



MEDICAID 201: ACCESSING CARE

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I. MAINTAINING COVERAGE AS STEP ONE

- a. **Recertification issues** (Avoiding Medicaid "Churning") – Huge numbers of Medicaid recipients lose their coverage during annual renewal, or recertification of eligibility. In response to this problem, the State Department of Health (SDOH) has taken steps in recent years to streamline the administrative requirements.

Advocates should always warn their clients of the need to comply with recertification requirements and respond to mailings. At the same time, we should be vigilant to ensure that local districts honor changes in the law that should make the process less burdensome to our clients. These changes include:

- i. **Documenting income no longer required at renewal** -- Effective January 1, 2008, Medicaid recipients who are not seeking long term care, and all FHPlus recipients, must be allowed to self-attest to the amount of their income at renewal. N.Y. Soc. Serv. L. §§ 366-a(5)(d) & (e), 369-ee(2)(d) as amended by L. 2008, c. 58.

The same goes for recipients of Medicare Savings Programs, the Family Planning Benefit Program, the Medicaid Buy-In Program for Working People with Disabilities, and the Medicaid Cancer Treatment Program – as long as recipients are not seeking coverage for long term care.

The exception is recipients who qualify for Medicaid using spend down. These recipients will still need to document the level of their income at renewal.

Local social services districts are directed to verify the accuracy of the income recipients attest to by comparing it to information which they already have access to, such as the RFI (Resource File Integration), a currently stored budget, or documentation in a current Food Stamp or HEAP case.

If a discrepancy is found, and income levels in existing files would result in ineligibility for a program, the local district is instructed to provide at least ten days notice to the recipient so that he or she can supply documentation of the lower income level. See 08 OHIP/ADM-4, available at:

<http://onlineresources.wnyc.net/pb/showquestion.asp?faq=103&fldAuto=3308>

- ii. **Documenting child and/or adult care expenses no longer required at Renewal.** Also effective January 1, 2008, the same group of Medicaid recipients will no longer need to document their child/adult care expenses. N.Y. Soc. Serv. L. §§ 366-a(5)(d) & (e), 369-ee(2)(d) as amended by L. 2008, c. 58; 08 OHIP/ADM-4, available at the link above.
 - iii. **Documenting residence no longer required at renewal** - Also effective January 1, 2008, the same group of Medicaid recipients must be allowed to self-attest to their residence, even if it has changed since the time of application. . N.Y. Soc. Serv. L. §§ 366-a(5)(d) & (e), 369-ee(2)(d) as amended by L. 2008, c. 58; 08 OHIP/ADM-4, available at the link above.
- b. **Statewide Enrollment Center** – Created in the 2008 budget session to help relieve pressure on the counties. NYSDOH will be contracting with an outside entity to accept applications/renewals for Medicaid, FHPlus and CHPlus. The Center will provide NYSDOH the opportunity to increase volume and further test simplification strategies. Plans include:
- i. Operating a consolidated hotline
 - ii. Telephone renewals w/self attestation
 - iii. Piloting other initiatives (elimination of fingerprinting?)

c. Continuity of Medicaid Coverage for County to County Moves

This issue has long plagued Medicaid recipients who move from one county to another in New York. New counties of residence have often required new Medicaid applications, even when eligibility status has not changed.

Legislation passed in 2008 and effective June 1, 2008, finally provides continuity of coverage for Medicaid recipients moving inter-district, as long as they have informed the original district of residence of their new address and any material changes in circumstances affecting Medicaid eligibility. The case must be transitioned to the new district without requiring termination in the old district or a new application in the new district. N.Y. Soc. Serv. L. §62(5)(a)(a-1) as amended by L. 2008, c. 58.

