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FINANCIAL ELIGIBILITY FOR MEDICAID AND THE MEDICAID SPEND-DOWN PROGRAM IN NEW YORK

TRAINING OUTLINE for ADVOCATES

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October 2003 rev'd Jan. 2005, 9/05, 6/07, 1/08, 5/09, 6/10

Medicaid Financial Eligibility and Spend-down Program in New York

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1. Medicaid Eligibility in General

A. An individual must meet three and sometimes four basic tests of eligibility:

i. Financial need

ii. Citizenship or legal permanent immigration status[1]

iii. State residence[2]

iv. Single persons and childless couples under age 65 -- must also cooperate with drug and alcohol screening.

This training focuses on Test No. 1 - financial need. This has 2 factors - Income and Resources, discussed more below

B. **Category** -- First, you must decide which category the individual who needs Medicaid falls into. Category determines everything: whether the individual may use "spend-down," how much income and resources they may have, which income and resources are excluded.

i. Category is defined by these characteristics of the *individual.*

a. Age – under 21, age 65+, in between

b. Disability

c. Caretaker relative of a child under 21 (parent, grandparent, etc.)

d. Pregnant

ii. It is the individual applicant's category, not that of his/her spouse, parent, child, that matters. Medicaid does not view eligibility by the "household," unlike some other benefits.

iii. Once you identify these characteristics, fit the individual into one of these basic three categories. Two of the categories are the "First Class" categories because they receive federal funding. The "Second Class" category is paid for solely by NYS.

***First Class Medicaid - Federal Categories*:**

i. Children and their Parent/Caretakers - **"AFDC-related"**

a. All persons under age 21,

b. Pregnant women

c. Parents or caretaker relative of children under 21

ii. Aged, blind, or disabled **"SSI-related"**

a. Persons age 65 or over

b. Certified disabled or blind - including children

Second Class Medicaid - State Funded Only

iii. Adults age 21 or over and under age 65 who are not disabled and who are not caring for a child under 21. "Safety Net Assistance"

C. Advantages of First Class Medicaid (federal groups):

i. Higher income and resource limits.

a. "Regular Medicaid Levels" in section 3 of HRA Medicaid chart.

b. EXPANDED Eligibility - pregnant women and children under age 19 - have higher income limits and NO resource limits - section 1 on HRA Medicaid chart (CHPlus A, PCAP)

c. COMPARE Box 7 on HRA Medicaid chart for income and resource standards for the Second Class Medicaid group (Safety Net Assistance)

ii. Federal sometimes has better disregards of income and resources - especially for earned income for SSI-related

iii. ONLY Federal may SPEND DOWN excess income and resources to qualify. Everyone else must meet income and resource limits in Box 7 or they are NOT eligible.

- TIP: Consider FAMILY HEALTH PLUS for people not eligible for spend-down, or with a high spend-down

D. What is Spend-down? Under the Medicaid Spend-down Program, some people who are not fully eligible for Medicaid because they have too much *income* or too much *resources* may use some of their past or current medical expenses to bring their *income or resources* down to the Medicaid levels.

Terminology: Spend-down = surplus income or resources = excess income or resources.

E. Who May Use Spend-down:

i. As stated above, only the First Class Medicaid recipients *may* participate in Spend-down. To review, these are:

- All persons under age 21, pregnant women, Parents or caretaker relative of children under 21 (AFDC-related)
- Aged 65+, certified disabled or blind adults or children (SSI-related)

ii. Who *may not* use spend-down

a. Second Class Medicaid recipients -- Adults age 21 or over and under age 65 who are not disabled and who are not caring for a child under 21. (Safety Net Assistance category)

- Always consider FAMILY HEALTH PLUS for this category as an alternative to Medicaid. Income levels Box 4(b) of HRA chart.

b. Even among the federal group, some may not use spend-down. **Pregnant women and children under 19 years of age** – If they are using the **expanded** eligibility levels and not the "regular" Medicaid levels, if their income is over those limits, *they cannot spend down to these expanded income levels.*[3] (Box 1 on HRA Medicaid chart). They must instead spend down to the "regular" Medicaid Income Levels (Box 3 on HRA chart), even though they are in a GROUP that qualifies for the expanded income levels.

- TIP – Because the expanded levels are so much higher the only children and pregnant women who might choose Spend-down are those who are *disabled*, with *earned* income, because of the special budgeting rules. *See* Quick Tips on SSI Budgeting for Aged, Blind & Disabled - materials p. 5.

2. How to Count Income and Determine the Spend-down Amount
Step One – Determine Household Size

To calculate the Spend-down, you must know the Household Size to determine the applicable income and resource levels. The household size will tell you WHOSE Income and Resources in the household must be counted, so you can go on to STEP TWO - determining the amount of countable income and resources.

A. The rule for determining household size depends on whether the applicant is:

i. SSI-related (aged, blind, disabled) or

ii. Everyone else -- including AFDC-related (pregnant, under age 21 or a caretaker for a child under 21) and the Safety Net Assistance category (between ages 21-65 and not disabled and not caring for a child)

- Single adults and childless couples UNDER age 65 use the same Household Size rule as for AFDC-related. But they MAY NOT use spend-down, and MAY NOT use the "regular" Medicaid income levels. They use the lower public assistance income levels.
  - They should consider FAMILY HEALTH PLUS as an alternative.

B. People who fit only one category must use the household size rule for their category.

Example 1: Sam is 67 and lives with his 53-year-old wife, Pam, who is not disabled. They have no kids under age 21.

- Sam must use the SSI-related rule for household size.
- Pam is in the Safety Net Assistance (2nd Class Medicaid) category so she uses the AFDC rule.

C. People who fit both the SSI and AFDC category have the right to choose the most favorable budgeting.

Example 2: If Sam and Pam were caring for their 19-year-old grand-daughter, he would have the option of using SSI- or AFDC-related budgeting.

- Pam would still be in the AFDC category for household size. But her Income and Resources would now be budgeted in the AFDC category, not Safety Net Assistance.
  - *Use the Quick Tips* on SSI Budgeting for Aged, Blind & Disabled to get a sense of whether an applicant who is disabled or age 65 or over, but also is a caretaker for a child or grandchild, would have a lower spend-down with SSI budgeting or AFDC budgeting. (Materials p. 5). Also p. 9 below - earned income deductions.

D. HOUSEHOLD SIZE FOR SSI-RELATED -- Aged (65 or over), blind or disabled persons (all ages)

	Household size for **INCOME**	Household size for **RESOURCES**
a. Lives alone or with spouse who receives SSI	ONE	ONE
b. Lives with children but no spouse	ONE	ONE
c. Lives with aged, blind, or disabled spouse who is not on SSI - no children	TWO	TWO
d. Lives with spouse who is not aged, blind or disabled AND if there are no children under age 18	**ONE if** spouse's income is less than $350 (2009-10 figure)[4] Spouse's income is NOT counted	TWO
	TWO if spouse's income is more than $350 (2009-10). Spouse's income is counted.	TWO
e. Lives with spouse who is not aged, blind or disabled AND if there ARE children under age 18[5]	**ONE** if spouse's income is less than the "allocation amount" ($350) for each child under 18, SIZE IS **ONE** Spouse's income is *not* counted.	TWO
	TWO if spouse's income is equal to or more than the "allocation amount" ($350) for spouse and each child under age 18. Spouse's income *is* counted in amount exceeding allocation amount for kids	
f. Child under 18	**ONE** but income and resources of parent(s) who live with child is deemed available using special rules	

Source: 18 NYCRR 360-4.2.

All rules apply to disabled persons age 18 and over. Box "f" is for disabled children under age 18.

E. HOUSEHOLD SIZE for "AFDC-related" people[6]:

i. General Rule: First, exclude anyone in the household receiving SSI, or public assistance benefits. They are not counted in Household size, and their income and resources are not counted.

ii. The Household Size is:

- The number of persons in the household who are applying for Medicaid (excluding any PA/SSI recipients)

PLUS

- Any "legally responsible relatives" who live with the applicant(s) who are *not* receiving PA/SSI (even if the relative is not applying for Medicaid). If they must be included in household size, their income is counted even if they are not applying.

WHO IS A LEGALLY RESPONSIBLE RELATIVE (LRR)?

Spouses are legally responsible for their spouses.

Parents are legally responsible for children under 21 (18 NYCRR 360-1.4(h)) BUT the income and resources of a parent will not be considered in the determination of eligibility of a pregnant minor or of a certified blind or disabled child who is age 18 years of age or older; or under the age of 18, but expected to be living separately from the parental household for 30 days or more OR participating in one of the home and community-based waivered programs. NYS Dept. of Health Medicaid Reference Guide (MRG) at p. 424

Children are never legally responsible for one another or for their parents, so do not have to be counted in the household size unless they are applying. They do not have to apply.

EXCEPTION: Pregnant teen living with parents:
Parents' income and resources are not counted.

iii. No one has to apply just because they live in the household or are related. However the income of a legally responsible relative *of anyone who does apply* who is living in the house must be counted.

F. Household size examples -- For Sam and Pam on page 4.

Example 1: Sam is 67 and lives with his 53-year-old wife, Pam, who is not disabled. They have no kids under age 21.

- What is Sam's household size?
  - Does Pam's income count for Sam's eligibility?
  - Do we need to know anything else to answer this question?
    - What is Pam's household size?

Example 2: Sam and Pam are caring for their 19-year-old grand-daughter.

- What is Sam's household size?
  - Does Pam's income count for Sam's eligibility?
  - Do we need to know anything else to answer this question?
  - Does Sam have any other option for counting household size? What information would you want to know to decide his options?
    - What is Pam's household size? Does she have any other option? What factor would you use to decide her options?

3. Step Two – Counting Income and Resources

A. **"Income"** is any money, earned or unearned, received from any source. It may be recurring or a one-time payment. Examples are wages, Social Security, pensions, Unemployment, child support, interest and dividends, distributions from an IRA or annuity. Some income of legally responsible relatives is deemed available. 18 NYCRR § 360-4.3.

- Income is generally counted in the month received. However, for income that is received quarterly or annually, such as interest, dividends, or IRA distributions, the amount is annualized and then pro-rated to determine a monthly amount. MRG p. 89.

B. **"Resources"** are savings and other property, liquid and non-liquid. If income is not spent in the month received, the same money then becomes a "Resource." MRG 63. Includes cash and other assets that can be converted readily to cash (bank or financial institution accounts, life insurance, stocks, bonds, mutual funds, CDs, IRAs.

C. **General Rule**. The "category" of the applicant/recipient dictates which rules apply on counting income and resources. There are three categories for these rules. A person is either in the AFDC-related, the SSI- related, or the Safety Net Assistance categories.

i. Rules for counting income and resources for AFDC-related Medicaid recipients apply to children, pregnant women and parents, even though no one receives AFDC anymore.

ii. SSI financial eligibility rules apply to aged, blind and disabled, including disabled children.

iii. Single/ Childless Couples under Age 65 (S/CC) eligibility is same as for Safety Net Program (SNP) cash benefits (18 NYCRR Part 352 and 370) except for a few liberalizations – see below.

