




Streamlining New York's Medicaid Excess Income Program

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Prepared by Manatt Health Solutions



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Executive Summary



New York State's Excess Income Program provides crucial access to Medicaid coverage to a relatively small number of recipients who have large or ongoing medical expenses, but whose household incomes are too high to meet the regular Medicaid income eligibility standards, which for many are far below the Federal poverty level. Yet, the complex and burdensome administrative requirements of the program compromises its value for participants, and consumes a disproportionate amount of scarce administrative time and resources, particularly for local departments of social services. This brief describes the Excess Income Program, its complex processing requirements, and select characteristics and utilization patterns for the approximately 60,000 Excess Income recipients who dwell in the community. The brief focuses on community recipients—as opposed to those residing in institutional settings—as community recipients face the greatest challenges and demand the greatest administrative resources to facilitate continued participation in the program. The brief concludes with options to simplify implementation of the Excess Income Program for the benefit of community-dwelling consumers, providers and local districts, alike.

THE EXCESS INCOME PROGRAM

At least 150,000 New Yorkers obtain Medicaid coverage through the Excess Income Program, approximately 4% of the total Medicaid population in the State. The program allows applicants with incomes above Medicaid's financial eligibility levels to obtain coverage after incurring medical expenses equal to the amount that their income exceeds the eligibility threshold. While most Medicaid beneficiaries must provide paperwork only annually to maintain coverage, Excess Income recipients must activate their Medicaid coverage each month by presenting proof of medical bills ("spending down") or payment ("paying in") to their local district offices. This requirement is in addition to completing the initial eligibility process and annual recertification paperwork required of all applicants. For the roughly 60% of Excess Income recipients residing in institutional settings—typically nursing homes—the institutional provider coordinates proof of ongoing medical expenses directly with the local department of social services. However, for those residing in the community, the task of activating monthly coverage falls to the recipient. It is these community-dwelling recipients ("community recipients") for whom the process is most burdensome, and who, in turn, require intensive assistance from local department of social services staff.

Excess Income community beneficiaries are primarily elderly or disabled and have chronic or significant health care needs, making the timely and accurate processing of their eligibility decisions particularly crucial. The vast majority—86%—are dually eligible for Medicare and Medicaid; only a handful of parents, children, and pregnant women in the community participate in the program.¹ Total annual Medicaid expenditures for this population are estimated to approach \$900 million. The State spends approximately \$19,000 per beneficiary per year, on average, for community Excess Income beneficiaries, though the monthly Medicaid expenditures for those who pay in (submit payment for the excess income amount directly to the local districts) are generally significantly lower than for those who spend down (show medical bills to the local districts). As a comparison, the average annual expenditure for all Medicaid enrollees in New York State

¹ NYSDOH Data.

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(including those in institutional care) was less than \$11,000 per enrollee in 2007, roughly 55% of the average cost for community-dwelling Excess Income enrollees.ⁱⁱ Home health care accounts for more than half of all monthly Medicaid expenditures associated with these community enrollees.

THE ADMINISTRATIVE PROCESS FOR COMMUNITY BENEFICIARIES

The month-to-month activation process is burdensome for community beneficiaries who face challenges gathering and submitting medical bills—sometimes many receipts for small payments such as co-pays for provider visits or prescription drugs. Likewise, local districts struggle with managing the large volumes of paper receipts and payments as well as intensive interaction with beneficiaries to track continued eligibility, a time-consuming process. Thus, while community Excess Income recipients make up only a small proportion of Medicaid beneficiaries in the State, the processing requirements of this program consume a disproportionate amount of scarce administrative time and resources.ⁱⁱⁱ

OPTIONS FOR STREAMLINING THE PROGRAM

While there is no one-size-fits-all approach to streamlining the program, the following options—ranging from “big ideas” that would reconfigure eligibility requirements to more modest changes that are possible within current program rules—could alleviate process burdens and consequent delays in much-needed coverage and care.

Create a new “buy-in” option with flat-fee premium amounts. The primary benefit of creating a “buy-in” is the administrative simplification that comes with replacing the “spend-down” calculation with a sliding scale flat fee premium. Local districts would no longer be required to collect and track bills for buy-in participants, nor would they be required to conduct a reconciliation of each individual’s account and refund or credit the consumer for amounts paid in but not used toward medical care. However, the low participation in the “pay-in” option under the current program indicates that simply replacing the current spend-down amounts with an equivalent flat fee premium would help a small fraction of program participants. Thus, the buy-in amount should be set lower than an individual’s pay-in amount, increasing program accessibility for consumers and enticing those who currently gather and submit medical bills to take advantage of the administrative simplicity of a monthly premium activation process.

Incentivize dually eligible recipients to enroll in managed care plans that align Medicare and Medicaid payments. Another buy-in option would be to combine it with participation in managed care. A large majority of community Excess Income recipients are dually eligible for Medicare and Medicaid. The high needs and costs of this population has prompted State and Federal efforts to seek alignment of Medicare and Medicaid payments for dually eligible populations through fully capitated managed care plans, including Medicaid Advantage Plus (MAP) and Programs of All-Inclusive Care for the Elderly (PACE). Allowing Excess Income community recipients the option to buy into these programs on a sliding scale premium basis could simplify the program

ⁱⁱ NYSDOH Medicaid Quarterly Reports—Calendar Year 2007.

ⁱⁱⁱ *Id.*

Executive Summary *(continued)*

for consumers, while aligning with State policy goals to maximize Federal payments and improve coordination of care. To incentivize participation in these managed care programs, and to establish longer-term activation of coverage for recipients, the buy-in premium amount should be set below current excess income amounts.

Implement a “plan of care” option that would allow prospective activation of Medicaid coverage.

A significant proportion of community Excess Income beneficiaries have ongoing and predictable medical costs, such as home care. Yet, these beneficiaries still must activate coverage each month by submitting bills to the local district.^{iv} The process burden for consumers, providers, and district workers could be streamlined by developing an option that allows those with predictable bills to prospectively activate coverage for months—or perhaps up to a year—at a time. The provider could develop a “plan of care” for the patient that states the amount and duration of care that is needed. The “plan of care”—signed by both the provider and the consumer—would then be submitted to the local district, triggering activation of coverage for the period designated in the plan. Each month, the provider would carve out the consumer’s liability from the medical bill, and submit the remaining portion to Medicaid for reimbursement.

Automate interaction between providers and local districts to facilitate activation of consumer coverage. Interactions between providers and districts could be automated to ease the monthly burden on the consumer, speed monthly processing of bills, and satisfy providers who rely on Medicaid. Currently, the onus is on the recipient to gather bills from providers and submit them to the district. Automating communications between providers and districts would eliminate this monthly burden on consumers, and speed the activation process considerably. Providers already receive automated information from the Medicaid program via databases and monthly rosters. Yet, providers do not have information about whether an enrollee is an Excess Income beneficiary or the excess income amount. To obtain that information, the provider generally must telephone the local district. In areas with large Medicaid programs, such as New York City, the local district agencies may restrict calls due to staffing constraints. By using the current data systems to give providers access to key information—such as the amount of the excess income—this process would be streamlined for consumers, districts, and providers alike. Each month, the provider would simply carve out the consumer’s responsibility and bill the remaining portion to the State for reimbursement.

Streamline State Administrative Systems. Changes to State and local data systems, and automated communication with other public programs for which health care expenditures count toward the excess income amount could alleviate some monthly processing burdens on local districts and speed activation of coverage for consumers. In addition, the State could make use of the new State Enrollment Center to centralize processing of bills and payments for some excess income beneficiaries.

^{iv} While most large home care agencies in New York City submit these bills in batches to HRA, the activation still must occur monthly.

Executive Summary *(continued)*

Reconfigure Eligibility. A fundamental underlying challenge when dealing with the Excess Income Program—as reflected in feedback from local districts, providers, and consumer advocates—is the financial burden experienced by what is generally an extraordinarily medically vulnerable and low-income population. This led many to suggest either increasing the underlying Medicaid eligibility limits for this population, or allowing an income deduction for housing or other basic expenses. The State could exercise an option under current Federal laws to disregard income used for certain purposes—such as housing—for targeted populations. This would essentially diminish the excess income amount and thus make the program more accessible for the lowest income population it serves. Of course, such a solution would come at a direct cost to the State, and would not eliminate the administrative challenges for those who remain in the program.

Each of the above options has benefits and drawbacks. While some—like the buy-in and plan of care options—would require a Federal waiver, they offer a more comprehensive approach. Others—such as changes in State data systems—may be permissible under current program rules, but would offer more incremental impact.

Background: New York's Excess Income Program

Medicaid is a joint Federal and state program that provides important medical assistance to the nation's low-income populations. Each year, the program serves nearly 62 million Americans nationwide including more than 4.1 million New Yorkers.^v Federal mandates dictate that each state offer public health insurance coverage to "categorically needy" individuals whose incomes are low enough to meet state-set eligibility levels. In addition, states may choose to offer coverage to certain individuals who have medical needs and would meet the eligibility criteria for Medicaid except that their incomes are too high.^{vi} Through this State option, New York offers much-needed Medicaid coverage through its "Excess Income Program" to residents who have substantial medical bills or those who nearly meet the income standards and choose to pay the difference to gain health insurance coverage.^{vii} Only those who are aged 65 or older, blind, disabled, pregnant, children under age 21, and parents of children under age 21 may obtain Medicaid through the Excess Income Program.^{viii}

More than 150,000 New Yorkers statewide obtain Medicaid coverage through the Excess Income Program, approximately 4% of all Medicaid beneficiaries in New York State. More than 60% of Excess Income recipients reside in institutional settings, typically nursing homes. Institutional recipients are often referred to as "NAMI," which refers to the requirement that they apply their net available monthly income (NAMI) toward the cost of care.

The remaining Excess Income participants reside in the community. Community Excess Income participants may activate coverage in one of two ways: (1) by "spending down" or (2) by "paying in." Individuals may "spend down" his/her excess income amount by incurring medical costs that equal or exceed the excess income amount and showing proof of those costs to the local departments of social services, which are the Medicaid agencies. Those with large, inpatient hospital bills may activate full coverage for six months at a time. Alternatively, recipients may submit payment for—or "pay in"—the excess income amount directly.^{ix} In New York State, applicants whose incomes place them above eligibility limits for regular Medicaid, but within

^v The Federal Centers for Medicare and Medicaid (CMS) estimate that 61.9 million people were enrolled at some point during FY 2007. Average enrollment (i.e., person-year equivalents) is estimated at 49.1 million for the same time period. See CMS "2008 Actuarial Report on the Financial Outlook for Medicaid" October 2008. Average monthly Medicaid enrollment was 4.1 million for Calendar Year 2007, according to the NYSDOH Web site at <http://www.health.state.ny.us/nysdoh/medstat/medicaid.htm>, last accessed November 20, 2008.

^{vi} Under Federal and State Medicaid law, when an otherwise eligible applicant or recipient's net available income exceeds the appropriate income standards, the applicant or recipient may become eligible for Medicaid coverage (1) after incurring medical expenses equal to or greater than the amount of excess income ("Spend Down") or (2) pre-paying the amount of excess income ("Pay-In"). 42 U.S.C. §1396b(f)(2); see also 18 N.Y.C.R.R. § 360-4.8; see also Crowley, Jeff "Medicaid Medically Needy Programs" Kaiser Family Foundation, January 2003.

^{vii} 18 N.Y.C.R.R. § 360-4.8.

