

TABLE OF CONTENTS

CATEGORICAL FACTORS

CATEGORICAL FACTORS 3

LEGALLY RECOGNIZED SAME-SEX MARRIAGES 5

LOW INCOME FAMILIES (LIF) 6

ADC-RELATED 4

AGE OF CHILD 9

RELATIONSHIP OF CHILD TO CARETAKER RELATIVE 10

LIVING WITH SPECIFIED RELATIVE 12

DEPRIVATION OF PARENTAL SUPPORT OR CARE 15

DEATH OF A PARENT 17

INCAPACITY 18

CONTINUED ABSENCE 20

UN/UNDER EMPLOYED TWO PARENT HOUSEHOLD 23

SSI-RELATED 24

AGE (65 OR OVER) 25

BLINDNESS 27

DISABILITY 29

SUBSTANTIAL GAINFUL ACTIVITY (SGA) 38

TRIAL WORK PERIOD 40

EMPLOYMENT SUBSIDIES 42

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES 43

UNDER AGE 21 52

PREGNANCY/NEWBORNS 55

FNP PARENTS58

FAMILIES LIVING WITH DEPENDENT CHILDREN UNDER 2159

SINGLES/CHILDLESS COUPLES (S/CC).....61

FAMILY PLANNING BENEFIT PROGRAM (FPBP).....62

FAMILY HEALTH PLUS and PREMIUM ASSISTANCE PROGRAM.....64

MEDICAID CANCER TREATMENT PROGRAM: BREAST, CERVICAL,
COLORECTAL AND PROSTATE CANCER67

CHILD HEALTH PLUS70

FOSTER CARE71

MEDICARE SAVINGS PROGRAM.....73

MEDICARE BUY-IN.....80

MEDICAID EXTENSIONS/CONTINUATIONS.....81

 SEPARATE HEALTH CARE COVERAGE DETERMINATIONS.....87

 SECTION 249E OF THE PUBLIC LAW 92-603.....89

 PICKLE ELIGIBLE (FORMERLY 503 CASES).....91

 WIDOWS/WIDOWERS.....93

 DISABLED ADULT CHILD (DAC) BENEFICIARIES.....95

 TRANSITIONAL MEDICAID (TMA)97

CATEGORICAL FACTORS

Policy: The Medicaid eligibility determination process begins with a determination of an applicant's category. The applicant may be eligible for Medicaid in any one of the following categories:

- receiving Supplemental Security Income (SSI);
- eligible under Low Income Families (LIF);
- eligible under Singles/Childless Couples (S/CC);
- ADC-related;
- receiving Foster Care or Adoption Assistance;
- Federal Poverty Level Programs;
- SSI-related (Aged, certified blind/disabled);
- under age 21;
- pregnant women;
- FNP parents; or
- parents living with their dependent children under age 21.

References:

SSL Sect.	366.1 453(1)(b)
Dept. Reg.	360-3.3 369 369.3(d)(1)
ADMs	OMM/ADM 97-2 94 ADM-12 93 ADM-34 87 ADM-22 82 ADM-24

Interpretation: The federal government participates in the cost of care for all categories except S/CC and FNP parents.

NOTE: New York State is currently providing Medicaid with federal participation to most recipients, regardless of category,

CATEGORICAL FACTORS

including Single Individuals and Childless Couples as a result of the time limited waiver granted to New York State, pursuant to Section 1115 of the Social Security Act.

Certain other persons are eligible for Medicaid as a result of their eligibility remaining in effect from a previous period of time. These persons are listed on **CATEGORICAL FACTORS, MEDICAID EXTENSIONS/ CONTINUATIONS**.

Disposition:

When the proper categorical relationship has been established, financial eligibility is determined according to the guidelines specified in the **INCOME** and **RESOURCE** sections of this manual, in addition to any applicable requirements found in the **OTHER ELIGIBILITY REQUIREMENTS** section.

This section describes the following categorical relationships and requirements:

- Legally recognized same sex marriages,
- Low Income Families (LIF);
- ADC-Related;
- SSI-Related;
- Under age 21;
- Pregnant women;
- Families living with their dependent children under age 21;
- Singles/Childless Couples (S/CC);
- FNP parents; and
- Medicaid Extensions/Continuations.

CATEGORICAL FACTORS**LEGALLY RECOGNIZED SAME SEX MARRIAGES**

- Policy:** Individuals who declare that they have been legally married in a jurisdiction that recognizes and performs same-sex unions must, regardless of gender, receive full faith, credit and comity as all other legally married persons when a district makes any Medicaid eligibility and case decision in New York State.
- References:** GIS 08 MA/023
- Interpretation:** Individuals of the same sex who have been married in a jurisdiction that recognizes and performs same-sex unions must receive equal treatment and recognition of such marriage. Equal treatment means that terms such as “husband”, “wife” and “spouse” are construed in a manner that encompasses legal same-sex marriages. Factors including but not limited to the following must be evaluated in the same manner for all legally performed marriages:
- Required signatures on applications;
 - Household composition and size;
 - Budgeting methodology;
 - Determination of Legally Responsible Relatives;
 - Spousal and Child Support issues
 - Health insurance premium payments;
 - Chronic/long term care budgeting issues, including transfers of resources for SSI-related A/Rs;
 - Income from trusts;
 - Homestead and resource exemptions for SSI-related A/Rs
 - Burial funds;
 - Estates; and
 - Liens and recoveries.
- Disposition:** Individuals who have been legally married in a same-sex union will have their eligibility for Medicaid and related programs determined in the same manner as individuals who are legally married that are not of the same sex.
- Documentation:** Documentation of a legally recognized same-sex marriage is only necessary in the same limited circumstances as documentation of any other marriage (for example, when an individual seeks spousal budgeting for long term care).

CATEGORICAL FACTORS

LOW INCOME FAMILIES (LIF)

Policy: Families with children under age 21, children under age 21 who are not living with caretaker relatives, applying caretaker relatives (including adult only cases) and pregnant women may be eligible for Medicaid under Low Income Families (LIF). (See **CATEGORICAL FACTORS ADC-RELATED LIVING WITH SPECIFIED RELATIVE** for more information on caretaker relatives)

Although for federal reporting purposes, deprivation of parental support or care due to continued absence, death, incapacity, or under/unemployment is recorded, families that do not meet the deprivation criteria are included in the LIF group.

References:

SSL Sect.	366 366-ee 367
ADMs	10 OHIP/ADM-01 OMM/ADM 97-2
GIS	09 MA/ 027

Interpretation: Although the ADC cash category no longer exists, Medicaid cannot be more restrictive than the ADC methodologies that were in effect on July 16, 1996. The LIF category consists of families with a deprivation and families without a deprivation.

Disposition: The financial standards under LIF provisions generally parallel those of the cash program; however, no methodology which is more restrictive than the methodology used in the ADC cash program on July 16, 1996, may apply to LIF. Because Medicaid and cash eligibility are de-linked, future changes made to the cash program will not automatically trigger changes to the Medicaid program.

If an A/R is determined eligible under the LIF criteria, deprivation factors are explored and appropriate WMS categorical codes used for reporting purposes. If the A/R is not eligible under LIF, eligibility must be determined under, Family Health Plus, Family Planning Benefit Program, etc.

Effective for eligibility periods on or after January 1, 2010, there is no resource test for LIF A/Rs. For A/Rs applying for Medicaid coverage for the three month retroactive period prior to January 1, 2010, there is a resource test.

CATEGORICAL FACTORS**ADC-RELATED**

Policy: The ADC program no longer exists as a cash grant program. However, Medicaid continues to have an ADC-related medically needy category. Persons who are members of families with a deprivation may be eligible under the ADC-related category of assistance if they meet the financial and all other eligibility requirements for Medicaid.

References:

SSL Sect.	366 366.1(a)(5) 366-ee
Dept. Reg.	360-3.3 369.2
ADMs	10 OHIP/ADM-01
GISs	09 MA/027 08 MA/022

Interpretation: In order for adult relatives of children to be eligible for Medicaid as ADC-related, the children must meet the appropriate categorical requirements. These include age, relationship, living with a specified relative, and deprivation of parental support and/or care.

NOTE: The A/R's statement of his/her relationship to the child which may or may not indicate a deprivation factor is acceptable unless there is a reason to doubt the validity of the relationship. A signed application indicating the relationship and deprivation factor is generally the only verification required. When the relationship or deprivation factor is questionable other verification is necessary.

Disposition: If an adult A/R and the child s/he cares for meet all the ADC-related requirements, their eligibility is compared to the Medically Needy Income level or the Medicaid Standard (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial.

Effective for eligibility periods on or after January 1, 2010, there is no resource test for ADC A/Rs. For A/Rs applying for Medicaid coverage for the three month retroactive period prior to January 1, 2010, there is a resource test.

NOTE: MEDICAID STANDARD, MBL LIVING ARRANGEMENT CHART is found in REFERENCE.

CATEGORICAL FACTORS**ADC-RELATED**

The following specific topics are considered in this section:

- Age
- Relationship of child to caretaker relative
- Living with specified relative
- Deprivation of parental support or care by:
 - Death
 - Incapacity
 - Continued absence
 - Un/Underemployed Two-parent Households

**CATEGORICAL FACTORS
ADC-RELATED****AGE OF CHILD**

Policy: A child under the age of twenty-one (21) who is deprived of parental support and/or care (See **CATEGORICAL FACTORS DEPRIVATION OF PARENTAL SUPPORT**) is ADC-related when s/he is living with a specified relative (See **CATEGORICAL FACTORS LIVING WITH SPECIFIED RELATIVE**). The A/R and his/her caretaker relative must meet all other requirements to be eligible for Medicaid.

References:

SSL Sect.	366.1(a)(5)(iii)
Dept. Reg.	360-3.3(b)(5)
ADMs	93 ADM-29
GIS	94 MA/015

When to Verify Status: When a child is obviously under the age of twenty-one it is not necessary to verify age. However, since an A/R's date of birth is generally relevant at some point during the eligibility process, it is recommended that date of birth be verified at the first application. Once documented, it is not necessary to re-verify an A/R's date of birth. An application or recertification is never delayed or denied for lack of age verification when the child is obviously under age twenty-one (21).

Verification: The documents used to verify Citizenship/Immigration Status can also be used to verify age.

Documentation: Sufficient to establish an audit trail:

- the date of birth,
- type of document,
- place and filing date of the document,
- any identifying numbers, and
- the name of the official who signed the document.

**CATEGORICAL FACTORS
ADC – RELATED****RELATIONSHIP OF CHILD TO CARETAKER RELATIVE**

Policy: Individuals caring for children who are deprived of parental support (See **CATEGORICAL FACTORS DEPRIVATION OF PARENTAL SUPPORT**) may be eligible for Medicaid as ADC-related. Both the caretaker relative and the child are ADC-related when the caretaker is within a certain degree of relationship to the child.

References: SSL Sect. 366.1(a)(iii)
Dept. Reg. 369.1(b)
ADMs 93 ADM-29

Interpretation: The following is a list of relatives who meet ADC-related criteria. The relationship may be by blood, half blood or adoption.

- (1) The child's father, mother, brother, sister, grandfather, great-grandfather, great-great grandfather, grandmother, great-grandmother, great-great grandmother, uncle, great-uncle, great-great uncle, aunt, great-aunt, great-great aunt, first cousin, nephew or niece.
- (2) The child's stepfather, stepmother, stepbrother, or stepsister, but no other step relative.
- (3) The spouses of any of the relatives listed above, even though the marriage may have been terminated by death, divorce or annulment.
- (4) When a child is born out of wedlock, paternity is adjudicated or acknowledged in writing for a paternal relative to qualify as ADC-related.
- (5) When a child has been surrendered to an authorized agency or adopted, relatives by either blood or adoption may qualify.
- (6) When a child is residing with both parents, both parents may be ADC-related, if a deprivation exists.
- (7) When a child is residing with more than one qualifying relative, other than his/her parents, only one adult relative may be ADC-related due to his/her relationship to the child. For example: a child lives with both grandparents, only one grandparent may be ADC-related through the children.

**CATEGORICAL FACTORS
ADC-RELATED**

RELATIONSHIP OF CHILD TO CARETAKER RELATIVE

(8) Two adults may each qualify as a caretaker relative if there are at least two children in the household that are not siblings.

NOTE: A caretaker relative can be under the age of 21 if s/he assumes a parental role. For example, a teenage parent living with his/her child, or an older brother who is the primary caregiver of younger siblings.

Verification: The A/R's statement of his/her relationship to the child is acceptable unless there is reason to doubt the validity of the relationship. A signed application indicating relationship is generally the only verification required. When the relationship is questionable other verification is necessary.