D. CHOICE OF METHODOLOGY**:** If a recipient fits into <u>both</u> categories (e.g. a disabled mother of a 5-year-old is both AFDC- and SSI-related), she has the <u>choice</u> of using the <u>more favorable methodology for budgeting income and resources</u>. MARG p. 21, 127-28.

4. Determining Net Income - Deductions from Income

A. Deductions are taken from *gross* income of the applicant, spouse, and other family members if counted in the "household size" above.

B. A complete list of income that is counted or disregarded is in the Medicaid Income Disregards chart, Appendix pp. 8 – 12 or http://wnylc.com/health/file/1

C. For everyone --

i. Public Assistance or SSI received by a spouse or parent or child is disregarded. That person and their income is "invisible" in the Medicaid household.

ii. In-kind income -- If family member OUTSIDE household, NON-legally responsible relative, or any one else pays DIRECTLY for rent, food, or any other expenses, this does not count as income. NOTE: State Dept of Health is contemplating changing this rule. 18 NYCRR § 360-4.3(3)

D. Most common disregards for AGED, BLIND and DISABLED

i. $20 deducted from gross monthly unearned income of single or couple. Maximum $20/couple. If unearned income is less than $20, then balance of $20 deducted from earned income.

ii. Health insurance premiums - Medicare Part B and Medigap or other health insurance premiums deducted. Pro-rate quarterly premiums. NEW: Part D premium, if not free because client joined an "enhanced" plan instead of a "basic" plan that has no premium for Medicaid recipients

iii. New exclusions effective July, 2004[7]:

Interest and dividends earned on resources no longer counts as income. This includes interest on Holocaust reparations. This exclusion is ONLY for people in the community, NOT for nursing home budgeting.

- HOWEVER, if interest is not spent in the month it is earned, it becomes a countable RESOURCE in the following month. So watch the balance on the bank accounts to make sure it doesn't exceed the applicable limit.

- Exceptions: Interest on those resources that are exempt only for a limited period of time DOES count as income. These are listed in Appendix p. 9, and include, e.g. retroactive SSI and Social Security benefits, which are exempt for 9 months following receipt, or unspent tax refunds related to the EITC (earned income tax credit)

iv. **EARNED income** – very favorable treatment. Deduct from gross monthly earnings of applicant AND their spouse or parent (for child under 18) (MRG 195-208)

- 1st $65 of monthly gross earnings
- Impairment related work expenses (IRWE's)
- Balance of $20 if not used up for unearned income
- Half of the remainder is disregarded
- For blind, more work-related expenses are then disregarded
- Income set aside for "PASS" plan - Plan to Achieve Self-Support" - only for certified disabled, not over 65 unless were disabled before 65.
- Only amount left after these deductions is counted.
- If disabled person is under 22 and in school, even better disregards - see MRG 180 and chart in appendix p. 9)
- TIP: Since over half of EARNED income is disregarded, where applicant, spouse or parent of disabled child has earned income, SSI budgeting may be more favorable than the AFDC budgeting.

EXAMPLE: Betty is age 67 and works. She is single. Her Social Security is $546.40/mo, before her Medicare Part B premium is deducted. She earns $1200/mo.

$546.40	Unearned income
– 96.40	Part B premium
– 20.00	Disregard (SSI-related)
$430.00	Net unearned income
$1,200.00	Earned monthly income
– 65.00	Earned income disregard
1,135.00	
÷ 2.00	
567.50	Half of remaining earned income
$567.50	Net earned income
+ 430.00	Net unearned income
$997.50	NET MEDICAID INCOME
– 767.00	Medicaid income level for One (age 65+)
$230.50	**Spend-down**

E. **Most common income disregards for AFDC-related:** under 21, caretaker relative of child under 21, pregnant

i. Health insurance premiums - deducted from income

ii. Child support - first $50/mo disregarded

iii. Earned income - Only may deduct $90 from gross monthly earnings. Does not matter how high payroll deductions are!

iv. Child care or incapacitated adult care -- Deduct up to $175/mo per child age 2+ or per incapacitated adult. May deduct $200/mo. per child under age 2

F. **Single Adults/Childless Couples age 21 - 65, not disabled**

i. NO deduction for health insurance premiums

ii. NO $20 disregard from unearned income

iii. Earned income - $90 deducted from gross earnings.

G. Net Income
Step Three – Subtract Deductions to calculate spend-down

Once deductions are taken from gross income of applicant and relatives who must be counted, this is the NET Medicaid income. From this, deduct the income level for the applicable Box on the HRA chart for the correct Household Size. The amount that is over the income level is the MEDICAID SPEND-DOWN.

BOX 3 – Regular Medicaid Levels - AFDC and SSI-related

- May spenddown

BOX 1 – Expanded Eligibility for Pregnant, Children under 19

- Note: 3d line of this box is effective ONLY until 3/1/05 for ages 6-19. After 3/1/05 they can only use 100% FPL
- May NOT spend down to these levels. If over these levels, must spend down to BOX 3 - Regular Medicaid

BOX 7 – Singles/ Childless Couples not Disabled, under 65

- MAY not spend down

EXAMPLES

EXAMPLE 1: Single 67 year old man receives Social Security – the gross amount, before his Medicare Part B premium is deducted, is $1,117.50. He pays $300 each quarter for a Blue Cross Blue Shield Medigap policy. His spend-down is calculated as follows - see Appendix p. 8 for explanation of deductions

$1,117.50	Gross Income - Social Security
– 20.00	Unearned income disregard
$1097.50	
– 100.00	Health Insurance premium (pro-rated monthly)
$997.50	
– 96.40	Medicare Part B premium (2009)*
$901.10	Net countable income
– 767.00	Medicaid Income Level for One
$134.10	MONTHLY SPEND-DOWN AMOUNT

EXAMPLE 2: Sam and Pam from our old example on page 4. Sam is 67 and lives with his 53-year-old wife, Pam, who is not disabled. They have no kids under age 21. She receives Social Security Retirement of $400/month and has no health insurance. He receives $956.20 in Social Security - gross, before Part B premium is deducted. We already figured out the household size for each.

What is household size for Husband? Two because wife's income is more than $350/mo. See box d on chart on page 5.

What is household size for Wife? Two - rule on page 6 for AFDC households.

What is spend-down for each? HUSBAND is over 65 - uses SSI budgeting

$1,060.50	Gross Income - Social Security - husband
– 20.00	Unearned income disregard
$1,040.50	
– 100.00	Health Insurance premium (pro-rated monthly)
$940.50	
– 96.40	Medicare Part B premium (2009)
$844.10	Net countable income - husband
+ 400.00	Wife Social Security (net)
$1,244.10	Total net income
–1,117.00	Medicaid Income Level for Two (2009)
$127.10	SPEND-DOWN AMOUNT - Husband

Wife Pam CANNOT use SSI budgeting. She uses AFDC budgeting - nothing is deducted. Even if she used SSI budgeting, she must include Husband's income, which puts her above the income limit for two. Their net income of $1244 also puts her above the income limit for Family Health Plus.

5. Counting Resources – and Resource Spend-down

A. Category -- Use the exclusions that apply to the individual's CATEGORY - same as for income: SSI-related, AFDC-related, or Singles/Childless Couples. Count resources of the applicant, spouse, and other family members who are counted in the household size. SEE Medicaid Resource Disregards Chart in appendix - pp 3-7.

B. The **Medicaid Resource Disregards Chart** located at: http://wnylc.com/health/file/3 shows which resources are counted and which are disregarded. The first column applies to parents/ caretakers of minor children. The third column applies to children and adults who are disabled, if disability budgeting is used.

C. Most common exemptions for resources -

i. **Home or co-op applicant lives in** – until 9/1/06, home was always exempt regardless of value.

- Since 9/1/06, because of federal Deficit Reduction Act, the equity value of the home must be under $750,000 IF applicant wants long-term care services, which include nursing home care as well as all home care services. There is still no home equity limit for all other Medicaid services.
- This equity limit does not apply if the individual's spouse or minor or disabled child live in the home.
- LIENS – Medicaid may not place a lien as long as applicant, spouse, or disabled or minor child is living in it. But CAUTION that if applicant goes into nursing home permanently OR dies with the home in his/her Estate, Medicaid may place a lien or make a claim against the Estate. Therefore it is best before applying for Medicaid to seek advice from a private elder law attorney to take steps to protect home.
- *Do not* simply transfer home out of the applicant's name without consulting an elder law expert, as this may have serious adverse income tax consequences because of capital gains.

ii. **Car** – exempt but rules are different for each category - see Resource Disregards chart p.1.

iii. **Bona fide loan** – exempt for everyone but see chart p.2 for rules

iv. **Burial plot** – is always exempt for applicant and for immediate family members - spouse, minor and adult children, etc. See chart p.3

iv. **Burial funds and life insurance and pre-paid burial agreements** – Rules vary by category. See chart p.2.

v. **Holocaust restitution payments** and other persecuted person payments. See http://tinyurl.com/KVFJ2L.

v. **Special rules for SSI-related category** (Age 65+, blind, disabled)

- Pension funds, IRA of SPOUSE are exempt - see chart p.4.
- Pension plan of applicant/recipient - IRA, Keogh, etc. exempt if receiving periodic payments in amounts that are actuarially sound. See chart p. 4 Payments are counted as income.
- Annuity - principal is exempt IF annuity is irrevocable, and if withdrawing periodic payments in amount that is actuarially sound. Called an "immediate" annuity.

vi. Some resources are exempt for a limited period of time - 1, 6 or 9 months. The time period may vary depending on the individual's category. See chart appendix pp. 5-6, e.g. income tax refunds, Earned Income Tax Credits (one extra month), proceeds of sale of real property while reinvest, federal relocation assistance, Social Security, SSI, or VA retroactive benefits. Note that interest on these resources does count as income, even for SSI-related persons.

5a. BASIC INCOME AND RESOURCE RULES IN NURSING HOMES and LOMBARDI & OTHER WAIVER PROGRAMS

A. If Recipient in Nursing Home has no spouse or minor children living in the community, s/he can keep:

RESOURCES – same as any Medicaid recipient (resources of $13,800 (2009) plus burial fund of $1500)

INCOME – Medicaid calculates the "Net Available Monthly Income" or "NAMI" which is the resident's entire income, after deducting:

- $50/month as a personal allowance,
- health insurance premiums.
- The entire NAMI must be paid to the home.

B. If Recipient in Nursing home has a spouse, minor or disabled child living in the community, recipient may keep the amounts above and give spouse the following levels, which are listed on the bottom of page 2 of the HRA chart under "Spousal Support & Resource Level" (Box 10). All figures are from State.[8]

INCOME – "Community spouse" can keep her own income in any amount, plus enough of "institutionalized spouse's" income to bring the total up to "minimum monthly maintenance needs allowance" ($2739/mo in 2009) balance must be paid to nursing home.

- IF community spouse needs more of institutionalized spouse's income, she can sue in Family Court for an order of support, or request a fair hearing, but must prove "exceptional circumstances resulting in significant financial distress." SSL 366-c(2)9g), (8)(b); 18 NYCRR 360-4.10(a)(3), (b)(6)
- IF community spouse's own income exceeds $2739 in 2009 Medicaid will ask for a contribution of 25% over that amount toward spouse's care. S/he can do a "spousal refusal."