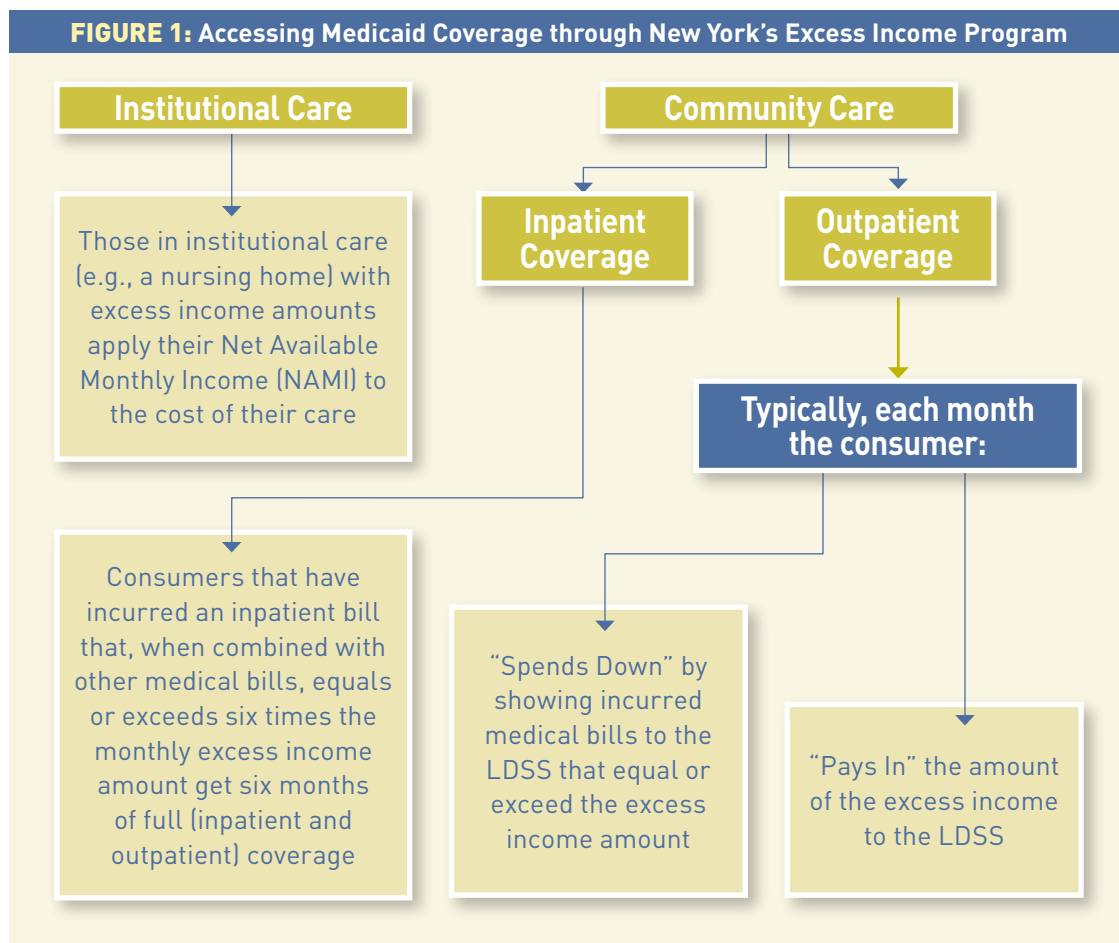
^{viii} 42 U.S.C. §1396b(f)(2); see also 18 N.Y.C.R.R. § 360-4.8. Also, applicants whose incomes place them above eligibility limits for Medicaid, but within limits for Family Health Plus (FHP) are given the choice to participate in either FHP or the Excess Income Program.

^{ix} 42 U.S.C. §1396b(f)(2); see also 18 N.Y.C.R.R. § 360-4.8. Note: Medical bills of a legally responsible relative (LRR) can also be used to meet the excess income amount. 87 ADM-4.

Background: New York’s Excess Income Program *(continued)*

limits for the State’s Family Health Plus (FHP) public health insurance program, are given the choice to either apply for regular Medicaid benefits through the Excess Income Program or to participate in Family Health Plus.^x

As a practical matter, the enrollment procedures for those in institutional settings differ from the process for those living in the community.^{xi} The institutional provider—rather than the beneficiary—typically coordinates proof of ongoing medical expenses directly with the local Medicaid agency. The task of establishing monthly eligibility for those in the community, on the other hand, falls to the recipient and requires extensive Medicaid worker involvement. Thus, we focus our analysis on community outpatient Excess Income beneficiaries—those who face the toughest challenges in maintaining active coverage month-to-month.



^x New York’s Family Health Plus Medicaid program offers coverage to parents with children under age 21 living in their household, and children aged 19-20 residing with their parents. Note: If there are outstanding medical bills to be paid by Medicaid, those eligible for FHP must first Spenddown in MA before transitioning to FHP.

^{xi} 87 ADM-4.

Methodology

This report is based on a series of interviews with State and local Medicaid officials^{xii}, consumer advocates, providers, and national and State policy experts; analysis of the Federal and State laws, rules, regulations, and program guidance; and a review of relevant literature. See also Appendix A. The report also draws upon data provided by the New York State Department of Health (NYSDOH) and New York City Human Resources Administration on Excess Income recipients' characteristics, utilization, and associated Medicaid expenditures. See also Appendix B and the Data Limitations section below.

The purpose of the report is to document the current administrative procedures and rules for community Excess Income recipients and to make recommendations for simplifying that process for enrollees, providers and the Medicaid agencies that implement the program. Key research questions driving this analysis include:

- What is the current administrative process at the local district level for Excess Income cases? What are the greatest challenges to this process for local districts and beneficiaries?
- What are the characteristics of beneficiaries participating in the Excess Income Program? What are their health care needs?
- To what extent do providers currently play a role in this administrative process?
- What is the State and Federal statutory and regulatory framework that guides implementation of this program?

Initial interviews with State and local Medicaid staff, and consumer advocates highlighted that community beneficiaries face the greatest administrative hurdles to participation in this program, and the greatest administrative burden to local districts. Thus, we focused the remainder of our analysis on the community population.

^{xii} We interviewed State Medicaid officials and Local District Medicaid Commissioners and staff in New York City (HRA), and Erie, Fulton, Onondaga, Schoharie, and Westchester Counties. These six districts were selected based on geographical distribution around the state (upstate, downstate), size, urban/rural, and the Commissioner's interest in participation in this project.

Enrollment Process and Activating Coverage

Medicaid eligibility in New York, including tasks related to Excess Income determinations, is implemented through 58 local departments of social services (“local districts”). Outside New York City, local districts are county agencies; in New York City, the local district is a City agency called the Human Resources Administration (HRA). Local districts report that determining and managing eligibility under Excess Income is among their most complex and time-consuming tasks. Program rules are intricate and require judgment in application. While local districts are required to ensure that program rules are applied in the way that is most advantageous to the recipient, determining how best to achieve that goal is often less than obvious. Participants themselves often are elderly or disabled recipients for whom the program offers access to life- and health-sustaining services, so the stakes for timely and accurate determinations are high. Further, many recipients require extensive assistance in understanding how to comply with program requirements.

The following section describes the rules and processes related to determining and maintaining eligibility for Medicaid recipients under current Excess Income eligibility standards.

ENROLLMENT PROCESS

At initial application, the local district worker calculates the prospective beneficiary’s income in the same manner as is done for any Medicaid applicant. Certain limited expenses—such as those for child care—are deducted from the applicant’s income; however, most living expenses, such as rent or food, are not deductible. The applicant’s net remaining income is then compared to the appropriate Medicaid threshold, according to the applicant’s eligibility category (e.g., pregnant, disabled, or child under 21) and household size. See Table 1 for the Medicaid Standard Income Level—the threshold used for most adults, childless couples, and low-income families—by household size for 2008. If the applicant’s income exceeds the threshold, the worker calculates the “excess income,” the difference between the household’s monthly income amount and either the Medicaid Standard Income Level or the Medically Needy Income Level, whichever is most beneficial to the applicant.^{xiii} These eligibility income levels are very low, ranging from 59% of the Federal poverty level (FPL) to 91% FPL, depending on household size. The worker may perform this calculation for an income accounting period of up to six months. To be eligible for community Medicaid benefits with long-term care, the applicant must also document that his/her resources are below the designated limits.

Table 1 shows these income and resource limits by household size for 2008.

^{xiii} See GIS 08 MA/022, available at http://www.health.state.ny.us/health_care/medicaid/publications/index.htm, last accessed November 20, 2008. Also, in New York, since the MNIL currently is larger than the Standard Level for each household size, the MNIL is generally used for this calculation.

Enrollment Process and Activating Coverage *(continued)*

TABLE 1. New York Medicaid Income and Resources Eligibility Levels, 2008

HOUSEHOLD SIZE	MEDICAID STANDARD INCOME LEVEL		MEDICALLY NEEDY INCOME LEVEL		RESOURCES LIMIT
	Monthly	Annual	Monthly	Annual	
% FPL	59-78% FPL	59-78% FPL	69-91% FPL	69-91% FPL	
One	\$673	\$8,067	\$725	\$8,700	\$13,050
Two	\$840	\$10,070	\$1,067	\$12,800	\$19,200
Three	\$999	\$11,981	\$1,234	\$14,800	\$22,200
Four	\$1,160	\$13,911	\$1,392	\$16,700	\$25,050
Five	\$1,326	\$15,907	\$1,550	\$18,600	\$27,900
Six	\$1,448	\$17,366	\$1,709	\$20,500	\$30,750
Seven	\$1,576	\$18,903	\$1,867	\$22,400	\$33,600
Eight	\$1,740	\$20,876	\$2,034	\$24,400	\$36,600
Each Add'l	\$95		\$159		\$2,850

Source: GIS 08 MA/ 022 available at http://www.health.state.ny.us/health_care/medicaid/publications/index.htm, last accessed Nov 08.

The local district notifies the applicant of the eligibility determination and the excess income amount, if applicable. Since 1987, the State has required all local districts to send with this notice a copy of the “Explanation of Excess Income Program” (DSS-4038) letter, which describes how the applicant can obtain Medicaid coverage by incurring medical bills.^{xv} Since 1996, all districts in New York have offered the option to pay in the excess income amount to obtain Medicaid coverage.^{xvi} Thus, the “Optional Pay-In Program for Individuals with Excess Income” (DSS-4538) form is also included with the determination notice.^{xvii} Workers and consumer advocates note that these forms are insufficient to explain the complex program, and sometimes confusing to the applicant.

For those who have not yet incurred bills or paid in sufficiently to meet the excess income amount, the Medicaid worker indicates in the Welfare Management System (WMS) that the individual is *provisionally* accepted into the Medicaid program (Coverage Code 06). This code does not provide Medicaid benefits to the individual, but holds the individual in the system until such time the excess income amount is met, either by showing bills (also called “spending down”) or by submitting payment for the excess income amount directly to the local districts (also called “paying in”). Individuals can choose whether to spend down or pay in.

ACTIVATION OF COVERAGE USING MEDICAL BILLS: “SPENDING DOWN”

To activate monthly outpatient coverage, the applicant may submit to the local district paid or unpaid medical bills not covered by a third party, such as Medicare, equal to the monthly excess income amount. Once enrolled in the Excess Income Program, the applicant typically must bring in or mail in his/her bills and receipts *each month*; coverage is activated once he/she has accumulated medical expenses equal to or greater than the excess income amount.^{xviii}

^{xiv} 42 C.F.R. § 435.831(a); 87 ADM-4, 96 ADM-15.

^{xv} 87 ADM-4, DSS Form 4038.

^{xvi} 96 ADM-15.

^{xvii} *Id.*

^{xviii} 87 ADM-4.

Enrollment Process and Activating Coverage *(continued)*

The “Explanation of Excess Income Program” (DSS-4038) letter suggests clients make any necessary doctors’ appointments or fill prescriptions in the early part of each month so that—after the excess income amount is met—the recipient has the benefit of a Medicaid card to cover additional medical expenses for that month. However, once activated, coverage is retroactive to the first of that month.^{xx} Alternatively, the applicant may activate six months of full coverage by submitting an incurred inpatient hospital bill that, when combined with any other eligible bills, equals six times the monthly excess income amount. **Table 2** shows the type and length of coverage that consumers may activate by submitting incurred medical bills.

