CIDNY FACT SHEET Medicaid

Information below is from the online address: http://www.health.ny.gov/health_care/medicaid/

What is Medicaid?

Medicaid is a program for New Yorkers who can't afford to pay for medical care.

How do I know if I qualify for Medicaid?

You may be covered by Medicaid if:

- You have high medical bills.
- You receive Supplemental Security Income (SSI).
- You meet certain financial requirements.

How do I apply for Medicaid?

You can request an application for Medicaid by phone, by mail or in person through your local department of social services (LDSS) or by contacting a Facilitated Enroller (FE).

An FE is a community agency trained to assist with Medicaid applications. An FE may have hours or a location that is more convenient than the LDSS. They are available to provide application assistance but you do not have to use an FE in order to apply. Individuals who are over the age of 65, certified blind or disabled, not certified disabled but chronically ill, or in need of Medicaid coverage of nursing facility services, should go to an LDSS not an FE. To locate an FE in your area, go to: http://www.nyhealth.gov/nysdoh/fhplus/apply/application_centers.htm.

Applications and assistance in filling them out can also be obtained by calling New York Health Options at 855-693-6765.

In New York City, applications can be obtained by contacting the Human Resources Administration (HRA) at (718) 557-1399.

Residents of New York City can mail applications to the Human Resources Administration at:

Initial Eligibility Unit
HRA/Medical Assistance Program
P.O. Box 2798
New York, NY 10117-2273

Pregnant women and children can apply at many clinics and hospitals. Contact your local department of social services to find out where you can apply.

If you are in a facility operated by the New York State Office of Mental Health, contact the Patient Resource Office.

If you are in a facility certified by the New York State Office for People With Developmental Disabilities, contact the Revenue Support Office.

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You no longer need to have a personal interview to be eligible for Medicaid. If you need help with understanding and filling out your application, you can call or visit your local department of social services or a facilitated enroller. You can also call New York Health Options at (855)693-6765.

What do I need to apply for Medicaid?

The necessary documentation needed to apply for Medicaid will depend on your category, whether you fall under the Modified Adjusted Gross Income (MAGI) guidelines or non-MAGI guidelines which are defined in the previous section.

MAGI Eligibility Groups include:

- Pregnant Women
- Infants and Children under age 19
- Childless Adults to include individuals who are: not pregnant, age 19-64 (age 19 – 20 living alone), not on Medicare, and could be certified disabled but not on Medicare
- Parents/Caretaker Relatives
- 19 & 20 year olds living with parents
- Family Planning Benefit Program
- Children in Foster Care (Chafee)

Non – MAGI Eligibility Groups include:

- SSI recipients
- Individuals who are age 65 or older, unless a parent/caretaker relative, blind or disabled and do not meet the criteria of the MAGI Eligibility Groups
- COBRA
- Medicare Savings Program (MSP)
- AIDS Health Insurance Program (AHIP)
- Foster Care and Former Foster Care
- Medicaid Buy-In for Working People with Disabilities
- Medicaid Cancer Treatment Program
- Residents of Adult Home run by LDSS, OMH Residential Care Centers/Community Residences

If you qualify under a MAGI eligibility group, you will have to provide documents to verify eligibility if necessary.

- If you are applying for Medicaid through New York State of Health, the New York State Marketplace, you may attest to your household income for the upcoming year. If your income is different than the income found on the data matches, income documentation may need to be provided.

- Citizenship/Immigration status and social security number will be verified through the federal data sources. If citizenship/immigration status or social security number does not match, documentation must be provided.

If you qualify under a non-MAGI eligibility group, the following is a guide to the documentation that must be submitted to help determine eligibility:

- If you are a U.S. citizen (born in the U.S. or one of its territories) and provide a valid Social Security Number (SSN), a match with the Social Security Administration (SSA) will verify your SSN, date of birth and U.S. citizenship. If SSA verifies this information, no further proof is needed. The SSA match cannot verify birth information for a naturalized citizen. You will need to submit proof of naturalization (e.g., Naturalization Certificate (N-550 or N-570) or a U.S. passport.
- Proof of citizenship or immigration status*
- Proof of age (if not verified by SSA), like a birth certificate
- Four weeks of recent paycheck stubs (if you are working)
- Proof of your income from sources like Social Security, Supplemental Security Income (SSI), Veteran's Benefits (VA), retirement benefits, Unemployment Insurance Benefits (UIB), Child Support payments
- If you are age 65 or older, or certified blind or disabled, and applying for nursing home care or need coverage for waivered services, you need to provide information on bank accounts, insurance policies and other resources
- Proof of where you live, such as a rent receipt, landlord statement, mortgage statement, or envelope from mail you received recently
- Insurance benefit card or the policy (if you have any other health insurance)
- Medicare Benefit Card (the red, white, and blue card)

*Note: Medicaid coverage is available, regardless of alien status, if you are pregnant or require treatment for an emergency medical condition and you meet all other Medicaid eligibility requirements.

