for Medicaid services)
  - In effect April 1, 2025
    - Dual-eligible, HCBS Waiver enrollees and people 65+ exempt
    - Applies to Medicaid Expansion Group only

- A tip about paying for Medicare and other health insurance premiums
  - If someone is paying a premium for their Medicare coverage (Part B and/or Part D), there may be ways of saving that money
  - Medicaid can choose to pay all or part of a person's other health insurance premium(s) if they decide the coverage would pay for things Medicaid would have to pay for (if it is cost-effective)
  - Ask your Care Manager about free Part D coverage, the Medicare Savings Program (MSP), the Medicare Insurance Premium Payment (MIPP), or the Health Insurance Premium Payment (HIPP)
    - Care Managers at Care Design have access to a full team of benefits & entitlements specialists who can help them with this if needed.

Medicaid Eligibility Redeterminations

- **Medicaid eligibility review twice a year**
  - In effect October 1, 2027
  - Only applies to people with Medicaid through NYSoH (Medicaid Expansion Group)
    - Requires data matching and review by Medicaid program (does not mean a traditional "recert" process)
      - Already occurs at application and once a year to renew coverage
      - Will occur more frequently – at least twice per year
    - In most cases, person themselves will not have to do anything
      - Data matching occurs in the background
    - Redeterminations on NYSoH are based on Modified Adjusted Gross Income (MAGI) reported on individual tax returns, so IRS records are used

Retroactive Medicaid Coverage

- **Retroactive coverage - currently**
  - Applying for Medicaid
    - If person met eligibility rules and had unreimbursed expenses that Medicaid would have paid for if they had coverage for up to 3 months prior to the date of application, Medicaid coverage can be given for that period of time
  - Lapses in Medicaid coverage (recertification not submitted before deadline)
    - If person continued to meet eligibility rules for up to 3 months after coverage ends, Medicaid coverage can be given to cover that gap

- **Starting October 1, 2027**
    - Medicaid can only go back up to 2 months for disabled people (only 1 month if not disabled)
    - Increases the importance of timely recertifications to avoid gaps in coverage and continuity of services

The Importance of Accurate Addresses

- **ALWAYS make sure the person's mailing address on file with Medicaid is correct!**
  - During the Public Health Emergency (PHE), some may have moved and not notified DSS/HRA (SSA for SSI recipients)
  - We know some people have lost Medicaid coverage because the recertification packet or other important information from Medicaid has been sent to an old address
  - Risks of not ensuring addresses are accurate and current can result in:
    - Notice being received by a person other than the intended recipient, making them vulnerable to fraud
    - Notice being returned to the post office
  - In both cases, coverage will end and the person's case will be closed due to failure to recertify/wrong address on file

Reporting Changes to Medicaid

- **Report any changes that could impact eligibility (income, living arrangement, change of address, third-party health insurance coverage, etc.)**
  - Requirement is to notify the appropriate Medicaid district within 10 days of the change
  - Timely notification is critical to ensure coverage continues
  - People receiving SSI benefits must notify their SSA office for the change to be made
  - Changes can impact many things
    - The county from which a person gets Medicaid
    - Availability of special budgeting
    - Whether someone has to pay a health insurance/Medicare premium
    - Availability of other potential benefits

Review/Respond to ALL mail from Medicaid

- **Review ALL notices, coverage decisions, and type of coverage given after recertification is submitted; respond to all requests for information**
  - Medicaid has to notify people of any changes to their coverage/case
  - Notification of negative action is sent 10 days prior to the change
    - New spenddown requirement
    - Increase in spenddown amount
    - Downgrade in coverage
    - Case closure
  - This is the best way to get ahead of any issues
    - It is easier to deal with issues before they happen, which is why the notice comes out before a change is made
    - Notices are issued to the person/advocate, not to the Care Managers
    - Share any info you know about the person's Medicaid eligibility or status based on communications from DSS/HRA that the Care Manager may not know about