TYPE OF COVERAGE	ACTIVATE COVERAGE	AMOUNT MET	LENGTH OF COVERAGE
Outpatient Coverage	Incurred medical bills or pay in	Monthly excess income amount	Month-to-Month
		2x or more the monthly excess income amount	Two months–Six months
Outpatient Coverage with Long Term Care	Incurred medical bills or pay in; and resources below specified amount.	Same as above	Same as above
Full Coverage (Inpatient and Outpatient)	Showing incurred inpatient or other bills	6x the monthly excess income amount	Six months
	Paying In	6x the monthly excess income amount	Six months
Institutional Care	Applying all net available monthly income (NAMI) to cost of care.	Monthly	Monthly ^{xxii}

*The excess income amount in the retroactive period is calculated using the applicant’s actual income during that period.

Countable Medical Expenses

Medical expenses for covered and non-covered Medicaid services, medical equipment, and prescriptions; bills from Medicaid providers and non-Medicaid providers; coinsurance charges for other insurance such as Medicare; and some over-the-counter expenses as prescribed by a doctor can be used to meet the excess income amount.^{xxiii} Medical bills of legally responsible relatives or those for whom the applicant is legally responsible also may count toward meeting the excess income.^{xxiv}

^{xix} Id.

^{xx} Confirmed with HRA official.

^{xxi} 87 ADM-4.

^{xxii} According to officials at HRA, typically coverage is activated in the system for a year for NAMI recipients, and institutional providers are notified at least monthly via roster of each patient’s NAMI amount, which must be carved out of the bill the provider submits to Medicaid for reimbursement.

^{xxiii} 87 ADM-4.

^{xxiv} 42 C.F.R. § 435.831(d); 18 N.Y.C.R.R. § 360-4.8(c)(1); 87 ADM-4.

Enrollment Process and Activating Coverage *(continued)*

Districts must count the bills in the order that is most beneficial to the recipient. Federal and State regulations require that payments made by the recipient for Medicare and other health insurance premiums, deductibles or other coinsurance charges—such as co-pays—be counted first, then expenses for non-covered services, and finally covered-services.^{xxv} For example, bills from a legally responsible relative, old or paid bills, bills from non-Medicaid providers, or bills for non-covered services (such as chiropractic care) are counted ahead of any bills that would be payable by Medicaid once coverage is activated (i.e., unpaid bills for covered services by a participating provider).^{xxvi}

The age of the bill and whether it has been paid are important to determining its use to meet the excess income amount. (See **Table 3**.) For example, at initial application, unpaid bills incurred *prior* to the three-month retroactive period—known as the pre-retroactive period—may be used to gain eligibility, as long as the provider is still seeking payment for the bills.^{xxvii} Likewise, paid or unpaid bills incurred in the three months prior to initial application—known as the retroactive period—beginning with the month in which the service was received or paid may count. In general, bills may be combined to activate coverage for a period of up to six months; and more than one accounting period may be used (e.g., the retroactive period may be treated as a separate accounting period). However, any balance paid in excess of the six-month liability cannot be carried forward to meet the spend-down liability in future accounting periods. The recipient may seek a refund for the excess paid amount from Medicaid providers, who could then bill Medicaid for the refunded amount. However, the provider has no obligation to do this. In general, portions of *unpaid* bills that have not been used to meet the excess income in a prior accounting period, may be carried forward to meet excess income in the next accounting period, so long as the provider is still seeking payment for the bill, and the recipient has not experienced a break in coverage (e.g., if the recipient failed to meet the excess income in any period).

^{xxv} Federal regulations require these expenses to be deducted from excess income; state regulations at NYCRR 360-4.8(c) require these expenses to be deducted in the following order: first any co-insurance charges paid, then non-covered expenses, then covered expenses. Federal law requires a state to deduct incurred medical expenses in an order based on one of the 3 options: (1) type of service; (2) chronological order by service date; or (3) chronological order by bill submission date. 42 C.F.R. § 453.831(h). New York deducts in an order based on the type of service and requires that expenses be paid in the following order:

- expenses incurred for Medicare and other health insurance premiums, deductibles or other coinsurance charges;
- expenses incurred for necessary medical and remedial services that are recognized under State law but are not covered by Medicaid;
- expenses incurred for necessary medical and remedial services that are covered under Medicaid.

18 N.Y.C.R.R. § 360-4.8(c)(1) Finally, the eligible expenses are prioritized for deduction. First priority must be given to bills that are not payable by Medicaid, such as paid bills, non-covered services, non-participating providers, medical expenses from an LRR whose income is available to the applicant or recipient and co-payments. After that, unpaid viable medical bills can be considered followed by medical bills payable by Medicaid. See 87 ADM-4. The oldest bills must be credited first: first to the retroactive period, then to the month of application and current accounting period then to a prospective accounting period. *Id.*

^{xxvi} *Id.*

^{xxvii} Federal regulations do not limit the age of unpaid medical bills, so long as the provider is still seeking payment for the bill. (42 C.F.R. § 435.831; 87 ADM-4).

Enrollment Process and Activating Coverage *(continued)*

TABLE 3. Incurring Bills to Meet the Excess Income Amount: Timing			
MEDICAL BILL INCURRED	STATUS	SERVICE/ PROVIDER	USE AND ORDER
Pre-retroactive Period	Paid prior to retroactive period	Any	None
	Unpaid, viable	Any	Applied, up to six months <i>at a time</i> , so long as there is no break in meeting the spend-down amount. ^{xxxii} Counted before any unpaid bills from the current period, but after any paid bills from the retroactive or current period.
Retroactive Period	Paid	Any	Applied to meet spend-down for a period of up to six months, beginning with the month of service or payment. Balance cannot be carried forward to meet spend-down in next period. ^{xxxiii}
	Unpaid	Any	Applied beginning with month of service to a spend-down period of up to six months <i>at a time</i> , so long as there is no break in meeting the spend-down amount. ^{xxxiv}
Application Period	Paid	Any	Applied to meet spend-down for a period of up to six months. Balance cannot be carried forward to meet spend-down in future periods. ^{xxxv}
	Unpaid	Covered	Applied to the monthly spend-down. No balance to carry forward as Medicaid pays any remaining balance.
	Unpaid	Non-covered	Applied, up to six months <i>at a time</i> .
After Determined Medicaid Eligible	Paid	Any	Applied, up to six months <i>at a time</i> .
	Unpaid	Covered	Applied to the monthly spend-down. (Medicaid pays any remainder.)
	Unpaid	Non-covered	Applied, up to six months <i>at a time</i> .

Sources: 87 ADM-4 and 96 ADM-15, unless otherwise noted.

^{xxviii} 87 ADM-4.

^{xxix} 96 ADM-15.

^{xxx} 87 ADM-4.

^{xxxi} Id.

^{xxxii} 96 ADM-15. A break in meeting the spend-down amount occurs when the recipient does not have enough medical expenses to meet the spend down in a given period, does not pay-in in that period, or has a "zero" spend-down amount in a period due to a change in circumstance such as income.

^{xxxiii} 96 ADM-15.

^{xxxiv} Id.

^{xxxv} 96 ADM-15.

^{xxxvi} LDSS Interviews.

Enrollment Process and Activating Coverage *(continued)*

Processing and Recording Medical Bills at the Local District

Local districts have varied processes to record the information about incurred medical bills used to meet the excess income amount.^{xxxvi} Some districts have specialty spend-down units, others allow recipients to visit any worker in any community office. Some offices process community and inpatient coverage at the same site, others have separate sites for community cases. Some offices have separate processing for home care clients, inpatient (six months) coverage, and month-to-month cases. In some smaller counties, the eligibility and undercare workers work closely alongside their local districts' adult services offices, which assist with the Medicaid application and monthly activation processes.

Consumers must gather and either mail or bring in their bills to the local district. This sometimes requires consumers to gather many small bills, such as co-pays, and also requires the consumers' attention regarding which bills he/she has used previously to meet the spend-down. This month-to-month administrative process is burdensome for consumers and workers alike. Districts encourage consumers to send or bring in bills toward the beginning of the month in order to activate coverage as soon as possible. A worker then reviews the bills to ensure their viability, whether they sufficiently meet the excess income amount, and that they have not been used previously.^{xxxvii} Sometimes office workers call providers directly to ensure that the providers are still actively seeking payment of the bill from the patient, or to verify what portion is covered by third-party insurance.^{xxxviii} The worker must record information about the bills used to meet the spend down including the provider, bill date, date of service, and amount.^{xxxix} Once a bill has been used in its entirety to meet the spend-down amount in any period, it cannot be used again. Some local district workers noted a significant issue of consumers trying to reuse previously used bills and clients having trouble remembering which bills have been used.

The process requires entering data into at least two different sub-systems within the State's Welfare Management System (WMS). The worker must first check the Medicaid Budget Logic (MBL) sub-system to verify the person's monthly excess income amount. The worker then enters another system to record the bills used: date, amount, and type of service. For this, most districts use the State's Excess Income/Pay In sub-system within WMS, though there are at least two districts that use their own local systems.^{xli} These systems are reconciled overnight by the State's data systems, often requiring that workers re-enter information into the system the following day to verify or complete a transaction. Workers expressed frustration in using multiple systems and screens to record this information.

^{xxxvi} LDSS Interviews.

^{xxxvii} Id.

^{xxxviii} Id.

^{xxxvix} Id.

^{xl} 96 ADM-15.

^{xli} LDSS Interviews.

Enrollment Process and Activating Coverage *(continued)*

If the incurred bills are inadequate to meet the monthly excess income amount, local districts have various methods to contact the consumer for additional bills or payment. At one New York City office, for example, the worker sends a manual notice to the consumer; in Westchester, the bills are recorded in the system, but no notice is sent.^{xlii}

The district also must notify the provider of each bill used to meet the spend-down of the amount that remains the financial responsibility of the recipient to pay.^{xliii} To do so, the district must send the "Provider/Recipient Letter" (DSS 3183), which includes the recipient's name, the type of coverage (i.e., outpatient only, or inpatient and outpatient) and information about which bills from that provider were used to meet the spend-down amount, including the bill date, service date, and amount.^{xliiv} If the recipient is responsible only for a portion of the bill, the provider may bill Medicaid for the remaining balance of the Medicaid rate for that service.^{xlv} If the recipient has used more than one bill to meet the spend-down, the district must send a separate letter to each provider, to maintain patient confidentiality.^{xlvi}

In general, outpatient cases are processed month-to-month, and indeed, the Explanation of Excess Income form provided to consumers focuses *only* on the one-month outpatient (and six-month inpatient) coverage.^{xlvii} Some districts prefer to limit the accounting period to one month because recipients may later submit bills for a given time period, which would trigger a recalculation for the entire accounting period.^{xlviii} In all, this processing of month-to-month cases generally requires an hour or more of case worker time, and generally a two-day processing period from receipt of medical bills to activation of coverage in the system.^{xlix}

^{xlii} Id.

^{xliii} 87 ADM-4.

^{xliiv} Id.

^{xlv} 87 ADM-4.