- Minor children and dependent children or parents (over 50% needs met by community or nursing home spouse) also get an allowance - $584/mo in 2008 (up to maximum $1750 per family)

RESOURCES – Community spouse can keep couple's joint and individual resources up to the greater of $74,820 (2009) or one-half of the couple's total combined assets up to $109,560 (2009). The balance is deemed available to institutional spouse for cost of care. A spouse can establish the need for more resources to generate enough interest income to bring income up to the spousal income allowance. *See* Robbins v. DeBuono, 218 F.3d 197 (2d Cir. 2000) (community spouse can have an increase in the CSRA to generate additional income without first allocating the institutionalized spouse's Social Security benefits to the community spouse).

SPOUSAL REFUSAL – under SSL 366.3(a) applies to institutional care, allowing spouses to refuse to contribute both income & resources in excess of the spousal allowances. The government has the right to sue a spouse who exercises this right. Form p. 17, available at http://wnylc.com/health/file/66.

C. The spousal impoverishment rules apply to couples at home where one spouse is in the Lombardi program or "nursing home without walls" or other waiver programs.

NOTE: *Evans v. Wing*, 716 N.Y.S.2d 269 (4th Dept. 2000), *rearg. den'd*, 724 N.Y.S.2d 143 (2001) holds that Medicaid recipient spouse must be able to retain more than the $50 personal needs allowance that would be allowed in the nursing home, and remanded to the State to determine an adequate allowance. In GIS-01-MA-021, DOH authorized married LTHHCP recipients to retain the "allocation amount," which is the difference between the income allowance for One and Two. In 2009 that is $350.[9] "Well" spouse also gets full Minimum Monthly Needs income & Resource allowance.

WARNING: The federal Medicaid agency, CMS, is taking a new position that would DENY a spousal impoverishment allowance to couples using any WAIVER program, based on interpretations of complex regulations. This denial would apply regardless of age – people under age 65 as well as over 65. As of May 2009, there are still spousal protections for Lombardi and other waivers, but not for the new Nursing Home Transition & Diversion Waiver or the TBI Waiver. When Lombardi and other waivers are renewed in the next few years, there is a danger that CMS will refuse to renew the spousal protections.

6. TRANSFER OF ASSETS

Amended by Deficit Reduction Act of 2005,[10] OBRA 1993, SSL § 366.5.

A. For Community Medicaid (includes home attendant, CHHA, private duty nursing, outpatient or acute hospital care, assisted living program, Consumer-Directed Personal Assistance Program – CDPAP, hospice, drug and alcohol treatment, and all waiver programs), there is STILL NO PENALTY for transfers of assets made prior to application. One may transfer $1 million today and apply for home care the *first day of the next month*.

NOTE: OBRA 1993 gives states the option to penalize transfers made for community Medicaid with the same disqualifications that apply to Long Term Care Medicaid. The New York legislature has so far rejected proposals to adopt this option.

WARNING FOR SSI RECIPIENTS – Effective Dec. 14, 2000, Congress reinstated transfer of assets penalties for SSI recipients. So someone receiving SSI and Medicaid WILL be cut off SSI for transferring assets. They should not be cut off Medicaid since those penalties do not apply to Medicaid. They should receive a "Stenson" notice after the SSI is terminated, giving them the right to recertify for Medicaid-only with no interruption in services.

WARNING FOR ALL MEDICAID HOME CARE RECIPIENTS – Even though there is no penalty for home care, a transfer of assets now may disqualify the individual from receiving Medicaid for nursing home care if needed within 5 years after the transfer. These rules have changed under the Deficit Reduction Act of 2005, effective in NYS in September 2006. Therefore, before advising someone to transfer assets, look to see if there are exempt transfers possible or other strategies to use to protect eligibility for nursing home care in the future.

B. TRANSFER PENALTY – The penalty or ineligibility period for nursing home, Lombardi and other "waiver" care.

NOTE: This section is an excerpt of a longer outline on the DRA, posted at http://wnylc.com/health/entry/38/.

i. What is the "look-back period" and when will it increase to 60 months?

When an individual applies for Medicaid for nursing home, they must document their assets for a specified period before the date they applied for Medicaid. This is the "look-back period." It is a disclosure period. An applicant must provide all bank statements, brokerage statements, etc. for the look-back period. The purpose

of the look-back period is for Medicaid staff to identify transfers of assets. If they find transfers, and it is not an "exempt" transfer, they then calculate a "penalty." The DRA increases the length of the look-back period.

- Before the DRA, the look-back was 36 months for all transfers, except that transfers into a trust had a 60- month look-back.

- After the DRA, the look-back for all transfers is 60 months. However, the 60-month look-back will be phased in gradually:

Date of Application	**Length of Look-back Period**	
	All transfers except into trusts	**Transfers into Trusts**
1993 until Jan. 30, 2009	36 months	60 months
February 1, 2009	36 + 1 = 37 months	60 months
March 1, 2009	36 + 2 = 38 months	60 months
Every month through Feb. 1, 2011	Look-back grows by one additional month, for example:	60 months
February 1, 2010	36 + 13 = 49 months	60 months
February 1, 2011	60 months for all transfers	

RECORD KEEPING TIP: Help clients start a system for saving their bank statements and other financial records now, if they do not do so already, in case they need to go into a nursing home in the future. It will be very burdensome to gather 5 years of records. And 5 years of records will be necessary even for the poorest individuals, who have to prove that they have *not* transferred any assets.

ii. What is the "penalty period?"

- DEFINITION: If a transfer is identified during the look-back period, and no exception applies, then a "Penalty Period" is calculated. The penalty is a waiting period that can be days, months, or years during which the individual is not eligible for Medicaid to pay for long term care, because of transfers of assets that were made during the "look-back period."

- LENGTH OF PENALTY or WAITING PERIOD - The DRA did NOT change how long the penalty period is. The length of the penalty depends on the amount transferred. To calculate the penalty period, divide the total value of assets transferred by the regional

average monthly cost of private nursing facility services, which is $9,838 in NYC in 2009. [1]

EXAMPLE: Judy transferred $30,000 before she applied for Medicaid nursing home care. The penalty is just over 3 months: $30,000 ÷ $9838 = 3.4 months. If she transferred $300,000 instead, the penalty would be 32 months.

iii. WHEN THE PENALTY PERIOD COMMENCES -- The DRA made a very significant change in WHEN the penalty period commences or "starts running."

a. PRE-DRA – The penalty period began to run the month after the date of the transfer. THIS RULE STILL APPLIES TO TRANSFERS MADE *BEFORE* FEBRUARY 8, 2006.

EXAMPLE: Betty transferred $ 27,000 on February 1, 2005 to her daughter, who does not live with her. Her remaining assets are within the asset limits -- $4150 for a single person, a $1500 burial fund and an irrevocable burial agreement that cost $5000. She applied for Medicaid Home Care in March 2005. She was fully eligible for Medicaid Home Care because there is no "transfer penalty" for Medicaid in the community. She receives home care until November 2006, when she has a stroke. No longer able to climb the stairs to her apartment, on Nov. 9, 2006, she goes into a nursing home and applies for Medicaid. Medicaid "looks back" three years to see what assets she transferred. The $27,000 she transferred in February 2005 is revealed in that "lookback." Since the transfer was BEFORE the new law was enacted, the penalty period began in March 2005, the month after she made the $27,000 transfer. The penalty was just under three months (the penalty rate in 2009 in NYC is $9,838 and expired as of June 1, 2005.

When she is admitted to the nursing home in November 2006, the transfer penalty had long ago expired, and she is fully eligible for Medicaid to pay for her nursing home care.

b. POST-DRA – Delayed Penalty Period

The penalty now begins "running" on the later of: "the date the assets are transferred *or* the "date on which the individual is eligible

[1] Penalty amounts change yearly and vary throughout the state. 2009 rates are in GIS 09/MA 001. http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/09ma001.pdf . Long Island is $ 10,852.00. Westchester and surrounding counties is $9439.00. Central $6938.00. Northeastern $7766.00 Rochester $8720.00. Western $7418.00.

for [Medicaid] …and would otherwise be receiving institutional level care …based on an *approved application* for such care but for the application of the penalty period…."[2]

This means that the penalty generally won't start running until the individual has already been admitted to a nursing home (or has applied for Lombardi or other waiver care - discussed later) AND has applied for Medicaid AND is financially eligible for Medicaid, except for the transferred assets. It is best understood by example.

EXAMPLE – Betty's case above UNDER THE NEW LAW – If Betty's transfer was on February 9, 2006 – after the DRA went into effect:

Home care – Betty would still be eligible for Medicaid home care after the transfer, the same as before. The new federal law does not change the current rules for community-based care.

When Betty enters a nursing home and applies for Medicaid in November 2006:

Look-back – Is still 3 years, because it is before Feb. 2009. This transfer made in Feb. 2005 will be revealed in the look-back.

The three-month penalty period that was caused by this transfer will first begin to "run" in November 2006 – This is the first month in which she is:

☒ in a nursing home,

☒ has applied for Medicaid, and

☒ is eligible to receive Medicaid, except for the transfer.

Betty's application will be denied because of the transfers. The penalty period will run for 3 months from November 2006 - January 2007. In those 3 months, Medicaid will not pay for her nursing home care. Her daughter or someone else must pay for it out of the transferred assets or other funds. In February 2007 she must re-apply for Medicaid and will be eligible.

[2] 42 U.S.C. 1396p(1)(D)(ii), as added by Sec. 6011 of the Deficit Reduction Act.

C. The new rule applies to all transfers made on or after February 8, 2006. Transfers made *before* February 8, 2006 will be assessed under the old rules. The penalty on these transfers started running the month after the transfer. Thus two different rules will be applied when Medicaid evaluates different transfers made in a Medicaid application.

EXAMPLE: Mary applies for Medicaid for nursing home care in February 2007. She made 2 transfers in the 3-year "look-back period," which began February 1, 2004. One transfer in January 2006 will be evaluated under the OLD rules -- the penalty will start "running" in the month after the transfer was made. The other transfer in March 2006 will be evaluated under the NEW rules -- the penalty will start "running" as explained above, once she applies for nursing home or Lombardi care.

D. THE PENALTY PERIOD CONTINUES TO RUN IF CLIENT LEAVES THE NURSING HOME AFTER MEDICAID APPLICATION IS DENIED BECAUSE OF A PENALTY

i. "Once a penalty period has been established for an otherwise eligible individual, the penalty period continues to run regardless of whether the individual continues to receive nursing facility services or remains eligible for Medicaid." ADM at 17. This means that one may enter a nursing home, apply for Medicaid, and have application rejected because of the transfer penalty. Once the application is rejected, you may then LEAVE the nursing home program, and the penalty period will run. While the penalty is running, there is no requirement that the client pay for or even receive any services, or that she be on Medicaid.

ii. Thus the penalty period will run even if the client leaves the nursing home and receives Medicaid home care - personal care, CHHA, Consumer-Directed -- or goes into a Medicaid assisted living program, or privately pays for home care, while running out the penalty period.

iii. After the penalty expires, if she needs and applies for nursing home care again, then she is eligible with no penalty (unless she's made subsequent transfers). If the penalty has not yet expired when she later enters a nursing home, then she is not eligible for those services until the remainder of the penalty has expired.

