

Medicaid as a Second Language

Today's Agenda:

- Differences between Medicaid programs
- Documentation easements
- Separate determination requirements
- Different Medicaid processes

Today's Agenda:

- Medicaid-related health care programs
- Medicaid extensions
- Coverage guarantees

SSI-Related Category

- Aged
- Certified Blind
- Certified Disabled

Medicaid as a Second Language

Single Individuals/ Childless Couples (S/CC)

- 21-64 years
- No children living in household

Low Income Families (LIF) include:

- Families with deprivation and children under 21
- Families without deprivation and children under 21
- Children not living with caretaker relatives
- Pregnant women

LIF & S/CC

- As a result of Welfare Reform Bill (chapter 434 of the laws of 1997)
- The two eligibility groups mirror the two Temporary Assistance Programs

Medicaid as a Second Language

LIF & S/CC

- Temporary Assistance has Family Assistance- Medicaid has Low Income Families (LIF)
- Temporary Assistance has Safety Net- Medicaid has Single Individuals/Childless Couples (S/CC)

Aid to Dependent Children (ADC)

- Continued Absence
- "Intact" Family with Incapacitation or unemployment
- Children Under 21
- Children w/out Caretaker
- Pregnant Women

Pregnant Women Eligibility

- Household income equal to or less than 100% FPL may be eligible for full MA
- Household income between 100-200% of FPL may be eligible for perinatal services

Medicaid as a Second Language

Eligibility For Children Under Age 19

- LIF
- Medically Needy
- Expanded eligibility

References

- SSL – Sect. 366
- SSL – Sect. 366.1
- SSL – Sect. 366.1 (a)
- SSL – Sect. 366.1 (a)(7)
- SSL – Sect. 366.2 (a)(8)
- SSL – Chapter 436 of Laws of 1997

References

- Dept. Reg. 360-1.2
- Dept. Reg. 360-1.3
- Dept. Reg. 360-2.4 (a)(2)
- Dept. Reg. 360-3.3
- Dept. Reg. 360-3.3 (b)(1)
- Dept. Reg. 360-3.3 (b)(2)
- Dept. Reg. 360-3.3 (b)(7)
- Dept. Reg. 360-5

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References

- 89 ADM-38
- 92 ADM-52
- 93 ADM-29
- 97 ADM-21
- 97 ADM-23
- 97 ADM-2
- GIS 03 MA/008

Documentation

- Information that should be included in the case record to support the statements made in the application, sufficient to establish an audit trail.

Household Composition

- Children who reside in your home can be counted in your household size.
- You do not need to verify household composition for each of the children.

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Students under 21

- High school students with earnings are not required to verify their status as students, unless the district has reason to believe that they are no longer attending school.

Students under 21

- Full time College, technical or vocational students who are employed must document this status with a letter from the school or current grade report if they have earnings which would make the difference in their eligibility.

Documentation of Social Security Numbers

- Applicants must provide SSN or proof that they have applied for an SSN.
- Not required of pregnant women

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Social Security Number

- Districts will use the Welfare Management System (WMS) to confirm the SSN provided is correct.
- WMS uses two processes to confirm a SSN is correct.
 - Verification
 - Validation

Social Security Number

- Verification
 - During application process, demographics matched to WMS info
- Validation
 - Once case is open, SSN & demographics matched to SSA info

Alcohol and Drug Abuse Screening and Referral Form

- LDSS 4571 is completed for Single Individuals and Childless Couples age 21-64 who are eligible for Medicaid only.
- Only section A is to be completed.

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Treatment of Vehicles

- Varies depending on category of assistance
 - Families with children
 - Single Individuals/Childless Couples

Treatment of Vehicles

- Equity value of second vehicle counted toward MA resource level
 - fair market value
 - outstanding loans
 - = equity value

Treatment of Vehicles

- For S/CCs, vehicle is exempt if fair market value is less than \$4650.
- If there's a second vehicle, equity value is counted toward the resource level.

Medicaid as a Second Language

Treatment of Vehicles

- Client John Doe has a 2000 Honda with a fair market value of \$18,000, but has \$13,000 in outstanding loans
 - \$5,000
 - 4,650
 - = \$350

Homestead

- Primary residence occupied by an A/R and/or members of his/her family
- Includes home, land and integral parts such as garages and outbuildings
- Generally exempt as long as it is the primary residence of the A/R of a family

References

- SSL – Sect. 366.2 (a)(1)
- Dept. Reg. 360-1.4 (f)
- Dept. Reg. 360-4.7 (a)(1)
- 92 ADM-53
- 91 ADM-30
- GIS 03 MA/008

Medicaid as a Second Language

Family Health Plus (FHP)

- 19-64 years of age not eligible for Medicaid
- Income limits but no resource test
- Free
- Broad benefits package but less than Medicaid
- Managed Care only

Eligibility Criteria FHP

- For parents with children under 21 and 19-20 year olds living with their parent
 - Gross incomes (no deductions) compared to 150% of the FPL
 - No Resource test