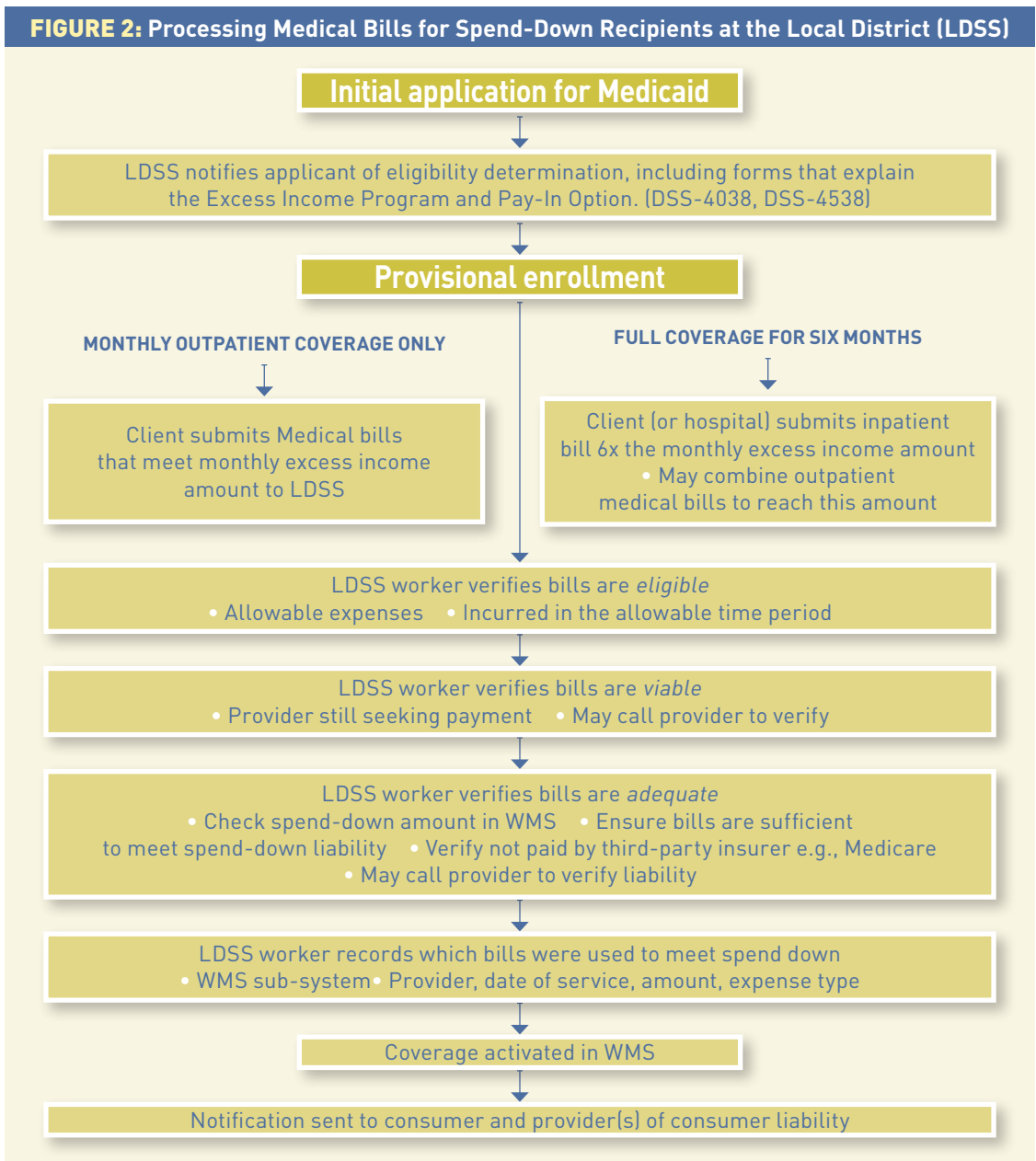
^{xlvi} Id.

^{xlvii} Id.

^{xlviii} LDSS Interviews.

^{xlix} Id.

Enrollment Process and Activating Coverage *(continued)*



Use of Public Program Bills to Meet Spend-down

Any medical expenses incurred or paid by a public program of the State on behalf of the recipient can be used to meet the spend-down amount.^l Some districts have a centralized process for communication with other State public programs regarding spend-down recipient bills.ⁱⁱ

^l 91 ADM-11.

ⁱⁱ For example, New York City.

Enrollment Process and Activating Coverage *(continued)*

Some district workers and consumer advocates noted that where automated systems do not exist, the ability to use public program costs to meet the spend-down was not well-known, and therefore not utilized to its full potential.

ACTIVATION USING PAY-IN OPTION

Federal law gives states the option to allow individuals to pay in their excess income amount to become eligible for Medicaid.^{lii} Since 1996, New York has required all districts to operate a State-approved pay-in program for Medicaid beneficiaries.^{liii} In doing so, the State noted that the pay-in option improves access to medical care by helping to ensure timely authorization of Medicaid eligibility, provides a simplified procedure for those with excess income amounts to achieve and maintain eligibility, and reduces processing time for Excess Income cases.^{liv}

Applicants are informed of the pay-in option with their notices of eligibility determination. Recipients who choose to do so must sign a separate contract with the local district, agreeing to pay in the excess income amount.^{lvi} Most often, recipients choose to pay monthly to get full (inpatient and outpatient) Medicaid coverage; however, paying for a period of up to six months in one lump sum is also allowed.^{lvii} Coverage for a given month is not activated until payment for that month has been received.^{lviii} If the recipient has not met a pay-in obligation for three months, and has not otherwise met the spend-down for those months, the district may terminate the recipient from coverage altogether.^{lix}

Local districts have enormous variation in the means by which pay-in is accepted; some counties do not accept cash, some do not accept personal checks, and some do not accept hand delivery of payment except at specified locations.^{lx} In general, the payment is then routed to the accounting department.^{lxi} In most districts, these functions are performed in the same location, though HRA does not allow consumers to pay in at community offices.^{lxii} Instead, New York City consumers must mail or bring payments to a separate office, the Division of Accounts Receivable and Billing (DARB) office.^{lxiii} An accountant records all pay-ins in a daily log^{lxiv} and the information is updated in the system overnight. At that time, Medicaid workers can view the information and activate coverage for those who have paid in.

^{lii} 42 U.S.C. §1396b(f)(2); See also 18 N.Y.C.R.R. § 360-4.8(4).

^{liii} 18 N.Y.C.R.R. § 360-4.8(c)(4); 96 ADM-15.

^{liv} 96 ADM-15.

^{lv} 96 ADM-15, "Optional Pay-In Program for Individuals with Excess Income" (DSS-4538).

^{lvi} 96 ADM-15.

^{lvii} Id.

^{lviii} Id.

^{lix} Id.

^{lx} LDSS Interviews.

^{lxi} Id.

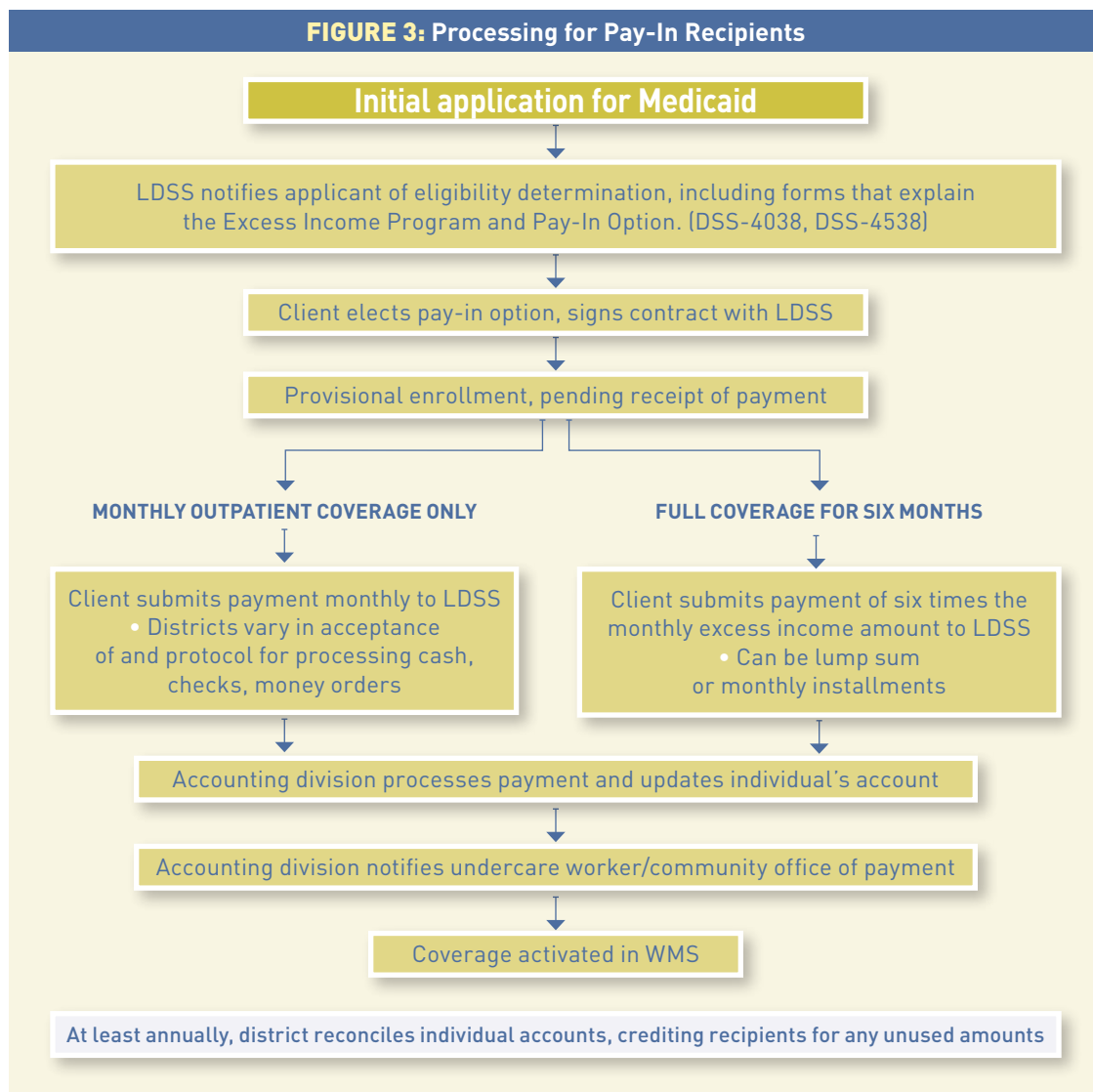
^{lxii} Id.

^{lxiii} Id.

^{lxiv} LDSS Interviews.

Enrollment Process and Activating Coverage *(continued)*

From receipt of payment to activation of coverage, the process generally takes at least two days.^{lxv} Though this is not a substantially different time period than that for processing bills, the pay-in process typically is less administratively burdensome for consumers and workers alike. At least one small county encourages consumers to pay in, rather than spend down. Approximately a quarter of recipients outside New York City choose to pay in.^{lxvi} However, this figure varies substantially among counties, from 63% of Excess Income participants utilizing pay-in in Cattaraugus, to 6% in Chautauqua. (Figures for New York City are not available.)



^{lxv} Id.

^{lxvi} NYSDOH data. In 14 counties, NYSDOH data indicates no pay in recipients. It is unclear whether this is attributable to lack of data or no participation in pay-in in those counties.

Enrollment Process and Activating Coverage *(continued)*

Some recipients use a combination of both spend-down and pay-in. The pay-in amount must be reduced by any applicable medical expenses incurred for that time period.^{lxxvii} In the case where the recipient pays in and later submits a medical expense for that time period, the district may either credit the recipient's next pay-in period or refund the amount to the recipient.^{lxxviii}

Local district offices must periodically—and at least annually—perform “reconciliations” of each individual's pay-in account and refund or credit the recipient any amount paid in and not used for medical expenses.^{lxxix} In large offices, this happens annually. Some smaller offices conduct the reconciliation more frequently. Paying in sometimes presents a financial hardship for beneficiaries.^{lxxxii} Any amounts the consumer has paid in are “locked” until a reconciliation is performed. The reconciliation process also creates an added layer of processing for the program, which some districts noted is burdensome and time-consuming.

In lieu of the usual pay-in option, one local district has a “Relief Repayment” system that is similar to the pay-in option, but allows prospective coverage.^{lxxxiii} Consumers agree to pay the excess income amount each month for a year and are activated for a year's worth of coverage.^{lxxxiv} This is useful in that it eliminates the need for workers to “touch” each case monthly, and prevents disruptions of coverage month-to-month. If the consumer does not pay the excess income amount for three consecutive months, the local district switches the account to a spend-down account, and the consumer must show incurred bills month-to-month to activate coverage.^{lxxxv} At the end of the year, any unused amounts from the relief repayment are refunded to consumers. This prospective activation of coverage eliminates breaks in coverage for recipients, and relieves the burden of month-to-month processing at the district.