Medicaid Best Practices to Avoid Disruption

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

Concerns and Current Issues

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

Disability Determinations and NYSoH

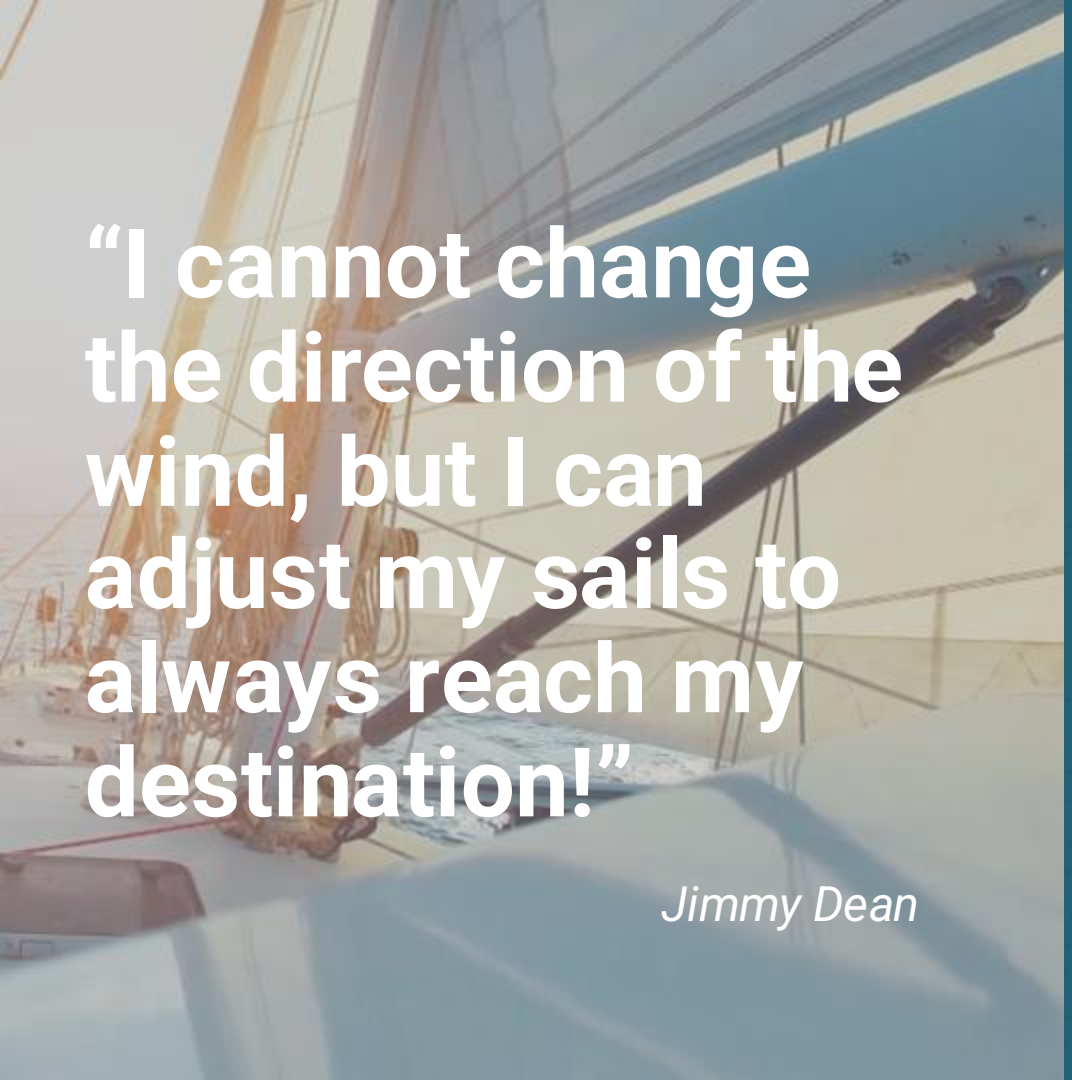
- **Being determined disabled means a person will need to get Medicaid from DSS/HRA**
- **People who receive SSI or SSDI have a disability determination from SSA because being determined disabled by SSA is a requirement for both programs**
- **People in receipt of certain special Medicaid budgeting (like MBI-WPD) have already been determined disabled by Medicaid because disability is a requirement for the program**
- **Disability determinations, whether through Medicaid or SSA have to be reviewed periodically**
    - Social Security conducts Continuing Disability Reviews (CDR) every 1-7 years
    - Medicaid disability certificates also expire and must be reviewed/renewed by Medicaid periodically (usually every 2 years)

When you need help…

- Appeal rights are always included with Medicaid correspondence
  - File for Fair Hearings quickly
    - Within 10 days of the date of the notice to request Aid to Continue (AC)
    - Within 60 days of the date of the notice without Aid to Continue

- Contact your Care Manager!
  - You do not have to do this alone.
  - Your Care Manager may not have all the details needed to help you, but they have a full team of people who specialize in Medicaid and other benefit programs to help them

- We can navigate this together!
  - Do not hesitate to ask questions – this can be complicated stuff!
  - Remember we are here to help – do not feel like you are alone in all of this!



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

Jimmy Dean

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