If I think I am eligible for Medicaid, should I cancel any other health insurance I might already have?

No. If you currently pay for health insurance or Medicare coverage or have the option of getting that coverage, but cannot afford the payment, Medicaid can pay the premiums under certain circumstances.

Even if you are not eligible for Medicaid benefits, the premiums can still be paid, in some instances, if you lose your job or have your work hours reduced. If you need help with a COBRA premium, you must apply quickly, to determine if Medicaid can help pay the premium.

You may be eligible for the Medicare Savings Program. This program pays your Medicare premiums and deductibles.

If you have Acquired Immune Deficiency Syndrome (AIDS), Medicaid may be able to help pay your health insurance premiums.

How do I know if my income and resources qualify me for Medicaid?

The chart below shows how much income you can receive in a month and the amount of resources (if applicable) you can retain and still qualify for Medicaid. The income and resource (if applicable) levels depend on the number of your family members who live with you.

2014 Income & Resource Levels*			
Family Size	Net Income for Families; and Individuals who are Blind, Disabled or Age 65+		Resource Level (Individuals who are Blind, Disabled or Age 65+ ONLY)
	Annual	Monthly	
1	$9,700	$809	$14,550
2	$14,300	$1,192	$21,450
3	$16,445	$1,371	$24,668
4	$18,590	$1,550	$27,885
5	$20,735	$1,728	$31,103
6	$22,880	$1,907	$34,320
7	$25,025	$2,086	$37,538
8	$27,170	$2,265	$40,755
9	$29,315	$2,443	$43,973
10	$31,460	$2,622	$47,190
For each additional person,	$2,145	$179	$3,218

add:			

*Effective January 1, 2014

Income and Resource Levels are subject to yearly adjustments.

You may also own a home, a car, and personal property and still be eligible. The income and resources (if applicable) of legally responsible relatives in the household will also be counted.

Can I be eligible for Medicaid even if I make more money than the chart shows?

Yes, some people can. Pregnant women, children, disabled persons, and others may be eligible for Medicaid if their income is above these levels and they have medical bills. Ask your Medicaid worker if you fit into one of these groups.

Individuals who are certified blind, certified disabled, or age 65 or older who have more resources may also be eligible. Ask your Medicaid worker if this applies to you.

If an adult has too much income and/or resources and is not eligible for Medicaid, that person may be eligible for:

- Family Health Plus or
- Family Planning Benefit Program

Expanded Income levels for Children and Pregnant Women

- Infants to age one and pregnant women - 223% of the federal poverty level.
- Children age 1 through 18 years - 154% of the federal poverty level.

Monthly Income Effective January 1, 2014*		
Number in Family	**154% FPL****	**223% FPL****
1	$1,498	$2,169
2	$2,019	$2,924
3	$2,540	$3,678
4	$3,061	$4,433
5	$3,582	$5,187
6	$4,103	$5,942

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7	$4,624	$6,696
8	$5,145	$7,451
For each additional person, add:	$522	$755

* Income Levels are subject to yearly adjustments.
** FPL = Federal Poverty Level

If a child has too much income and is not eligible for Medicaid, the child may be eligible for Child Health Plus.

Can I get reimbursed for bills I paid for?

We may be able to pay you for some bills you paid before you asked for Medicaid. You can be paid for bills you paid before you asked for Medicaid and for bills you pay until you get your Medicaid card. Bills you paid before you asked for Medicaid must be for services you received on or after the first day of the third month before the month that you asked for Medicaid. For example, if you ask for Medicaid on March 11th, we may be able to pay you for services you received and paid for from December 1st until you get your Medicaid card.

We can pay you for some bills even if the doctor or other provider you paid does not take Medicaid, even if you paid the bills before you asked for Medicaid. After the day you ask for Medicaid, we can pay you only if the doctor or other provider takes Medicaid.