Examples of acceptable forms of verification are:

birth certificate
baptismal certificate
court papers
adoption papers
marriage certificate
other documentation from schools or social services agencies

Documentation: Sufficient to establish an audit trail:

- (a) signed application; and
- (b) if the living relationship is questionable: type of document; date and place of filing; and identifying numbers of the available document or name of the official signing the document.

**CATEGORICAL FACTORS
ADC - RELATED****LIVING WITH SPECIFIED RELATIVE**

Policy: In order for a child and a caretaker relative to be ADC-related they must be living together.

References: SSL Sect. 366.1(a)(5)(iii)

Dept. Reg. 360-3.3(b)(5)

INFs 07 OHIP/INF-1

Interpretation: The determination of eligibility for ADC-relatedness includes consideration of the living arrangement of the dependent child who has been deprived of parental support. The child must be living with his/her parent or caretaker relative. The child is considered to be living with the parent or other relative as long as the relative takes responsibility for the care and control of the child, even though:

(1) circumstances may require the temporary absence of either the child or relative;

(2) the child has been placed in the home of such relative by a court, except when placement is on a board basis with a plan for supervision and control by the local department of social services through its Child Welfare program.

In situations of equally (50-50) shared (physical and legal) custody, the dependent child is considered to be living with both parents and both parents get the benefit of ADC budgeting. However, when a court order for equally shared custody of the child(ren) is not followed, a determination must be made as to which parent is actually the primary caretaker. Which parent has greater physical custody and responsibility for medical, education, day care and similar needs are factors to consider when making this determination.

Verify Status: (a) When the A/R indicates the presence of a child in the household;

**CATEGORICAL FACTORS
ADC-RELATED**

LIVING WITH SPECIFIED RELATIVE

- (b) When the A/R indicates the absence, incapacity, death or the presence of both parents of the dependent child.

Verification:

A signed application indicating the household composition is generally sufficient to verify the A/R's living arrangement. However, if the living arrangement is questionable other forms of verification are necessary. For example: a non-relative landlord statement or school records.

To determine the primary caretaker of the child(ren) when the court order indicates equally (50-50) shared joint physical and legal custody, but one parent claims the custody is not equally shared, consider which parent has the primary responsibility for:

- Assisting the child with homework or school related tasks
- Paying tuition cost related to the child's education
- Arranging and paying for the cost of day care
- Transporting the child to and from school or day care
- Responding to emergencies at the child's school or day care center or dealing with law enforcement
- Arranging medical and dental care for the child
- Making decisions regarding the child's future
- Paying for food and clothing when the child visits the other parent

Other factors to consider:

- If the parents reside in different school districts, where does the child attend school?
- If one parent is given visitation rights, the other parent is generally the custodial parent.
- Who claims the child on his/her income tax may be an indicator of the primary caretaker.

Only members of the household are included in the case.

**CATEGORICAL FACTORS
ADC-RELATED**

LIVING WITH SPECIFIED RELATIVE

A child is considered to be living with the individual as long as the individual has care and control of the child. The child can then be added to the household count. This policy applies even if the child or parent is temporarily absent.

Documentation: Sufficient to establish an audit trail:

- (a) signed application indicating the household composition; or
- (b) if the living arrangement is questionable: type of document; date and place of filing; and identifying numbers of the available document or name of the official signing the document.

Disposition: When the child has been determined to be living with the A/R, the other categorical requirements detailed in **CATEGORICAL FACTORS ADC-RELATED** are considered in determining eligibility as ADC-related.

NOTE: The A/R's statement of his/her relationship to the child which may or may not indicate a deprivation factor is acceptable unless there is a reason to doubt the validity of the relationship. A signed application indicating the relationship and deprivation factor is generally the only verification required. When the relationship or deprivation factor is questionable other verification is necessary.

**CATEGORICAL FACTORS
ADC-RELATED****DEPRIVATION OF PARENTAL SUPPORT OR CARE**

Policy: An A/R is ADC-related when s/he is the caretaker relative of a child under the age of twenty-one (21) and that child is deprived of parental support and/or care. That child is also ADC-related. The A/R must meet all other requirements to be eligible for Medicaid.

References: SSL Sect. 366.1(a)(5)(iii)
Dept. Reg. 360-3.3(b)(5)
ADM 97 ADM-20

Interpretation: A child is considered deprived of parental support and/or care when any of the following conditions exist:

- death of a parent;
- physical or mental incapacity of a parent;
- continued absence of a parent; or
- un/underemployed two-parent household.

When there are multiple children in a household, there may be multiple deprivation factors. For example: a woman who has two children from a previous marriage remarries and has two children by the second husband. The second husband is in an accident and becomes incapacitated. The children from the second marriage are considered deprived of parental support because of their father's incapacity. The two children from the mother's previous marriage are deprived of parental support/care because of the absence of their birth father.

It is possible for children in a household to be ADC-related based on different deprivation factors. Using the above example, when the father recovers from his accident, returns to work, and is no longer incapacitated, his children are no longer ADC-related based on incapacity. The other two children, from the woman's previous marriage, continue to be deprived of parental support/care, because their father is absent from the home. The mother and her first two children are ADC-related. The second two children and their father must be evaluated for ADC-relatedness based on un/under employment.

**CATEGORICAL FACTORS
ADC-RELATED**

DEPRIVATION OF PARENTAL SUPPORT OR CARE

Deprivation is established for at least one dependent child, in a household, for the caretaker relative to be ADC-related.

When a child is no longer deprived of parental support/care, s/he and his/her caretaker relative remain categorically eligible for ADC-related Medicaid until the end of the third month following the month in which the deprivation ended. This is a categorical extension only. The family must continue to meet all other ADC-related eligibility requirements (See **CATEGORICAL FACTORS ADC-RELATED**). These additional three (3) months of ADC-related categorical eligibility are provided while the household is overcoming the effects of deprivation.

When to Verify:

When the A/R indicates the presence of a child in the household and that the child is deprived of parental support and/or care due to the absence, incapacity, death or a two-parent household with a designated principal wage earner.

NOTE: The A/R's statement of his/her relationship to the child which may or may not indicate a deprivation factor is acceptable unless there is a reason to doubt the validity of the relationship. A signed application indicating the relationship and deprivation factor is generally the only verification required. When the relationship or deprivation factor is questionable other verification is necessary.

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

DEATH OF A PARENT

Policy: When a child under the age of twenty-one (21) is deprived of parental support and/or care due to the death of one or both parents, the child and the remaining parent or other caretaker relative are ADC-related. The A/R must meet all other requirements to be eligible for Medicaid.

References: SSL Sect. 366.1(a)(5)
Dept. Reg. 360-3.3(b)(5)
ADMs 93 ADM-29

Verify Status: When the A/R indicates that a child in the household has a deceased parent.

Verification: When eligibility is based on deprivation of parental support/care due to death, verification of the death of the parent is obtained from the applicant's/recipient's written and/or oral statements.

NOTE: See **CATEGORICAL FACTORS RELATIONSHIP OF CHILD TO CARETAKER RELATIVE** for information on verifying/documenting relationship.

Documentation: Sufficient to establish an audit trail:

- (a) the date of death; and
- (b) relationship to child.

Disposition: When a child is deprived of parental support/care due to the death of a parent, the child and his/her caretaker relative(s) are ADC-related. In addition, the child and/or caretaker relative may be eligible for other survivor benefits from Social Security, Veterans' Administration, employers, etc.

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

INCAPACITY

Policy: When a child under the age of twenty-one (21) is deprived of parental support and/or care due to the incapacity of one or both parents, the child and the parent or caretaker relative may be ADC-related. The A/R must meet all other requirements to be eligible for Medicaid.

The incapacity results from a medical condition and substantially reduces or eliminates the parent's ability to support/care for his/her child. The incapacity must have existed for at least thirty (30) days or be expected to last at least 30 days.

NOTE: The A/R's statement of his/her relationship to the child which may or may not indicate a deprivation factor is acceptable unless there is a reason to doubt the validity of the relationship. A signed application indicating the relationship and deprivation factor is generally the only verification required. When the relationship or deprivation factor is questionable other verification is necessary.

References: SSL Sect. 366.1(a)(5)(iii)
Dept. Reg. 360-3.3(b)(5)
ADMs 74 ADM-180

Verify Status: When the A/R indicates that a child in the household has an incapacitated parent.

A woman is pregnant or has recently given birth. Pregnancy and/or child birth, by themselves, are not considered incapacitating. There must be additional medical evidence that the mother is incapacitated.

A parent is in, or has recently been released from a hospital, nursing home, or other medical facility.

A parent appears to be or indicates that s/he is blind, sick or disabled.

A parent is in an alcohol or drug treatment program, or indicates that s/he wants treatment.

A parent is in receipt of Workers' Compensation, Veterans' Benefits, N.Y.S. Disability Insurance or RSDI Benefits.

Verification: When eligibility is based upon deprivation of parental support/care due

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

INCAPACITY

to incapacity, the local district verifies and documents the incapacity of the parent and the expected duration of that incapacity through the applicant/recipient's written and/or oral statements.

Documentation: Sufficient to establish an audit trail:

- Receipt of SSI or RSDI Benefits due to disability
- Receipt of Veteran's Disability Benefits
- Receipt of NYS Disability Benefits
- Worker's Compensation
- Other similar benefits
- Disability/Blindness Certificate.
- Receipt of benefits or certification of disability/blindness must be expected to last for at least 30 days.

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

CONTINUED ABSENCE

Policy: When a child is deprived of parental support and/or care due to the continued absence of one or both parents, the child and the remaining parent or caretaker relative are ADC-related. The A/R must meet all other requirements to be eligible for Medicaid.

Generally, when a child is deprived of parental support/care due to the absence of a parent, the A/R is referred to IV-D, to establish paternity and/or secure medical support. (See **OTHER ELIGIBILITY REQUIREMENTS LEGALLY RESPONSIBLE RELATIVES PARENTS AND CHILDREN IV-D REQUIRMENTS**)

References: SSL Sect. 366.1(a)(5)

Dept. Reg. 360-3.3(b)(5)

Interpretation: Continued absence of a parent exists when one or both parents are not living with the child. The absence must interrupt or terminate the parent's ability to function as a provider of maintenance and/or care for the child.

The following are examples of continued absence.

- Imprisonment - A parent is incarcerated.
- Divorce, annulment, or legal separation - Custody of the child, support, alimony and other financial arrangements are usually agreed upon and established by a court.
- Abandonment or desertion - A parent has left or never lived in the child's home. The absent parent may or may not be contributing to the care and maintenance of the child. There is no legal agreement.
- Removal from custody - A child is removed from the custody of his/her parent(s) by court order.

For the purpose of establishing eligibility for Medicaid, continued absence only exists when the duration and/or nature of the parent's absence interrupts or stops the parent from providing maintenance, physical care, and/or guidance to the child.

When the parent's absence is of the duration and/or nature that s/he is still functioning as the A/R's parent, continued absence can

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

CONTINUED ABSENCE

not be used as the deprivation factor. For example: a parent is temporarily absent due to employment in another city, but continues to provide financial support and care to the child.

When to Verify Status: When the A/R indicates that s/he is caring for a child and that the child's parent is not living in the household.

Verification: When eligibility is based upon deprivation of parental support/care due to continued absence, the local district verifies the absence of the parent and, as necessary, the relationship of the parent to the child through the applicant/recipient's written and/or oral statement including the signed application.

When parents share joint custody or are both actively involved with the child, it is determined which parent provides the child's primary home and care. The following are guidelines for joint custody cases and other instances where the child has substantial and continued contact with both parents.

If the parents reside in different school districts, where does the child attend school? Who selects the child's school?

Who assists the child with homework or school related tasks?

Are there any tuition costs related to the child's education? If so, who pays those costs?

If the child is enrolled in day care, who makes the arrangements and pays the costs?

Who is responsible for taking the child to and from school or day care?

Which parent is listed as the contact for emergencies at the child's school or day care centers?

Who arranges medical and dental care for the child?

Who initiates decisions regarding the child's future?

Who responds to emergencies involving the child (i.e., medical or law enforcement emergencies)?

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

CONTINUED ABSENCE

Who provides food and clothing for the child when the child visits the absent parent?

Who has visitation rights? If one parent is given visitation rights, the other parent is the custodial parent.

Who claims the child on his/her income tax may be an indicator of the primary caretaker, but the decision takes into account all the circumstances.

Does one parent pay child support to the other?

When both parents actually share equally in providing for the child, there is no deprivation due to continued absence.

NOTE: If only one parent is applying, the child is included in that parent's household. If both parents apply as separate households, the child is included in the household which results in the most advantageous budgeting for the child.