This change in law was required as a result of federal litigation filed in the Eastern District in 2005. See, *Luberto v. Daines*, Index No. CV-05-5421 (EDNY). The consent decree negotiated in *Luberto* applies the new policy to recipients who notify local districts of moves on or after December 28, 2007. See LCM 09 OHIP/LCM-1, available at: <http://onlineresources.wnyc.net/pb/showquestion.asp?faq=106&fldAuto=3301>

Neither the new law nor the consent decree apply to institutionalized individuals who move to a different facility, and problems have arisen in applying the new policy to inter-district moves by recipients of home care and transportation services. If your clients run into any of issues related to inter-district moves and continuation of home care or transportation services, please contact counsel on *Luberto*, Peter Vollmer, at pvollmer96@aol.com.

d. Suspending, rather than Terminating, Medicaid Coverage for Incarcerated Recipients

Traditionally, counties have closed Medicaid cases when recipients are incarcerated, even for short periods of time. In 2007, the law was changed to provide that Medicaid eligibility shall be maintained, in effect suspended, during incarceration in both local facilities (jails) and state facilities (prisons). Upon release, former prisoners shall have their

Medicaid reinstated. See N.Y. Soc. Serv. L. §366(1-a), added by L. 2007, c. 355.

The new law, which became known as the Medicaid Suspension Law for Prisoners, applies to inmates who received Medicaid immediately prior to incarceration on or after April 1, 2008. The law does not apply to New York Medicaid recipients who are incarcerated in federal prisons or state or local facilities in other states.

For inmates considered permanently absent (in state prisons), the family household size will be decreased. For inmates in temporary absence (in county jails), the prisoner will remain in the household count for purposes of ongoing eligibility of the other household members. See 08 OHIP/ADM-3, available at: <http://onlineresources.wnyc.net/pb/showquestion.asp?faq=103&fldAuto=3297>

Be on the look out for difficulties with immediate reinstatement of eligibility for Medicare Savings Programs and other programs that pay for third-party health insurance coverage, as these premium payments will be discontinued upon incarceration. In addition, advocates should be sure to notify local districts of their clients' incarceration and release dates. County correctional facilities currently have no obligation to report incarcerations or releases to local social services districts.

II. MEDICAID MANAGED CARE

- a. **Background.** New York's Medicaid program was initially set up under a fee-for-service model, which meant that recipients could access services from any provider that accepted Medicaid. Today, most, but not all, New York residents who are covered by Medicaid are required to join managed care plans. New York's Medicaid managed care program is codified at N.Y. Soc. Serv. L. §364-j. State regulations on managed care exist at 18 NYCRR 360-10 et seq., but note that these regulations do not accurately reflect the law.

Under Medicaid managed care, enrollees in plans receive most of their health service through the plan's network of providers. Enrollees are required to have a primary care provider (PCP), who acts as a gatekeeper to services within the plan. Medicaid recipients in managed care plans need to get referrals from their PCP in order to

access specialists, durable medical equipment, and other non-primary care services.

b. Mandatory Medicaid Managed Care

In most counties in New York, most Medicaid recipients are required to join a Medicaid managed care plan – which means that after they have been found Medicaid eligible they will be asked to choose a plan. If they do not choose a plan within specified time frames, which differ by population category, they will be auto-enrolled in into a randomly assigned plan.

Some counties mandate more populations into managed care than others. Several counties have only voluntary managed care programs. Some have managed care only for the Family Health Plus program. A few counties have no managed care options for either Medicaid or Family Health Plus.

Because Medicaid managed care is continually expanding in New York, the best way to get accurate information about the program in your county is to check the latest posting on the SDOH website. You will find a map of NYS coded by type of managed care program at this link:

http://www.health.state.ny.us/health_care/managed_care/mmc_counties/

c. Exemptions and Exclusions from Mandatory Managed Care.

Some Medicaid recipients are exempt under the law, so that enrollment with a plan is voluntary, no matter which county they live in.

i. Does your client qualify for an exemption?

Your client may be exempt from mandatory managed care if:

- a. he or she can prove joining will impose a barrier to accessing care (no geographically accessible provider; pregnant & provider not in a network; chronic condition and provider not in a network; or language barrier). See N.Y. Soc. Serv. L. §364j(3)(b)
- b. he or she lives in an alcohol/substance abuse program or a facility for the mentally retarded

- c. he or she is mentally retarded and gets care from an intermediate care facility (or has health needs like a person getting such care)
- d. he or she is in the "care-at-home" program (or as health needs like a person getting such care)
- e. he or she is Native American
- f. he or she is dually eligible and is NOT enrolled in a Medicaid Advantage Plan
- g. he or she is enrolled in the MBI-WPD and is not required to pay a premium. See NY Soc. Serv. L. §364-j(3)(b) & (c).

ii. Exemptions that the State Commissioner of Health can eliminate.