PROVIDER ACCESS AND INTERACTION

Currently, providers have limited access to patients' coverage information. While providers can directly view whether a patient's Medicaid coverage is active,^{lxxvii} they cannot see whether a recipient is enrolled through the Excess Income Program. Therefore, recipients with provisional coverage—those who have not spent down or paid in a given month—will appear to have no Medicaid coverage to providers. The provider must call or otherwise contact the local district to learn if this patient is an Excess Income recipient, and the amount of the excess income.^{lxxviii} This process consumes provider and worker time, and is sometimes difficult for providers to get in a

^{lxxvii} 96 ADM-15.

^{lxxviii} Id.

^{lxxix} 18 N.Y.C.R.R. § 360-4.8(c)(4)(i)(d); 96 ADM-15.

^{lxxx} LDSS Interviews.

^{lxxxi} Id.

^{lxxxii} Id.

^{lxxxiii} Id.

^{lxxxiv} Id.

^{lxxxv} Id.

^{lxxxvi} Id.

^{lxxvii} Interviews with SDOH and DSS workers.

^{lxxviii} Interviews with SDOH, DSS workers, and providers.

Enrollment Process and Activating Coverage *(continued)*

timely manner.^{lxxix} Some local districts, including HRA, limit provider's access via phone to certain days/hours per week, and number of inquiries per phone call.^{lxxx} This may hinder the receipt of timely care, as some providers will not provide services to a patient until the status of the health insurance coverage has been verified.

USE OF SUPPLEMENTAL NEEDS TRUSTS

Supplemental Needs Trusts provide an option for disabled individuals to qualify for public benefits, including Medicaid.^{lxxxi} Community Medicaid beneficiaries, who would otherwise have an excess income amount, may put some or all of their monthly income in the trust, which then pays for certain living expenses—such as rent, electricity, food, or clothing—on behalf of the beneficiary.^{lxxxii} The income sent to the trust is not counted in the Medicaid eligibility determination, providing a way for enrollees to be eligible for Medicaid without excess income.^{lxxxiii} By Federal law, disabled beneficiaries of any age are eligible to participate in these trusts.^{lxxxiv} While consumer advocates encourage the use of these trusts as a means to gain Medicaid eligibility, they note that consumers sometimes find it difficult due to substantial upfront costs of participation.^{lxxxv} While some local district workers inform consumers of this option, most districts do not; and some districts viewed participation as cheating the system.^{lxxxvi}

^{lxxix} Id.

^{lxxx} HRA Interview, Visiting Nurse Service of New York Interview.

^{lxxxi} Bogart, Valerie, "Supplemental Needs Trusts," Selfhelp Community Services, Revised October 2007.

^{lxxxii} Id and 18 NYCRR § 360-4.3(e).

^{lxxxiii} Id and 96 ADM-8.

^{lxxxiv} 42 U.S.C § 1396p(d)(4)(A) and (C).

^{lxxxv} Interviews with consumer advocates in New York City.

^{lxxxvi} Interviews with local districts.

Characteristics and Health Care Needs of Excess Income Enrollees

Community Excess Income enrollees are largely elderly (38%) or disabled (56%). The vast majority (86%) are dually eligible for Medicare and Medicaid.^{lxxxvii} Recipients often live on fixed incomes, typically receiving retirement and disability payments through Social Security. The average age of “spend-down” enrollees is 61 years; half are 62 years or older.^{lxxxviii} Likewise, the average age of those who pay in is 63 years, and half are 64 years or older. Only a handful of parents (4%), children (1%) and pregnant women (<1%) in the community participate in the program.^{lxxxix} These groups also are much more likely than the aged and disabled to have provisional—rather than active—coverage.

While Excess Income enrollees represent a small proportion of the total Medicaid population, many of these recipients have chronic health conditions and require intensive or ongoing care. Total annual Medicaid expenditures for community Excess Income recipients are estimated to approach \$900 million. On average, Medicaid spends \$19,000 per community Excess Income enrollee. For the large majority of these beneficiaries who are dually eligible, Medicaid acts as a secondary payer, which means that this figure understates the full scope of the health care needs and costs of this population.

DATA LIMITATIONS

Data for New York’s Excess Income population is very limited and has not been intensively analyzed previously.^{xc} New data compiled specifically for this report by NYSDOH and HRA describe the characteristics, utilization patterns, and associated Medicaid costs of a cohort of community outpatient beneficiaries who had Medicaid coverage in October 2007. Both those who activated their coverage by spending down or paying in that month (“active enrollees”) and those who were enrolled, but who had not activated their coverage, in that given month (“provisional enrollees”) are included in the data. Those who had coverage but no Medicaid expenses (“utilization”) during that month are also included in the data.

Due to data limitations, it is not possible to conclusively report *statewide* costs, characteristics or utilization for this population. While data on enrollment, cost, and utilization for Excess Income enrollees in counties outside of New York City are available, data irregularities discovered by NYSDOH in the course of this research render the NYSDOH data for New York City largely unusable. Thus, HRA provided supplemental data that were substituted for the New York City enrollment data reported by NYSDOH to approximate statewide totals. Enrollment information on institutional care enrollees in New York City was not available from HRA, nor were equivalent cost and utilization data.

^{lxxxvii} NYSDOH data.

^{lxxxviii} Id.

^{lxxxix} Id.

^{xc} To the authors’ knowledge.

Characteristics and Health Care Needs of Excess Income Enrollees *(continued)*

Despite these limitations, it is possible to make a number of important observations from the available data. A statewide estimate of community Excess Income program enrollment levels is possible by combining NYSDOH and HRA data. For characteristics, cost and utilization of community enrollees, reliable data from NYSDOH on residents outside of New York City is available, and statewide data that undercounts New York City enrollment also exists. While it is possible that there is a systematic bias in the missing New York City data, there is no reason to suspect that the data are skewed, nor does there appear to be any discernable pattern of bias in the data. As such, we have reported statewide estimates that represent an up-weighting of the New York City cost and utilization, derived from the data provided by NYSDOH. We have drawn some conclusions about New York City and statewide cost and utilization patterns based on this data, which we present in this report with appropriate caveats.

ENROLLMENT AND PARTICIPATION

New York's Excess Income Program provides coverage to at least 150,000 individuals, more than half of whom live in institutional care settings, such as nursing homes.^{xcii} Approximately 67,000 live in the community; most are elderly or disabled and have either had an inpatient hospital stay, or have ongoing or significant outpatient medical costs. The remaining enrollees—at least 82,000, possibly significantly more due to possible underreporting of these enrollees in New York City—live in institutional long-term care. Of the non-institutional enrollees, 61,000 either spend down or pay in to obtain coverage; the remaining obtain coverage as a result of a hospital stay. Roughly half of community Excess Income enrollees live in New York City. Of community recipients outside of New York City, approximately three-quarters are spend-down, and approximately one-quarter pay in. Reliable information on the distribution of spend-down and pay-in recipients in New York City is not available.

Of all community Excess Income enrollees, roughly one-quarter do not activate coverage in a given month, meaning that they are only “provisionally” enrolled and do not receive any Medicaid benefits. These proportions vary significantly by region. In New York City, almost 90% of Excess Income enrollees activate coverage in a given month, while upstate the proportion is closer to 60%. New York City residents make up half of the total statewide enrollment in the Excess Income Program, but account for 60% of the total active enrollee population. Enrollees may be provisional—or inactive—in a given month for a number of reasons. If the beneficiary's medical costs are insufficient to meet the spend-down, the coverage remains provisional. Administrative processing issues—such as submission of payment or bills late in the month, or confusion or error on the part of the beneficiary, provider, or agency—also can result in a failure to activate coverage. Finally, some beneficiaries forgo care or payment due to the inadequate financial resources to cover their spend-down obligations.

^{xcii} Base data provided by NYSDOH for October 2007. Due to apparent underreporting of data on enrollment in New York City in the data provided by NYSDOH (the cause of this undercount has not yet been determined, but is under investigation by NYSDOH), supplemental data was collected from the New York City Human Resource Administration (HRA) for October 2007. The data provided by HRA was substituted for the New York City data provided by NYSDOH to yield the reported statewide totals. HRA was unable to report data on institutional care enrollees for New York City - the total shown reflects the data obtained from NYSDOH, which may significantly undercount institutional care enrollees in New York City, as was observed in the case of inpatient and community care spend-down recipients.

Characteristics and Health Care Needs of Excess Income Enrollees *(continued)*

Table 4. Excess Income Enrollees, October 2007

METHOD TO ACHIEVE ELIGIBILITY OR ACTIVATE COVERAGE	NUMBER OF ENROLLEES ^{xcii}		
	ACTIVATED COVERAGE IN SAMPLE MONTH	DID NOT ACTIVATE COVERAGE IN SAMPLE MONTH	Total
Community Spend-down in NYS Excluding NYC	9,565	13,346	22,911
Community Pay-in in NYS Excluding NYC	7,916	16	7,932
Community Excess Income in NYC Including Spend Down and Pay In ^{xciii}	26,968	3,192	30,160
Total Community Outpatient (Statewide)	44,449	16,554	61,003
Inpatient Hospital Stay	5,804	N/A	5,804
Institutional Care ^{xciv}	82,285	N/A	82,285
Total Excess Income Program (Statewide)	132,538	16,554	149,092

Note: The limitations of this data are described in the endnotes, as well as an accompanying methodological memorandum, available upon request.

AVERAGE EXCESS INCOME AMOUNT

Due to data limitations, no statewide data exist regarding average excess income amount, nor are there data on excess income amounts available for community beneficiaries who spend down. For those who pay in, monthly excess income amounts outside of New York City average \$155, with a median of \$85. A small number of enrollees have very high excess income amounts, but half of pay-in recipients have excess income amounts of \$85 or less. Statewide data suggest that excess income amounts among those who pay in in New York City are much higher, averaging \$200 or more with a median of more than \$100 per recipient. For those who spend down, community office managers in New York City estimate that the majority have excess income amounts of \$200 or less; the bulk of the remaining recipients have excess income amounts between \$200–\$400, and only a small proportion of recipients have excess income amounts of more than \$400 per month.^{xcv}

COSTS AND UTILIZATION OF COMMUNITY EXCESS INCOME ENROLLEES

Community Excess Income enrollees typically have ongoing and critical health care needs. Of those who activate coverage in a given month, either by spending down or paying in, about 85% have medical costs above and beyond the spend-down amount in that month that are reimbursed by Medicaid. On average, the State spends roughly \$19,000 per beneficiary per year, to cover Excess Income recipients in the community. As a comparison, in 2007, the average expenditure for all Medicaid enrollees in New York State (including those in institutional care) was less than \$11,000 per enrollee per year, roughly 55% of the average cost for Excess Income enrollees.^{xcvi} Average expenditures per active Excess Income beneficiary in any given month were \$2,100, though those who pay in have significantly lower monthly expenditures on average than those who spend down (\$1,500 and \$2,500, respectively).

^{xcii} Sample month is October 2007.

^{xciii} Data obtained from HRA did not permit a clear delineation of community spend-down and community pay-in enrollees.

^{xciv} Institutional care includes private and public skilled nursing facilities as well as private and public health related facilities. Recipients in these facilities achieve Medicaid eligibility by contributing their Net Available Monthly Income (NAMI) toward the cost of care. This total may significantly undercount enrollees in New York City, and thus understate total enrollment.

^{xcv} According to data provided by HRA, by email, October 2008.

^{xcvi} NYSDOH Medicaid Quarterly Reports—Calendar Year 2007.

Characteristics and Health Care Needs of Excess Income Enrollees *(continued)*

The data suggest significant variation among the population, with a few very high-cost enrollees and many lower-cost beneficiaries. The median cost per month is significantly lower than the average—for those who pay in, the median expenditure falls in the range of \$400–\$500; for those who spend down, the median expenditure is in the range of \$800–\$1000.