Documentation: Sufficient to establish an audit trail.

The A/R's statement(s) are acceptable unless there is reason to doubt their validity. In such instances the following documentation should be pursued:

- the address of the absent parent (when obtainable), name and address of person or organization providing information, and date obtained;
- name and address of person or organization verifying that parent is not in home, and date obtained; or
- name of document verifying absence, any identifying numbers and/or dates, and name of the official who signed the document.

**CATEGORICAL FACTORS
ADC-RELATED
DEPRIVATION OF PARENTAL SUPPORT OR CARE**

UN/UNDER EMPLOYED TWO PARENT HOUSEHOLD

Policy: A child (See **CATEGORICAL FACTORS, ADC-RELATED, AGE OF CHILD**), residing with both parents, meets the criteria for ADC-U as long as one of the two parents has been identified as the principal wage earner. This is regardless of whether or not either parent is working, actively seeking employment or has recently been employed. A child whose custody (physical and legal) is evenly shared both parents/households met the categorical eligibility criteria for ADC. Both parents are also considered to be ADC-U.

NOTE: The A/R's statement of his/her relationship to the child which may or may not indicate a deprivation factor is acceptable unless there is a reason to doubt the validity of the relationship. A signed application indicating the relationship and deprivation factor is generally the only verification required. When the relationship or deprivation factor is questionable other verification is necessary.

References:

SSL Sect.	349
ADMs	OMM/ADM 97-2 97 ADM-20
INFs	07 OHIP/INF-1

Interpretation: The principal wage earner may be either parent if neither of the parents is working. If no other deprivation exists, the family is always related to the ADC-U category.

Verify Status: When a child is residing in a two-parent household and neither parent is incapacitated.

Disposition: When a household is determined to be ADC-U-related, the household's income is budgeted using the ADC-related disregards. (See **INCOME ADC-RELATED DISREGARDS**)

If the household is not eligible under ADC budgeting, the A/R is budgeted under FHP; if ineligible under FHP, eligibility is determined for FPBP, etc.

CATEGORICAL FACTORS**SSI-RELATED**

Policy: Persons who are aged (65 and over), certified blind or certified disabled are eligible for Medicaid if they meet financial and other eligibility requirements. These persons are SSI-related.

References:

SSL Sect.	366 366-ee
Dept. Reg	360-3.3(b) 360-5 368
ADMs	10 OHIP/ADM-01 91 ADM-27 87 ADM-41
GIS	09 MA/027 08 MA/022

Medicaid Disability Manual

Interpretation: Eligibility for SSI-related A/Rs is determined by comparing income, after appropriate deductions to the Medically Needy Income level or the Medicaid Standard (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial. Resources are compared to the appropriate resource levels. When an A/R is SSI-related and ADC-related, s/he is offered a choice between SSI-related budgeting and ADC-related budgeting. (See **INCOME BUDGETING**) If the individual's income eligibility is the same under both budget types and the individual is not eligible for, or does not wish to participate in Medicaid Buy-In for Working People with Disabilities (MBI-WPD), the individual must be given the ADC-related category of assistance, since benefits under this category are not limited based on resources.

A certified blind or disabled individual who documents or attests to resources in excess of the Medicaid resource level must have eligibility considered for FHPlus. Resources are not considered in the eligibility determination for FHPlus.

The following sections describe SSI categorical requirements:

- Age (65 and over);
- Blindness; and
- Disability.

**CATEGORICAL FACTORS
SSI-RELATED****AGE (65 OR OVER)**

Policy: All persons 65 years of age and over are eligible to receive Medicaid, if they meet the financial and other eligibility requirements.

References:

SSL Sect.	366 366.1 366-ee
ADMs	10 OHIP/ADM-01
Dept. Reg.	360-3.3(b)(1)
GISs	09 MA/027

Interpretation: When determining eligibility for A/Rs age 65 or over, local districts offer a choice between the SSI-related budgeting and ADC-related budgeting if the A/R also meets the requirements for ADC-related Medicaid. If the individual's income eligibility is the same under both budget types, the individual must be given the ADC-related category of assistance, since benefits under this category are not limited based on resources. (See **INCOME** ADC-RELATED BUDGETING)

When to Verify Status: Verify status when:

- (1) the A/R's birth date indicates that s/he is age 65 or approaching 65.
- (2) the A/R indicates that s/he receives Medicare, Social Security, Railroad Retirement or other pension benefits. These benefits may indicate that the A/R is aged. However, these benefits may be based on disability, early retirement, etc.

Verification Process: The age of a certified blind or certified disabled adult does not affect eligibility, and therefore, verification of age does not delay case processing.

The following documents are used to verify age:

Birth Certificate
Adoption papers or records
Hospital or clinic records
Driver's License

**CATEGORICAL FACTORS
SSI-RELATED**

AGE (65 OR OVER)

Church records
Baptismal Certificate
Vital Records Office of the New York State Department of Health
Municipal Local Registrar Records
U.S. Passport
Census records
Immigration and Naturalization Service Records
Records of birth maintained by SSA
Physician's statement

Documentation: Sufficient to establish an audit trail:

the date of birth,
place and date of filing,
identifying numbers of the available document, and
the name of the official who signed the document.

Disposition: Persons 65 or over are advised of benefits which may be available to them under the Supplemental Security Income (SSI) program. If they appear eligible and express interest they are referred to the local Social Security District Office for a determination of SSI eligibility. Application for SSI is **not** a condition of eligibility for Medicaid.

**CATEGORICAL FACTORS
SSI-RELATED**

BLINDNESS

Policy: Persons of any age are eligible to receive Medicaid when they are certified blind by the Commission for the Blind and Visually Handicapped, providing they meet the financial and other eligibility requirements.

References:

SSL-Sect.	366 366-ee
Dept. Reg.	368
ADMs	10 OHIP/ADM-01 87 ADM-41
GISs	09 MA/027

Medicaid Disability Manual

Interpretation: To be eligible as blind, individuals are certified as legally blind by the Commission for the Blind and Visually Handicapped. Total blindness is not required for such certification and all A/Rs evidencing obvious visual impairments are considered for this category. If a person shows evidence of multiple impairments, a classification of blindness takes precedence over other disabilities.

If an A/R's vision improves to the point that s/he is no longer certified blind, the A/R remains SSI-related for two months following the month his/her blindness is overcome. To be eligible for Medicaid, the A/R must still meet all other requirements.

Exception: Persons who were eligible as Medicaid-only blind persons in December, 1973 **and** who continue to meet the December, 1973 criteria for blindness, continue to have their blindness evaluated by the Commission for the Blind and Visually Handicapped in accordance with the December, 1973 standards for as long as they remain eligible for Medicaid.

When to Verify Status: Verify status when:

- (1) the A/R indicates blindness or a severe vision impairment on the application.
- (2) When the A/R shows evidence of blindness or obvious visual impairment.
- (3) When the A/R indicates present or past employment at a workshop for the visually handicapped.

**CATEGORICAL FACTORS
SSI-RELATED**

BLINDNESS

- (4) When the A/R indicates on the application that s/he is in receipt of Social Security Disability benefits or other disability pension benefits based on his/her visual impairment.

**Verification
Process:**

Verification of legal blindness for the purpose of establishing eligibility for Medicaid is certification from the Commission for the Blind and Visually Handicapped (CBVH). If the A/R is unable to provide his/her certification, the local district submits form LDSS-2353, "Eye Examination Clearance - Blind Applicant for Medicaid" to the Commission to determine if the A/R is registered. If the A/R is unknown to the Commission, a report of an eye examination by an ophthalmologist or an optometrist is submitted on the appropriate form (i.e., LDSS-3377 Rev. 2/82, Mandatory Eye Examination Report, Commission for the Blind and Visually Handicapped) to the Commission for certification.

Documentation: Sufficient to establish an audit trail:

- (a) a copy of the certification of blindness from the Commission for the Blind and Visually Handicapped included in the case record; or
- (b) the date of certification, Commission Registration number and/or name of the official who signed the document.

Disposition:

If the A/R meets the above requirements, s/he is considered SSI-related and his/her income and resources are compared to the medically needy income levels in **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** and the resource levels also found in **REFERENCE MEDICAID RESOURCE LEVELS** to determine eligibility for Medicaid. Such persons are offered a choice between the SSI-related budgeting methodology and the ADC-related budgeting methodology, provided s/he meets the requirements for ADC. If the individual's income eligibility is the same under both budget types and the individual is not eligible for, or does not wish to participate in Medicaid Buy-In for Working People with Disabilities (MBI-WPD), the individual must be given the ADC-related category of assistance, since benefits under this category are not limited based on resources.

The A/R is advised of the benefits available through the SSI program. If s/he is interested, s/he is referred to the local SSA District Office for a determination of his/her SSI eligibility. Application for SSI is **not** a condition of eligibility for Medicaid.

**CATEGORICAL FACTORS
SSI-RELATED**

DISABILITY

Policy: Persons under the age of 65, who are certified disabled by either the Social Security Administration (SSA), the State Medicaid Disability Review Team, or local Medicaid Disability Review Team are eligible to receive Medicaid providing they meet all the financial and other eligibility requirements.

Disability is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

A child may be determined disabled if s/he has a medically determinable physical or mental impairment that results in marked and severe functional limitations that have lasted or are expected to last for at least 12 months or result in death.

The standards used to determine disability for Medicaid A/Rs are the same as those used by SSA to determine eligibility based on a disability for SSI or Retirement, Survivors' Disability Insurance (RSDI) (See Medicaid Disability Manual). However, for the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) (See **CATEGORICAL FACTORS MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES**) the first step of the sequential evaluation, known as the SGA test (See **CATEGORICAL FACTORS SUBSTANTIAL GAINFUL ACTIVITY**), is eliminated.

All disability determinations for MBI-WPD are performed by the State Disability Review Team.

References:

SSL Sect.	366 366-ee
Dept. Reg.	360-2.4(a)(2) 360-3.3(b)(2) 360-5
Medicaid Disability Manual	
ADMs	10 OHIP/ADM-4 10 OHIP/ADM-2 10 OHIP/ADM-01 04 OMM/ADM-5

**CATEGORICAL FACTORS
SSI-RELATED**

DISABILITY

	03 OMM/ADM-4
	92 ADM-52
	90 ADM-17
	88 ADM-42
	87 ADM-41
	80 ADM-48
	78 ADM-35
INFs	92 INF-41
	87 INF-4
	05 OMM/INF-1
LCMs	98 OMM/LCM-009
	98 OMM/LCM-003
GISs	10 MA/003
	09 MA/027
	06 MA/005
	05 MA/023
	96 MA/028

Interpretation:

The receipt of SSI or RSDI benefits based on a disability is acceptable proof of disability. Persons in receipt of Railroad Retirement benefits as "totally and permanently" disabled are also considered disabled for Medical Assistance purposes. Workers' Compensation, New York State Disability and Veterans' Administration benefits do not confer automatic disability for Medicaid purposes. A separate disability determination is completed for recipients of these programs. Potentially disabled A/Rs are advised of any benefits that they might qualify for under SSI and/or RSDI and referred to the SSA district office. Application for SSI, however, is not a condition of eligibility for Medicaid. A/Rs for Medicaid, who claim an impairment or unemployability due to sickness or disability that has or is expected to last at least 12 months, are referred to the local or State Medicaid Disability Review Team or the Social Security Administration.

All disability determinations for MBI-WPD as well as determinations for individuals who are age 65 or over and are establishing a pooled trust are performed by the State Disability Review Team.

Medicaid disability reviews are conducted when a determination of disability will yield a Medicaid benefit to the A/R or a financial benefit to the Medicaid program. For example:

CATEGORICAL FACTORS SSI-RELATED

DISABILITY

- More favorable budgeting that would enable a single adult or member of a childless couple (SCC) to obtain Medicaid or Family Health Plus if he/she does not meet the public assistance standard of need;
- Budgeting that would enable an A/R who is otherwise financially ineligible to obtain full Medicaid benefits, with or without a spenddown;
- Exclusion of an asset from a transfer penalty if the A/R has transferred the asset to an adult child who is determined to be disabled;
- Exclusion of funds deposited in a pooled trust.

An example of a financial benefit to the Medicaid program is the placement of an SCC A/R into a federally participating category which assists in meeting the cost neutrality provisions of the 1115 Managed Care Waiver.

Disability determinations are completed for all A/Rs under the age of 65 who are citizens or qualified aliens not in the federal five year ban, and who appear to meet the Social Security Administration disability criteria. The A/R is given an informed choice between SSI-related budgeting and any other appropriate category when s/he is eligible under more than one category.

