Medicaid/Medicare, Managed Long-Term Care & Pooled Trusts

Disclaimer

- **Please note:** The following content is for informational purposes only. It is not to be interpreted as legal advice and the information contained is not necessarily applicable to your specific cases/clients.

3

Medicaid and Medicare

- Medicaid is limited to those with low income and minimal assets. Medicare has no income or asset limit, but requires that you or your spouse have a work history to qualify, with some exceptions.
- Medicare is generally limited to those 65+, unless you have ESRD, ALS, or have received SSD for a minimum of 2 years.

4

Medicare

- **Traditional**
  - → Part A: Hospital Coverage
  - → Part B: Doctor Coverage – essential services
  - → Does not cover vision, hearing, dental
- **Medicare Advantage**
  - → Part C = A + B, administered by a private plan
  - → Can provide coverage beyond the scope of traditional Medicare
- **Part D** → Drug coverage
  - → Extra Help

There is a special program called the Low Income Subsidy (LIS) which helps with Medicare Part D cost sharing. LIS is also known as "Extra Help." The Social Security Administration administers LIS -- you don't apply through your Part D plan.

5

Medigap Plans

- Plans A – F
  - → provide different coverage
  - → varying copays
- Administered by private plans
- Can go onto Medicare.gov to compare plans

6

Medicare Savings Program (MSP)

Funded by the State Medicaid program, **Medicare Savings Programs (MSPs)** help eligible individuals meet some or all of their cost-sharing obligations under Medicare. *See* N.Y. Soc. Serv. L. § 367-a(3)(a), (b), and (d). There are three separate MSP programs, the Qualified Medicare Beneficiary (QMB) Program, the Specified Low Income Medicare Beneficiary (SLIMB) Program and the Qualified Individual (QI) Program.

NOTE: You can divert excess income into a Pooled Trust in order to qualify for an MSP program WITHOUT applying for full Medicaid benefits. If you do receive Medicaid and divert your excess income into a pooled trust, you likely qualify for an MSP. If you are not automatically screened, you should speak to your LDSS.

7

Medicaid Resource and Income Limits 2018

Community Medicaid: Aged, Disabled, Blind People (Non-MAGI Category):

- Resources: (includes savings/checking accounts, CDs, stocks, other liquid savings):
  - **Living Alone $15, 150**
  - **Couple $22,200**
- Income:
  - **Living Alone $842**
  - **Couple $1,233**

8

Spousal Impoverishment Protections

Spousal Impoverishment Protections: The spouse of a nursing home resident, an MLTC recipient, or a Waiver Program Participant is allowed to keep a reasonable level of income and resources to live on, while still permitting Medicaid payment for the Medicaid recipient's care.

- **Income Allowed Monthly for Community Spouse: $3090.00**
- **Resources: Community Spouse may have up to the greater of $74,820 or one-half of the couple's total combined assets up to $115,920**
- This total includes the Community Spouse's own resources in his/her own name, plus any of the long term care Spouse's own resources that exceed $15,150, plus any of their joint resources. The spouse must actually transfer his/her own individual and their joint resources that exceed the individual resource limit to the Community Spouse.

9

Income Spend Down

- Medicaid income budgeting is very specific and each client will have different exemptions and deductions.
- When an individual or couple has income in excess of their monthly limit, they can still be eligible for Medicaid with a Spenddown (DAB category ONLY). You have several options to meet this limit:
  1. Submit unpaid Medical bills equal to the excess income to DSS
  2. Pay the excess income amount directly to DSS
  3. A disabled individual may divert excess into a *Supplemental Needs Trust/Pooled Trust* to deposit "excess" income monthly. Money put into the trust is exempt from Medicaid, so the spenddown is reduced or eliminated.

10

Spending Down Excess Resources

If you have excess resources, you can become eligible for Medicaid by spending the excess. Here are some recommended ways of spending down:

- Household items or expenses;
- Pre-need Funeral Agreement and/or burial fund;
- Purchases for Fair Market Value*

*** Warning – How transfers effect nursing home coverage:**

Though you may receive Medicaid home care now despite having transferred assets, if you later need nursing home care, there are penalties for transferring assets. The local district will review all transfers of assets for the 60 months (5 years) preceding your application for **institutional Medicaid**. The penalty will delay your eligibility for Medicaid coverage for a period of time that depends on the amount transferred.