Always ask the doctor or other provider if he or she takes Medicaid. After you ask for Medicaid, we will not pay you if the doctor or other provider does not take Medicaid.

There are a few more rules:

- The bills you paid must be for services that the Medicaid program pays for. These services include, but are not limited to, doctors, home care, hospitals and drugs.
- We may only be able to pay what Medicaid pays for the services. This may be less than the bill you paid.
- We can pay you only when we decide you can get Medicaid and only if you could have gotten Medicaid when you paid the bill.
- We can pay you only when the bills you paid were for services that you needed.
- You must give us the bills and prove that you paid them.

How long does it take to get Medicaid?

Generally, local districts must determine if you are eligible and send a letter notifying you if your application has been accepted or denied within 45 days of the date of your application. If you are

pregnant or applying on behalf of children, the local district has 30 days from the date of your application to determine if you are eligible for Medicaid. If you are applying and have a disability which must be evaluated, it can take up to 90 days to determine if you are eligible.

What are my rights?

The Medicaid application, Access NY Health Care, tells you what your rights are when you apply for Medicaid. See the pages titled "Terms, Rights and Responsibilities." People who receive Medicaid have privacy rights. Medicaid keeps your health information private and shares it only when we need to.

If you are not satisfied with a decision made by the local social services district, you may request a conference with the agency. You may also appeal to the New York State Office of Temporary and Disability Assistance and request a Fair Hearing.

How do I request a State fair hearing?

You can ask for a fair hearing by:

1) Telephone: You may call the state wide toll free number: 800-342-3334; **OR**

2) Fax Number: (518) 473-6735; **OR**

3) On-Line: Complete and send the online request form at: **http://otda.ny.gov/programs/applications/**; **OR**

4) Write: to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201.

In New York City you can also:

Bring a copy of this notice to the New York State Office of Temporary and Disability Assistance at:

- 14 Boerum Place, 1st Floor, Brooklyn, or
- 111 Livingston Street, 4th Floor, Brooklyn, NY 11201

Will there be a lien (legal claim) placed on my estate (my assets) when I die?

If you receive medical services paid for by Medicaid on or after your 55th birthday, or when permanently residing in a medical institution, Medicaid may recover the amount of the cost of these services from the assets in your estate upon your death.

What health services are covered by Medicaid?

In general, the following services are paid for by Medicaid, but some may not be covered for you because of your age, financial circumstances, family situation, transfer of resource requirements, or living arrangements. Some services have small co-payments. These services may be provided using your Medicaid card or through your managed care plan if you are enrolled in managed care. You will not have a co-pay if you are in a managed care plan, except for pharmacy services, where a small co-pay will be applied.

- smoking cessation agents
- treatment and preventive health and dental care (doctors and dentists)
- hospital inpatient and outpatient services
- laboratory and X-ray services
- care in a nursing home
- care through home health agencies and personal care
- treatment in psychiatric hospitals (for persons under 21 or those 65 and older), mental health facilities, and facilities for the mentally retarded or the developmentally disabled
- family planning services
- early periodic screening, diagnosis, and treatment for children under 21 years of age under the Child/Teen Health Program
- medicine, supplies, medical equipment, and appliances (wheelchairs, etc.)
- clinic services
- transportation to medical appointments, including public transportation and car mileage
- emergency ambulance transportation to a hospital
- prenatal care
- some insurance and Medicare premiums
- other health services

If you are eligible for Medicaid, you will receive a Benefit Identification Card which must be used when you need medical services. There may be limitations on certain services.

For you to use your Benefit Identification Card for certain medical supplies, equipment, or services (e.g., wheelchair, orthopedic shoes, transportation), you or the person or facility that will provide the service must receive approval before the service can be provided (prior approval).

Will I have to pay co-payments?

The following services are subject to a co-payment:

- Clinic Visits (Hospital-Based and Free Standing Article 28 Health Department-certified facilities) - $3.00;
- Laboratory Tests performed by an independent clinical laboratory or any hospital-based/free standing clinic laboratory - $0.50 per procedure;

- Medical Supplies including syringes, bandages, gloves, sterile irrigation solutions, incontinence pads, ostomy bags, heating pads, hearing aid batteries, nutritional supplements, etc. - $1.00 per claim;
- Inpatient Hospital Stays (involving at least one overnight stay; is due upon discharge) - $25.00;
- Emergency Room - for non-urgent or non-emergency services - $3.00 per visit;
- Pharmacy Prescription Drugs - $3.00 Brand Name, $1.00 Generic;
- Non-Prescription (over the counter) Drugs - $0.50.