E. EXCEPTIONS to TRANSFER PENALTY

i. <u>HOME</u> – One may transfer the home without any penalty to a:

- spouse,
- child under 21, or who is or blind or disabled,

- "a son or daughter of such person who was residing in such home for a period of at least two years immediately before the date such person became an institutionalized person, and who provided care to such person which permitted such person to reside at home rather than in an institution or facility"[3];

- sibling with equity interest who lived in home for 1 year.

ii. Transfers of assets other than the home:

- *Transfers to the **spouse –*** The community spouse may keep the higher of $74,820 in assets or half the couple's assets up to $99,540.

- Transfers to the individual's **child who is certified blind or disabled**, *or* to a **supplemental needs trust established for the benefit of the individual's blind or disabled child**.

- Transfers to a **supplemental needs trust** established for the benefit of either:
  - *Applicant, but only if s/he is under age 65,*
  - *Applicant's disabled adult child, OR*
  - *Any individual under 65 years of age who is disabled (does not have to be related to the person setting up the trust).*

- The client can show that she didn't intend the assets to be a "gift" but to sell them at ***fair market value***, or for other valuable consideration.

- The assets were transferred exclusively for a ***purpose other than to qualify*** for medical assistance for nursing facility services.

- Transfers of ***Holocaust Reparations***

- **Undue Hardship –** Transfer penalty will be waived if it would deprive the individual of:
  - Medical care such that her health or life would be endangered; OR
  - Food, clothing, shelter or other necessities of life but only if
  - Best efforts have been made to have the assets returned, and "…After payment of medical expenses, the individual's or couple's INCOME AND/OR RESOURCES ARE AT OR ABOVE

[3] SSL 366.5(c)(3)(i)(D)

THE ALLOWABLE MEDICAID EXEMPTION STANDARD for a household of the same size." In other words, a couple must have income below $1,117/mo. and resources below $20,100.

F. Strategies for Working Around Transfer Penalty

- Minimize the transfer by pre-paying rent and other expenses - Because these payments are for fair market value, they are not subject to the transfer penalty.
- Purchase pre-paid burial arrangements
- Pay off mortgage or debt
- Enter into caregiver agreement
- Purchase Long-Term Care Insurance
- Use annuity or loan with promissory note, in combination with the transfer (more explained in outline on DRA posted at http://wnylc.com/health/entry/38/
- Purchase a life estate in someone else's home
- If an applicant purchases a life estate in his daughter's home, the money paid to the daughter for this purchase will not be counted as a transfer, but the applicant must reside in the home for a continuous period of at least one year after the date of purchase.

> **Life Estate** – The right to live in a home for the rest of one's life. When the holder of the life estate dies, the home passes to the holder of the "remainder" interest.

7. Resource Spend-Down & Retroactive Medicaid – Special Issues

A. Resources are counted at midnight on the first day of the month for which eligibility is sought. If a client was transferring resources or spending down, and wants to apply for Medicaid the following month, be sure that their checks CLEAR by the end of the month before they apply. At midnight on the first day of the month they apply, their assets must be UNDER THE APPLICABLE RESOURCE LIMIT.

Once they are in a month for which they seek Medicaid coverage, they can NO LONGER transfer assets. If assets are over the limit in that month, the client is eligible in that month only after s/he has incurred medical bills that equal the EXCESS RESOURCES and any income spend-down as well.[11]

B. **EXAMPLE:** Mr. H is an elderly man living alone. He was spending down privately on home care and applied for Medicaid in July 2009. On midnight of July 1st, his bank account showed he had a balance of $15,000. The fact that a check cleared *on* 7/1/09 for $1750, bringing his balance below the $13,800 limit does not necessarily make him eligible for July. It depends on what the $1750 was spent on. If the $1750 was used for:

- Purchasing a television for himself, or for a gift (transfer of assets) to his niece, even though there is no transfer penalty for community Medicaid, these are not expenses permitted for spending down excess assets in the same month one is seeking eligibility. He still has $1750 too much in his account for July. He would be eligible in July only if he had $1750 in unpaid or paid medical bills. If, however, he had purchased the TV or given his niece the $1750 in June, then he would have been resource-eligible in July.

- A *pre-paid funeral agreement and/or a $1500 burial fund*, this is permitted for reducing excess assets. 91 ADM-17 p. 4.

- *Medical bills*, such as private paid home care, then he meets the resource spend-down for July. (He was $550 over the resource limit for one person in 2009). BUT Medicaid will not reimburse him for the $1750. Medicaid will only pay medical bills *other* than the $1750 bill that were incurred in July, since that bill was needed to MEET the resource spenddown. (NOTE he can also meet the spend-down with certain other old or recent medical bills – see below).

    - He only has to meet the resource spend-down once – in July. After that, he is eligible with NO resource spend-down, but he can't use the same bills again to meet the INCOME spend-down.

    - Notice (materials p. 14) states he has an income spend-down of $517. He is eligible in JULY for bills exceeding the combined amount of his RESOURCE and INCOME spenddown = $550 + $517 = $1,067. In August, he only has to meet the income spend-down of $517.

    - According to 91-ADM-17, viable medical bills incurred before the retroactive period may be used to reduce excess resources as well as income. (p. 6, Attachment I Example B).

C. Retroactive Medicaid

i. Medicaid can be retroactive for up to 3 full calendar months before the month of application.[12] Applicant's resources must be within the

allowed limits during the retroactive months desired. Or he must have past or current medical bills that meet the spend down - more on this later.

ii. Applicant may choose to begin the retroactive eligibility in any of the three months before the month of application, but eligibility must then be maintained in each subsequent consecutive month, meaning that the income spend-down must be met in each month. See 91-ADM-17.

iii. Retroactive eligibility is important for 2 reasons:

a. Medicaid will pay certain outstanding bills incurred in the 3-month pre-application period. See http://wnylc.com/health/entry/18

b. Client or her family may be reimbursed for bills they PAID in the 3-month pre-application period.

ii. *Advocacy tip*: Be sure to notice the effective date of eligibility on the NOTICE OF ELIGIBILITY.

a. If you are looking for retroactive eligibility, be sure the notice states the correct eligibility date or "pick-up" date. Otherwise, when client requests reimbursement for services they paid for months later, reimbursement will be denied. By that time the 60-day deadline to appeal the eligibility notice will have expired.

b. Where a resource spend-down is involved, Medicaid may make an error and find the client was NOT eligible in an earlier month because of excess resources. If you are concerned about payment or reimbursement for services provided in the earlier month, you will need to advocate to roll back the eligibility date. Deadline to request a hearing is 60 days from the notice!

- EXAMPLE: For Mr. H above, Medicaid found him eligible 8/1/09 even though he applied in July. (Notice on p. 14). He is concerned about bills he owes for July. He will have to show the CASA that he met the resource-spenddown of $550 in July, so that his effective date will be the date he met his spend-down. If he can't convince the CASA office to change the date in writing by 10/25/09, he must request a hearing before that date.

8. SPOUSAL REFUSAL & OTHER REMEDIES IF INCOME & RESOURCES EXCEED MEDICAID LEVELS.

After you calculate the countable income and resources, and they appear to be too much – DON'T GIVE UP. Some or all of the individuals in the family may be eligible using special rules:

A. Use EXPANDED income limits, and NO resource limit for children under 19 (born after 10/1/83) and pregnant women.

B. PLAY WITH HOUSEHOLD SIZE – Not everyone in the household has to apply – exclude people who do not have to be counted, if they have income or resources.

Example: Two sisters under age 18 live with their mother. One sister receives $600/month in Social Security because her father died. The mother works part-time, and after deducting the earnings deductions ($90, child care) her income is $1000 per month. If both sisters apply, the Family Income is $1600/month which is too high for a Family of 3 ($1,285/mo.). But if only the sister without Social Security applies, the Family Size is 2, the countable income $1,000, and the Income limit is $1,117. She and her mother are both eligible for Medicaid.

C. **Choice of Methodology:** If an applicant is both SSI-related (over 65 or disabled) AND AFDC-related (under 21 or takes care of a child under 18), s/he can choose which category she wants to apply in.

Example: Mrs. Smith is 67 years old and is caretaker-relative for her 14-year-old grand-daughter. She is both SSI-related (over 65) AND AFDC-related (caretaker relative). If she works, she may prefer to use the SSI earned income deductions which are higher than the AFDC earned income deductions.

D. **Spousal or Parental Refusal –** If an applicant lives with a legally responsible relative (parent or spouse) whose income or resources are too high, the relative can sign and submit a statement that s/he cannot contribute toward the applicant's medical expenses and support. Under this "**spousal refusal**," that relative's income or resources cannot be counted. Only the applicant's income and resources will be counted, and will be compared to a Household Size of One. For persons in the community, this state law -- Soc. Serv. Law § 366.3(a) -- is unique to New York and is not in federal law. 18 NYCRR 360-4.3(f), 89 ADM-47. Federal law does have a similar provision for institutionalized spouses. *Morenz v. Wilson-Coker*, 2d Cir., 2005. Proposals to repeal the state version are made every year and have been made for the 2005 Budget.

FORM for indicating failure/refusal to support - Appendix p. 85 or http://wnylc.com/health/file/66.

NOTE: The responsible relative is still liable for support. He or she may be sued for support by the City in Family Court. Though there is no written policy, HRA practice is to use as a benchmark the income and resource levels applicable to INSTITUTIONALIZED SPOUSES -- if they have less than the nursing home spousal impoverishment levels, a suit is not likely.[13] A Channel 4 news story on the support suits in late 2000 shamed then Mayor Giuliani into announcing that they would cut back on these suits.

NOTE: A relative who signs a "refusal" must still divulge their assets and income to Medicaid. Medicaid might be able to deny the application based on failure to verify eligibility.

E. **USE CHILD HEALTH PLUS, FAMILY HEALTH PLUS, EPIC, or the Medicaid Buy-In Program for People under age 65 who are disabled and working** – Some children or adults under age 65 may be better off being excluded from the Medicaid household and applying for CHP or FHP instead. Disabled adults under age 65 who have earned income may qualify for the Buy-In. SEE links:

EPIC – http://tinyurl.com/YQEWX3

Medicaid Buy-In for Working People with Disabilities – http://tinyurl.com/5BLT8W

Child Health Plus – http://tinyurl.com/MY4LAZ

Family Health Plus – see section 18 below. Also see Basic Health Law outline from The Legal Aid Society.

F. Does client or family have old medical bills OR has s/he used EPIC or ADAP? They might be eligible for credit against their spend-down – see next section.

9. WHOSE BILLS CAN BE USED TO MEET SPEND-DOWN:

A. Include bills for all persons in household who are *applying* for Medicaid AND their legally responsible relatives, even if they are not applying.[14]

DEFINITION: Spouses are legally responsible for their spouses. Parents are legally responsible for children under 21, 18 NYCRR 360-1.4(h).

NOTE: If legally responsible relative is doing a spousal/parental refusal, you can't use their bills.

B. Also include bills for family members for whom applicant is legally responsible, even if they are NOT applying. E.g. a parent who is applying

even though 19-year-old child is not because child has independent income. Child's medical bills can apply toward parent's spend-down.

10. DOES A BILL HAVE TO BE PAID TO COUNT TOWARD THE SPENDDOWN?

NO!!! Bills only have to be *incurred* to count toward the spenddown.[15] The Medicaid office may not demand proof that the bill was paid.