Important Changes to Medicaid Enrollees' Appeal and Fair Hearing Rights – Effective May 1, 2018

11

- Enrollee is entitled to written notice at least 10 days before the plan says it will reduce or stop any services (this is unchanged).
- **EXHAUSTION REQUIREMENT:** Enrollee **MUST** first request an **Internal Plan Appeal** and receive a **Final Adverse Determination BEFORE** requesting a State Fair Hearing. Enrollee has **60 days** to make this request.
- Enrollee may request an Internal Plan Appeal orally via telephone, but must follow up an oral request with a written request by mail or fax. Enrollee must give written authorization to anyone requesting an appeal on their behalf, or the appeal may not be processed

Important Changes to Medicaid Enrollees' Appeal and Fair Hearing Rights – Effective May 1, 2018

12

- **Aide Continuing** must be requested **twice** during the appeals process – you must request aide continuing directly from the plan before the proposed reduction or denial goes into effect – essentially, Enrollees have approximately 10 days to request aide continuing at this stage. Once you receive a Final Adverse Determination from the Plan, you must again request aide continuing from OTDA when you request a State Fair Hearing. This request must also occur within 10 days of the Final Adverse Determination, even though you have 120 days to request a Fair Hearing.
- **Enrollees have 120 days to request a State Fair Hearing** from the date of the Final Adverse Determination. **Only Exception**: if Plan fails to timely respond to Internal Plan Appeal, Enrollee may request a State Fair Hearing without receiving a Final Adverse Determination from the Plan.

  Note: Even if a Plan fails to issue a Notice for an action, such as a reduction in services, the Enrollee still must request an Internal Plan Appeal. If the Plan fails to process such an appeal, the Enrollee may request a State Fair Hearing and argue that "exhaustion" has been deemed by the Plan's failure to respond.

13

Changes to MLTC Plan Eligibility and Enrollment – Effective April 1, 2018

- MLTC plans are now essentially only for individuals applying to receive homecare services. There is limited coverage of nursing home stays, but only if the stay is temporary.
- For a new long-term nursing home Medicaid applicant, the type of Medicaid to apply for is Fee-for-Service Medicaid. If you are already on an MLTC plan when you enter the facility, you will be transitioned into Fee-for-Service Medicaid after 3 months of permanent institutionalization (or a long-term stay).
- After initial MLTC enrollment, enrollee has a very short window to switch MLTC plans. From there, the enrollee is locked into their plan for 12 months.

Long-Term Care Medicaid Services

- Home health care
- Nurse case management
- Therapy
- Transportation
- Home delivered meals
- Supplies and equipment
- Adult Day Health Care
- Audiology, Dental, Optometry, Podiatry
- Consumer Directed Personal Assistance Services

Four Types of Managed LTC Plans

- **MLTC Medicaid Plan**
  - Does not cover Medicare Services – Keep your Medicare doctors
- **Medicaid Advantage Plus**
  - Covers Medicare and Medicaid services, must use Plan's providers
- **FIDA – Fully Integrated Duals Advantage**
  - Like a Medicare Advantage Plan + MLTC Medicaid Plan - Covers Medicare and Medicaid in one plan
- **Program of All-Inclusive Care for the Elderly (PACE)**
  - Covers Medicare and Medicaid services - Must use PACE PCPs and network providers; Many services offered at day center headquarters

Steps for Accessing Long-Term Care Medicaid Services

1. Apply for LTC Medicaid
2. Schedule State RN Evaluation
3. Research LTC Programs
4. Enroll in LTC Program
5. Obtain Supplemental Needs Trust

1. Apply for LTC Medicaid

- **Community-Based Long Term Care Medicaid**
  - Mainstream and Supplement A Forms
  - Documentation
  - No look-back period
- Up to 45 day app. review period
  - Watch for incomplete app. notice
- Resource: Healthy Capital District Initiative – 462-1459

2. Schedule a State RN Evaluation

- **Conflict Free Evaluation and Enrollment Center (CFEEC)**
  - 855-222-8350
- Call after Medicaid app. submitted
  - RN appointment in 5 – 7 business days, can vary
  - Valid for 75 days
- Must score 5 or higher on UAS; also evaluate home
- Can evaluate in a nursing home, not hospital
- Phone call can be difficult for some seniors
- 3 hour evaluation

Research LTC Programs

- **NYMedicaidChoice.com – 1-888-401-MLTC (6582)**
- CFEEC RN assists -
  - Provides brochure, calls NY Medicaid Choice

Enroll in LTC Program

- Program's Enrollment Specialist will coordinate
- Several Steps/Visits
  1. Program's RN Evaluation
  2. Plan of Care development
  3. Enrollment Signing
  4. Phone call or electronic submission to NY Medicaid Choice or DSS
- Deadline 18/20th of month

Obtain Supplemental Needs Trust

- Can be done post-enrollment signing
- Timing of disability review and DSS rebudgeting
- Practical issues of starting a Trust

Pooled Trust Notification Bill

Passed on Dec. 8, 2017 and effective June 18, 2018 (may be delayed if DOH believes regs. are necessary to implement)

- Applicant who is or reasonably appears to be eligible for medical assistance under subparagraph two of paragraph (c) of subdivision one of this section, except for having income exceeding applicable income levels.
- Notice shall be included with the eligibility notice
- Notice shall explain, in plain language, the rules for depositing income in a trust …
- … shall include information on how to enroll in such a trust and how to request that the local social services district re-budget medical assistance based on participation in such a trust.