There is no co-payment on private practicing physician services (including laboratory and/or x-ray services, home health services, personal care services or long term home health care services).

Co-pay Maximum

You are responsible to pay a maximum of up to $200 in a co-pay year. Your year begins on April 1st and ends March 31st each year. If you reach your maximum of $200, a letter will be sent to you exempting you from paying Medicaid co-payments until April 1st.

Co-pay Exemptions

The following are exempt from all Medicaid co-payments:

- Children under 21.
- Pregnant women. (Pregnant women are exempt during pregnancy and for the two months after the month in which the pregnancy ends.)
- Family planning (birth control) services -This includes family planning drugs or supplies like birth control pills and condoms.
- Residents of an Adult Care Facility licensed by the New York State Department of Health.
- Residents of a Nursing Home.
- Residents of an Office of Mental Health (OMH) or Office for People with Developmental Disabilities (OPWDD) certified Community Residence.
- Enrollees in a Comprehensive Medical Case Management (CMCM) or Services Coordination Program.
- Enrollees in the Home and Community Based Services (HCBS) or Traumatic Brain Injury (TBI) waiver programs.
- Psychotropic and Tuberculosis drugs.

You cannot be denied care or services because of your inability to pay a co-payment. A provider has the right to ask you for the co-payment at each visit and bill you for any unpaid co-payments.

What is a Medicaid managed care program?

Enrollment in a Medicaid managed care program through a Health Maintenance Organization (HMO), clinic, hospital, or physician group is available at any local department of social services. You may be required to join a managed care plan. When you join a managed care program, you will choose a personal doctor who will be responsible for making sure all your health care needs are met. The doctor will send you to someone else if you need more help than the doctor can provide.

What does managed care cover?

Managed care covers most of the benefits recipients will use, including all preventive and primary care, inpatient care, and eye care. People in managed care plans use their Medicaid benefit card to get those services that the plan does not cover.

Do I have to join a managed care plan?

In many counties you can join a plan if there is one available and you want to. However, there are some counties where families will have to join a plan. In these counties there are some individuals who don't have to join. Please check with your local social services department to see if you have to join a plan.

Of special interest to persons with disabilities:

If you think you are disabled, and if you meet the criteria for disability included in the Social Security Act, you may be eligible for Medicaid.

If you believe you are disabled, you should furnish the local department of social services with medical evidence about your impairment(s).

It may be necessary for you to have further examinations and/or tests for the disability to be determined.

The cost of such examinations, consultations, and tests requested by the disability review team, if not otherwise covered, will be paid by the local social services agency.

NOTE: Persons who are denied for reasons of failure to meet the disability criteria are entitled to appeal the disability decision that led to the denial of their application. See the section of this page entitled ""What are my rights?". Any person dissatisfied with the Fair Hearing decision of the New York State Office of Temporary and Disability Assistance may also appeal to the court system.

The following questions are only for people who are 65 years of age or older, certified blind, certified disabled, or in need of care in a nursing home. These individuals have a resource test.

What are resources?

Resources are cash or those assets, which can be readily converted to cash, such as bank accounts, life insurance policies, stocks, bonds, mutual fund shares and promissory notes. Resources also include property not readily converted to cash (i.e., real property)

Can I still keep part of my income if I am in a nursing home (Residential Health Care Facility) or in an intermediate care facility for the developmentally disabled?

Yes. Under Medicaid you are allowed to keep a small amount for your personal needs. You can also keep some of your income for your family if they are dependent on you. A spouse who remains in the community may also keep resources and income above the levels shown.

What is a "lookback" period?

When applying for Medicaid for nursing facility services (Nursing Home), the local department of social services will look at financial transactions to determine whether any assets have been transferred or given away for less than fair market value during a certain time period prior to your application in order to determine if a transfer of assets penalty period needs to be applied. This is known as the "lookback" period. Currently the "lookback" period is 60 months (5 yrs) prior to the month you are applying for coverage of nursing home care.

A penalty period may be imposed for the transfer of non-exempt assets for less than fair market value. The penalty period results in a period of ineligibility for Medicaid coverage of nursing facility services.