Eligibility Criteria FHP

- For Single Individuals & Childless Couples and 19-20 yrs not living with their parents
 - Gross incomes (no deductions) compared to 100% of the FPL
 - No Resource test

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FHP Eligibility for Pregnant Women

- Pregnant women applying for health insurance are not eligible for FHP
- Must receive coverage under Medicaid

FHP Eligibility for Pregnant Women

If a women becomes pregnant after enrollment her options are:

- To continue her coverage under FHP
- OR**
- Switch to Medicaid

Child Health Plus B (CHP B)

Eligibility criteria:

- Children under 19 not eligible for CHP A
- May or may not have premium
- Broad benefits package but less than CHP A
- Managed care plan only
- No income limit
- No resource test

Medicaid as a Second Language

Medicare Savings Program

Program that pays Medicare premiums for:

- SSI cash Medicare eligible beneficiaries
- Qualified Medicare beneficiaries (QMB)
- Specified Low Income Medicare beneficiaries (SLIMBs)

Medicare Savings Program

QMB

- Pays either Medicare Part A or B premium
- Must conditionally enroll in Medicare Part A
- Pays Medicare Part A & B coinsurance and deductibles

Medicare Savings Program

QMB levels for 2003:

- Single person's income below \$769/ month, with resources below \$4,000
- Couple's income below \$1,030/ month, with resources below \$6,000

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Medicare Savings Program

SLIMB

- Pays for Medicare Part B premium only
- Must have Medicare Part A

Medicare Savings Program

SLIMB levels for 2003:

- Single person's income below \$918/ month, with resources below \$4,000
- Couple's income below \$1,232/ month, with resources below \$6,000

Medicare Savings Program

QI1

- Pays for Medicare Part B premium only
- Must have Medicare Part A
- No resource requirement:
 - Single person's income below \$1,031
 - Couple's income below \$1,384

Medicaid as a Second Language

Family Planning Benefits Program (FPBP)

Services include:

- Male and Female sterilization
- Comprehensive reproductive health history and physical exam
- FDA approved birth control methods, devices and supplies

Family Planning Benefits Program

- Pregnancy testing and counseling
- Preconception counseling
- Emergency contraception (morning after pill that is taken within 48 hrs of unprotected sex)

Family Planning Benefits Program

Eligibility criteria:

- Individuals who are of child bearing age
- Permanent residents of NYS
- Family incomes at or below 200% of the FPL
- Teens (<21) whose own income is at or below 200% FPL, if they are unable to provide parents income information

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Family Planning Benefits Program

Eligibility criteria:

- Citizens or aliens with satisfactory immigration status
- Otherwise not eligible for MA or FHP or waive their right to these programs
- No resource test, AFIS, photo ID, drug and alcohol or child support requirements

Local District Responsibilities

- Train providers on eligibility criteria
- Inform providers of relevant changes to FPBP program
- Follow up on applications
- Notify applicants of determinations
- Establish procedures to aid in process
- Cooperate with providers

Family Planning Provider Responsibilities

- Assist client in completing application
- Conduct face-to-face interview
- Obtain applicant's signature on release statement
- Gather documentation
- Forward all applications to LDSS
- Act as applicant's representative at local district

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Breast and Cervical Cancer Treatment Program (BCCTP)

Eligibility criteria:

- Individuals under 65 years of age
- Income at or below 250% FPL
- Not covered under any creditable insurance; and
- Need treatment for breast and cervical cancer

Breast and Cervical Cancer Treatment Program

Application & Enrollment- Healthy Women Partnership (HWP):

- Acts as the designated qualified entity to enroll
- Assists individuals to complete MA application form
- Receives and prepares applications
- Satisfies the face to face interview

Breast and Cervical Cancer Treatment Program

Application & Enrollment- Cancer Services Program

- Receives completed applications
- Certifies need for screening
- Certifies diagnostic category, staging and treatment needed
- Forwards applications to OMM

Medicaid as a Second Language

Breast and Cervical Cancer Treatment Program

Application & Enrollment- OMM

- Reviews completed applications
- Makes final determination of eligibility
- Enters individual's information into WMS
- Retains cases for BCCTP Undercare and Recerification

Medicaid Buy-In for Working People with Disabilities (MBI-WPD)

- New eligibility groups:
 - Basic: recipients have SSI medical disability, but are income ineligible for SSI
 - Medically Improved: recipients no longer determined disabled but still determined severely medically impaired

Medicaid Buy-In for Working People with Disabilities (MBI-WPD)

Eligibility Criteria

- Age- 16-64
- Work
- Certification of disability
- Income test- SSI-Related budgeting, net income compared to 250% FPL
- Resource test- at or below \$10,000

Medicaid as a Second Language

Consolidation Omnibus Budget Reconciliation Act Continuation Coverage Program (COBRA)

- Persons who lose health insurance through their employment can choose to pay the entire premium to retain health insurance

COBRA

Eligibility criteria:

- Person must have lost group health insurance due to a qualifying event
- Insurance must be cost effective
- Income can not exceed 100% FPL

