NEW YORK STATE | Department of Health

Understanding NYS Medicaid
An Overview

Children's Waiver Training

January 2021

HCBS Children's Waiver Training Overview

HCBS Overview	LOC/ Eligibility Determination	Waiver Enrollment	POC Development	Referral	Maintaining Waiver Enrollment / Service Delivery	Transfer / Disenroll
Children's Medicaid System Overview / Children's Waiver Overview	CANS-NY/ Eligibility Assessment	Capacity Management	Plan of Care/Person-Centered Planning Requirements	HCBS POC Workflow and MMCP Authorization	Care Management Requirements	Waiver Disenrollment
Health Home Care Management	NODs and Fair Hearing	Participant Rights and Protections / Conflict Free Care Management	Service Delivery		Service Delivery Requirements	Transferring to Adult Services or OPWDD waiver
HCBS Provider Requirements	Children and Youth Evaluation Services (C-YES) – the Role of the Independent Entity	Conflict Free Care Management				
Medicaid Overview / Medicaid and the Children's Waiver						
Service Definitions						

Required for only Health Home Care Managers
Required for only HCBS Providers
Required for Both
Optional for Both

Agenda

- ✓ What is Medicaid?
- ✓ Third Party Health Insurance
- ✓ What is Medicaid Managed Care?
- ✓ Applying for Medicaid
- ✓ Medicaid Budgeting
- ✓ Family of One
- ✓ Excess Income
- ✓ Renewing Medicaid

What is Medicaid?

- **Medicaid** is a public health insurance program for individuals whose income and/or resources are below certain levels. Medicaid has its own eligibility criteria that must be satisfied for an individual to receive public health insurance benefits.
- For providers to receive payment from the Medicaid program, the individuals receiving the services must have Medicaid.
- Individuals with other health insurance, such as private insurance or Medicare, may still be eligible for Medicaid if they meet the participation requirements.

What Does Medicaid Cover?

- All regular medical checkups and needed follow-up care
- Immunizations
- Doctor and clinic visits
- Medicine
- Medical supplies
- Medical equipment and appliances (wheelchairs, etc.)
- Lab tests and x-rays
- Eye care and eyeglasses
- Emergency care
- Dental care
- Nursing home care
- Emergency ambulance transportation to a hospital
- Hospital stays

Third Party Health Insurance (TPHI)

- Third-party payers are any other parties that are, by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service. Examples are:
  - Health Insurance Plans (Self-Insured or Group Health plans offered by or through an employer or an employee organization)
  - Managed Care Organizations
  - Service Benefit Plans
  - Pharmacy Benefit Managers, Dental and Vision Benefit plans
  - Workers Compensation and Liability insurance (including automobile, homeowners and medical malpractice)
  - Indemnity plans (if review of the plan determines that the policy provides for payment of health care items or services, including policies that pay a cash benefit to the policyholder if the payment is conditional upon the occurrence of a medical event)
- Individuals with Third Party Health Insurance are not disqualified from receiving Medicaid.

What is Medicaid Managed Care?

- Medicaid Managed Care Plans (MMCP) are health insurance companies that oversee and coordinate the care a member receives and are designed to manage cost, utilization, and quality.
- Improved access to care, health care quality, and member outcomes are key objectives of Medicaid Managed Care.
- Enrollment into a MMCP is mandatory unless the individual is otherwise excluded or exempt from Medicaid managed care.
    - Exempt means the individual can choose to enroll in a MMCP but is not required to, such as:
        - Individuals with special needs and who are participating in programs for which the State has not yet developed a Medicaid Managed Care program
        - Native Americans
    - Excluded means the individual cannot enroll in a MMCP, such as individuals who:
        - have private comprehensive health insurance
        - do not have full Medicaid coverage
        - live in a residential setting operated/overseen by the State
- Certain types of MMCPs have eligibility requirements in addition to Medicaid coverage.

Benefits of Medicaid Managed Care

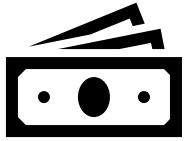
- View the whole picture of a child/youth's healthcare, including physical health, social and emotional health, and behavioral health
- Identify issues early and get the help and services children/youth and families need
- Optimal results from healthcare services; access to Specialty Care Centers, including out of network providers if the needed specialty provider is not in the plan's network
- No co-pays, except for pharmacy
- Provides the same benefit as regular Medicaid, although different rules may exist for prior authorization and billing

Applying for Medicaid

Where can members get additional information on applying for Medicaid?