A penalty period is not applied for the transfer of your home to the following individuals:

- Spouse
- Child under the age of 21
- Sibling who has an equity interest in the home and has resided in the home for at least one year immediately prior to you entering the Nursing Home.
- Adult child who resided in the home for at least two years, immediately prior to you entering the Nursing Home and who provided care to you which permitted you to reside at home rather than in a medical facility.

For more information regarding the transfer of assets and penalty periods, please contact your local department of social services.

What is a Life Estate? Will it make me ineligible?

A life estate is limited interest in real property. A life estate holder does not have full title to the property, but has the use of the property for his or her lifetime, or for a specified period. The life estate is not considered a countable resource, and no lien may be placed on it.

If you or your spouse sell the life estate interest for less than fair market value, it can be considered a transfer of assets and may be subject to the penalty period.

Am I allowed to have a pre-paid burial fund?

You may establish an irrevocable pre-need funeral agreement with a funeral firm, funeral director, undertaker or any other person, firm or corporation which can create such an agreement for your funeral and burial expenses. Pre-need burial agreements purchased for certain members of your family on or

after January 1, 2011 must also be irrevocable. The pre-need funeral agreement is used towards burial and funeral expenses and is not counted as a resource when determining Medicaid eligibility.

If you (your spouse) do not have an irrevocable pre-need funeral agreement or if the irrevocable pre-need agreement has less than $1500 designated for non-burial space items, you may be allowed to have money set aside in a burial fund. The limit for single individuals is $1500 or $3000 for a couple. Please note, these funds, must be kept separate from any non- burial fund related resources.

What is a Community Spouse?

A community spouse is someone who's husband/wife is currently institutionalized or living in a nursing home. The community spouse is not currently living in a nursing home and usually resides at the couple's home.

I am a community spouse. Will I be allowed to keep any income or resources?

If your spouse is institutionalized or living in a nursing home, you will be permitted to keep some income known as a minimum monthly maintenance needs allowance (MMMNA). If you are currently receiving income in excess of the minimum monthly maintenance needs allowance, you may be asked to contribute twenty-five percent (25%) of the excess income to the cost of care for the institution

For current Medicaid Beneficiaries:

How do I find my local Medicaid office?

The Medicaid office is located in your local department of social services. A listing of offices can be located here: http://www.health.ny.gov/health_care/medicaid/ldss.htm

If you live in the five boroughs of New York City, your offices are run by the Human Resources Administration (HRA). A listing of offices can be found at:

http://www.nyc.gov/html/hra/html/home/home.shtm

How do I order a new benefit card?

To order a new Medicaid Benefit Identification Card, please call or visit your local department of social services.

Members residing in the five boroughs of NYC can call the HRA Infoline at 1 (718) 557-1399 or the HRA Medicaid Helpline at 1(888) 692-6116.

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How often do I have to renew?

Most renewals are on an annual basis. You will receive a renewal packet by mail prior to your renewal date. Your packet will let you know if there are other methods available to you for recertification such as phone or internet renewal.

Please note that Medicaid mail cannot be forwarded. This means that if you changed your address at the post office and not with the Medicaid office, you will not receive your Medicaid mail. You must notify your Medicaid office of all address changes to ensure you receive any notices sent by them.

What do I have to do if I move from one county to another?

It is important to notify your Medicaid office any time you move especially when you are moving to another county. Your original county needs to notify the new county and get your case transferred.

If you are currently enrolled in a managed care plan that is not offered in the new county, your local department of social services will notify you so that you can choose a new plan

I'm pregnant, how do I get a card for my baby?

To request a card for your unborn baby, you will need to obtain a letter from your doctor with your anticipated due date and provide it to your local department of social services. Those living in NYC need to provide their letter to their Human Resources Administration (HRA) office.

Once the Medicaid office receives the letter, they will issue you an unborn/infant card which you will use to take the baby to the doctor once he/she is born, until the child's permanent card is issued.

How do I report Medicaid fraud?

You can report Medicaid fraud by calling the Fraud Hotline 1-877-873-7283 or by filing a complaint online athttp://www.omig.ny.gov/data/content/view/50/224/index.php?option=com_content&view=article&id=650

If you send an e-mail to Medicaid@health.state.ny.us please include your phone number so they can respond to you as quickly as possible.