COBRA

- Medicaid will pay premium only; recipient must pay co-insurance and/or deductibles
- Family coverage is available

Medicaid as a Second Language

References

- 03 ADM-4
- 02 ADM-7
- 01 ADM-6
- Dear Commissioner Letter 3/25/02

Rosenberg and Stenson

- When TA case is closed, the separate MA determination is made from information in the TA case record (Rosenberg)
- When a SSI cash benefit is discontinued, a separate MA determination is made from information provided by Social Security (Stenson)

Medicaid Separate Determinations

- There are NO work rules for Medicaid
- If an A/R is being denied, closed or sanctioned from TA for employment purposes a separate determination is required for MA

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Medicaid Separate Determinations

- If denying TA, case should be reviewed for MA eligibility

Medicaid Separate Determinations

- When denying a single Safety Net (SN) individual for excess income and income exceeds 100% FPL – then MA will also be denied

Medicaid Separate Determinations

- When denying/closing a single Safety Net (SN) individual for non-compliance with drug/alcohol requirements - then MA will also be denied/closed

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Medicaid Extensions

- Transitional Medical Assistance (TMA)
- Child Support Extension
- Six month extension from Temporary Assistance
- Rosenberg and Stenson

Transitional Medical Assistance (TMA)

- For families transitioning off TA, a six month Medicaid extension is mandated under certain circumstances

Transitional Medical Assistance (TMA) Criteria

- The caretaker relative has had an increase in earnings or new employment
- Dependent child in household
- Family on LIF three of past six months

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Transitional Medical Assistance (TMA)

- The A/R may be eligible for an additional six months of Medicaid, if certain requirements are met
 - Four month block
 - Two month block
- This extension continues when the A/R moves to a different district

Increased Support Collection Extensions

- When the TA case closes for increased support a 4 month Medicaid extension is generated

Six Month Extensions

- Failure to appear for TA recertification results in six month extension of MA
- Recipients must still report changes in income, residency, household composition during period

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References

- 90 ADM-30
- 82 ADM-5
- 80 ADM-84
- 80 ADM-19
- 03 OMM/ADM-2

Medicaid Coverage Guarantees:

- Pregnant women
- One year continuous coverage for infants and children
- Managed Care six month guarantee

Presumptive Eligibility for Pregnant Women

- Means of immediately providing Medicaid services for prenatal care pending a full Medicaid determination

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Qualified Providers

- Prenatal Care Assistance Program (PCAP)
- Public Health Nursing Service
- Article 28 facility (hospital, diagnostic and treatment center)

To Find Qualified Providers

- Call:
1- 800 - 522 - 5006

Prenatal Care Assistance Program (PCAP)

- Pregnant women of all ages
- Income limit up to 200% FPL: no resource test
- Free
- Covers all prenatal and delivery care plus 60 days postpartum care
- Presumptive eligibility through PCAP providers

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Guarantee

- A woman determined eligible for Medicaid for any day during her pregnancy remains eligible for Medicaid coverage for the remainder of the pregnancy and 60 days post-partum.

IV-D

- Pregnant women are not required to comply with IV-D requirements during guarantee

Continuous Coverage

- Most children under age 19 who are eligible for Medicaid will be covered for 12 months

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Newborn Guarantee

- A child born to a pregnant woman who is on Medicaid or FHPlus will remain eligible for Medicaid until the end of the month in which the child turns age one

Continuous Coverage Exceptions

- Children who are non-qualified aliens and therefore only eligible for emergency medical services under Medicaid
- SSI-related children

Continuous Coverage begins:

- Each time a child is determined fully eligible for Medicaid
- Each time a child is re-determined fully eligible for Medicaid, e.g. renewal or undercare re-budgeting.

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Continuous Save Date (CSD)

- WMS is programmed to recognize circumstances that guarantee Continuous Coverage and to establish a Continuous Save Date
- CSD is generally 12 months from the MA coverage from date

Managed Care Guarantee

- Six month "Guarantee" of coverage through a health plan
- Available to enrollees in all health plans
- Guarantee period begins with month of enrollment

Managed Care Guarantee

- If determined ineligible during the guarantee period – provides coverage for remainder of six month period
- No change to benefit package services for FHP
- Only plan covered services (plus family planning and pharmacy) for MA/MC
- May not switch plans while in receipt of guarantee coverage

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Managed Care Guarantee

- Individuals who lose and regain eligibility within 90 days
 - Reenrolled with same health plan
 - Not eligible for new guarantee period
 - If disenrolled and re-enrolled – guarantee “thru” date must be shortened (if system generates a new six month guarantee period)

Managed Care Reminders

- MA individuals who become excluded are not eligible for guarantee, EXCEPT
 - Individuals who go to spenddown
 - FHP individuals who begin receiving health insurance

References

- SSL Sect. 364-I, 368-a
- Dept. Reg 360
- 99 ADM 3
- 97 ADM 10
- 97 ADM 2
- 95 ADM 21

Medicaid as a Second Language

References

- 91 ADM-47
- 90 ADM -9
- 00 OMM/INF-01