- Option 1: Families apply at NY State of Health or call 855-355-5777
- Option 2: Household of one applications are filed at the LDSS, a directory can be found here

Medicaid Budgeting



Community Budgeting

Community budgeting is when the LDSS counts family income (and resources if the child/youth is certified disabled) in the budget. The household's income (and resources if certified disabled) is then compared to the appropriate levels to determine financial eligibility for Medicaid.

Institutional (Family of One) Budgeting

Institutional budgeting or **"Family of One"** budgeting is when the LDSS counts only the child/youth's income (and resources if certified disabled) in the budget. The child/youth's own income and resources, if applicable, are then compared to the appropriate levels to determine financial eligibility for Medicaid.

Institutional or Family of One Budgeting

What is Family of One?

- In general, certified disabled children/youth who are expected to be out of the household for at least 30 days or are participating in a waiver are eligible to have Medicaid eligibility determined under the SSI-related budgeting methodology as a family of one without counting parental income and resources.
- For the purposes of the Children's Waiver, non-disabled children/youth eligible for Children's Waiver services may have their Medicaid eligibility determined under ADC-Related budgeting as a family of one without counting parental income (resources are not considered under this budgeting methodology for anyone).
- This means that if a child/youth is not found Medicaid eligible under community budgeting and meets HCBS LOC, etc., criteria, Medicaid eligibility can be determined under Institutional or Family of One budgeting.

More details on the Children's Waiver and Medicaid will be covered in the next webinar

Under Family of One Medicaid, the HHCM or C-YES will only have to gather/document the child/youth's income/resource data, not the parent(s)

Excess Income Program

- Some people have too much income to qualify for Medicaid. The Excess Income Program is a way for certain individuals to receive Medicaid coverage even though their income is over the Medicaid level.
- The amount the individual's income is over the Medicaid level is referred to as excess income. It is also sometimes referred to as surplus income or spenddown.
- It is like a deductible.
- If the individual is Medicaid eligible except for having excess income and can show medically necessary paid or unpaid medical bills to their Local Department of Social Services (LDSS) when at least equal to their excess income liability in a particular month, Medicaid will pay additional medical bills beyond that for the rest of the month.
- Individuals without medical bills can also pay their excess income to the Local Department of Social Services to receive coverage.

Who Can Participate in the Excess Income Program?

To participate in the Excess Income Program, individuals must be categorically medically needy as follows:

- Under age 21
- Age 65 or older
- Certified blind or certified disabled
- Pregnant
- Parent of a child under the age 21

How is the Excess Income Amount Determined?

- The excess income amount is determined by the Medicaid worker at the Local Department of Social Services.

- It is the difference between the Medicaid income level for a single individual and the individual's monthly net countable income after applicable deductions.

- There are different deductions based on the individual's category.

Excess Income

How does the Excess Income Program work?

- The Excess Income Program works similarly to meeting a deductible; the excess income liability must be met each month to receive Medicaid coverage.
- Individuals should submit medically necessary paid or unpaid medical bills to the Local Department of Social Services when at least equal to the monthly excess income amount to receive Medicaid coverage for that month.
  - Individuals are responsible for medical bills up to the excess income amount; Medicaid will only pay those bills over the excess amount
  - If an individual has been hospitalized recently, the inpatient hospital bill can be applied toward their excess income liability to receive inpatient and outpatient coverage for six-months

Excess Income & Medicaid Coverage

- If an individual has not met their excess income liability, provisional coverage (no coverage) will be authorized.

- If an individual has met a one-month excess income liability, outpatient coverage will be authorized for that month. Outpatient coverage includes but is not limited to doctor and dental visits, laboratory and X-ray services, prescription drugs, outpatient hospital services.

- If an individual has met a six-month excess income liability, outpatient and inpatient coverage will be authorized for six months.

- Children's Medicaid Spend-down Coverage Guidance

Excess Income & Medicaid Coverage

- If an individual has not met their excess income liability, provisional coverage (no coverage) will be authorized.
  - If an individual has provisional coverage but has not met his/ her spenddown, the individual can remain enrolled in the Health Home if they are otherwise eligible, but the Health Home cannot bill for services unless the individual has met the spenddown for that particular month.

Can a special needs trust be used for the excess income program?

Medicaid will not count the assets in an exception trust if the trust meets the required criteria for establishing such trusts. Income directly diverted to an exception trust, or income received and then placed into the trust is excluded when determining income eligibility for a certified disabled individual under community rules. The income exclusion applies only to income that is placed into the A/R's own exception trust during the same month in which the income is received.