Disability determinations are completed for Aliessa aliens (qualified aliens in the five year ban and PRUCOL aliens) only if a determination of disability will provide a Medicaid benefit for the A/R. There is no financial benefit to the Medicaid program, as federal financial participation cannot be obtained for these A/Rs, nor are they included in the federal 1115 waiver. Thus, if an Aliessa alien A/R is eligible for full Medicaid coverage without a disability determination, there is no requirement to perform a Medicaid disability review for the A/R.

When a non-SSI-related Medicaid recipient dies, his/her case, medical condition and expenditures are reviewed for referral to the Medicaid Disability Review Team.

The disability review process takes into consideration the severity and extent of the individual's medical condition and resulting functional limitations. It may also take into account the individual's

**CATEGORICAL FACTORS
SSI-RELATED****DISABILITY**

age, education and previous work experience. All A/Rs who are potentially SSI-related as disabled persons or their representatives are informed of the disability category. The information includes, but is not limited to:

- (a) The disability review process;
- (b) The need for the individual to cooperate in securing detailed medical documentation from treating sources and the possible need for the individual to have an examination(s), consultation(s) and/or diagnostic test(s);
- (c) The need for the individual to provide social and functional information, such as education and details of their past work experience;
- (d) The time frames involved in the disability process; and
- (e) The potential benefit(s) to the individual of a disability certification, such as a different budgeting methodology, an increased Food Stamp benefit and the identification of medical and/or social resources that may assist the A/R.

Each A/R who is potentially SSI-related as a disabled individual (or his/her representative) must complete a LDSS-1151 - "Disability Interview." Special emphasis is placed on the individual's education, special training if any, work experience during the past fifteen (15) years, disability related income, medical care received and the individual's functional capacity.

Districts may not require an individual to come to the district for an interview. However, districts may complete the Disability Interview form (LDSS-1151) by telephone.

To initiate the medical evidence packet, districts may mail the LDSS-1151 and the district-specific Release of Medical Information form to the applicant or they may conduct a telephone interview to complete the LDSS-1151 form. If attempting to conduct the interview by telephone districts must make three attempts to contact the individual before resorting to the mail. When the LDSS-1151 form is returned to the district, it is important that the information on the form be reviewed by the district worker for completeness and the form is signed by the worker. If the form is not complete, it is the responsibility of the worker to contact the applicant and obtain the information before submitting the packet for a disability review.

**CATEGORICAL FACTORS
SSI-RELATED**

DISABILITY

Whether the district chooses to obtain completed disability forms by mail or via the telephone, if the individual requests assistance or wishes to have an interview in person, the district must accommodate the request.

Medical evidence is gathered as soon as possible to meet the time frames of the application/recertification process. Medical evidence may include a completed LDSS-486: "Medical Report for Determination of Disability," from a physician, hospital admission and discharge summaries, clinic reports, diagnostic test results and reports from practitioners such as therapists, nurse practitioners, physicians' assistants, optometrists, chiropractors, psychiatric social workers and audiologists.

**CATEGORICAL FACTORS
SSI-RELATED****DISABILITY**

The local or State Medicaid Disability Review Team evaluates the medical evidence, considering such factors as the individual's age, education, work experience and residual functional capacity to determine if the A/R is disabled. The Medicaid Disability Review Team completes the LDSS-639: "Disability Review Team Certificate" for each potentially disabled A/R. The LDSS-639 contains the determination and the regulatory basis for that determination. It documents any request(s) for additional medical and/or social information, the effective date of disability and expiration date of disability, if applicable. The entire disability determination process is completed within 90-days of the initial application/recertification. If the process takes more than 90 days, on the 90th day the A/R is sent a written statement giving the reason for the delay. When the disability process is completed, the A/R is given a written notice of the determination, the reasons for it and the regulatory basis. (See **OTHER ELIGIBILITY REQUIREMENTS DECISION AND NOTIFICATION**)

There are two categories of disability:

Group I includes persons who show no possibility of engaging in any substantial gainful work activity. They have a physical and/or mental impairment(s) which is disabling and considered irreversible. These cases have no disability end date on the LDSS-639 "Disability Review Team Certificate."

Group II includes individuals who have disabling impairments at the time of determination, but are expected to show an improvement in physical and/or mental status, enabling them to become capable of substantial gainful activity. Some reasons for improvement are: the condition is arrested; a remission occurs; therapeutic advances occur; and/or rehabilitation.

NOTE: End dates for all Group II certifications must be tracked through WMS and medical evidence gathered for a continuing disability review prior to the Group II disability end date.

When an individual re-applies after previously being certified disabled, another disability review is not necessary if the disability end date has not yet expired, unless: 12 months or more have elapsed since the date of the last case closing, or the individual has in the interim engaged in a useful occupation, or has had a significant change in treatment such as surgery or rehabilitation.

**CATEGORICAL FACTORS
SSI-RELATED****DISABILITY**

Medicaid is available for recipients who are certified disabled through the second month following the month in which disability ceases. When a recipient's health improves and s/he is no longer certified disabled, the recipient remains SSI-related for two months following the month his/her disability ends. To be eligible for Medicaid, the recipient must still meet all other requirements. (See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** for medically needy requirements and **REFERENCE MEDICAID RESOURCE LEVELS** for resource requirements)

- When to Verify:**
- (a) When the A/R indicates that s/he is in or was in receipt of SSI benefits based on disability;
 - (b) When the A/R indicates that s/he is in receipt of RSDI benefits based on disability;
 - (c) When the A/R indicates that s/he has excessive medical bills;
 - (d) When the A/R indicates that s/he is in or has recently been released from a hospital, nursing home or other institution;
 - (e) When the A/R indicates that s/he is or was chronically sick, disabled, or mentally impaired;
 - (f) Substance abuse (alcoholism or drug abuse) in and of itself is not considered a disability under the Social Security disability criteria. Individuals who have substance abuse disorders are asked about and evaluated for any other co-existing mental or physical impairments they may have that prevent them from working;
 - (g) When the A/R indicates that a continuing illness or disability was his/her reason for leaving school or employment;
 - (h) When the A/R indicates receipt of benefits based on illness or disability (e.g., Workers' Compensation, Veterans' Benefits, NYS Disability, employer disability pensions, etc.);

**CATEGORICAL FACTORS
SSI-RELATED****DISABILITY**

- (i) When the A/R appears to suffer from a physical and/or mental impairment. Some examples are difficulty walking, standing, breathing, concentrating, following instructions or remembering;
- (j) When the A/R indicates present or past employment at a sheltered workshop or participation in a rehabilitation program;
- (k) When the A/R indicates that s/he has outstanding medical bills during the three-month period prior to the date on which s/he became eligible for SSI;
- (l) When the NYS Department of Health identifies cases with potentially disabling diagnoses that have not previously been reviewed for disability.

Verification:

When the A/R is SSI-related because s/he receives SSI or RSDI, the A/R provides documentation of the Social Security Administration's determination of disability. A copy of the SSA benefit check is sufficient proof of disability since it shows the RSDI claim number. Certain alpha suffixes on the claim number identify the check as a disability payment (See **INCOME SOCIAL SECURITY RETIREMENT, SURVIVORS AND DISABILITY INSURANCE/RAILROAD RETIREMENT AND VETERAN'S BENEFITS**). Local districts contact the SSA office to determine the current alpha suffix for disability checks.

When an A/R loses eligibility for SSI cash for reasons unrelated to his/her medical condition, generally a disability determination is not required. If the A/R lost eligibility prior to the date when SSA was to be reevaluating the A/R's medical condition, the A/R is considered disabled until his/her medical diary reexamination date. The local district contacts the SSA district office to obtain the medical diary reexamination date and the reason why SSI benefits were terminated.

When the determination of disability is made by the local or State Medicaid Review Team, a copy of the most current LDSS-639: "Disability Review Team Certificate" is included in the case record.

NOTE: End dates for all Group II certifications must be tracked through WMS and medical evidence gathered for a continuing disability review prior to the Group II disability end date.

**CATEGORICAL FACTORS
SSI-RELATED**

DISABILITY

Documentation: Sufficient to establish an audit trail:

- (a) A copy of the RSDI award letter, RSDI check or sufficient identifying information (i.e., date of award, name of official signing the document);
- (b) A current LDSS-639 indicating Group I or Group II certificate of disability by the State or local Review Team;
- (c) The code indicating disability on the SDX;
- (d) An SSA 1610 completed by the SSA district office; or
- (e) A copy of the information from the Third Party Query System.

Disposition: When an A/R is certified disabled, s/he is SSI-related. After following the appropriate budgeting procedures (See **INCOME SSI-RELATED BUDGETING METHODOLOGY**), his/her income is compared to the Medically Needy Income level or the Medicaid Standard (and MBL Living Arrangement Chart as appropriate) whichever is most beneficial (See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS, LIVING ARRANGEMENT CHART**). His/her resources are compared to the appropriate Medicaid resource level (See **REFERENCE MEDICAID RESOURCE LEVELS**). SSI-related A/Rs are offered a choice between SSI-related budgeting and ADC-related budgeting methodology, when they also meet ADC categorical requirements. If the individual's income eligibility is the same under both budget types and the individual is not eligible for, or does not wish to participate in Medicaid Buy-In for Working People with Disabilities (MBI-WPD), the individual must be given the ADC-related category of assistance, since benefits under this category are not limited based on resources.

The A/R is advised of benefits which may be available to him/her under the Social Security Disability (SSD) and/or Supplemental Security Income (SSI) programs. If s/he is interested, s/he is referred to the local Social Security District Office for a determination of SSI and/or SSD eligibility.

The A/R is also informed of the possibility of receiving an increased Food Stamp benefit if an individual is certified disabled. When a PA or Medicaid recipient is certified disabled, the cost of his/her medical care and services may be claimed as SSI-related retroactively from the effective date of disability, subject to the two year federal claiming limitations.

**CATEGORICAL FACTORS
SSI-RELATED****SUBSTANTIAL GAINFUL ACTIVITY (SGA)**

Description: Persons who are performing Substantial Gainful Activity (SGA) are not usually considered disabled. However, local districts must refer all such cases to the State Disability Review Team for a disability determination for the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD).

Policy: SGA is work activity that involves performing significant physical and/or mental activities for pay or profit. Work can be substantial and gainful even if it is performed part-time or requires less responsibility than former work.

Activities such as household tasks, hobbies, club activities or social programs generally are not considered substantial gainful activity.

References: Dept. Reg. 360-5.2

Disability Manual

GISs 06 MA/029
04 MA/031

Interpretation: The amount of gross monthly earnings from work activities (minus appropriate impairment-related work expenses) may establish that the individual is engaging in SGA.

The maximum amount of gross earnings is identified in the **REFERENCE SUBSTANTIAL GAINFUL ACTIVITY**. When an individual's gross earnings from work activities average in excess of the identified monthly amount, this generally demonstrates the ability to engage in SGA in the absence of evidence to the contrary (See **DISABILITY MANUAL**). Federal regulations provide for annual automatic cost of living adjustments to the SGA threshold amount.

NOTE: When evaluating whether or not an individual is performing SGA, consider the nature of the work being done, the adequacy of the performance, any special employment conditions and the amount of time that is spent in work activity.

When to Verify: When a potentially disabled A/R declares that s/he is employed.

**CATEGORICAL FACTORS
SSI-RELATED****SUBSTANTIAL GAINFUL ACTIVITY (SGA)**

Documentation: Sufficient to establish an audit trail:

- Employer statement concerning any subsidy, special condition of employment, performance at work;
- Pay stubs; or
- Impairment-related expense receipts.

**CATEGORICAL FACTORS
SSI-RELATED****TRIAL WORK PERIOD****Policy:**

A trial work period (TWP) is a period during which a certified disabled individual may test his or her ability to work and still maintain disability status. During this trial work period, an individual who is still medically impaired may perform "services" in as many as nine (9), not necessarily consecutive, months. "Services" in this section means any activity in employment or self-employment for pay or profit or the kind of activity normally done for pay or profit.

Effective January 1, 2005, a trial work period month is any calendar month in which the certified disabled recipient earnings exceed the TWP level. The TWP amount changes each year. The current amount can be found in **REFERENCE TRIAL WORK PERIOD**. For self-employed individuals, a calendar month counts as a trial work month when his/her earnings are more than the TWP level or the individual works more than 80 hours per month. Federal regulations provide for annual cost of living adjustments to the trial work threshold amount.