Dually-Eligible Enrollees

For the more than 86% of beneficiaries who are dually eligible for Medicare and Medicaid, Medicare is the primary payer, and Medicaid acts as secondary coverage. For those eligible for full Medicare coverage (Medicare Parts A and B), Federal funds pay for most primary care, specialty care, imaging, labs, and hospital inpatient care costs. Virtually all dual-eligibles also have coverage under Medicare Part D, under which Federal funds cover the bulk of prescription costs. Medicare outpatient (Part B) coverage has a monthly premium of approximately \$96 per person, as well as a significant co-insurance charge for most services.^{xcvii} Recipients may use these costs to meet their excess income amount, or, once activated, Medicaid may cover these costs for certain recipients.^{xcviii} Because Medicare covers a significant portion of total health care costs for full dually eligible individuals, the total cost of health care per dually eligible Excess Income recipient is likely much higher than the monthly costs reported here, which reflect only those portions covered by Medicaid. Nevertheless, Medicaid costs for these recipients are substantial, in part due to limitations in Medicare covered services. For example, Medicare does not provide coverage for long-term home care services.^{xcix} This can be a substantial sum for elderly or disabled enrollees who require long-term care. Additionally, Medicare currently covers only a limited portion of mental health costs; and costs for eye care, dental care, podiatry, and some outpatient prescription drug costs are covered solely by Medicaid.^c

Overall Medicaid Costs of Community Excess Income Recipients

While on average, the State spends \$2,100 or more per active beneficiary per month, or \$19,000 per year, to cover Excess Income recipients in the community, beneficiaries in New York City have significantly higher costs than beneficiaries who live in the rest of the State. New York City residents have average Medicaid costs of roughly \$2,400 per month and \$24,000 per year. In contrast, non-NYC residents have average Medicaid costs of roughly \$1,600 per month and \$14,000 per year.

Those who pay in have significantly lower monthly expenditures, on average, than those who spend down. Statewide, Medicaid expenditures for pay-in beneficiaries are an estimated \$1,500 monthly and \$14,000 annually, on average. In contrast, Medicaid expenditures for spend-down beneficiaries statewide are an estimated \$2,500 monthly, and \$23,000 annually, on average. This holds true for both beneficiaries living in New York City and those living outside of New York City.

^{xcvii} Birnbaum, M. "The Costs and Policy Implications of Covering Dual Enrollees of Medicaid and Medicare." United Hospital Fund, April 2006.

^{xcviii} Medicaid covers the cost of Part B premiums for individuals in all category groups, and the cost of co-insurance for Qualified Medicare Beneficiaries (QMB) or QMB Plus categories. For a full list and description of categories and corresponding Medicaid coverage, see http://www.cms.hhs.gov/DualEligible/02_DualEligibleCategories.asp, last accessed March 4, 2009.

^{xcix} Dual eligible Medicare beneficiaries in the following categories are eligible for full Medicaid benefits: Medicaid Only, QMB Plus, SLMB Plus. For a full description of the different categories, see http://www.cms.hhs.gov/DualEligible/02_DualEligibleCategories.asp. See also, Birnbaum, M. "The Costs and Policy Implications of Covering Dual Enrollees of Medicaid and Medicare." United Hospital Fund, April 2006.

^c Id.

Characteristics and Health Care Needs of Excess Income Enrollees *(continued)*

TABLE 5. Monthly and Yearly Average Expenditures for Community Recipients

Community Recipient Type/Region	Number of Enrollees ^{ci}	
	Monthly Average Expenditures ^{cii}	Yearly Average Expenditures ^{ciii}
New York City Recipients	\$2,434	\$24,231
Rest of State Recipients	\$1,628	\$14,330
Pay-In Recipients	\$1,450	\$14,301
Spend-Down Recipients	\$2,531	\$22,556
Total Community Recipients Statewide	\$2,090	\$19,454

Note: The limitations of this data are described in the endnotes, as well as an accompanying methodological memorandum, available upon request.

Cost and Utilization Patterns of Community Excess Income Enrollees

A review of the cost and utilization patterns of community Excess Income enrollees is an important component of developing targeted initiatives toward streamlining enrollment and activation of benefits for this population. Figures 4 and 5 reflect the cost and utilization by service for community Excess Income recipients who are active and have received Medicaid benefits (payment for services) during the reference period. Data were provided by NYSDOH, and adjusted to account for the undercount in New York City enrollment (detailed above) based on enrollment data provided by HRA.^{civ}

Data are reported in two ways: (1) monthly cost and utilization for active community Excess Income program recipients in October 2007; and (2) yearly cost and utilization for all community Excess Income program enrollees (active or provisional) in the October 2007 cohort who received Medicaid benefits through the Excess Income program at any time during the year October 2007–September 2008. The monthly and yearly analyses reveal substantively different patterns of cost and utilization. While monthly numbers reflect only those recipients who were active in a given month, yearly sums include all recipients who were active at any time during the year. Thus, the yearly costs reflect a larger cohort of recipients. Each data set provides important information as it relates to the streamlining initiatives proposed in this report.

Overall, home health care accounts for more than half of all monthly Medicaid expenditures associated with community Excess Income enrollees. For New York City enrollees, home health care accounts for more than 70%—for non-NYC residents, it is closer to 40%. By comparison, home health care accounted for only 4% of Medicaid costs for Medicaid beneficiaries in 2007.^{cv} Aside from home health care, no other single service category accounts for more than 15% of total costs.

^{ci} Sample month is October 2007.

^{cii} Reflects all recipients with Medicaid costs in October 2007.

^{ciii} Reflects full-year Medicaid costs for the year Oct 2007–Sept 2008 for all enrollees from the October 2007 cohort.

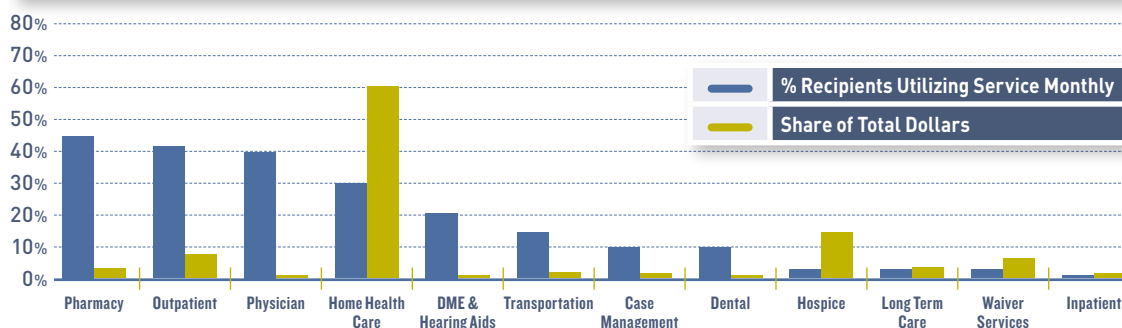
^{civ} Monthly and yearly data on the cost and utilization of community excess income program enrollees (spend-down and pay-in) from the October 2007 cohort (individuals enrolled in the community excess income program as of October 2007) were provided by NYSDOH. Data were reported separately for enrollees in New York City and Rest of State. Statewide monthly and yearly cost and utilization levels were estimated based on aggregation of spend-down and pay-in enrollees, and an upweighting of reported New York City enrollee cost and utilization based on New York City enrollment levels provided by HRA.

^{cv} Id.

Characteristics and Health Care Needs of Excess Income Enrollees *(continued)*

On a monthly basis, after home health, the next largest cost centers are hospice care, outpatient visits, and waiver services. Ranking services by the proportion of Excess Income recipients that utilize them, we find that monthly, more than 40% of excess income program enrollees utilize pharmacy, outpatient and physician services, and 30% utilize home health care.

Figure 4: Cost and Utilization of Services by New York State Community Excess Income Program Recipients, October 2007



Source: Data provided by the New York State Department of Health and adjusted to account for the undercount in New York City enrollment based on enrollment data provided by the New York City Human Resource Administration.

On a yearly basis, home health care remains the largest cost center, again accounting for more than half of the total Medicaid costs associated with community Excess Income program beneficiaries. However, the portion of beneficiaries utilizing home health care is not significantly higher in the annual data than the monthly data, suggesting that those utilizing home health care do so on a consistent basis throughout the year.

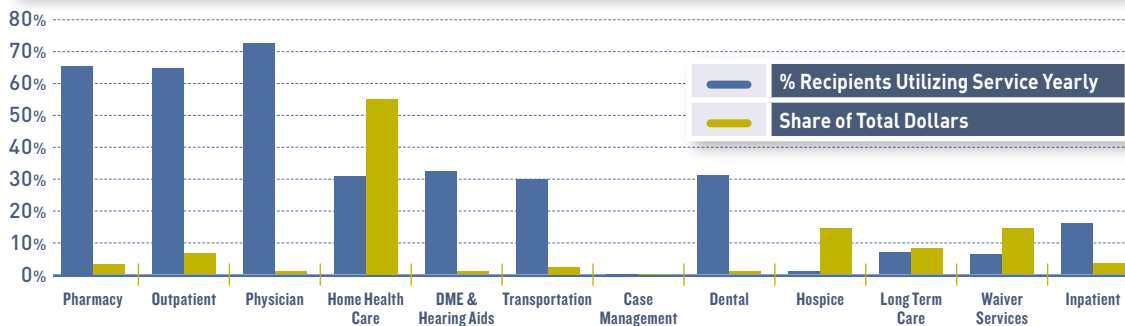
In contrast to the consistent use of home health care, the proportion of enrollees utilizing other key services increases substantially when considered on a yearly basis. While physician services, outpatient care, and pharmacy remained those services used by the largest proportion of beneficiaries, the numbers increased substantially—from roughly 40% utilizing each of these services monthly to more than 60% utilizing them yearly. A similar increase can be observed in durable medical equipment, dental services, home health care and transportation. Waiver services, inpatient and institutional long-term care rank among the largest cost centers annually, with a significantly higher share of recipients utilizing these services on an annual basis.

Comparing the results for monthly and yearly utilization, it is clear that a significant number of community recipients may use certain high-cost services—such as short-term institutional care or inpatient admissions, at some point during the year—but not necessarily on a monthly basis. While this pattern might be expected in the case of inpatient admissions or other intensive services, it is more surprising in an area like pharmacy, where consistent utilization might be expected among a generally high-cost, high-need population.^{cvi}

^{cvi} Note that the findings of high hospice and case management utilization in the monthly data as compared to the yearly data may represent a data anomaly, an outlier month, or a policy change relative to Medicaid reimbursement for these services. Additional research would be necessary to determine the cause of these counterintuitive findings.

Characteristics and Health Care Needs of Excess Income Enrollees *(continued)*

Figure 5: Cost and Utilization of Services by NYS Community Excess Income Program Recipients, October 2007–September 2008



Source: Data provided by the New York State Department of Health and adjusted to account for the undercount in New York City enrollment based on enrollment data provided by the New York City Human Resource Administration.

For those who spend down, utilization patterns largely mirror the overall patterns described above. Home health care accounts for roughly two-thirds of the total monthly costs, and closer to 80% of total monthly costs in New York City. Otherwise, the cost and utilization patterns of spend-down recipients do not differ significantly from the program overall, likely because these enrollees account for the majority of participants.

Utilization among the community pay-in population follows fairly similar patterns to those who spend down, except for home care. While home care remains the largest category, it accounts for only one-third of costs among the pay-in population, compared to over 60% of the costs among the spend-down population. In terms of costs, as for the overall population, home health care is followed by waiver services and outpatient care on a monthly basis, and waiver services, long-term care, and outpatient care on a yearly basis. In terms of the number of enrollees utilizing a given service, the largest cost centers do not differ significantly from the spend-down population, except that only 20% of pay-in beneficiaries utilize home health care, as compared to 30% for the spend-down population, on a yearly basis.

For additional cost and utilization details, see Appendix C.

Options for Streamlining the Excess Income Program

While no one-size-fits-all approach could adequately address the need to streamline this complex program for all beneficiaries, the following options could help alleviate process burdens and increase access, while decreasing the likelihood for breaks in coverage and delays in much-needed care. These options range from “big ideas” that would revamp portions of the program and thus require changes in Federal or State guidance, to “smaller” ideas that are possible within current program rules and thus may be more immediately actionable. No single option is intended to replace the existing system. Rather, the options offer additional flexibility to provide for consumers with diverse needs.