An expense is <u>incurred</u> on date liability for the expense arises, usually the date of service.[16]

11. WHAT BILLS CAN BE USED TO MEET SPENDDOWN:

Deduct in the following order:[17]

A. HEALTH INSURANCE – Deductibles and copayments for Medicare or private health insurance (note that cost of *premium* was already deducted from income to calculate spend-down).

B. Medically necessary expenses <u>not covered by Medicaid</u> (chiropractors & podiatrists, services by physicians who don't accept Medicaid, over the counter items).

To count over-the-counter items such as vitamins, lotions, ointments, etc, submit the following. See sample at pp. 81-84 of materials.

i. Get a physician's note explaining *why the item is medically necessary*, and stating the *daily dosage* prescribed. If these are regular recurring expenses, have physician state that these have been prescribed as necessary since X date and will be necessary on an ongoing basis.

ii. Collect receipts showing the cost of the items over 1-2 months.

iii. Make a list that shows the cost of each item pro-rated for a month. For example, if MD prescribes Vitamin E 500mg./day, and a bottle of 100 500mg tablets costs $15, then the monthly cost is about $5.

iv. Send the whole packet to the CASA in home attendant cases and request that they credit client for spend-down at $x per month. Specify the period of time, e.g. retroactively to Jan. 1, 2003 and ongoing thru 12/03.

v. Send a cc to the home attendant vendor or CHHA - since they want to get paid, they may push HRA to process the credit.

C. Medical expenses that ARE covered by Medicaid – hospital and physician bills, prescriptions, transportation for medical care, hearing aids & eyeglasses, medical supplies & equipment.

i. **POLICY NOTE** The reason for applying bills in this order is to help the applicant. It is better for her to meet the spend-down on items Medicaid wouldn't otherwise pay for, and then to use Medicaid for Medicaid-covered services.

ii. If the service is one requiring "prior approval," regulations limit credit toward spend-down to the service approved, or the amount approved, provided that district gave Notice of amount of service found medically necessary. The regulation at 18 NYCRR § 360-4.8(c)(3) states, "For services regularly requiring prior approval, *after* the social services district tells the recipient the amount of services that are medically necessary for him/her, as determined by the district according to applicable regulations, additional medical services over and above the amount which is medically necessary cannot be used to reduce the amount of the recipient's excess income."

EXAMPLE – Client was approved for 12 hours/day home care but wants 24 hours. Client's spend-down is $1000/month. Client wants to privately pay a home care worker to provide extra care, and apply $1000 of that cost to meet her spend-down. This regulation prohibits her from doing that, if the local district has given her written notice that it is approving only 12 hours of home care. Some counties, like Nassau, may permit it.

D. Costs of medical care or drugs paid for or incurred by a NYS or local public program other than Medicaid, including:

- **EPIC**
- ADAP
- OMRDD
- Physically Handicapped Children's Program (PHCP)
- Early Prevention Programs
- Local public school district, counties, or municipalities on behalf of handicapped children

i. The actual subsidy paid by these public programs counts toward the spend-down, not just the small copayment that the applicant might pay.[18]

ii. Can use bills incurred and paid for any of these publicly-funded medical services in the MONTH of application for Medicaid or in the THREE MONTHS BEFORE filing the MA application. Don't forget that not only client's bills but certain other family members' bills can be used. See p.26.

iii. If so, write to EPIC (or other program) and request a printout of expenses paid by EPIC program during a specified period of time. SAMPLE form letter at p. 23 of materials

- INCLUDE A SIGNED RELEASE - sample of HIPAA-compliant release at 24-25.

iv. Some programs might complete the form designed for this purpose – MAP 2069N or 91-ADM-11 Attachment – copy at materials p. 22. However, the EPIC Program instead sends a computer printout - see SAMPLE at pp. 26-27.

v. Send the printout with a cover letter to Medicaid explaining how client should be credited for EPIC subsidy and copayments. SAMPLE at p. 28.

vi. Since EPIC subsidy is PAID, as explained below, you can only use bills incurred and paid during the 3 months before client applied for Medicaid and then after, during the application period.

vii. Once client is on Medicaid, technically she is no longer eligible for EPIC. However, there is an argument that if client is on Medicaid only with a spend-down, then she should continue to be eligible to use EPIC, and then use the EPIC subsidy to meet her spend-down. The problem is logistics - how to obtain the EPIC printout in time to meet the current spenddown.

viii. **EPIC Recertification** – EPIC recipients should indicate they do not have any other drug coverage if they are on the Medicaid spend-down program. They use the EPIC card until they have met the spenddown, then switch to the Medicaid card. Submit proof to Medicaid that client met spenddown, as described above.

12. USING PAST MEDICAL BILLS TO GET CREDIT FOR MEDICAID SPENDDOWN – Old bills of the applicant and other family members described at p.26 above can be used to get "credit" against the Medicaid spend-down. This credit can make them eligible for full Medicaid for a long period of time, depending on the amount of old bills and the amount of the spend-down.

A. Using old bills is a special advantage of NEW APPLICANTS for Medicaid. Later, after they have received Medicaid for awhile, they will have "used up" these old bills by applying them to meet their spenddown. No bill may be used more than once. Once the old bills are used up, client can only meet the spenddown by incurring new medical bills each and every month (with an exception for inpatient hospital bills described below).

- At that point, those under age 65 may prefer to switch to Family Health Plus (or children to Child Health Plus B).

B. How old can bills be – PAID vs. UNPAID bills?[19]

- **Paid** bills can only be used if the medical services were provided within the 3 calendar months before the month of application.[20]

  WARNING! FILE APPLICATION ON TIME: Make sure the *signed* application is filed within the current calendar month if client wants credit for bills PAID within past 3 months.

  Example: Client has bills for care provided in June, and it is now September. The application must be signed and filed by the end of September in order for Medicaid to pay the June bill directly, or to reimburse the client for a paid bill, or to credit the bill against the spenddown. If you are referring the client to apply at a Medicaid office, make sure to tell them the deadline for filing the signed application if they want those bills paid, reimbursed, or credited against the spenddown.

- **Unpaid** bills can be much older – they can be used as long as the bill is still "viable," which means that the provider is still trying to collect it. Some local districts may use a cut-off of six years, since a provider has six years to sue a patient for a medical bill. HRA may accept even older bills if they are viable. If the applicant has not received a "demand letter" (collection letter) for a bill in more than a year, he/she can ask the provider to send another bill. Since this may trigger a collection action, the applicant may want to discuss this option and his/her eligibility for spenddown with the local district before deciding.

C. Medicaid budgeting periods – 96 ADM-15 (copy at p. 42). Medicaid with a spenddown is certified for a period of between 1 and 6 months. The month of application must be included as one of the months. If the applicant needs bills incurred within the three pre-application months to be paid or reimbursed, the budgeting period can occur 1, 2, or 3 of the pre-application months. The months must be consecutive, so if one wants to include the 1st of the 3 pre-application months, one must include all three of these months. If one includes the three pre-application months, then a 6-month budgeting period would also include the month of application and the next 2 months.

Length of budgeting period – If the amount of past bills meet the spenddown for a full 6 months, then the applicant is certified for full Medicaid for a 6-month period. If the amount of past bills meets the spenddown only for 2 months, then the applicant is certified only for 2 months of full Medicaid.

D. Carrying past bills forward beyond the current budgeting period --

Whether or not past medical bills can be carried forward to future 6-month budgeting periods depends on whether the bills are PAID or UNPAID – see below.

i. **PAID BILLS** – To get credit against the spenddown for past PAID bills, the bills must have been paid within the 3 calendar months before applying for Medicaid, for medical care provided within those same 3 months. If a client paid a medical bill six months ago, she gets no credit for this bill at all.

These paid bills can be used as "credit" against the spend-down for only up to six months after the application is filed. Unlike unpaid bills, they cannot be carried forward for longer periods. For this reason, Medicaid will give "credit" for paid bills first, then for past unpaid bills.

ii. **UNPAID BILLS** – Unpaid bills can be used as credit against the spend-down indefinitely into the future, as long as the period of coverage is continuous. If the unpaid bills are more than enough to meet the spend-down for six months, then six months will be authorized. After that 6-month period, another period of up to six months will be authorized until the bills are used up. The final authorization period may only be for 1 month instead of 6, if the remaining bills are only enough to meet the spend-down for one month.

NOTE: Break in coverage stops use of bills. Before 1996, UNPAID BILLS could be carried forward forever. The ADM issued in 1996 changed this. If, with the old unpaid bills, the person does not incur enough bills to meet the surplus in a budgeting period, the old bill cannot be carried forward further.

EXAMPLE: Marge has a $25/mo. spend-down. She had an old bill that met her spenddown for 8 months through September. She still has $15 left from the old unpaid bill. In October, she must incur another $10 in new expenses to add to the $15 remaining of the old unpaid bill to equal her spenddown for that month. If she does not incur $10 in expenses in October, she may not carry forward the remaining $15 from the old unpaid bill to future months.

E. **EXAMPLE of PAID and UNPAID BILLS:** Donna, a 66-year-old married woman, is applying for Medicaid in November with an income spend-down of $20 per month (Social Security is $807 – $20 disregard = $787; income limit is $767; $787 – $767 = $20). Her husband is 62 receives early retirement of $280. He is not applying because he is not disabled. (see Family Size chart above at p. 5 - his income does not have to be counted).

- She can be authorized for 6 months of Medicaid by showing that she or her spouse have *unpaid bills* for $120 in past medical expenses for care provided as long as 6 years ago.

- She can also meet the spend-down for 6 months if she has $120 in *paid bills* for care provided within the 3 months before she applied for Medicaid. If the paid bills are older, she cannot use them.

- She can meet the spend-down by combining paid and unpaid bills, but will want to use the paid bills first, since they cannot be carried forward past the current budgeting period.

F. Strategy for choosing the budgeting period:

- Which 6-month period should Donna choose for her Medicaid budgeting period? Her options are:
  - Include 3 retroactive months (August - Jan)
  - Begin in month of application (Nov. - Apr)
  - In between - begin in September or October and then for 6 months)

- If any of the past bills were incurred within the 3-month retroactive period, and she wants Medicaid to PAY them, or reimburse her if she already paid them, she must include all or part of the retroactive period in her 6-month budgeting period. So the 6-month period would begin August, September, or October. However, the bill (or part of the bill) that she wants Medicaid to PAY or REIMBURSE cannot be used to meet the spend-down.
  - If the past bills were all incurred *before* the 3-month retroactive period, Medicaid won't pay them. There is no point to including the 3-month retroactive period in her budgeting period because she has no bills for Medicaid to pay or reimburse. So she should elect the 6-month period beginning in November to get the longest period of Medicaid eligibility.