References:

Dept. Reg. 360-5.9

GISs 06MA/029
 04 MA/031

Disability Manual

Interpretation:

For the purpose of calculating the number of months associated with a trial work period, the time spent on certain activities is **NOT** considered if the activity is:

1. Part of a prescribed program of medical therapy;
2. Carried out in a hospital under the supervision of medical and/or administrative staff;
3. Not performed in an employer-employee relationship; or
4. Not normally performed for pay or profit.

**CATEGORICAL FACTORS
SSI-RELATED****TRIAL WORK PERIOD**

During the trial work period the A/R may still be considered disabled even if the earnings exceed the Substantial Gainful Activity (SGA) limit (See **REFERENCE** SUBSTANTIAL GAINFUL ACTIVITY).

At the end of the trial work period, there is an evaluation of the individual's ability to perform SGA. The evaluation may include a medical review to see if the individual still meets the disability criteria.

When to Verify: When a certified disabled A/R indicates potential earnings from employment or indicates s/he would like to work.

Documentation: Sufficient to establish an audit trail:

Pay stubs;

Returned clearance in case record; or

Note indicating duration of employment.

CATEGORICAL FACTORS**EMPLOYMENT SUBSIDIES**

- Description:** An employer may subsidize the earnings of an individual with a disability by paying more in wages than the reasonable value of the actual services performed.
- Policy:** When determining whether or not subsidized employment constitutes Substantial Gainful Activity (SGA), only the real value of the work is considered. When determining financial eligibility for Medicaid, the entire income from subsidized employment is considered.
- References:**
- ADMs 87 ADM-44
 83 ADM-65
- Disability Manual
- GISs 06 MA/029
 99 MA/014
- When to Verify:**
- (a) When an apparently disabled individual is earning over the Substantial Gainful Activity (SGA) figure (See **REFERENCE SUBSTANTIAL GAINFUL ACTIVITY**);
 - (b) When an individual's pay may not reflect the actual level of productivity;
 - (c) When the A/R's employment is sheltered;
 - (d) When a childhood disability is involved; or
 - (e) When a mental impairment is involved.

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

Policy: Sections 62-69 of Part A of Chapter 1 of the Laws of 2002 extends Medicaid coverage to working disabled applicants/recipients (A/Rs) who have net incomes at or below 250% of the Federal Poverty Level (FPL) and non-exempt resources at or below the appropriate Medicaid Resource Level.

Unlike other Medicaid programs, the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) is a work incentive program and work activity is a requirement of eligibility.

SSI-related budgeting, including allocation and deeming, is used for determining net available income and resources. (See **INCOME MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES** for a discussion on budgeting of income and **RESOURCES MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES** for budgeting of resources.)

At application, individuals in the MBI-WPD program may attest to resources other than trusts, burial funds and Third Party Health Insurance, if not requesting Medicaid coverage of long term care services. At renewal/recertification, individuals in the MBI-WPD program may attest to income including interest income, residence, and itemized resources but must document employment.

Managed Care is a voluntary option for MBI-WPD individuals who are income eligible under 150% FPL. Mandatory Managed Care counties cannot require these individuals to enroll in a Managed Care plan. MBI-WPD individuals with income at or above 150% FPL are excluded from Managed Care. Such individuals may voluntarily participate in Managed Long Term Care.

References:

SSL Sect.	366(1)(a)(12) & (13)
ADM	11 OHIP/ADM-1 11 OHIP/ADM-7 10 OHIP/ADM-2 04 OMM/ADM-5 03 OMM/ADM-4
GISs	11 MA/017 10 MA/003 09 MA/015 08 MA/027 08 MA/004

CATEGORICAL FACTORS**MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES**

Interpretation: The Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) consists of two groups of A/Rs, the Basic Coverage Group and the Medical Improvement Group. For eligibility in either group, work activity must be documented.

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

A. The Basic Coverage Group

The Basic Coverage Group includes individuals who meet the following requirements:

- The A/R is certified disabled (See **CATEGORICAL FACTORS SSI-RELATED BLINDNESS AND SSI-RELATED DISABILITY AND ACCEPTABLE PROOF OF DISABILITY**).
- The A/R is at least 16 years of age, but under the age of 65.
- The A/R is working and receiving financial compensation. There is no minimum number of hours that an individual must work per month, nor is there a minimum wage requirement. However, there must be work activity in each month that MBI-WPD coverage is sought, unless the individual has been granted a grace period.
- The A/R has a net income at or below 250% of the FPL.
- The A/R has non-exempt resources that do not exceed the appropriate Medicaid Resource Level.

1. Basic Coverage Group Work Requirements

For the MBI-WPD program, work consists of engagement in a work activity for which financial compensation is received. The Basic Group has no minimum number of hours for such work activity.

Proof of work activity includes: current pay stub(s); paycheck(s) or a detailed written statement from an employer. If these documents are not available, the individual's income tax return, W-2 form, or records of bank deposits may be used. If an individual is not required to pay taxes, a sheltered workshop employee, for example, the applicant is not denied eligibility for the MBI-WPD program.

A time-limited activity that prepares an individual for work, such as a training program, does not meet the work requirement because it is preparation for work. Once a training program is completed and employment secured, an individual may be eligible for the MBI-WPD program.

Seasonal work may be considered work for the MBI-WPD program for the duration of the employment. If the work ends, a grace period may be granted if the individual continues to look for employment.

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

2. Grace Periods for the Basic Coverage Group

Grace periods for the Basic Coverage Group allow for lapses in work activity due to job loss or a change in medical condition that is through no fault of the individual. The Job Loss Grace Period and the Change in Medical Condition Grace Period provide coverage up to six months in a twelve-month period. Multiple grace periods are allowed in the twelve-month period but the sum of the grace periods may not exceed six months. The first day of the grace period starts the twelve-month period. Both types of grace periods require written verification, one from the employer for the job loss grace period and one from an acceptable medical source for the change in medical condition grace period. If the recipient has not secured employment by the end of the grace period, his or her eligibility for MBI-WPD ends and continued eligibility under other Medicaid programs must be evaluated.

B. The Medical Improvement Group

The Medical Improvement Group includes individuals who meet the following requirements:

- The A/R is at least 16 years of age, but under the age of 65.
- The A/R has a net income at or below 250% FPL.
- The A/R has non-exempt resources that do not exceed the appropriate Medicaid resource level.
- The A/R has lost eligibility under the Basic Coverage Group due to the direct and specific result of medical improvement. The A/R is no longer certified disabled, but continues to have a severe medically determined impairment. A recipient can only be added to the Medical Improvement Group by action of the State Disability Review Team at the time of a Continuing Disability Review (CDR).
- The A/R is working and receiving financial compensation. The A/R in the Medical Improvement Group must be employed at least 40 hours per month and earn at least the federally required minimum wage.

1. Medical Improvement Group Work Requirements

For the MBI-WPD program, work consists of engagement in a work activity for which financial compensation is received. For the Medical

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

Improvement Group, work activity must be at least 40 hours per month and paid at no less than the applicable federal minimum wage.

Proof of work activity includes: current pay stub(s); paycheck(s) or a detailed written statement from an employer. If these documents are not available, the individual's income tax return, W-2 form, or records of bank deposits may be used. If an individual is not required to pay taxes, a sheltered workshop employee, for example, the applicant is not denied eligibility for the MBI-WPD program.

A time-limited activity that prepares an individual for work, such as a training program, does not meet the work requirement because it is preparation for work. Once a training program is completed and employment secured, an individual may be eligible for the MBI-WPD program.

Seasonal work may be considered work for the MBI-WPD program for the duration of the employment. If the work ends, a grace period may be granted if the individual continues to look for employment.

Any working individual who had coverage discontinued under the MBI-WPD Medical Improvement Group and is reapplying for the MBI-WPD program, must meet all of the requirements for the MBI-WPD Basic Coverage Group, including certification of disability, in order to participate in the program again.

2. Grace Periods for the Medical Improvement Group

Grace periods for the Medical Improvement Group allow for lapses in work activity due to job loss or a change in medical condition that is through no fault of the individual. The Job Loss Grace Period and the Change in Medical Condition Grace Period provide coverage up to six months in a twelve-month period. Multiple grace periods are allowed in the twelve-month period but the sum of the grace periods may not exceed six months. The first day of the first grace period starts the twelve-month period. Both types of grace periods require written verification, one from the employer for the job loss grace period and one from an acceptable medical source for the change in medical condition grace period. If the recipient has not secured employment by the end of the grace period, his or her eligibility for MBI-WPD ends and continued eligibility under other Medicaid programs must be evaluated.

CATEGORICAL FACTORS**MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES****NOTE:**

- Grace periods may be authorized if the individual's income does not meet the hourly work and/or wage requirement. This may be due to a job loss or change in medical condition. Written verification for either grace period is required.
- If, at the end of a change in medical condition grace period, the individual continues to work less than 40 hours a month, a Continuing Disability Review (CDR) must be performed to determine eligibility for the Basic Coverage Group.
- If an individual is not working at the end of a job loss grace period, Medicaid eligibility must be determined in a non-SSI-related category, as the individual is medically improved, and not disabled. If the individual needs a disability determination, a CDR must be performed for the Aid to the Disabled program.

3. Other Medical Improvement Group Work Issues

- Local districts must review the individual's work activity and wage rate every 6 months.
- If the individual's income does not meet the hourly work and/or wage requirement or has increased or decreased at the time of the 6 month work and wage review, the local district must re-determine eligibility for the MBI-WPD program and/or determine eligibility for other Medicaid programs and take appropriate action. If the individual's work hours fall below the required 40 hours or the minimum wage requirement, the individual may be eligible for a grace period.
- To determine the hourly wage for a self-employed individual in the Medical Improvement Group, gross monthly income is divided by the number of hours worked as attested by the recipient. The result is rounded to the nearest penny and compared to the federal minimum wage.

NOTE: The six-month work and wage check does not eliminate the recipient's responsibility to report any change income within 10 days of the change.

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

Eligibility under the Medicaid Level

The MBI-WPD program is the most advantageous program for an A/R who is found to meet the eligibility requirements for both Medicaid without a spenddown and the MBI-WPD program. This is because a person in the MBI-WPD program can medically improve without an adverse impact on eligibility while A/Rs who are in receipt of Medicaid under the Aid to Disabled program will lose such eligibility in the event they have medical improvement.

In situations where the A/R is found to be eligible for Medicaid without a spenddown AND the MBI-WPD program, the A/R is encouraged to choose the most advantageous program, and must be given a copy of the *Explanation of the MBI-WPD Program* and have all questions answered regarding the program and its eligibility requirements so that he/she may make an informed choice between the two programs.

Substantial Gainful Activity (SGA) and Transition to MBI-WPD

New Medicaid applicants:

If the gross earnings from work, minus Impairment Related Work Expenses (IRWES) (See **INCOME IMPAIRMENT RELATED WORK EXPENSES**) are greater than the SGA level (See **CATEGORICAL FACTORS SUBSTANTIAL GAINFUL ACTIVITY** and **REFERENCE SUBSTANTIAL GAINFUL ACTIVITY**), and the individual does not have acceptable certification of disability, a disability determination must be performed by the State Disability Review Team for the MBI-WPD program.

If the gross earnings from work minus IRWES are less than the SGA level, the A/R is encouraged to participate in the MBI-WPD program, or the Medicaid Aid to the Disabled program, whichever is most beneficial.

Medicaid renewals:

If a certified disabled Medicaid A/R who is not participating in the MBI-WPD program reports an increase in income and the earnings from work minus IRWEs are greater than SGA, the individual must be transitioned to the MBI-WPD program.

CATEGORICAL FACTORS

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES

If the gross earnings are less than SGA, the individual is encouraged to participate in the MBI-WPD program, or the Medicaid Aid to the Disabled program, whichever is most beneficial.

Extended Period of Eligibility

A/Rs who have lost SSDI benefits due to substantial work, following a nine-month trial work period, and who are entitled to a 36-month extended period of eligibility (EPE), may be enrolled in the MBI-WPD Basic Coverage Group for the duration of the EPE. IF all other eligibility requirements for the program are met a new disability determination is not necessary. Approximately 2-3 months prior to the end of the EPE, appropriate medical evidence must be obtained and submitted with a complete disability packet to the SDRT for a Continuing Disability Review (CDR). Documentation of the diagnosis(es) for which the applicant was determined disabled by SSA must be obtained in order for the CDR to be performed.

Trial Work Period and Transition to MBI-WPD

A/Rs in the Aid to the Disabled category of Medicaid may be granted a Trial Work Period (See **CATEGORICAL FACTORS TRIAL WORK PERIOD**) of up to 9 months to determine if the A/R can develop a consistent pattern of work. In such instances, care must be taken to transition the recipient to the MBI-WPD program before the Trial Work Period ends or the disability certificate expires. Subsequent Continuing Disability Reviews (CDRs) for these individuals must be performed by the State Disability Review Team (SDRT).