What is a Pooled Supplemental Needs Trust (SNT)?

A type of SNT in which a not-for-profit trustee agrees to manage assets for the benefit of a person with disabilities to preserve that person's eligibility for government benefits.

Federal and NYS law both permit the use of a pooled SNT by persons with disabilities as a way to protect income and resources for the purpose of determining Medicaid eligibility.

Pooled Trust Basics

- One Master Trust document for multiple beneficiaries
- Joinder Agreement for each beneficiary
- Funds pooled for investment purposes and tracked separately
- Non-profit organization is trustee with financial institution co-trustee (NYS requirement)
- Individual can establish themselves
- May also be established by parent, grandparent, guardian, court or POA
- Funds remain with the trust at death
- No age limit / over 65 okay

Using a Pooled Trust

- The pooled trust allows persons to obtain Community Long-Term Care services, while maintaining their ability to use their income to meet living expenses.

"Income received by an individual and placed into a pooled SNT in the same month will be disregarded for Medicaid eligibility purposes".

Determination of disability

- If over the age of 65 a separate determination of disability is required
- If beneficiary received SSI or SSD prior to the age of 65, most counties will not require separate proof
- This paperwork is to be filed through the local Medicaid office and the determination is made by DOH in Albany

Enrolling in a Pooled Trust

- Master Trust already in place
- Submit Joinder Agreement, documentation and initial deposit.
- Deposit surplus income (NAMI) monthly
  (Must be able to proof deposits made timely)
- Submit disbursement requests for distributions

Administration of Account

- Deposits of income required monthly
- Must be made in month income is received
- Documentation for disbursements
- Sole benefit
- No cash to beneficiary / Payments made to third parties
- Pooled trusts charge a monthly administrative fee
- Accounts terminate at death of the trust beneficiary under federal statute

Eligible Disbursements

Typically pay living expenses:

Rent	Mortgage
Condo Maintenance	Home/Renters insurance
Repairs/Maintenance	Property taxes
Utilities	Furniture
Groceries for bene.	Adult diapers/OTC items

Other personal needs
Purchases appropriate for bene.
Transportation/Vehicle expenses (owned by bene.)

Prohibited Disbursements

- Cash to beneficiary or bank accounts
- Items for others (sole benefit)
- Capital improvements to property not owned by beneficiary
- Leases between spouses
- Leases with POA when POA signs as landlord and tenant
- Both rent and mortgage/property taxes, etc.
- Items covered by government benefits
- Alcohol, tobacco, firearms, illegal activity, bail, restitution

What happens if beneficiary enters Nursing Home?

- If simply a Rehab period, beneficiary gives monthly income to NH during rehab period.
  - Deposits to trust restart after return home
- If permanent placement:
  - Stop deposits, notify Pooled Trust, and use balance until funds depleted

What happens if the beneficiary Dies?

- Sub-trust accounts terminate upon the death of the beneficiary
- In accordance with Federal and State statute, no disbursements may be made for expenses incurred after death
- Some trusts allowed final disbursements for expenses incurred prior to death, however updated SSA policy no longer allows this

  (POMS – SI 01120.203 3 b)
- Remaining funds are retained by the trust (otherwise would go to the State)
- Note: While pre-need funeral arrangement may be paid from a pooled trust during the beneficiary's lifetime, the pooled trust cannot pay funeral expenses after death. Pre-need funeral arrangements are highly recommended.

Selecting a Pooled Trust

- Look for an organization experienced in the administration of supplemental needs trusts
- Make sure good records are maintained and appropriate substantiation for disbursements is required.
  - When a trustee makes distributions without proper detailed documentation, your client's benefits are at risk
- Reputation
- Fees are clearly defined (no hidden expenses).
- Cheapest does not mean best. Protect your clients. Use a reputable trust.

Contact Information

Heidi J. Flatt, CPA, CGMA
Chief Operating Officer
NYSARC Trust Services
flatth@nysarc.org ***518-860-1259***

Kelly M. Barrett, Esq.
Staff Attorney
Center for Elder Law & Justice
kbarrett@elderjusticeny.org ***716-853-3087 x 229***

Ben Baskin, MPH
Director of Enrollment and Marketing
Eddy SerniorCare
Benjamin.Baskin@sphp.com ***518-831-6361***