Some recipients are exempt only until SDOH (sometimes with approval from OMH as well) determines that the county's mandatory plan is ready to enroll them, at which point they are no longer exempt. This group includes:

- a. Dual eligibles who are enrolled in Medicaid Advantage Plans,
- b. HIV+ recipients,
- c. Adults with serious and persistent mental illness,
- d. Children with serious emotional disturbance, and
- e. SSI recipients. See NY Soc Serv L. §364-j(3)(g).

Many counties have already ended the exemption for SSI recipients, Adults with serious and persistent mental illness (SPMI) and Children with serious emotional disturbances. See the map on the SDOH website at http://www.health.state.ny.us/health_care/managed_care/mmc_counties/. Elimination of the exemptions for dual eligibles in Medicaid Advantage and HIV+ individuals are likely not far off.

iii. Is your client excluded from Medicaid managed care?

Recipients who are statutorily excluded from the Medicaid managed care program include:

- a. Those in foster care with voluntary agencies,
- b. Those qualifying for Medicaid under spend down,
- c. Those living in an institution,
- d. Those in a Medicare long term care program,
- e. Infants living with incarcerated mothers,

- f. Those using Emergency Medicaid,
- g. Those using Medicaid only for TB related services,
- h. Blind or disabled children living away from their parents,
- i. Those receiving hospice services,
- j. Those in Medicaid's Restricted Recipient program,

- k. Those with other insurance,
- l. Infants weighing 1200 grams or less at birth or otherwise meeting SSI-related categorical definitions,
- m. Those in the MBI-WPD program who pay a monthly premium.
See NY Soc. Serv. L. 364-j(3)(d).

iv. Exclusions that Local Commissioners can Eliminate.

Some recipients are excluded only until the county's social services district permits them to participate. These recipients include:

- a. Those living in homeless shelters and
- b. Foster care children in the direct care of the local district.

d. Services.

Under either Medicaid managed care or fee-for-service Medicaid, recipients are legally entitled to all medically necessary care, which is defined as care that is "necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap..." See NY Soc. Serv. L. §365(a)(2).

i. Services covered by Medicaid under state law include:

- a. Hospitalization
- b. Out-patient care
- c. Mental health care
- d. Dental care
- e. Physical therapy
- f. Diagnostic tests
- g. Durable medical equipment, and
- h. Pharmacy.

For a full list, see NY Soc. Serv. L. §365-a(3).

ii. **Some Medicaid covered services are carved out of Medicaid managed care.**

One of the basic tenets of managed care is that recipients are to receive services through their health plan. However, in New York, certain Medicaid services are “carved out” of managed care. To access these carved out services, enrollees use their Medicaid card and can go to any provider that accepts regular (or fee-for-service) Medicaid.

Some specialized services are specifically carved out under state law [i.e. day treatment for those with developmental disabilities -- for a complete list see N.Y. Soc. Serv. L. §364j(3)(e)]. Other services can be carved out of Medicaid managed care by the State Commissioner of Health. See §364-j(3)(x).

Currently, SDOH carves out prescription drugs and mental health services for SSI recipients. For a complete listing of services carved out as well as those that must be provided by managed care plans, see the Medicaid Managed Care Model Contract, Appendix K, available at http://www.health.state.ny.us/heath_care/managed_care/pdf/mahpcontr05.pdf

e. **Clients’ Rights in Medicaid Managed Care.**

- i. **Disclosure.** Managed care plans must tell enrollees about the coverage offered, prior authorization rules, how to get referrals and prior authorization rules as well as how to file grievances and utilization review appeals.
- ii. **Grievance Procedures.** All enrollees have the right to file grievances when they have a problem with their plan or the care they are receiving. The timelines and appeals associated with grievances are specified in New York’s Public Health Law at §4408-a.
- iii. **Utilization Review Appeals.** Enrollees who are denied services because they are not medically necessary are also entitled to appeal the plans decision by asking first for a utilization review and then appealing that determination. The appeal has two stages, the first for review by a clinical peer within the plan and the second with

an external reviewer with the State Insurance Department. See PHL §4900 et seq.