SSI 1619 (b) Program and Transition to MBI-WPD

An A/R who has lost eligibility for 1619 (b) due to excess income and/or resources may be enrolled in the MBI-WPD Basic Coverage Group without a disability determination if the SSI medical diary date has not yet expired and all other eligibility requirements are met. Approximately 2-3 months prior to the medical diary date, appropriate medical evidence from providers must be obtained and submitted to the SDRT for a CDR. Documentation of the diagnosis(es) for which the applicant was determined disabled by SSA must be obtained in order for a CDR to be performed.

CATEGORICAL FACTORS**MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES**

Documentation: Applicants for the MBI-WPD program must provide proof of disability. Acceptable proof of disability includes the following:

- A current disability certification by the State or local Disability Review Team (DRT);
- a verification of receipt of Railroad Retirement benefits due to total and permanent disability;
- A current disability certification by the Social Security Administration (SSA), for SSDI benefits; this may include a current award letter, proof of receipt of SSDI benefits such as a check or bank statement listing the benefit, or a Medicare card;
- A current certification from the Commission for the Blind and Visually Handicapped (CBVH);
- A current letter from SSA placing the individual in a SSDI Extended Period of Eligibility;
- A current SSA letter informing the individual that he/she is no longer eligible for the 1619 (b) program (the SSA medical diary date is required).

NOTE: Districts must track the disability end date for an MBI-WPD program recipient who is in an Social Security Disability Income (SSDI) 36 month Extended Period of Eligibility or who has transitioned to the MBI-WPD program from the SSA 1619(b) program.

NOTE: End dates for all Group II certifications must be tracked through WMS and medical evidence gathered for a continuing disability review prior to the Group II disability end date. The DOH-5029, "Medical Report for MBI-WPD MI CDR" must be used when gathering medical information for a Continuing Disability Review (CDR) for an individual in the MBI-WPD Medical Improvement (MI) Group. One DOH-5029 completed in its entirety, and signed and dated by an acceptable medical source is submitted to the State Disability Review Team for a determination of the individual's continued MI eligibility. To be completed in its entirety, the treating physician must complete Part A of the form filling in all current diagnoses. Parts B, C and D must be completed if indicated (see instructions on the form. Acceptable medical sources are listed in the NYS "Medicaid Disability Manual". If an acceptable medical source does not complete the DOH-5029 in its entirety and sign and date the form, the district must follow the instructions in the NYS "Medicaid Disability Manual" for gathering medical information for the CDR.

CATEGORICAL FACTORS**MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES**

Applicants for the MBI-WPD Program must provide proof of work activity. Acceptable proof of work activity includes the following:

- A current pay stub(s), paychecks, or a written statement from the employer stating the hours worked and the wages paid;
- A current income tax return, W-2 form, or records of bank deposits;
- If the individual is not required to file an income tax return, work activity may be documented by pay stubs or a letter from the employer stating the hours worked and wages paid. If the individual presents a personal check as a “paycheck”, a statement from the employer is needed to document that the check is for work activity. If the recipient is in the Medical Improvement group, the letter must also include the number of hours worked;
- A self-employed individual may present a worksheet of hours worked, for whom, and income earned from each client.

CATEGORICAL FACTORS**UNDER AGE 21**

Policy: Persons under the age of 21 are eligible for Medicaid if they meet all other eligibility requirements. For Medicaid purposes, a person under the age of 21 is a child.

References:

SSL Sect.	366 366.1(a) (5) 366-ee
Dept. Reg.	360-3.3(b) (3)
ADM	10 OHIP/ADM-01 01 OMM/ADM-05
GIS	09 MA/027

Interpretation: All children under age 21 regardless of school attendance, marital status or relationship to other members of the family are potentially eligible for Medicaid. The child's eligibility is first determined using Low Income Families (LIF) budgeting. (See **INCOME LOW INCOME FAMILIES (LIF) BUDGETING METHODOLOGY**) If the child is ineligible under LIF budgeting the child's eligibility is determined using the ADC-related budgeting methodology. (See **INCOME ADC-RELATED DISREGARDS ADC-RELATED BUDGETING**) If the child is ineligible under ADC-related budgeting and under the age of 19, the child's eligibility is determined under the appropriate expanded poverty level programs. If the child is certified blind or certified disabled his/her eligibility may be determined using SSI-related budgeting. (See **INCOME SSI-RELATED BUDGETING METHODOLOGY**) Children between the ages of 19 and 21, who are not determined eligible under the aforementioned categories, must have their eligibility evaluated under Family Health Plus. If the person is not eligible under FHP, eligibility is determined for the Family Planning Benefit Program, etc.

NOTE: Infants under age one (1) or a baby born to a woman in receipt of Medicaid, including FHPLus, FPBP, etc., at the time of birth, is automatically eligible for Medicaid until the end of the month the baby turns one (1). (See **CATEGORICAL FACTORS MEDICAID EXTENSIONS/CONTINUATIONS**)

CATEGORICAL FACTORS

UNDER AGE 21

When to Verify: When a child is obviously under the age of twenty-one it is not necessary to verify age. However, since an A/R's date of birth is generally relevant at some point during the eligibility process, it is recommended that date of birth be verified at the first application. Once documented, it is not necessary to re-verify an A/R's date of birth. An application or recertification is never delayed or denied for lack of age verification when the child is obviously under twenty-one (21). A newborn's first name, sex, and date of birth are added to the case as soon as the district is informed of the birth, with the documentation obtained later.

Verification: The date of the birth (DOB) is acquired only once, preferably at first application for assistance provided by a program [Public Assistance (PA), Medicaid, Food Stamps (FS) or Services], since the information is not subject to change. The WMS inquiry or Clearance Report is sufficient, even if the information is entered by another district, unless there is reason to believe the system information is not correct or the A/R is misrepresenting himself or herself.

Examples of acceptable forms of verification:

When a newborn is entered on WMS by the Newborn System, the information on WMS is sufficient to verify age. The district may request a birth certificate, but if it is not provided the information on WMS is sufficient.

The district attempts to obtain verification from the applicant first.

Examples include:

- | | |
|--|-----------------------|
| Birth Certificate | Baptismal Certificate |
| Adoption papers | Passport |
| Driver's License | Census records |
| Immigration and Naturalization Service (INS) records | Hospital records |
| Bureau of Vital Statistics records | Physician records |
| Church records | Marriage records |
| Employer's records | SSA records |

CATEGORICAL FACTORS**UNDER AGE 21**

Documentation: Sufficient to establish an audit trail:

the date of birth, type of document, place and date of filing, and identifying numbers or the available document or name of the official who signed the document.

Disposition: When determining eligibility for a child under age 21 the net income of the child's household after applying the appropriate budgeting methodology is compared to the income level (Medically Needy level, Medicaid Standard or federal poverty level as appropriate). (See **INCOME MEDICALLY NEEDED LEVELS** for discussion of income level and **REFERENCE MEDICALLY NEEDED INCOME AND FEDERAL POVERTY LEVELS**) Treatment of the household's resources depends on the budgeting methodology used. (See **REFERENCE MEDICAID RESOURCE LEVELS**)

NOTE: Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Single/Childless Couples (SCC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (under age 21), and parents living with their dependent child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

SSI-related individuals residing with children under age 21 may be LIF or ADC-related. If the SSI-related individual, not seeking long-term care services, LTC services, is eligible as LIF or ADC there is no resource test. In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19 if income is at or below the appropriate poverty level.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE**)

CATEGORICAL FACTORS**PREGNANCY/NEWBORNS**

Policy: Pregnant women are eligible for Medicaid, if they meet all other eligibility requirements. Infants under age one (1) or a baby born to a woman in receipt of Medicaid, including FHPlus, FPBP, etc., at the time of birth is automatically eligible for Medicaid until the end of the month the baby turns one (1). (See **CATEGORICAL FACTORS MEDICAID EXTENSIONS/CONTINUATIONS**)

References:

SSL Sect.	366 366-ee
Dept. Reg.	360-3.3(b)(4) 360-3.3(c)(5)
ADMs	10 OHIP/ADM-01 01 OMM/ADM-6 OMM/ADM 97-2 95 ADM-21 90 ADM-9 87 ADM-39 85 ADM-33 85 ADM-13 80 ADM-47
INF	00 OMM/INF-01
GISs	10 MA/011 10 MA/006 09 MA/027 00 MA/024 91 MA042

Interpretation: A pregnant woman applying for health insurance is not eligible for Family Health Plus (FHPlus). A woman who becomes pregnant after enrolling in FHPlus is counseled on her options of either remaining in FHPlus until the end of her pregnancy and the 60 day post-partum period or switching to full Medicaid coverage. The counseling includes providing information on the services available under Medicaid compared to FHPlus, and assisting the woman in determining if her current providers also participate in Medicaid fee-for-service or managed care.

Pregnant women with household income equal to or less than 100% of

CATEGORICAL FACTORS**PREGNANCY/NEWBORNS**

the federal poverty level may be eligible for full Medicaid coverage. Pregnant women with household income greater than 100% of the federal poverty level and equal to or less than 200% of the federal poverty level may be eligible for perinatal care and are eligible for enrollment in Medicaid Managed Care. Perinatal care coverage provides most Medicaid covered care and services. (See **OTHER ELIGIBILITY REQUIREMENTS PREGNANT WOMEN** and **REFERENCE COVERED SERVICES FOR PREGNANT WOMEN**)

A woman determined eligible for Medicaid for any day during her pregnancy remains eligible for Medicaid coverage for at least 60 days from the date the pregnancy ends, regardless of any changes in the family's income or household composition. Eligibility continues until the last day of the month in which the 60th day occurs. This eligibility period is granted in all instances where a Medicaid application was made prior to the end of the pregnancy and the pregnant woman was determined eligible for Medicaid. At the end of the 60-day period, the A/R's circumstances are re-evaluated. If the A/R is not found eligible for full Medicaid, the A/R is budgeted under FHP; if ineligible under FHP, eligibility is determined for FPBP, etc.

When to Verify: When an A/R indicates she is pregnant;

When an A/R indicates that she has recently given birth.

Verification: A birth or pregnancy may be verified by:

- (a) Information from the New York State Medicaid New Born System.
- (b) Notification from a Managed Care Organization, Article 28 Prenatal Care Providers, or other medical provider is acceptable; notification can be verbal or written. If notification is verbal, an appropriate notation is made in the case record with the name of the person and the organization providing the information and the date.
- (c) For a woman who has an established case (whether there is an unborn on the case or not), written or verbal notification of the birth from an immediate family member or medical provider, or, in exceptional circumstances, an alternate reliable individual or agency, is acceptable. If notification is verbal, an appropriate notation is made in the case record with the name

CATEGORICAL FACTORS**PREGNANCY/NEWBORNS**

of the person and the organization providing the information and the date.

- (d) Any official government, medical or church record continues to be an acceptable form of documentation of birth.
- (e) Individuals who are initially eligible for Medicaid as a “deemed” newborn are considered to have provided satisfactory documentation of citizenship and identity, by virtue of being born in the United States, and will not be required to further document citizenship or identity at any subsequent Medicaid eligibility redetermination/renewal.

NOTE: Verification is NOT required for name, date of birth, or social security number in order to provide the one-year extension for the newborn.

Disposition:

The eligibility of a pregnant woman is determined first under the LIF budgeting methodology. If ineligible under LIF budgeting, eligibility is determined using ADC-related budgeting methodology. If ineligible under ADC-related budgeting, the poverty levels are used for the pregnant woman and other children residing with her. This includes two-parent families. (See **CATEGORICAL FACTORS UN/UNDEREMPLOYED TWO-PARENT HOUSEHOLDS**) There is no resource test for pregnant women and newborns. Pregnant women are requested to voluntarily provide their social security number. However, pregnant women cannot be denied Medicaid for failure to provide an SSN.

NOTE: Pregnant women have a right to apply for presumptive eligibility (See **OTHER ELIGIBILITY REQUIREMENTS PRESUMPTIVE ELIGIBILITY**) at the site of a provider.

NOTE: When an LDSS is notified via WMS Report WINR 5225 (Upstate) or WINR 0796 (NYC), or through any other means that a baby has been born with a low birth weight designation (weighing less than 1200 grams at birth), and the mother is in a managed care plan, the LDSS must inform the health plan in writing within 5 days. The 5 day clock begins on the day that the district received such notification. Notification to the plan may be made in electronic form.

CATEGORICAL FACTORS**FNP PARENTS**

Policy: Stepparents who reside with their spouse and their spouse's children, but have no other children of their own residing in the household are considered FNP parents.