G. Strategy where client has combination of OLD and RECENT bills

i. Medicaid will pay outstanding bills only for Medicaid providers. So if client has more than enough bills to meet the spend-down, leaving some left over for Medicaid to pay, make sure to use the bills for NON-Medicaid providers to meet the spend-down, so Medicaid will pay the remaining ones to Medicaid providers

ii. In the same example, Donna has $120 in VERY OLD bills that meet the spend-down for six months, but she also has $60 in bills incurred in

September. Since she met the spend-down with the old bills, Medicaid will pay her September bills or reimburse her if she paid them. So, she should use the OLD bills first, and then have Medicaid pay or reimburse the more recent bills. In that case, you will need to choose a budgeting period that includes September and October – 2 months of the 3-month retroactive period. So she'll get coverage for 4 additional months – November - Feb.

iii. Variation – Donna has $250 in past medical bills when she applies. If the bills are *unpaid* and viable OR were for care provided and *paid* for within the 3 months before she applied, she will be authorized for Medicaid for a 6-month period, using $120. After that initial 6-month period, then, she has $130 left in past bills.

WHICH BILLS totaling $120 SHOULD SHE USE TO MEET the first 6-month spend-down?

ANSWER: She should first use any recent PAID bills, leaving older UNPAID bills since they can be carried forward to future budgeting periods. If after she uses $120 in RECENT PAID bills, she has $130 in remaining bills and –

- If the $130 left was PAID, she cannot carry forward the balance of $130 of this paid bill to qualify for Medicaid after the 6th month.

- If the $130 left was UNPAID and still viable, she MAY carry forward the $130 to meet the spend-down for a second 6-month period, using $120 of the $130 balance. This leaves $10 of past unpaid medical expenses, which is enough only to meet part of the 13th month's spend-down of $20. She will only be authorized for a single 13th month if she incurs another $10 in medical expenses in that month.

H. STRATEGY with MEDICARE SAVINGS PROGRAM

Clients deciding whether to enroll in the Medicare Savings Program (QMB, SLMB)[4] have a dilemma. If they enroll in this program, Medicaid pays their Part B premium ($96.40/mo 2009). Their countable income increases by that amount, thus increasing their spend-down. If client has past unpaid bills that will meet the spend-down for now and/or into the future, then this tips the scale in favor of enrolling in the Medicare Savings Program. SEE case example in materials - pp. 71-79.

I. Example of combined RESOURCE and INCOME SPENDOWN

[4] What about QI-1, you ask? By law, you cannot have both Medicaid and QI-1. However, you can have both Medicaid with a spend-down and either QMB or SLMB.

Mr. H, in example above, has a $550 resource spend-down and a $517/mo income spenddown. He applied in July. He can meet the resource spenddown either with new medical bills incurred in July, or also with old unpaid bills that are still viable (see p.29 above).[21]

First he uses bills to meet the resource spend-down. Once that is met, any remaining unpaid bills can be carried forward. They can be used to meet the income spend-down in the current and future budgeting periods. They can be used until the bills are "used up" OR until there is a break in coverage. See p.31.

Example: Sue is a 66-year-old single retiree with a $100 income spend-down. She also has a resource spend-down of $2000, which she does not want to spend. She has a 4-year-old hospital bill of $8000. She applies in October. Her spend-down for October is:

$2,000	Resource spend-down
+ 100	Income spend-down
$2,100	Total spend-down

$8,000	Old unpaid bill
– 2,100	Part of bill applied to meet October spenddown
$5,900	Amount of unpaid bill that can be carried forward to meet spend-down after October. This is enough to meet her income spend-down for 59 months, assuming her budget remains the same.

Would Sue's options be different if she were 62? What would make a difference?[22]

13. Special rules for inpatient hospital stays

For inpatient hospital bills, Medicaid requires the client to pay more of the bill than for all other outpatient care. For outpatient care, prescriptions, etc., once the client incurs medical bills that equal ONE MONTH of their excess income spend-down, they have met their spend-down, and Medicaid will pay the rest of the bills for that month. But for a hospital stay, even when a hospital stay is only one night, Medicaid requires the client to be responsible for SIX MONTHS of their income spend-down.[23]

EXAMPLE: Mary is age 64 and receives Social Security disability but has no Medicare. Her spenddown is $100 per month. She was in the hospital for one night in June 2002, and was billed for $2000 in July 2002. She brought the unpaid bill when she applied for Medicaid in September 2002.

Will Medicaid pay any part of the bill?

Yes. The bill was incurred in June, which is within the 3 calendar months before the month of application. This is within the retroactive period.[24]

How much of the bill will Medicaid pay?

Medicaid would pay only for the amount of the bill that is above $600, which is 6 times her monthly spenddown, because the bill is for inpatient care. She is liable for the first $600 of the bill, then Medicaid pays the rest at the Medicaid rate.[25] Since Mary has incurred a bill equal to her spend-down for 6 months, she should also be authorized for full Medicaid for September, October, and November --a 6-month budgeting period that began in June.

TIP – Make sure the signed Medicaid application is FILED within the third calendar month after the month in which she was hospitalized

14. Staying On the Spend-down Program

A. New applicants who apply for Medicaid with a spend-down should receive a written notice explaining the amount of their spend-down and explaining the rules. (A copy of part of the notice used in NYC is at the end of the manual).

i. If the applicant has brought in bills with the application that meet their spend-down for at least one month, the written notice should tell them the number of months that they are fully authorized for Medicaid. The maximum number is six months, but a new authorization will give up to another six months until old bills are used up. The Medicaid card should be activated for the months of authorization.

ii. If the applicant has not brought in medical bills, then the notice will state that they will be authorized for Medicaid once they bring in bills that meet their spend-down for that month. (All the rules about paid and unpaid bills described above apply). For these clients, even if they receive a Medicaid card, it will not be activated until they bring in bills that meet their spend-down.

iii. If a new applicant does not bring in bills that meet the spend-down within 3 months of receiving the notice that tells them what their spend-down is, then they will have to RE-APPLY for Medicaid later, when they have bills that meet the spend-down. For this reason, it is not worth it to apply for Medicaid if the client does not expect to meet their spend-down within the 3 months after they apply.

Example: John applies for Medicaid and in June receives a notice that his spend-down is $50 per month. John has no past medical expenses and has no other medical bills until October. He takes them to the Medicaid office, but is told he must reapply.

B. Past paid bills can be used to meet the spend-down for up to six months. . As described above, she would get additional months as long as she has old *unpaid* bills that meet her spend-down.

C. MEETING SPEND-DOWN MONTH TO MONTH -- Once the past bills are used up, she must bring to the local department of social services bills incurred *in that month* that meet her spend-down for that month. Then Medicaid will pay any remaining outpatient bills for that month. Medicaid will pay inpatient bills after the applicant incurred six times their monthly spend-down. See above.

   i. FAXING BILLS - In NYC, since mid-2009, clients may fax bills instead of going to the Medicaid office in person. They should use the cover sheet posted at http://wnylc.com/health/afile/55/73/. The fax number is

      FAX 917-639-0645

      On the fax be sure to fill in the blanks for client's NAME and CIN, and also specify

      - Is the bill paid or unpaid and
      - Specify which month to activate Medicaid for (this is generally the month in which the bill was incurred - but perhaps they are allowing longer budgeting periods)

D. If in the next month the client has no medical bills, she does not have to go to the Medicaid office. She will not have Medicaid for that month. If in the next month, the client does have medical bills, then she brings them to the Medicaid office to get Medicaid for that month. In New York City, if the client does not meet her spend-down for more than two months (so she does not have Medicaid for more than two months), she will have to re-apply

E. **RECERTIFICATION** – Like all Medicaid recipients, those in the spend-down program must recertify at least once a year. If they don't recertify, their case will be closed. If they never used Medicaid during the last authorization period, they will not receive a Recertification package in the mail. They must meet their spend-down and use Medicaid at least once during the authorization period to receive a recertification package in the mail. If they don't, they must re-apply.

F. **HOME ATTENDANT / PERSONAL CARE** – A special arrangement exists for clients receiving Medicaid home attendant care or personal care, at least in NYC. Under their contract with HRA, the vendors bill the client for their monthly spenddown. Client does not have to show that she incurred spend-down each month. The client's Medicaid card is activated all the time – it does not have to be reactivated at the beginning of each month.

NOTE: Since the spend-down need only be INCURRED and not PAID (See p.27), the mere act of receiving the bill is sufficient to continue Medicaid eligibility. Payment of the bill is not a requirement for continuing home care or Medicaid.

G. **CHHAs** – CHHAs do not have the same contractual arrangement with HRA that home attendant agencies have. They must actually bill the client at the beginning of each month for the amount of their spend-down. The client must submit that bill to Medicaid to show that she incurred bills that equal her spend-down. Medicaid is then activated, and the CHHA may bill Medicaid for the amount that exceeds the spend-down. Some CHHAs, such as VNS and Selfhelp, have a special arrangement with HRA by which they submit the bill to HRA directly each month to activate Medicaid. The client need not take the bill to Medicaid herself.

15. PAY-IN PROGRAM. An alternative way of meeting the spend-down is through the PAY-IN program.[26] Once enrolled in this program, the Medicaid recipient can pre-pay her spend-down to the local department of social services for up to six months at a time. The pay-in program eliminates delays in processing the bills and getting Medicaid coverage activated.

This program is especially helpful for people with small spend-downs. For example, for someone with a low spend-down - such as under $20, It is much more convenient to pre-pay $120 to Medicaid in order to obtain 6 months of full coverage, instead of bringing bills down to the office every month. If she pre-pays for 6 months, she qualifies for Medicaid inpatient and outpatient coverage. If she pre-pays for less than 6 months, she is covered only for outpatient care. If she needs inpatient care, she will have to meet a full 6 months of her monthly spend-down.

The Medicaid caseworker should be able to give the client forms to enroll in the Pay-In Program. These include pre-addressed envelopes for sending in the payment.

The client may have someone else pay-in their spend-down - it does not have to be paid by the client herself. *Wonderful use of emergency funds from charities.*

16. PLACING EXCESS INCOME INTO SUPPLEMENTAL NEEDS TRUST (SNT)

A. Until recently SNTs were viewed solely as a method of sheltering extra assets, such as a settlement or inheritance. The original directive issued by the State Dept. of Health, 96-ADM-8, titled “OBRA ’93 Provisions on Transfers and Trusts,” fostered this view. However, the State Dept of Health amended this directive by a letter dated September 23, 1997 which states:

> "While most exception trusts are created using the individual's resources, some may be created using the individual's income, either solely or in conjunction with resources**. Income diverted directly to a trust or income received by an individual and then placed into a trust is not counted as income to the individual for Medicaid eligibility purposes.** Verification that the income was placed into the trust is required. In order to eliminate the need to verify this on a monthly basis, it is recommended that you advise the recipient to divert the income directly to the exception trust."

Note this letter uses the term "exception trust" for what is otherwise known as a "supplemental needs trust." A link to this letter, the training outline, documents needed to enroll in the NYSARC pooled trust, list of pooled trusts in NYS, are posted at http://wnylc.com/health/14/.

B. ELIMINATE SPEND-DOWN IN COMMUNITY BUDGETING

By placing one's excess monthly income in the SNT, once this is documented, HRA must adjust the Medicaid budget to eliminate the spend-down.

NOTE: The spend-down or "NAMI" cannot be eliminated for nursing home budgeting using this method. For chronic care budgeting, all income is to be applied to the cost of care "including income disregarded or considered unavailable for the purpose of determining MA eligibility." 18 NYCRR § 360.9; 42 CFR § 435.832(c). There is some gray area as to whether an SNT can be used to eliminate the spend-down for waiver participants.