- iv. **Fair Hearings.** Medicaid managed care enrollees are not limited to the managed care appeals process. Under state and federal Medicaid law, Medicaid managed care enrollees also have fair hearing rights, with aid continuing. Enrollees are entitled to request a fair hearing if services are denied or not provided with reasonable promptness. If the denial is from a plan provider as opposed to the plan, the enrollee must first request that the plan review the provider's decision.

Enrollees can simultaneously pursue an appeal through the managed care plan and a fair hearing. If the external review decision and the fair hearing decision conflict, the fair hearing decision prevails. The plan's obligations to honor Medicaid enrollees' notice and hearing rights are spelled out in the Medicaid Managed Care Model Contract, Sections 25 and 26 (see web link above).

III. USING MEDICAID WITH MEDICARE

a. Background.

Low-income Medicaid recipients can age into Medicare at age 65 or qualify after 24 months of disability (no waiting period for those with ALS or ESRD). See 42 CFR parts 406.5, 407.10, 422.50, 423.30. In NYS, over 600,000 people are eligible for both programs (dual eligibles).

Enrollment in Medicare is a condition of eligibility for Medicaid. See 05 ADM-OMM5, MRG, p. 344.1. Accessing care now becomes more complicated.

b. What changes for Duals?

- i. Medicare is not free, even for the low-income -- there are premiums, deductibles and Medicare pays only 80% of the bills.
- ii. Medicare service package is not as comprehensive -- no long-term care, routine dental or eye care, hearing aids. Prescription drug coverage is more limited (the formulary is more restrictive and there is a doughnut hole).

- iii. Medicare is the payor of first resort. Generally, Medicaid will “wrap around” to help with cost-sharing and fill in service gaps.
 - a. Clients need to see providers that accept both Medicare and Medicaid to maximize the wrap.
 - b. Medicaid will NOT wrap around Medicare Part D (although duals are automatically eligible for the Low Income Subsidy – see below).

c. Medicaid’s Medicare Savings Programs (MSPs) can help duals and those above Medicaid’s income levels with Medicare’s premiums and other cost-sharing. There are three separate MSP programs – QMB, SLMB & QI-1 (100, 120 & 135% of FPL, respectively – see box 8 on HRA chart). There is no resource test for any of these programs.

- i. QMB pays Medicare Parts A & B premiums, all deductibles and co-pays. Enrollees can have Medicaid and QMB at the same time.
- ii. SLMB pays for the Part B premium only. Enrollees must have Medicare Part A and can have Medicaid with spend down as well (which will “wrap around” and pay Medicare cost-sharing once spend down is met).
- iii. QI-1 pays for the Part B premium only. Like SLMB, QI-1 requires enrollees to have Medicare Part A. Unlike SLMB, enrollees cannot have Medicaid at the same time.

SLMB & QI-1 coverage is retroactive*, with refunds, for 3 months prior to application. However only within current calendar year fro QI-1 (GIS 07 MA 027).

Clients can apply for MSP programs through DSS if not already on Medicaid – by mail if not also applying for Medicaid. (GIS 07 MA 027). People applying for Medicaid should be automatically assessed for MSP eligibility (00 OMM/ADM-07, GIS 05 MA 033).

d. Help with Medicare Part D’s Costs and Service Gaps

- i. No Medicaid drug coverage for dual eligibles (& duals must take Part D unless they have “creditable coverage”)

- ii. Low-income persons can get help with the costs of Part D through Part D's Low Income Subsidy (LIS)
 - a. LIS eliminates the doughnut hole and brings co-pays down to fairly nominal levels
 - b. Medicaid and MSP enrollees automatically qualify for the LIS Program.
- iii. Medicaid will not cover costs of drugs not covered by Part D plans -
- big issue with off-label drugs, other non-formulary prescriptions.
- iv. Denials at the pharmacy do not trigger notice and appeal rights –
have to request a written coverage determination
- v. Appeal process is not user friendly (call Cathy Roberts in Empire Justice Center's Albany Office 1-800-635-0355)
- vi. No limit on annual co-pays (\$200 limit in Medicaid)