Fathers of an unborn who reside with the mother of the unborn and have no other children of their own residing in the household are considered FNP parents.

References:

SSL Sect.	366 366-ee
ADMs	10 OHIP/ADM-01 97 OMM/ADM-2
GISs	09 MA/027 01 MA/043 99 MA/028

Interpretation: FNP parents receive LIF budgeting. When they are not eligible under LIF, eligibility is determined under the medically needy standards using ADC-related budgeting.

Effective for eligibility periods on or after January 1, 2010, there is no resource test for FNP Parents. For A/Rs applying for Medicaid requests coverage for the 3-month retroactive period prior to January 1, 2010, there is a resource test.

FNP parents cannot spend down to obtain full Medicaid coverage.

FNP parents who are not eligible for Medicaid have eligibility for Family Health Plus determined by comparing their gross income to the appropriate federal poverty level for a family living with children. When not eligible for Family Health Plus, eligibility is determined for the Family Planning Benefit Program, etc.

CATEGORICAL FACTORS**FAMILIES LIVING WITH DEPENDENT CHILDREN UNDER AGE 21**

Policy: A family including two birth and/or adoptive parents in which their child under age 21 is not deprived of parental support or care due to incapacity, may be eligible for Medicaid if the parents are living with their child and the family meets all other eligibility requirements. The deprivation for the child is considered to be the un/under employment of the parent. Stepparents and fathers of an unborn living with the pregnant woman who have no other children in the household may also be eligible for Medicaid.

References:

SSL Sect.	366 366.1(a) (7) 366-ee 466.1 (a) (5) 366.2 (a) (8) 368-a.1 (j)
Dept. Reg.	360-3.3 (b) (7) 360-3.3 (b) (5)
ADMs	10 OHIP/ADM-01 OMM/ADM 97-2 89 ADM-38
GISs	09 MA/027

Interpretation: A one or two-parent family including a child under the age of 21 may be eligible for Medicaid if the family meets the Low Income Families (LIF) or ADC-related budgeting requirements.

The living arrangement of the child is considered. The child must be living with his/her parents. The child is considered to be living with the parents as long as the parents take responsibility for the care and control of the child, even though circumstances may require the temporary absence of either the child or one or both parents.

When a budget surplus exists, the parents and the child may be eligible with a spenddown or the child may be otherwise eligible under the poverty level budgeting methodology. (See **INCOME MEDICALLY NEEDY INCOME LEVELS**)

Effective for eligibility periods on or after January 1, 2010, there is no resource test for families living with dependent children under age 21. For A/Rs applying for Medicaid coverage for the 3-month retroactive period prior to January 1, 2010, there is a resource test.

CATEGORICAL FACTORS**FAMILIES LIVING WITH DEPENDENT CHILDREN UNDER AGE 21**

Stepparents and fathers of an unborn, with no children of their own, who have income at or below the Medicaid standards may be eligible for Medicaid, but are not eligible with a spenddown.

CATEGORICAL FACTORS

SINGLES/CHILDLESS COUPLES (S/CC)

Policy: Persons between the ages of 21 and 65 who are not living with their child under the age of 21 and do not meet the requirements for any other category of assistance must meet all the Singles/Childless Couples (S/CC) categorical requirements in order to be eligible for coverage under Medicaid.

References:

SSL Sect.	366 366.1(a) 366-ee
Dept. Reg.	360-1.2 360-1.3 360-3.3
ADMs	10 OHIP/ADM-01 97 ADM-21 97 ADM-23 OMM/ADM 97-2
GIS	09 MA/027

Interpretation: When an A/R is not related to any other category for Medicaid, eligibility is determined in accordance with S/CC policy. If the A/R is ineligible using the S/CC budgeting methodologies, eligibility must be considered under Family Health Plus and Family Planning Benefit Program as appropriate.

NOTE: Parents living with their child over the age of 21 are considered a childless couple for S/CC budgeting purposes.

Disposition: The income of S/CC A/Rs are compared to the Medicaid Standard. (See **REFERENCE MEDICALLY NEEDY INCOME LEVELS and FEDERAL POVERTY LEVELS**)

Effective for eligibility periods on or after January 1, 2010, there is no resource test for S/CC A/Rs. For A/Rs applying for Medicaid coverage for the 3-month retroactive period prior to January 1, 2010, there is a resource test.

CATEGORICAL FACTORS**FAMILY PLANNING BENEFIT PROGRAM (FPBP)**

Description: The FPBP provides Medicaid reimbursement for family planning services on a fee-for-service basis. Federal financial participation for such services is 90 percent in accordance with Section 1903(a)(5) of the Social Security Act. There is no local cost for services provided under the FPBP.

Policy: The FPBP provides Medicaid coverage for family planning services only to men and women of childbearing age with incomes at or below 200% of the federal poverty level (FPL). FPBP services are available only to persons who are not otherwise eligible for Medicaid or Family Health Plus, or who have indicated in writing that they want to apply for the FPBP only.

References:

SSL Sect.	366(1)(a)(11)
ADM	02 OMM/ADM-7
GISs	06 MA/028 06 MA/017

Interpretation: Males and females of child-bearing age whose income is at or below 200% of the FPL, may be eligible for the FPBP when they:

- are New York State residents; and
- are citizens or otherwise eligible immigrants with satisfactory immigration status; and are either:
- not otherwise eligible for Medicaid or Family Health Plus (FHPlus) or have indicated in writing that they want to apply for the FPBP only; or
- under age 21 and living with their parents and apply for family planning services and do not have parental financial information. Eligibility is determined by comparing only the income of the person under 21 to 200% of FPL.

There is no resource test for the FPBP.

CATEGORICAL FACTORS

FAMILY PLANNING BENEFIT PROGRAM (FPBP)

Family planning services include:

- Most FDA approved birth-control methods, devices, and supplies (e.g., birth control pills, injectibles, or patches, condoms, diaphragms, IUDs);
- Emergency contraception services and follow-up care;
- Male and female sterilization;
- Pre-conception counseling and preventive screening and family planning options before pregnancy

The following additional services are considered family planning only when provided within the context of a family planning visit and when the service provided is directly related to family planning:

- Pregnancy testing and counseling;
- Comprehensive health history and physical examination, including breast exam and referrals to primary care providers as indicated (mammograms are not covered);
- Screening and treatment for sexually transmitted infections (STIs);
- Screening for cervical cancer and urinary tract or female related infections;
- Screening and related diagnostic laboratory testing for medical conditions that affect the choice of birth control, e.g. a history of diabetes, high blood pressure, smoking, blood clots, etc.;
- HIV counseling and testing;
- Counseling services related to pregnancy, informed consent, and STD/HIV risk counseling;
- Bone density scan (only for women who plan to use or are currently using Depo-Provera); and
- Ultrasound (to assess placement of an intrauterine device).

The FPBP does not cover abortions or treatment for infertility.

The authorization period for FPBP is 12 months and the authorization must begin with the first month of the application. Retroactive coverage is not available under the FPBP. Before the end of the initial 12-month authorization period, the recipient will require a full re-determination of eligibility under all of the applicable eligibility requirements for the FPBP.

CATEGORICAL FACTORS**FAMILY PLANNING BENEFIT PROGRAM (FPBP)**

NOTE: County-specific Family Planning Exclusion Statements must not be used for applicants who apply using the Access NY Health Care application DOH-4220.

CATEGORICAL FACTORS**FAMILY HEALTH PLUS (FHPlus) and FAMILY HEALTH PLUS PREMIUM ASSISTANCE PROGRAM (FHP-PAP)**

Description: FHPlus provides comprehensive managed care health insurance to low-income adults who have income above the current Medicaid levels. With few exceptions, adults cannot have private health insurance. All adults age 19-64 who apply for Medicaid and appear to be ineligible for reasons of excess income are evaluated for their potential eligibility for FHPlus. (See **CATEGORICAL FACTORS PREGNANCY** for treatment of pregnant women).

The prescription drug benefit under the Family Health Plus Program is administered by the Medicaid Program, and not by the health plan. FHPlus recipients must use a NYS Common Benefit Identification Card (CBIC) to obtain pharmacy benefits.

The Family Health Plus Premium Assistance program is available to A/Rs who have or have access to qualified and cost-effective employer sponsored health insurance (ESI) and who are otherwise eligible for Family Health Plus. An A/R with access to ESI is an individual whose employer offers health insurance benefits to its employees, and the individual is eligible for those benefits. For example, an employer may only offer benefits to employees who work full-time. In addition, the ability of the applicant to enroll in those benefits must be reasonable and uncomplicated. For example, if the employer is not cooperative in providing necessary plan information to the applicant or to the district, then the district would be unable to determine if "access" exists.

Individuals in receipt of FHP-PAP shall have available to them health care services including: payment of the recipient's share of the premium, co-insurance, any deductible amount, and the cost sharing obligations for the A/R's employer-sponsored health insurance that exceed the amount of the person's FHPlus co-payment obligations. The A/R will also receive services and supplies otherwise covered by the FHPlus program, but only to the extent that such services and supplies are not covered by the person's employer sponsored health insurance.

NOTE: Although COBRA coverage is not considered employer sponsored insurance, if the health insurance meets the standard benefit package and passes the FHP-PAP cost effectiveness test, such COBRA payments qualify for payment under the FHP-PAP.

CATEGORICAL FACTORS

FAMILY HEALTH PLUS (FHPlus) and FAMILY HEALTH PLUS PREMIUM ASSISTANCE PROGRAM (FHP-PAP)

Policy:

Applicants who meet the following criteria may be eligible for FHPlus:

- are age 19 through 64,
- are New York State residents,
- meet certain citizenship/alien status requirements,
- are ineligible for Medicaid based on income,
- meet certain income requirements, and
- are **not** employees or family members who are federal employees who are eligible for and have access to employer-sponsored health coverage. **NOTE:** Temporary or part-time public employees who are ineligible for employer-sponsored coverage may, if otherwise eligible, receive Family Health Plus.

NOTE: Effective September 1, 2010, otherwise eligible employees of the State, county, municipal governments, as well as public school districts may enroll in Family Health Plus or the Family Health Plus Premium Assistance Program.

The majority of Medicaid eligibility standards and rules apply for FHPlus applicants; however, there are several differences such as a higher income level. Photo ID requirements do not apply to FHPlus.

Before eligibility for Family Health Plus can be established, the A/R must select a health plan. To avoid gaps in coverage in instances when the A/R changes from Medicaid eligibility to Family Health Plus eligibility, a daily benefit-package flip process will be applied in all local departments of social services.

Every month, on the Monday prior to the monthly primary pulldown, a systemic identification of current recipients authorized for Family Health Plus who are not enrolled in a health plan for the following month will be reported to the district on a Potential FHP Auto Assignment Report. On the Wednesday prior to the monthly pulldown, the recipient will be auto-assigned to a FHPlus plan for the first of the following month. Auto-assignments are done based on the following criteria:

- If the recipient has a history of enrollment within the past year with a Medicaid Managed Care or FHPlus quality plan, the individual will be assigned to that plan;
- If only one FHPlus plan operates in the district, the individual will be assigned to that plan;

CATEGORICAL FACTORS

FAMILY HEALTH PLUS (FHPlus) and FAMILY HEALTH PLUS PREMIUM ASSISTANCE PROGRAM (FHP-PAP)

- If more than one FHPlus plan operates in the district, the auto-assignments will be divided first among the quality plans in that district (utilizing the table of quality plans used in the Auto-assignment Algorithm for Medicaid Managed Care); and
- If no quality FHPlus plans operate in the district, assignments will be made among all FHPlus plans in the district that are open to auto-assignment for Medicaid Managed Care.

NOTE: If an adult applying for coverage under Family Health Plus has existing insurance coverage that is not specifically listed below, the adult is not eligible for Family Health Plus, regardless of the limited nature of the coverage:

- Accident-only coverage or disability income insurance;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including auto insurance;
- Worker’s compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics;
- Dental-only, vision only, or long term care insurance;
- Hospital indemnity or other fixed dollar indemnity coverage;
- Specified disease coverage;
- Prescription-only coverage.

