Human Resources Administration
Department of Social Services

Medical Assistance Program (MAP)

MEDICAID ALERT

February 4th, 2022

Changes to the LDSS-3183, "Provider or Managed Long-Term Care Plan and Recipient Letter"

This Alert is to advise Managed Long-Term Care plans, Medicaid Providers, Client Representatives, Community Based Organizations, Advocates, and Agencies assisting consumers in applying for Medicaid or asking to review a case for excess income coverage; of the change to the New York State Department of Health LDSS-3183, "Provider or Managed Long-Term Care Plan and Recipient Letter".

The existing LDSS-3183 form has been redesigned, renamed and split into two forms as follows:

OHIP-3183, "Provider and Recipient Letter"
OHIP-0128, "Managed Long-Term Care Plan (MLTC)/Recipient Letter"

Certain out-of-pocket medical expenses are recognized under State law, but are not covered by Medicaid. These incurred medical bills are the responsibility of the enrollee and must be paid by the enrollee first to meet a spenddown liability.

Consumers who submit medical bills will receive an OHIP "Provider and Recipient Letter" OHIP-3183 (see attached) once an action has been taken on their excess income case.

The amount of the consumer's excess owed to the managed long-term care plan must also be reduced by these costs. The agency is required to advise the MLTC enrollee and the plan when such expenses have been applied toward the consumer's monthly spenddown. The newly created OHIP-0128, "Managed Long-Term Care Plan (MLTC)/Recipient Letter" (see attached), is used to inform the MLTC plan of the action taken on the consumer's surplus case.

On the reverse side of the new OHIP-0128 form, there is information for both the MLTC plan and the enrollee regarding the actions taken in reducing the excess income spenddown and the number of months affected.

This change in forms will affect the Medicaid Excess Income Unit and the Homecare Services Program Managed Long-term Care (MLTC) Unit.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

OHIP-3183 (6/21)

PROVIDER/RECIPIENT LETTER

(Provider and Recipient Responsibilities)

To: Provider (Name/Address)	**To: Recipient** (Name/Address)	**CIN Number**

This is to advise the Medicaid provider and the Medicaid recipient of the sharing of certain costs between the recipient and the Medicaid program. The Medicaid provider named on this letter must adhere to all payment exclusions/limitations as noted on this letter before billing the Medicaid program for this recipient.

Medicaid has been authorized for the above recipient for the period of_____. This authorization is for:

☐ Medicaid Covered Outpatient Care Only ☐ All Medicaid Covered Inpatient and Outpatient Care

This decision was based on the agency determining that the recipient has excess income and/or resources. As informed in the Notice of Decision, individuals with excess income and/or resources must incur medical expenses at least equal to the amount of the excess income and/or resources to become eligible for Medicaid coverage.

The following medical expenses are the responsibility of the recipient named above and are not to be billed to the Medicaid program by the provider.

Date of Service	**Patient's Name**	**Patient's Account Number**	**Amount**

The recipient is responsible for $ _____ of the following medical expense. After the Medicaid provider deducts this amount from the Medicaid rate or fee, the Medicaid provider may bill the balance, if any, to the Medicaid program.

Date of Service	**Patient's Name**	**Patient's Account Number**	**Amount**

Eligibility Worker (Print)	**Eligibility Worker (Signature)**	**Date**
Supervisor (Print)	**Supervisor (Signature)**	**Date**

PROVIDER, RECIPIENT AND AGENCY: SEE REVERSE FOR IMPORTANT INFORMATION AND INSTRUCTIONS.

PROVIDER, PLEASE NOTE: Since the recipient is responsible for the medical expenses or portions thereof as indicated on the front side of this letter, billing the Medicaid program for such medical expenses without specific authorization from the Department would be inappropriate and may constitute a fraudulent act which may result in recovery action and possible criminal prosecution.

RECIPIENT, PLEASE NOTE: You may receive a separate letter for each Medicaid provider that you used to become eligible for Medicaid. The purpose of this letter is to advise you of unpaid medical expenses for which you are responsible. These are the unpaid medical expenses which were presented to the agency to be used to help you become eligible for Medicaid coverage.

Copies of each letter sent to you are being sent to the Medicaid provider, so that the provider is aware of your responsibility for the medical expenses listed on the reverse side of this letter. When more than one provider is involved, each provider will receive a separate letter listing only the amount for the services they provided to you. This is being done to guarantee the confidentiality of your medical services.

If you live in New York City and have any questions about the information in this letter, please call the HRA Infoline at 718/557-1399.

If you live outside of New York City and have any questions about the information in this letter, please call your Local Department of Social Services. A list is available at the New York State Department of Health website at https://www.health.ny.gov/health_care/medicaid/ldss.htm.

AGENCY, PLEASE NOTE: A separate letter **MUST** be completed for each Medicaid provider detailing only the amounts of the services they provided.

OHIP-0128 (6/21)

MANAGED LONG-TERM CARE PLAN (MLTC)/RECIPIENT LETTER

(Managed Long-Term Care Plan and Recipient Responsibilities)

To: MLTC Plan (Name/Address)	**To: Recipient** (Name/Address)	**CIN Number**

This is to advise the MLTC plan that the amount an enrollee owes to the plan (Excess Income) has been adjusted.

The recipient has provided proof of paid or incurred medical expenses in the amount of $_____ for the period of _____. After these medical expenses are deducted from the recipient's monthly excess income liability of $_____, the adjusted amount that the recipient owes to the MLTC plan is $_____ for the period of _____.

Eligibility Worker (Print)	**Eligibility Worker (Signature)**	**Date**
Supervisor (Print)	**Supervisor (Signature)**	**Date**

MLTC PLAN AND RECIPIENT:
SEE REVERSE FOR IMPORTANT INFORMATION/INSTRUCTIONS.

OHIP-0128 (6/21) Reverse

MLTC PLAN, PLEASE NOTE: The MLTC plan is responsible for collecting the excess income amount from the recipient. This letter advises the plan that the recipient submitted proof of paid or incurred medical expenses. The amount indicated in this letter has been applied to reduce their monthly excess income amount.

RECIPIENT, PLEASE NOTE: Since you are enrolled in a MLTC plan, you are required to pay your excess income to that plan. This letter is being sent to show you the amount of your reduced monthly excess income now that we have deducted your paid or incurred medical expenses from your excess income. Your reduced excess income amount will be collected by the MLTC plan.

If you submitted incurred bills, you may receive a separate letter advising of cost sharing between you and the provider.

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