EFFECT ON SSI – Income cannot be transferred into an SNT to qualify an individual for SSI or to increase the SSI level. This is because transfers of income as well as assets incur a transfer penalty.

C. For rules on WHO may set up an SNT, and the TYPE of SNT that may be used, please see the separate outline on Supplemental Needs Trusts, available at http://wnylc.com/health/entry/5/. NOTE that individuals age 65 or over may only use a "pooled" trust run by a non-profit organization.

17. Medicaid Buy-In for Working People with Disabilities (MBI-WPD)

This program can ELIMINATE the spend-down for younger disabled persons (age 16 - 65) if they work, even very part-time.

	Single	Couple
Income limit is 250% Federal Poverty level	$2,257	$3,036

Resource limit.....$13,800 $20,100

See http://tinyurl.com/5BLT8W; also http://www.nls.org/pdf/summer-2003.pdf; SSL § 366, subd. 1 (b)(12)

18. LIENS & RECOVERIES FOR MEDICAID EXPENDITURES

92 ADM-53; 02 OMM/ADM-3 at http://tinyurl.com/KPAOR2.

A. Medicaid has the least onerous policies and procedures for collecting money from a recipient or former recipient as repayment for Medicaid services provided.

GENERAL RULE: No Administrative Overpayments -- Unlike Food Stamps and SSI, the Medicaid agency cannot "recoup" or collect an overpayment from a recipient who received services while ineligible. Generally, Medicaid must obtain a court judgment that services were improperly received in order to collect from a current or former recipient while s/he is still alive. 42 USC 1396p. Exceptions are described below.

B. **EXCEPTIONS** – When can Medicaid Collect

i. Liens on a Home or other Real Property –

Generally there are no Medicaid liens to collect MA benefits correctly paid. Medicaid can place a lien on a home only of an institutionalized individual, and only if the individual is not expected to return home. Lien dissolves if individual returns home. 42 USC 1396a(a)(18), 1396p; SSL 369(2)(a)(ii), 18 NYCRR 360-7.11(a)(3), 92 ADM-53

a. NO lien can be placed if any of these relatives lives in the home: a spouse, a child under age 21 or disabled child, or a sibling who has lived there one year before institutionalization and has an equity interest in the home

b. No lien can be placed as long as client has subjective intent to return home. Anna W. v. Bane, 863 F. Supp. 125 (WDNY 1993)(holds SSI rules apply, which use test of subjective intent to return home).

c. A lien validly placed cannot later be liquidated if any of these relatives live in the home: a sibling who has lived there for a year regardless of any equity interest, a child who provided care to the individual has resided there for two years, any other dependent relative lives there, or property is income-producing for the institutionalized individual

ii. Personal Injury Awards or Settlements – Medicaid can recover from these lawsuit or insurance awards or settlements, but only for MA furnished after the personal injury occurred, and for Medicaid paid as a result of the injury (Soc. Serv. Law §104-b, 42 USC 1396a(a)(25)(B), (H))

iii. For Medicaid incorrectly paid – Medicaid can recover from real property or otherwise only if it obtains a court judgment.

iv. For Medicaid correctly paid, there is no recovery from a living Medicaid recipient (except for the lien on property of an institutionalized person above). But –

MA must now recover from the estate of deceased recipients who were 55 or older when they received Medicaid services, but only after the death of a surviving spouse, minor or disabled child. The amount recoverable is limited to MA paid after the person turned 55. (OBRA 1993 lowered age from 65 and made recovery mandatory instead of optional) SSL § 369.

v. Recoveries from legally responsible relatives for MA payments under SSL § 366.3(a) – (Spousal or parental refusal). 02 OMM/ADM-3, page 17, section D. One of the exceptions is for children under 18 who are expected to live separately from their parents for more than 30 days.

19. Family Health Plus

(Thanks to The Legal Aid Society Health Law Unit for this part of outline)

A. What is Family Health Plus?

Family Health Plus ("FHPlus") is a Medicaid program for uninsured adults between the **ages of 19 and 64**. FHPlus enrollees must enroll in a managed care plan.[27] When applying, applicants should be informed about whether they are eligible for Medicaid and/or FHPlus. If the applicant is eligible for regular MA she cannot enroll in FHPlus. However, if the applicant is only eligible for MA with a spend-down, she can choose to enroll in FHPlus. N.Y. Soc. Servs. L. §369-ee(2)(a)(2); 01 OMM/ADM-6 at 11-12.

The current income and resource limits, along with other info on Family Health Plus, is posted at http://tinyurl.com/YB35B9.

i. **Income.** You cannot spend-down to FHPlus.

a. Parents who live with children under 21 and 19-20 year olds living with their parents must have a gross income of less than 150% of

the poverty level. See Section 4(a) of the Medicaid Chart.

b. Single and childless couples and 19-20 year olds who do not live with their parents must have gross income less than 100% of the poverty level. See Part 4(b) of the Medicaid Chart.

ii. **Asset limits** – For the first time, effective August 1, 2005, there are asset limits for this program. These limits apply to new applications signed and filed after AUGUST 1, 2005, and to recertifications on existing cases where the re-authorization will be effective beginning on or after August 1, 2005. These limits were initially higher than Medicaid limits, but effective April 1, 2008, Medicaid limits were increased to be the same as FHP ($13,800 singles, $20,100 couples). See Section 4 of the HRA Medicaid Chart; see also 05 OMM/ADM-4, http://tinyurl.com/AVZ5JY.

PENALTIES ON TRANSFERS OF ASSETS – Under 05 OMM/ADM-4:

> "Since Family Health Plus only covers nursing home care on a limited basis, a prohibited transfer of assets will not affect an individual's eligibility for Family Health Plus. However, S/CC-related applicants who have sold or given away any resources for less than the fair market value in the past 12 months are ineligible for all Medicaid covered care and services. Therefore, effective August 1, 2005, an S/CC-related individual who has sold or given away any resources for less than the fair market value in the past 12 months is ineligible for Family Health Plus for the duration of the penalty period (12 months)."
>
> 05 OMM/ADM-4 at p. 3.

iii. Copayments – Also for the first time, FHP enrollees must pay copayments as of Sept. 1, 2005. As in Medicaid, providers may not refuse services to FHP enrollees who are unable to pay, but may bill the consumer for the copayment. The letter that the State Dept. of Health is sending to FHP consumers states,

> "*Family Health Plus members who cannot afford the co-payment may not be denied a service based on their inability to pay. Your provider cannot refuse to give you care or services because you are unable to pay. (However, you will still owe the unpaid co-pay amounts to the provider and the provider may ask you for payment later or send you a bill.)"*

The copayment amounts are:

- Hospital care ($25 per stay)
- Non-urgent ER visits ($3 per visit)
- Clinic visits ($3 per visit)
- Covered medical supplies ($1 per)
- Lab tests ($.50 per test)
- Radiology Services ($1 per service)
- Brand name RX ($6)
- Generic RX ($3)
- Covered over the counter RX ($.50)
- Clinic visits ($5)
- Physician visits ($5)
- Dental visits ($5 per visit, capped at $25 per annum)

EXCEPTIONS – There are NO copayments for these services: emergency services; family planning services and supplies, mental health clinic visits, chemical dependence clinic visits, psychotropic drugs, TB drugs, prescription drugs for DOH-licensed adult care facility residents.

THESE FHP CONSUMERS DO NOT HAVE TO PAY COPAYMENTS: Those under 21; pregnant; nursing home residents; OMH and OMRDD facility residents

iv. **Citizenship/Immigration Status and Residency.** Same as Medicaid. See endnote 1. However, unlike the Child Health Plus, undocumented and non-immigrants are not eligible for FHPlus. Must be NYS resident.

v. **Applicants must be uninsured**. Applicants must be uninsured at the time they apply to qualify for FHPlus. But if they prove that their insurance will terminate, they may still apply. See 02 GIS MA/013. The Medicaid program is supposed to ensure there is not a gap in coverage. Id. The theoretical availability of **COBRA** is not considered insurance. People can apply for FHPlus while receiving COBRA if their coverage is going to end. However, individuals cannot apply for FHPlus if they have **Medicare** (either Part A or Part B or both). See 02 OMM/INF-02 at http://tinyurl.com/NHKB8T.

NEW: **Stricter rules for who is eligible for Family Health Plus** – For applications/ renewals filed after 9/1/05, anyone who is a government employee, or whose spouse is a government employee, is not eligible for Family Health Plus.

vi. **No pre-existing conditions bar**. Applicants with pre-existing conditions can still get FHPlus coverage, the plans must enroll them!

vii. FHPlus enrollees must have a photo id. There are **no** finger imaging and/or drug and alcohol screening. See 01 OMM/ADM-6 at 9; but see id. at 13.

B. What Does FHPlus cover?

All FHPlus enrollees must enroll in a FHPlus managed care plan and all services, including pharmacy and family planning, are provided through the plan. FHPlus enrollees receive primary, preventive, specialty and inpatient care. The FHPlus plan gets to determine if it will cover dental care (those plans that do get rate adjustments from the Department of Health).

FHPlus Enrollees have their **first 6 month's of coverage guaranteed**, even if their income goes above the guidelines (enrollees have a duty to report if their circumstances change). There is **no cost sharing** (i.e. no co-pays or co-insurance) in the FHPlus program**. BUT** Gov. Pataki has proposed high copayments in 2005.

FHPlus will **not** pay for long-term care services for the chronically ill, like nursing home stays, personal care services, hospice care, intermediate care facilities for developmentally disabled and private duty nursing. FHPlus **does** cover up to 40 home care visits in lieu of hospitalization. FHPlus also does not cover non-emergency transportation, medical supplies, non-prescription medica-tions (other than diabetic supplies and equipment). See SSL §369-ee(1)(E); 01 OMM/ADM-6 (Attachment VI describes FHPlus benefit package).

CHANGE IN VISION BENEFIT -- Effective Sept. 1, 2005, the vision benefit will include in any 24-month period:

- ONE eye exam
- ONE pair of prescription eyeglass lenses and frame OR contact lenses is medically necessary
- ONE pair of medically necessary occupational eyeglasses.
- Replacement of lost, damaged, or destroyed eyeglasses is no longer covered.

Caution: In 2005, Gov. Pataki proposed to eliminate from coverage inpatient and outpatient mental health and alcohol and substance abuse services, dental, vision, speech care, durable medical equipment, hospice care. The compromise was struck to cut vision benefits, but the proposal

may return.

D. How to Apply for FHPlus.

FHPlus coverage does not begin until the applicant is enrolled in a FHPlus plan. If they have large hospital bills for the three months prior to their enrollment date, they can try to use the Medicaid Spend down program to pay for these bills for the three month prior to their enrollment date. In addition, if applicants have bills that they incurred more than 90 days after their date of application (the date the applicant submitted all documentation and signed her application) she can request reimbursement. See GIS 02 MA/033.