Renewing Medicaid

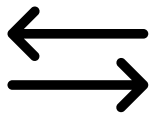
If a member already has Medicaid, they'll eventually need to undergo a Medicaid renewal. Below are some key things you should know to assist:

When is Medicaid eligibility renewed?
Medicaid eligibility is generally renewed annually

How is Medicaid eligibility renewed?
A renewal Packet is mailed to the family approximately two months prior to the annual renewal date

What happens if the renewal packet is not returned to the LDSS by the deadline indicated in the packet
Medicaid coverage may be discontinued for failure to renew

When renewing Medicaid for Family of One, are the parents required to include their income and resources, if applicable, on the child/youth's renewal form?
Yes, attestation of parental income and resources, if applicable, is required on the Medicaid renewal



Should Medicaid eligibility be redetermined when a child/youth is discharged from the Children's Waiver?
Yes. Medicaid eligibility is redetermined when there is a change in circumstances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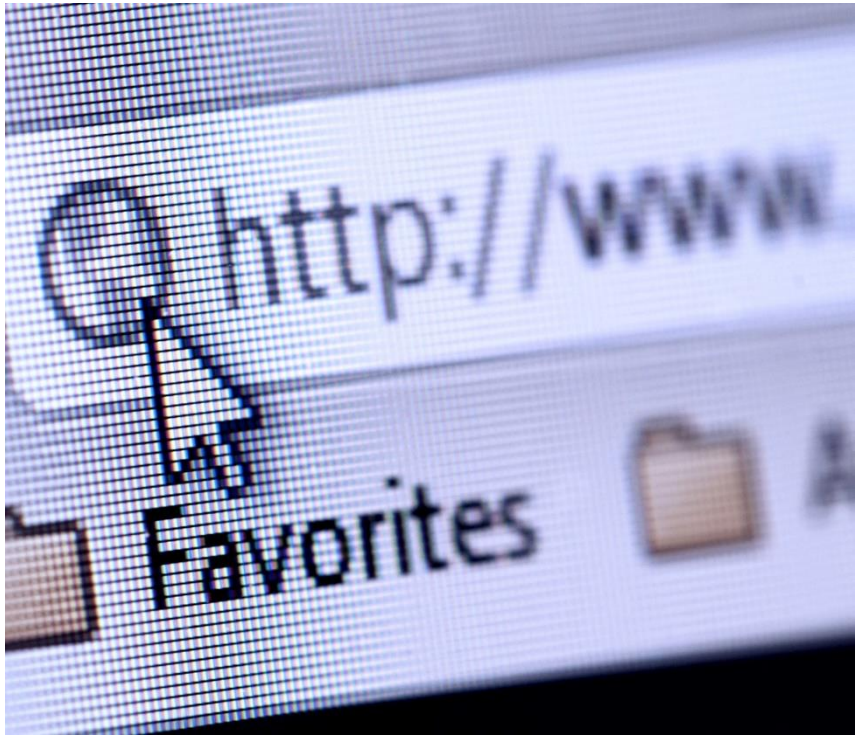
Appendix

Resources and Questions

- HHCMs and HH CMAs should first talk with their Lead Health Home regarding questions and issues they may have
- Questions, comments or feedback on Health Homes Serving Children to: hhsc@health.ny.gov or contact the Health Home Program at the Department of Health at 518.473.5569
- Specific Questions/Comments regarding Transition services BH.Transition@health.ny.gov
- Subscribe to the HH Listserv http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/listserv.htm



Department of Health Complaints

- Enrollees and providers may file a complaint regarding managed care plans to DOH
  - 1-800-206-8125
  - managedcarecomplaint@health.ny.gov
- When filing:
  - Identify plan and enrollee
  - Provide all documents from/to plan
  - Medical record not necessary

- Issues not within DOH jurisdiction may be referred

- DOH is unable to arbitrate or resolve contractual disputes in the absence of a specific governing law

- File Prompt Pay complaints with Department of Financial Services: https://www.dfs.ny.gov/insurance/provlhow.htm

Children and Youth Evaluation Service
Your Connection to Home and Community-Based Services

Referral Form Instructions

- The Children and Youth Evaluation Service (C-YES) accepts referrals from individuals and providers including a parent, wider family member, doctor, therapist, school guidance counselor, CBOs, and others

- Individuals and families should call C-YES so that we can send you a Referral Form and a pre-paid return envelope in the mail right away! You can mail back the form in the envelope at no cost to you. Call C-YES at 1-833-333-CYES (1-833-333-2937). TTY: 1-888-329-1541

- Providers and Organizations with secure email protocols can download the Referral Form below. Return the form to: CYESREFERRAL@MAXIMUS.COM. Be sure to include the child/youth's name and contact information.

- C-YES Referral Form