CREATE A BUY-IN FOR EXCESS INCOME PARTICIPANTS

One option for streamlining is to allow Excess Income participants to buy in to Medicaid coverage through payment of a flat premium. Instead of an individually tailored pay-in amount, the recipient would be responsible for paying a flat fee premium based on a sliding scale according to the beneficiary’s income. The flat fee premium would be calibrated to be lower than the participant’s current pay-in amount to incentivize consumers to utilize the buy-in option rather than simply paying in or spending down with bills.

The primary benefit of creating a buy-in is the administrative simplification that comes with replacing the spend-down calculation with a sliding scale flat fee premium. Local districts would no longer be required to collect and track bills for buy-in participants, nor would they be required to conduct a reconciliation of each individual’s account and refund or credit consumers for amounts paid in, but not used toward medical care.

However, the low participation in the pay-in option under the current program indicates that simply replacing the current spend-down amounts with an equivalent flat fee premium would help a small fraction of program participants. Thus, the buy-in amount should be set lower than an individual’s pay-in amount, increasing program accessibility for consumers and enticing those who currently gather and submit medical bills to take advantage of the administrative simplicity of a monthly premium activation process.

To implement this option, the State would need to seek Federal approval for a Section 1115 waiver, which allows states to depart from Federal rules. Because waiver requests must be “budget-neutral,” New York would need to show that the buy-in option will not cause Federal Medicaid spending to increase. It is possible that the budget-neutral requirement could be satisfied by combining this option with other programs in New York’s existing comprehensive 1115 waiver demonstration program.^{cvi}

^{cvi} New York currently has a Medicaid Buy-In for the Working Disabled which, under Federal law, is available only those who can perform work. The option we propose would be available to all those who are eligible for the Excess Income program, regardless of ability to perform work and regardless of disability status (e.g., elderly, non-disabled). Further, the Medicaid Buy-In Working Disabled requires that premiums be set as a percentage of individual’s earned and unearned income, which lacks the administrative simplicity of the option proposed here which would require lump sum premiums based on the range in which an individual’s gross income falls. In New York State, premiums of 3% of earned income plus 7.5% of unearned income are required for those who participate in the Medicaid Buy-In program for the Working Disabled, for those whose income exceeds 150% FPL. Though, it should be noted that no premiums have been collected to-date due to the administrative difficulty of implementing the automated collection and premium tracking system required for this program. (SSL §366.1(a)(12) and SSL §366.1(a)(13); 06 ADM-4, 04 OMM/ADM-5, 03 OMM/ADM-4, GIS 03MA009).

Options for Streamlining the Excess Income Program *(continued)*

OPTIMIZE MEDICARE-MEDICAID INTEGRATION AND ALIGNMENT

A second, and more far-reaching option, would be to align the needs of Excess Income participants with emerging State and Federal policy goals related to the dual-eligible population. While only 12% of Medicaid recipients statewide are dually eligible for Medicare, expenditures on these recipients represent 42% of total Medicaid costs.^{cvi} The high needs and costs of this population have prompted State and Federal efforts to seek alignment of Medicare and Medicaid payments for dually eligible populations through fully capitated managed care plans including Medicaid Advantage Plus (MAP) and Programs of All-Inclusive Care for the Elderly. To date, these efforts have met with mixed results; as of January 2009, for example, only 420 people statewide were participating in Medicaid Advantage Plus plans. Poor participation has been linked, in part to a host of administrative challenges at the State and Federal level. Most recently, however, New York State has indicated its intent to aggressively pursue the enrollment of dual eligibles in managed care plans. The State has recently reinvigorated its efforts to encourage MAP plans, and is working with the new Federal administration to ease hindrances at the Federal level. Given that more than 86% of Excess Income participants are dually eligible for Medicare and Medicaid,^{cix} pursuing potential synergies in administration or processing for these enrollees could simplify the program for consumers, while aligning with State policy goals.

Specifically, New York could craft a managed care buy-in option for dually eligible Excess Income recipients. This option would utilize a flat fee premium similar to the buy-in, and based on a sliding scale. Like the buy-in, this option would be significantly less burdensome administratively than the Excess Income program because it would preclude the need for the consumer and the local district to sort through monthly paperwork, and also preclude the need for the local district to perform the annual reconciliation. Also, enrolling these recipients in both Medicare and Medicaid managed care could bring significant additional benefits, including ensuring coordination of care, alignment of payments from Medicare and Medicaid, and maximization of Federal funds.^{cx}

Given the enormous medical complexity of this population, the potential for care coordination to provide improved quality and efficiency is substantial. Further, one of the responsibilities of the plan would be to ensure that all enrollees are taking full advantage of federal Medicare reimbursement. Thus, the plan structure becomes a vehicle for coordinating multiple funding streams and benefits, and interfacing with the recipient on eligibility and payment issues.

In order to incentivize consumer participation in a managed care plan and to ensure that more people would be able to afford to participate, the flat fee premium should be set substantially below the recipients' current excess income thresholds. Not only is this a financial issue for most recipients—as evidenced by the low participation in the current pay-in option under the Excess

^{cvi} Birnbaum, M and Leslie Powell, "Managing Care for High-Cost Elderly Duals: A Challenge for Medicaid" United Hospital Fund, September 2008.

^{cix} Of the 67,020 non-pay-in community spend-down enrollees in January 2007, 14,069 (21%) are aged, 21,172 (32%) are disabled, and 32,459 (48%) are dually eligible. Note that there is likely to be overlap in these categories. Data provided by NYSDOH in July 2008.

^{cx} Because community Excess Income recipients typically must activate monthly under current rules, they may be less likely to be enrolled in certain categories for dual-eligibles that draw down additional Federal funds (e.g., QMB and SLMB). Enrolling these beneficiaries for longer periods would thus also optimize draw-down of additional Federal funds to support them. Previous research suggests that a significant proportion of beneficiaries eligible for QMB are not enrolled in the program. See <http://archive.gao.gov/t2pbat4/150626.pdf>.

Options for Streamlining the Excess Income Program *(continued)*

Income Program—but some recipients may be concerned about disruptions in provider relationships or loss of control due to joining a managed care plan. Because enrollment in a managed care plan for Medicare beneficiaries is optional under Federal law, participation could not be mandated. Lower flat fee premiums are likely to go a long way to overcoming these barriers. The State also should provide a period of guaranteed eligibility, as is done under Medicaid Managed Care generally in the State, subject only to the beneficiaries' payment of the flat fee premiums. Finally, to maximize the potential benefits of managed care, the State should extend the period of eligibility from the current six months to a full year, as is currently provided under Medicaid generally.

Implementation of this option would require a Federal waiver. However, unlike the buy-in option outlined above, the potential cost savings from an increased level of coordination of care, and maximization of Medicare funds for this chronic need population are likely to be significant, perhaps even sufficient to offset any increase in costs.

SIMPLIFY ACTIVATION OF COVERAGE

A principal challenge under the Excess Income Program is the monthly activation of coverage. Typically for community Excess Income participants, activation involves the flow of information between multiple points of contact—the recipient, providers, and Medicaid—before coverage can be activated and services paid. The provider bills the recipient, the recipient submits the bill to the local district, the provider bills Medicaid, and Medicaid pays the provider. The following section explores options to reduce these multiple points of contact and reduce the burdens related to activation of coverage generally.

Implement a Prospective “Plan of Care” Option

Interviews with local districts suggest that many consumers present the same type of bills month after month to meet the excess income amount.^{cx1} Automating the process for proving these expenses would have multiple benefits including reducing or eliminating breaks in coverage for those with chronic illness, such as those who require home care, prescriptions, mental health care, dialysis, and other ongoing services. Under this option, consumers who have ongoing needs could present to the district a provider “Plan of Care,” which would state the patients' ongoing medical needs and likely costs. The district would then prospectively activate consumer coverage for a period of up to six months.

A prospective plan of care approach has been used previously by HRA in a pilot project with the Visiting Nurse Service of New York, one of the largest home health care providers in the State. The pilot allowed those with relatively low excess income amounts, and relatively high and ongoing costs of care, to activate coverage prospectively. Those with excess income amounts of \$200 or less could be automatically and prospectively activated for coverage for up to six months at a time; those with excess income amounts between \$201–\$400 could be prospectively activated for up to four months at a time. All others could activate monthly. Through the pilot, approximately 1,000 spend down patients were able to activate coverage; of these, approximately 40% had monthly excess income amounts between \$1 and \$200; another quarter had excess

^{cx1} Westchester Interview, DSS Interviews.

Options for Streamlining the Excess Income Program *(continued)*

incomes that range from \$200–\$400; and the remaining clients had monthly excess income amounts of \$400 or more. This pilot ran for several years, but was suspended by mutual consent between HRA and Visiting Nurse Service of New York while the agency reassesses changing utilization patterns in certified home health aide services.^{cxii}

While prospective activation of coverage would eliminate the risk of breaks in activated coverage, the district could still satisfy the requirements of the current Excess Income Program by processing bills as they are received each month for the recipient. Alternatively, the district could perform this check every few months. In the case where the provider plan of care is not met, the district could inform the recipient that he/she will need to revert to normal spend-down processing requirements. For the district to be assured the consumer remained in the provider's care, and that the provider continued to bill the consumer for the excess income amount, a systematic verification process would be needed. One possibility would be to utilize the forthcoming long-term care regional assessment centers, or the statewide enrollment center, to verify this information.

Implementing this practice statewide likely would require a waiver. Under the general medically needy spend-down statutory authority, states must take into account—except to the extent prescribed by the Secretary—the costs incurred for medical care.^{cxiii} Federal regulations state that an expense is “incurred” on the “date liability for the expense arises.”^{cxiv} Under Federal guidance, “incurred expenses” are those expenses that are “(a) recognized under state law; (b) rendered to an individual, family, or financially responsible relative, and for which the individual is liable in the current accounting period or was liable in the three-month retroactive period.”^{cxv} “Incurred expenses” are separate from “projected expenses,” which are “expenses for services which have not yet been incurred, but are reasonably expected to be.”^{cxvi} Significantly, a state may not project medical and remedial care expenses that are not for institutional care services (excluding acute care facility services).^{cxvii} Nevertheless, using an 1115 Waiver, the State could waive the governing Federal statute authorizing these regulations. Alternatively, the State could request that the new Federal administration modify the Federal regulations to permit prospective expenses.

Streamline Communications Between Home Care Agencies and Local Districts Outside New York City

Aside from the Visiting Nurse Service of New York pilot described above, most home care agencies in New York City work directly with HRA to submit bills in batches monthly, reducing the burden on the recipient to send or bring bills to the HRA community office to activate coverage for the month. Outside New York City, however, approximately 36% of recipients who spend down each month and 23% of recipients who pay in each month utilize home care services, with a relatively large monthly cost per recipient (\$2,600 and \$1,600, respectively). Yet, not all counties

^{cxii} Information from the Human Resources Administration, via email, March 2009.

^{cxiii} 42 U.S.C. § 1396a(a)(17).

^{cxiv} 42 C.F.R. § 435.831(d).

^{cxv} State Medicaid Manual §3628.

^{cxvi} *Id.*

^{cxvii} *Id.*

Options for Streamlining the Excess Income Program *(continued)*

have a streamlined system for direct communication with home care providers. If these agencies had a direct relationship with the local district, similar to the system in New York City, the agency could communicate directly with the local district regarding activating coverage for beneficiaries each month. This approach would give the home care agency more control over whether a patient has activated Medicaid coverage; and it would reduce the burden on the consumer to bring or send bills monthly to the local district.

It is possible that this model could be extended to other high-volume health care providers serving large numbers of Medicaid Excess Income enrollees with ongoing health care needs. This could be implemented without any change in State or Federal law.