Applicants join a FHPlus managed care plan for a 12 month period, with the right to switch plans without cause for the first 90 days. An enrollee may change plans for good cause during the next 9 months. Family members do not have to join the same FHPlus plan.

i. **New applicants.** People can apply for FHPlus at their local Medicaid office, with a community based facilitated enroller, or with a FHPlus managed care plan. The enroller will submit the completed application within 5 days of the signature on the application. The local Medicaid office must make a determination on eligibility within **30 days for households with pregnant women and/or children** and **45 days for all others from the date of the application**. Applicants currently are experiencing delays of up to 6 months in the processing of these applications. (The State claims it has 90 days to put client up into a plan).

ii. **Transitioning households.**

a. Public assistance recipients with children under 21 in their household should be offered transitional Medicaid when their work income makes them ineligible for PA. When their transitional Medicaid is ending, the family should receive a separate redetermination for MA/FHPlus eligibility. A “seamless” transition should occur from Medicaid to FHPlus for these families. See 01 OMM/ADM-6 at 20-22.

b. **Medicaid/FHPlus for singles/childless couples:** Single and childless couples who are deemed ineligible for Safety Net Assistance because of income and/or resources below 100% of poverty will continue to receive Medicaid pending a separate determination. A similar seamless transition should occur from FHPlus to Medicaid for individuals whose earnings dip. 01 OMM/ADM-6 at 20-22.

c. **Newborns**. All babies born to a woman who is enrolled in FHPlus

will be provided 1-year automatic Medi-caid coverage. SSL 366(4)(1); 01 OMM/ADM-6 pp15-17.

iii. **Recertification**. FHPlus uses an annual mail-in recertification process, not a face-to-face appointment in order to maintain eligibility and enrollment.

20. CHECKLIST FOR SPEND-DOWN CASES

A. First make sure budget was done in best way to minimize spend-down:

1. **If applicant is 65+, blind, or disabled** , does applicant or spouse have **earned** income? (or if a disabled child, does parent have earned income)? Did you use special SSI-related budgeting to disregard earned income?

2. **Is the disabled adult under age 65 and working**? If so, consider the Medicaid Buy-In.

   If not working and under 65, consider Family Health Plus.

3. **Is applicant a child under 19 (born after 10/1/83) or pregnant woman**?

   Are you using EXPANDED income limits, and NO resource limit? Medicaid chart box 1.

4. **PLAY WITH HOUSEHOLD SIZE** -- Not everyone in the household has to apply - exclude people who do not have to be counted, if they have income or resources. Use household size rules. P. 18. Excluded family members may be eligible for CHILD HEALTH PLUS, FAMILY HEALTH PLUS**.**

5. **Choice of Methodology:** Is applicant <u>both</u> SSI-related (65 or over, blind, or disabled) AND AFDC-related (under 21 or takes care of a child under 21), s/he can <u>choose</u> which category she wants to apply in.

   Example: Mrs. Smith is 67 years old and is caretaker-relative for her 14-year-old grand-daughter. She is <u>both</u> SSI-related (over 65) AND AFDC-related (caretaker relative). If she works, she may prefer to use the SSI earned income deductions which are <u>higher</u> than the AFDC earned income deductions.

6. **Spousal or Parental Refusal –** Does applicant live with a legally responsible relative (parent of child under 21 or spouse) whose income or resources are too high? If so, will relative sign a "**spousal refusal**" stating that relative's income or resources <u>cannot</u> be counted? Only the applicant's income and resources will be counted, and will be compared to a Household Size of One. Spouse who refuses may not receive Medicaid, but may apply for EPIC.

7. Once you have checked the above, and client still has a spend-down, consider whether s/he can use CHILD HEALTH PLUS, FAMILY HEALTH PLUS, EPIC, or the Medicaid Buy-In Program for People under age 65 who are disabled and working.

B. If they still need Medicaid and have a spend-down:

1. Make sure client may use spend-down (is she 65+, disabled, under 21, or caring for child relative who is under 21? (if not, may not spend down - must consider Family Health Plus, Child Health Plus)

2. Does client or spouse have PAST UNPAID medical bills that are still viable (incurred within last 6 years)?

   - Make sure to check YES on application page 10 line 1 and 8
   - If so, collect them and ask for credit against the spend down for the future until they are used up (Outline pp 25-29)

3. Does client or spouse have past PAID bills incurred and paid in three months before the month of application? If so, these can be used as credit for the first 3 months of Medicaid beginning with the month of application.

   - Make sure to check YES on application page 10 line 1 and 8
   - If so, collect them and ask for credit against the spend down for the future until they are used up (Outline pp 25-29)

4. Has client used EPIC or ADAP in 3 months prior to month of application?

   - If so, make sure to indicate this on application (page 10 line 17)
   - Obtain proof from EPIC/ ADAP of amount they paid in bills during this period and in month of application and submit for credit against spend-down. Outline pp. 23-24.

5. Does client have recurring over-the-counter medical expenses? Or did she have them in the 3 months prior to the application?

   If so, get the necessary physician's statement of medical necessity, receipts, and submit for credit. Outline pp. 21-22.

6. Supplemental Needs Trust - Does client want to enroll in the NYSARC trust, or, if under 65, would she like to establish her own SNT? See http://wnylc.com/health/14

7. If spend-down is small, and client does not receive home attendant services, can she enroll in the PAY-IN Program? Outline p. 33

ENDNOTES

[1] All qualified aliens (including lawful permanent residents, or green card holders, who entered after August 22, 1996) and people who are permanently residing under color of law ("PRUCOL") are eligible. See the new NYS Administrative Directive 04-ADM-07 "Citizenship and Alien Status Requirements for the Medicaid Program" explaining how to know if a client is eligible as PRUCOL - Person Residing Under Color of Law or otherwise. http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/04adm-6.pdf The ADM implements Aliessa v. Novello, 96 N.Y.2d 418, 730 N.Y.S.2d 1 (2001).

[2] Must be either a New York resident, or, while temporarily in the state, require immediate medical care not otherwise available. Out-of-state resident is not eligible if enters New York solely to obtain medical care, though someone who gives up residency elsewhere and moves to NYS is eligible. SSL 366(1)(b), 18 NYCRR § 360-3.2(g), MARG 392-8. "Residence" is state where a competent adult intends to remain indefinitely or came to for work, or if incompetent, the state where the individual is living. There is no minimum time limit to establish state residency

[3] 18 NYCRR 360-4.8(5)

[4] This is **"allocation amount**" in 2010 - the amount allocated from a non-SSI spouse to a non-SSI child. Figure changes each year. GIS 09 MA/026.
It is the difference between the income level for 1 and 2.

[5] This scheme was upheld. Glosenger v. Perales, 616 N.Y.2d 330 (N.Y. 1994); Marzec v. DeBuono, 95 N.Y.2d 262; 2000 N.Y. LEXIS 2913; 716 N.Y.S.2d 376 (Oct. 2000), *reversing* 697 N.Y.S.2d 788 (4th Dept. (1999)).

[6] 18 NYCRR 360-4.2. (a) For needy individuals under 21, pregnant women, persons ineligible for ADC solely because their incomes and resources exceed ADC eligibility standards, and parents described in section 360-3.3(b) of this Part, an MA household is all MA applicants/recipients who live together in a single dwelling who apply for or receive MA as a unit, and any legally responsible relative who does not receive HR, ADC, or SSI and resides with an applicant/recipient. Any person who receives HR, ADC, or SSI will not be included as a member of an MA household, and the income and resources of such a person will not be considered when social services districts determine the MA eligibility of the applicant(s)/recipient(s).

(b) For adults who are aged, certified blind or certified disabled, an MA household is the aged, blind or disabled person and his or her spouse who lives with him or her if the spouse is: (i) also aged, certified blind or certified disabled, or (ii) has remaining income after allocation which is equal to or greater than the difference between the medically needy income standard for one, and the medically needy income standard for two. For other aged, certified blind or certified disabled adults who live with their spouses, an MA household consists of one person for income purposes, but consists of two persons for resource purposes. For all other aged, certified disabled, or certified blind applicant(s)/recipient(s), an MA household consists of one person.

(c) Special rules. (1) An MA household which contains a pregnant woman will be increased by one if the pregnancy is medically verified, except for applicant(s)/recipient(s) whose eligibility is being determined under the budgeting methodology used for aged, certified blind and certified disabled individuals. The increase will begin three months prior to the month of application or on the date of conception, whichever is later.

(2) A household member who is temporarily absent, as defined in section 360-1.4(p) of this Part, will continue to be included in the household.

[7] Social Security Protection Act of 2004, Public Law 108-203 [H.R. 743], signed Mar. 02, 2004, amending 42 U.S.C. § 1382a(b)(21) - (23); *See* Social Security Administration Program Operations Manual System (POMS) section SI 00830.710 and 830.500C; NYS GIS 04/MA/027

[8] http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/06ma029.pdf

[9] http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/09ma001.pdf

[10] The NYS Department of Health administrative directive implementing the DRA was issued on July 20, 2006. 06 OMM/ADM-5, dated July 20, 2006 entitled, "Deficit Reduction Act of 2005 - Long Term Care Medicaid Eligibility Changes." See, http://www.health.state.ny.us/health_care/medicaid/publications/pub2006adm.htm. The DRA went into effect on August 1, 2006 in New York State. The federal agency responsible for Medicaid, CMS, issued guidance on the DRA on July 27, 2006. http://www.cms.hhs.gov/SMDL/SMD/list.asp#TopOfPage - scroll down to Transfer of Assets.

[11] 18 NYCRR 360-4.8(b)

[12] 42 CFR 435.914, 18 NYCRR 360-2.4(c)

[13] See Commr v Fishman, NYLJ 7/23/98 p. 22 col. 3 (dismissing suit for spousal support based on failure to plead that spouse of nursing home resident had sufficient ability to contribute toward ill spouse's care at time care provided, defines "sufficient ability," at least in nursing home context, as resources exceeding community spouse allowance); See also Matter of Craig, 82 N.Y.2d 388, 392 (1993)(responsible relative determined by sufficient ability to pay at time expenses incurred.

[14] 42 CFR 435.831(d)

[15] 42 USC 1396a(a)(17), 42 CFR 435.831(d), 18 NYCRR 360-4.8(c), MRG 223-231.

[16] 42 CFR 435.831(d)

[17] 18 NYCRR 360-4.8(c)

[18] 91 ADM-11 (copy in materials pp. 62-65a), 18 NYCRR § 360-4.8(c)(1).

[19] 96 ADM-15, which amends 87 ADM-4 to implement 1994 changes in 42 CFR 435.831. See also 96 ADM-12, 87 INF-19, 91 ADM-11.

[20] This rule stems from the federal provision that extends Medicaid coverage retroactively to the first day of the 3-month period prior to the month of application, to extent applicant was eligible for Medicaid. 42 CFR 435.914.

[21] 91 ADM-17, 18 NYCRR 360-4.1(b)(v), -4.8(b).

[22] She could not use spend-down if she were 62 UNLESS she is disabled OR caring for a child under age 21 who lives with her.

[23] 18 NYCRR 360-4.8(c)(2)

[24] 42 CFR 435.914. 18 NYCRR 360-2.4(c)

[25] Hospital bills are counted toward the spend-down at the private pay rate. An average daily rate is calculated. If the surplus is met with a few days private rate, Medicaid picks up the remaining days. *See* 90 ADM-46.

[26] SSL 366(s)(b); 18 NYCRR 360-4.8(c)(4), 96 ADM-15

[27] See N.Y. Soc. Servs. L. § 369-ee et. seq. 01 OMM/ADM-6