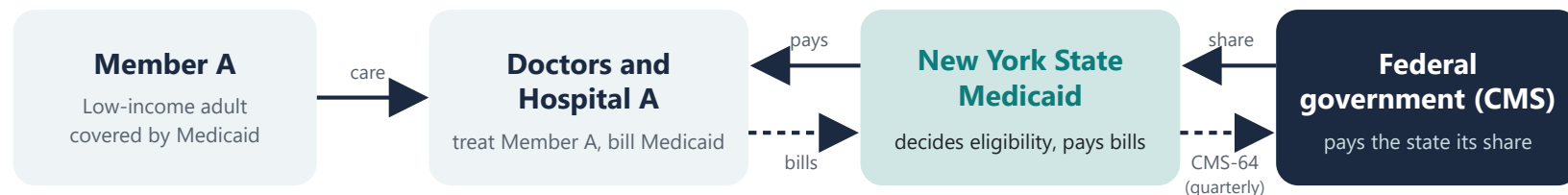


Member A, explained: who pays for the care

Member A is on **Medicaid the whole time**, not private insurance and not a Marketplace plan. Only the Medicaid **category** changes, and that changes who pays what behind the scenes.



The state pays the doctors in full, then claims the federal share back each quarter.
How big that share is depends on the member's Medicaid **category**.

The two categories: same care, different split

New adult group (ACA Medicaid expansion)

Federal 90%

10%

Low-income adults 19–64 who don't fit an older category. Congress pays 90%.

SSI-related disabled group

Federal 50%

State 50%

Traditional category for people with a disability. Paid at New York's regular rate (50%).

■ Federal share ■ New York's share Bars are drawn to scale.

What happened, step by step

Synthetic member, real New York Medicaid prices. Not a real member, provider or state filing.

1

Jan 1, 2026
Member A qualifies as a low-income adult and joins the **new adult group** (90% federal).

2

May 20 – Aug 5
Six bills, including a 4-day heart-failure stay. New York pays **\$7,074.48** and claims 90% back.

3

Aug 14, 2026
Social Security approves SSI disability, **backdated to June 1**. New York moves Member A to the **disabled group from June 1**.

4

Next quarter
Bills from June 1 should have been 50% federal. New York re-funds them and **returns the difference** on the CMS-64.

The money on the five bills after June 1 (\$6,952.52)

Before the change (new adult group)



After the correction (disabled group)



■ Federal ■ New York Same total bill (\$6,952.52) in both bars.

Moves from federal to New York

\$2,780.99

most of it from the hospital stay (\$2,584.23)

Change to the doctors' and hospital's pay

\$0

they keep exactly what they were paid

May 20 visit (before June 1)

No change

Member A really was a new adult then

Member A

No change

still covered, same benefits, no bill

Amounts are summed claim by claim, matching the Member A worksheet.

Who gains or loses money?

Handled correctly, nobody loses; each side pays its proper share. Losses come from not fixing it, or fixing it badly.

Fee-for-service, corrected (the right outcome)

Who	Result	Why
Federal government	Pays \$2,780.99 less	Back to the correct 50% share.
New York State	Pays \$2,780.99 more	Not a loss: this is its correct share for a disabled member.
Doctors / Hospital A	\$0	Payment unchanged.
Member A	No change	Coverage and benefits unchanged.

Managed care: Member A stays in the same plan

The state pays the health plan a monthly premium per member ("capitation"); the plan pays the doctors. The disabled premium is usually much higher than the new-adult premium.

Who	Result	Why
Health plan	Gains	Owed the higher disabled premium from June 1.
New York State	Pays more	A higher premium, with only 50% federal match on it.
Federal government	Pays 50% of a bigger premium	Instead of 90% of a smaller one.
Doctors / Hospital A	\$0	The plan's payments to them don't change.

Bad data for next year

If bills stay coded as new adult, next year's premiums are set from the wrong data.

Wrong federal reports

CMS-64 totals by group are off; new-adult costs look higher than they are.

Work and friction

Staff time to rework old bills; clawbacks and rebilling for providers months later.

Fee-for-service, never corrected (the trap)

Who	Result	Why
Federal government	Overpays \$2,780.99	Keeps paying 90% for a member who should be at 50%. Federal taxpayers lose.
New York State	Audit risk	Keeps the money for now, but an Inspector General or CMS review can find it and require repayment, sometimes with interest.
Doctors / Hospital A	\$0	Payment unchanged.
Member A	No change	Coverage unchanged.

Why it gets missed

The doctors' pay doesn't change, so systems that only re-process a bill when the payment changes skip it. The eligibility record is fixed, but the federal money never follows.

Managed care: Member A must move to another plan or back to fee-for-service

Who	Result	Why
Health plan	Loses	The state takes back June–August premiums; the plan claws back the claims it paid.
Doctors / Hospital A	Can lose	Must refund the plan and rebill the right payer. If that payer's filing deadline has passed, they may never be paid.
New York State	Risk of paying twice	Re-pays the care through the correct route; if a clawback is missed, it pays a premium and the claims.
Federal government	Back to 50%	Once everything is re-routed correctly.

Synthetic example for discussion. Match rates: 90% for the ACA new adult group; 50% New York regular rate. Reporting split per CMS state plan approval letters (new adult share on the CMS-64.9VIII series, the rest on the CMS-64.9 series).