Automate Processing by Linking with Providers

A more ambitious option for streamlining the activation process would be to allow providers to submit bills for provisional Excess Income enrollees directly, thereby activating coverage when the excess income amount is met. Medicaid eligibility and billing systems could be adapted to: 1) allow providers to have real-time access to the recipients' outstanding excess income balance; 2) permit providers to record amounts billed directly to recipients to meet their excess income obligations; 3) allow the provider to bill Medicaid immediately for the balance. Ideally, this would occur seamlessly in one transaction, without further action from the recipient.

In the eMedNY online database, providers currently may view whether an individual's Medicaid coverage is active, but not an individual's excess income amount. This information is available to providers by phone from the local district—a process that requires time from both the provider and the local district workers. With direct access to the excess income amount for a patient, a provider could bill the patient for that amount, and bill the remainder directly to Medicaid.^{cxviii} Because providers currently have “view-only” access to patient information in eMedNY,^{cxix} it is unlikely that a mechanism could be built in the short term to allow providers to relay this information back to the State in the same transaction.^{cxx}

An alternative approach is to allow the provider to send such information in batches to the local district, either physically or electronically. The Eligibility Data and Image Transfer System (EDITS),^{cxxi} for example, currently used by HRA to allow providers to send information regarding initial Medicaid eligibility in electronic batches, is one vehicle that might be tweaked for this purpose.^{cxvii} In fact, HRA is currently planning to expand this system to allow providers to electronically submit information pertaining to existing Medicaid users, not just for initial eligibility determination.^{cxviii}

^{cxviii} The Principal Provider System, a WMS sub-system, presents an example of how local districts currently “lock out” the consumer's responsibility for certain hospital bills, allowing the hospital to bill Medicaid directly for the remaining amount. In this process, though, the onus remains on the local district to review each individual's excess income amount and “lock out” this amount in the system.

^{cxix} “eMedNY is the name of the New York State Medicaid program claims processing system. The system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible clients... Computer Sciences Corporation (CSC) is the eMedNY contractor and is responsible for its operation.” Source: <http://www.emedny.org/>.

^{cxx} Interview and communications with HRA.

^{cxxi} <http://www.nyc.gov/html/hra/html/programs/edits.shtml>.

^{cxvii} Interview and communications with HRA.

Options for Streamlining the Excess Income Program *(continued)*

Automation in this way would essentially eliminate the need for recipients to bring or mail bills each month to the local district. While this system would not require any statutory or regulatory changes, there are several logistical issues that must be considered prior to implementation. For example, consideration would need to be given to how to reconcile accounts when an individual does send payments or receipts to the local district. Because the provider whose bill is submitted to activate coverage must continue to seek payment from the patient for the excess income amount, providers may be reluctant to be the “first-mover” and thus saddled with the patient’s entire spend-down liability that month. Finally, the capacity of the existing information systems to adapt to this model warrant further exploration, as even modest changes to State and local information systems can prove challenging.

ADMINISTRATIVE CHANGES

Interviews with local district officials and others revealed a number of modest administrative changes that incrementally relieve burdens of the current system.

Streamline Systems Processing For Month-To-Month Cases

Local district workers are frustrated with the amount of time they must spend processing each spend-down case monthly.^{cxxiv} The current process typically requires workers to enter at least two separate Welfare Management System (WMS) sub-systems to complete the process, and is at least a two-day process from submission of bills or payment to activation of coverage. Streamlining this process into one screen on WMS and allowing same-day entry into the sub-system would save worker time and would also provide more timely activation of coverage for consumers. Any change to the WMS system presents challenges; however, an effort to revamp the WMS system is underway, and this streamlining could be included in that process.

Use of New State Enrollment Center

NYSDOH recently released a request for proposals to implement a new statewide enrollment center for Medicaid that would centralize and streamline enrollment and renewal tasks for Medicaid, Family Health Plus, and Child Health Plus. This centralized enrollment center also presents an opportunity for the State to centralize processing of spend-down cases, thus removing this burden from the local district. Instead of sending bills and receipts each month to local districts, the beneficiary could mail them directly to the statewide center. The center would have specially trained processors who could activate coverage in the system, ideally same-day, for these recipients. Centralizing the process to a few workers would eliminate the need to train the thousands of Medicaid workers statewide in the complex activation process for this comparatively small proportion of the Medicaid population. Since the center is managed directly by the State, it would no longer be necessary to wait for the local district’s input to be “cleared” overnight in the State’s data system before coverage is activated. This would, in turn, speed the activation process for beneficiaries as center workers activate same-day coverage for beneficiaries.

^{cxiii} Interview and communications with HRA.

^{cxiv} LDSS Interviews.

Options for Streamlining the Excess Income Program *(continued)*

Using the centralized portal may not work for all beneficiaries. As one local district noted, Excess Income beneficiaries sometimes prefer face to face interaction with community Medicaid workers. The centralized process could be piloted as an option for local districts that agree that using the statewide center would be beneficial.

Centralize/Automate the Process for Public Program Bills

While some districts automate the application of public program bills to the excess income amount, not all do this. Further centralization could simplify the monthly administrative process for workers. Additionally, consumer advocates are concerned that consumers are unaware that expenses made by the State on their behalf for other public programs may be used to meet their excess income amounts, and that better knowledge of public program utilization is needed. Once participation in a public program is established, monthly bills could be sent directly from the program to the local district, or a statewide centralized system—such as the new State enrollment center—alleviating the processing burden for local districts and consumers.

RECONFIGURE ELIGIBILITY

Finally, a fundamental underlying challenge when dealing with the Excess Income Program—as reflected in feedback from local districts, providers and consumer advocates alike—is the financial burden experienced by the participating population. Excess Income participants are, by definition, extraordinarily medically vulnerable. And, with Medicaid eligibility levels dipping significantly below the Federal poverty line for most recipients, meeting Excess Income requirements presents an enormous burden, often competing with basic necessities. Indeed, numerous local districts reported that applicants often lacked enough income after accounting for rent and food to pay their excess income amount. This led many to suggest either increasing the underlying Medicaid eligibility limits for this population or allowing an income deduction for housing expenses.

In fact, this is possible under Federal law. Section 1902(r)(2) of the Social Security Act allows a state to use less restrictive income and resource methodologies in determining eligibility and to disregard different kinds or greater amounts of income and/or resources than the cash assistance programs. Under this provision, states can “disregard” for purposes of Medicaid eligibility a blanket amount (e.g., \$100) or a specific type of income, such as income used for home maintenance or repair. And Section 1902(r)(2) can be used to target specific eligibility groups of individuals already covered under a state’s Medicaid plan. Thus, New York could use Section 1902(r)(2) to essentially establish a higher income level for the medically needy. New York would need to submit a State Plan Amendment to implement this change.^{cxv}

Of course, such a solution would come at a direct cost to the State, and would not eliminate the administrative challenges for those who remain in the program.

^{cxv} 42 C.F.R. §435.1007(e).

Conclusion



The Medicaid system in New York, as in many states, is a complex web of eligibility categories and processing techniques. The State has made efforts to streamline these categories as well as enrollment and renewal procedures for beneficiaries. While Excess Income recipients make up only 4% of all Medicaid beneficiaries in the State, the current activation process for approximately 40% of these recipients—community outpatient beneficiaries that must activate coverage month to month—is costly and time-consuming for both consumers and local district offices. Streamlining the activation of coverage process will decrease or eliminate delays some consumers currently face in reactivating Medicaid coverage on a monthly basis, which is disruptive to care for this high-need population. Changes in eligibility criteria, as well as the process by which eligibility is determined, also can reduce the disproportionate time Medicaid workers spend processing these cases each month.

Since this paper is the first analysis of New York’s Excess Income program and there are several outstanding questions about the program and its enrollees, further research is encouraged. Specific questions worth further exploration include:

- How much does New York State spend annually to administer the Excess Income program?
- What are the enrollees’ sources of income that keep them from qualifying for regular Medicaid?
- How long do enrollees remain in the Excess Income program?
- Why do enrollees move back and forth between provisional and active statuses?
- What administrative approaches to the Excess Income program have been adopted by other states?

Appendix A

Local District Interviews

We interviewed New York State Department of Health officials and Commissioners and staff from six local districts of social services in 2008-2009. Together, these districts represent approximately three quarters (74%) of all Medicaid recipients, and 58% of all community Excess Income recipients in the State (see Appendix B):

- Clinton County
- Erie County
- New York City (Human Resources Administration)
- Onondaga County
- Schoharie County
- Westchester County

In addition to LDSS Interviews, we conducted interviews with the following Consumer Advocates and Providers:

- Selfhelp, New York
- The Center for Independence of the Disabled, NY
- Empire Justice Law Center
- Visiting Nurse Service of New York

Appendix B

Community Excess Income Enrollees by District

SOCIAL SERVICES DISTRICT	2007 AVERAGE MONTHLY MEDICAID ELIGIBLES	COMMUNITY EXCESS INCOME ENROLLEES OCTOBER 2007 *		
		Spend-Down	Pay-In	TOTAL
New York State	4,106,785			61,003
New York City	2,717,591			30,160
Rest of State	1,389,195	22,911	7,932	30,843
Albany	36,234	518	367	885
Allegany	8,329	139	87	226
Broome	32,397	440	379	819
Cattaraugus	13,689	122	204	326
Cayuga	12,189	470	—	470
Chautauqua	25,989	466	31	497
Chemung	17,364	178	173	351
Chenango	9,556	299	134	433
Clinton	13,840	363	174	537
Columbia	7,252	302	—	302
Cortland	8,306	139	86	225
Delaware	6,533	179	105	284
Dutchess	23,251	563	200	763
Erie	145,738	806	—**	806
Essex	5,256	139	94	233
Franklin	8,293	318	—	318
Fulton	11,461	374	74	448
Genesee	7,993	116	74	190
Greene	6,762	126	74	200
Hamilton	480	13	—	13
Herkimer	11,565	158	136	294
Jefferson	17,205	201	176	377
Lewis	4,393	80	70	150
Livingston	6,878	192	89	281
Madison	8,950	223	—	223
Monroe	114,178	1,198	703	1,901
Montgomery	9,718	366	63	429
Nassau	114,959	2,197	—	2,197
Niagara	31,076	218	324	542
Oneida	39,993	532	465	997
Onondaga	67,723	537	551	1,088

Appendix B (continued)

SOCIAL SERVICES DISTRICT	2007 AVERAGE MONTHLY MEDICAID ELIGIBLES	COMMUNITY EXCESS INCOME ENROLLEES OCTOBER 2007 *		
		Spend-Down	Pay-In	TOTAL
Ontario	11,056	122	136	258
Orange	48,799	511	375	886
Orleans	7,101	148	—	148
Oswego	21,550	349	—	349
Otsego	8,160	131	95	226
Putnam	4,327	120	83	203
Rensselaer	20,879	423	189	612
Rockland	48,003	250	230	480
St. Lawrence	19,855	462	—	462
Saratoga	17,111	170	218	388
Schenectady	20,061	303	161	464
Schoharie	4,261	104	62	166
Schuyler	2,874	22	28	50
Seneca	4,147	71	49	120
Steuben	17,047	314	—	314
Suffolk	120,191	3,533	—	3,533
Sullivan	12,821	461	—	461
Tioga	7,148	85	100	185
Tompkins	10,235	220	123	343
Ulster	21,313	416	223	639
Warren	7,437	145	95	240
Washington	8,798	206	122	328
Wayne	10,400	111	141	252
Westchester	100,102	1,942	608	2,550
Wyoming	4,338	126	60	186
Yates	3,635	93	—	93
Other (OMH/OMR)	N/A	101	1	102

Sources: Average monthly Medicaid eligibles for calendar year 2007, available at the New York State Department of Health Web site, http://www.health.state.ny.us/nysdoh/medstat/el2007/2007-cy_eligibles.xls. Community Excess Income Enrollee data for October 2007 provided by the New York State Department of Health, via email in October 2008, and the New York Human Resources Administration, via email in January 2009.

*Includes both provisional and active cases.

**Erie does not offer a pay-in option, but a Relief Repayment option for which they estimate there are approximately 2,000 enrollees monthly.



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