References:

SSL Sect.	369-ee
ADMs	10 OHIP/ADM-7 09 OHIP/ADM-1 09 OHIP/ADM-2 08 OHIP/ADM-1 05 OMM/ADM-4 01 OMM/ADM-6
INF	08 OHIP/INF-6
GISs	10 MA/07 09 MA/024 08 MA/034 08 MA/021 08 MA/007 08 MA/003

CATEGORICAL FACTORS**MEDICAID CANCER TREATMENT PROGRAM: BREAST, CERVICAL, COLORECTAL AND PROSTATE CANCER (MCTP)**

Description: The Medicaid Cancer Treatment Program for Breast and/or Cervical Cancer provides full Medicaid coverage to individuals who meet the established criteria to qualify for the Centers for Disease Control and Prevention (CDC) screening under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The Medicaid Cancer Treatment Program for Colorectal and/or Prostate Cancer provides full Medicaid coverage for individuals who are screened and/or diagnosed by the Cancer Services Program Partnerships (CSPP) or a CSPP provider and meet established criteria. Individuals must be in need of treatment for these types of cancers or pre-cancerous conditions. Coverage is available for all medically necessary Medicaid services for the period of time the individual needs treatment.

In New York State cancer screening is conducted by the New York State Department of Health's Cancer Services Program (through the Cancer Services Program Partnerships (CSPP)). The income standard for the CDC screening program is 250% of the FPL. There is no resource test.

A list of CSPP is available on the Department of Health's website at <http://www.health.state.ny.us/nysdoh/cancer/center/partnerships.htm>.

or

By calling the Cancer Services Program at 1-866-442-2262.

Policy: Individuals who meet the following criteria are eligible for the Medicaid Treatment Program for Breast and/or Cervical Cancer:

- have been screened by their local CSPP and diagnosed as needing treatment for breast and/or cervical cancer or a precancerous condition;
- are uninsured (no creditable coverage);
- are New York State residents;
- are U.S. citizens or aliens with satisfactory immigration status;
- and
- are ineligible for Medicaid under any of the mandatory categorical groups (i.e., pregnant women, parents of a dependent child, Low Income Families, or the disabled).

CATEGORICAL FACTORS**MEDICAID CANCER TREATMENT PROGRAM: BREAST, CERVICAL, COLORECTAL
AND PROSTATE CANCER (MCTP)**

NOTE: While the federal program restricts eligibility to women under age 65, New York State will cover any males or individuals 65 years of age or older who meet the screening and eligibility requirements.

Individuals who meet the following criteria are eligible for the Medicaid Cancer Treatment Program for Colorectal and/or Prostate Cancer:

- have been screened by their local CSPP or a CSPP provider and found to be in need of treatment for colorectal and/or prostate cancer or pre-cancerous condition;
- have income at or below 250% Federal Poverty Level (FPL);
- are less than 65 years of age;
- are uninsured (no creditable coverage);
- are New York State residents;
- are U.S. citizens or aliens with satisfactory immigration status; and
- are ineligible for Medicaid under any of the mandatory categorical groups (i.e., parents of a dependent child, Low Income Families, or the disabled).

CATEGORICAL FACTORS**THE MEDICAID CANCER TREATMENT PROGRAM: BREAST, CERVICAL,
COLORECTAL AND PROSTATE CANCER (MCTP)**

References: SSL Sect. 366(4)(v)

 GISs 07 MA/026
 05 MA/038

Interpretation: There are specific application forms and unique procedures for the MCTP. If an individual meets the CSPP screening and diagnosis criteria for treatment for breast, cervical, colorectal or prostate cancer, the CSPP assists the individual with completing the MCTP application process. The State Department of Health's Cancer Services Program reviews the application, certifies the need for treatment and submits the application to the State Office of Health Insurance Programs (OHIP).

State OHIP staff review each application and make the final determination of eligibility. If it appears the individual may be eligible for regular Medicaid under any of the mandatory categories, the case will be authorized by State OHIP staff for at least 90 days and the individual will be sent a letter referring him/her to apply for Medicaid at the local district. For an individual to continue on the MCTP past the 90 days, the individual must show a notice of decision by the county or show just cause why they did not apply. State OHIP staff will work with the local district to coordinate the closing of the MCTP case and the opening of the Medicaid case in the district if required. If the individual is not otherwise eligible for Medicaid, State OHIP staff will maintain the case in District 99; this includes undercare and renewal.

Transportation is authorized by local department of social services staff.

NOTE: Individuals eligible for the MCTP are not eligible for managed care.

CATEGORICAL FACTORS
CHILD HEALTH PLUS

Description: The federal Balanced Budget Act (BBA) of 1997 (Public Law 105-33) created the State Children's Health Insurance Program as Title XXI of the Social Security Act (Child Health Plus in New York State).

Policy: Title XXI provides health care coverage to low-income children who are currently uninsured. Pursuant to Title XXI, New York State enhanced its existing Child Health Plus program. Any child who is determined financially ineligible for Medicaid is referred to Child Health Plus (CHPlus).

References: Public Health Law – Title 1-A of Article 25

Dept. Reg. 360-4.8

ADMs 10 OHIP/ADM-4
98 OMM/ADM-8
91 ADM-18
91 ADM-11
89 ADM-40

Interpretation: As part of the process of applying for CHPlus children are screened to ascertain whether they appear to be Medicaid eligible. Any applying children who appear to be Medicaid eligible will be required to apply for Medicaid. This process also applies to children who are currently enrolled in CHPlus and appear potentially Medicaid eligible at the time of annual CHPlus recertification.

State law requires significant outreach efforts for both CHPlus and Medicaid. These efforts include public education campaigns and the designation of community-based enrollers who will assist children applying for and enrolling in CHPlus or Medicaid, whichever is appropriate. The enroller will submit applications to the local department of social services (LDSS).

If an LDSS receives an application for a child who is ineligible for Medicaid due to excess income or immigration status and a plan selection has been made, the LDSS must, on a daily basis, mail the application and documentation, including a copy of the ineligible Medicaid budget for cases denied for excess income, directly to the selected CHPlus plan. If a plan selection has not been made and there is only one CHPlus plan in the county, the application and supporting documentation is mailed directly to that plan. If a plan selection was not made and there are multiple CHPlus plans available in the county, the LDSS must send the application and supporting information to the Corning Tower, Room 1619, Empire State Plaza, Albany, New York 12237.

CATEGORICAL FACTORS**CHILDREN IN FOSTER CARE**

Policy: All children in foster care who are in the care and custody of the Office for Children and Family Services commissioner or local district commissioner, and who are citizens or have satisfactory immigration status, are categorically eligible for Medicaid. In addition, children adjudicated as juvenile delinquents pursuant to Article 3 of the Family Court Act and placed into the custody of the Office of Children and Family Services, pursuant to Section 353.3 of the Family Court Act, and who are citizens or have satisfactory immigration status, are categorically eligible for Medicaid.

References: SSL Sect. 366.3(a)
Title 10

Dept. Reg. 360-3.3(a) (4)

GIS 11 MA/006
05MA/041

Chapter 58 of the Laws of 2010, Part F

Interpretation: All children in foster care are categorically eligible for full Medicaid coverage, regardless of their Title IV-E status, as long as they are citizens or have satisfactory immigration status and are otherwise eligible. A separate Medicaid financial determination is not necessary.

All children adjudicated as delinquents under Article 3 of the Family Court Act and placed in the care and custody of the Office of Children and Family Services pursuant to Section 353.3 of the Family Court Act are categorically eligible for full Medicaid coverage, regardless of their Title IV-E status, as long as they are citizens or have satisfactory immigration status and are otherwise eligible. A separate Medicaid financial determination is not necessary.

The district making the foster care payment is responsible for the child's Medicaid, as long as the child remains a resident of New York State. If a child enters certain facilities certified by the Office of Mental Health (OMH) or the Office for People with Developmental Disabilities (OPWDD), the State may be responsible for the child's Medicaid

CATEGORICAL FACTORS

CHILDREN IN FOSTER CARE

coverage while s/he remains in the facility. (See **OTHER ELIGIBILITY REQUIREMENTS STATE AND FEDERAL CHARGES OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES**)

When this situation occurs, it is likely that OMH or OPWDD will contact the local district to request that the child's county Medicaid coverage be terminated so that the State can establish coverage. Districts must cooperate with OMH and/or OPWDD so that appropriate coverage can be established expeditiously.

When a Title IV-E child in foster care moves out of state, the state where the child resides is responsible for providing Medicaid. If a child who is receiving Title IV-E payments from another state resides in New York State, and application for Medicaid is filed with the local district in which the child resides. The child's name, date of birth, social security number, third party health insurance information and verification of Title IV-E is documented in the case record and a New York State Medicaid case is opened.

The provisions of categorical eligibility cease to apply when a child in foster care is placed in permanent absence status in a medical facility as defined in 18NYCRR 360-1.4. For persons in permanent absence status, chronic care budgeting is used to determine eligibility.

IV-D referrals or determinations of good cause must be made as appropriate. Support from parents of a certified blind or disabled child is not sought when the child is expected to be living separate and apart from his/her parents for 30 days or more.

When a child in foster care is discharged, a separate Medicaid eligibility determination must be performed based on the child's living arrangements at discharge (residence in the community). Continuous coverage provisions apply. However, a child who is discharged from foster care who is a citizen or who is in satisfactory immigration status and is in receipt of Title IV-E kinship guardian assistance payments (KinGAP) must be provided with Medicaid without regard to their income and resources. The local social services district making the KinGAP payment is the district of fiscal responsibility.

CATEGORICAL FACTORS

MEDICARE SAVINGS PROGRAM

Policy: Certain A/Rs who receive Medicare may be eligible for Medicaid to pay the Medicare premium, coinsurance and deductible amounts.

References:

SSL Sect.	366 366-ee 367-a(3)a
ADMs	11 OHIP/ADM-2 10 OHIP/ADM-05 10 OHIP/ADM-3 10 OHIP/ADM-01
INFs	10 OHIP/INF-3
GISs	09 MA/027 08 MA/ 016 05 MA/033 05 MA/013

Interpretation: There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles, through the Medicare Savings Program.

Qualified Medicare Beneficiaries (QMBs)

The A/R must:

1. be entitled to benefits under Part A of Medicare; and
2. have income equal to or less than 100% of the federal poverty level.

If the A/R meets the above criteria, s/he is eligible for Medicaid payment of the Medicare Part A and B premiums, coinsurance and deductible amounts.

Specified Low-Income Medicare Beneficiaries (SLIMBs)

The A/R must:

1. have Part A of Medicare; and
2. have income greater than 100% but less than 120% of the federal poverty level.

CATEGORICAL FACTORS

MEDICARE SAVINGS PROGRAM

If the A/R meets the above criteria s/he is eligible for Medicaid payment of the Medicare Part B premiums.

Qualified Disabled and Working Individuals (QDWIs)

The A/R must:

1. have lost Part A benefits because of return to work;
2. be a disabled worker less than 65 years of age;
3. have income equal to or less than 200% of the federal poverty level;
4. have resources not in excess of twice the SSI limit; therefore, resources cannot exceed \$4,000 for a household of one or \$6,000 for a household of two; and
5. not be otherwise eligible for Medicaid.

If the A/R meets the above five criteria s/he is eligible for Medicaid payment of the Medicare Part A premium, not the Medicare Part B premium.

Qualifying Individuals – (QI)

The A/R must:

1. have Part A of Medicare;
2. have income equal to or greater than 120% and less than 135% of the federal poverty level.

NOTE: There is no resource test for QI. Additionally, individuals cannot be eligible for Medicaid and QI status at the same time.

If the A/R meets the above criteria s/he is eligible for Medicaid payment of the Medicare Part B premiums, each month.

Applicants should use the DOH-4328 when applying for this benefit. The DOH-4220 or the LDSS-2921 may not be required for persons applying for MSP benefits only.

Each state has been given a capped allocation to fund these premium payments.

CATEGORICAL FACTORS

MEDICARE SAVINGS PROGRAM

NOTE: See **REFERENCE MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS** for a chart displaying the Medicaid Levels and Federal Poverty Levels.

The A/R may spend down income to become eligible for Medicaid. The A/R may also spend down income to become eligible for Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLIMB). However, the Medicare premium cannot be applied in whole or in part to reduce excess income. At the time of application, the applicant is encouraged to make a choice to apply the Medicare Premium to their spenddown to attain Medicaid eligibility **OR** to forego Medicaid eligibility for eligibility in the Medicare Savings Program. The advantages and disadvantages of both programs must be fully explained. An A/R may switch between spenddown and Medicare Savings Program; however, in the interest of accuracy and administrative efficiency, the A/R is encouraged to select and remain in one of the two programs.

Eligibility for the MSPs must be determined even if an applicant does not indicate that he or she is applying for the MSP on the DOH-4220 or LDSS-2921.

NOTE: The ACCESS NY Supplement A does not have to be completed if the person is applying for MSP only.

If applicants are applying for MSP-only they may complete DOH-4328 (Medicare Savings Program Application). There is no resource test for persons applying solely for MSP and who are not Qualified Disabled and Working Individuals (QDWI). However, if they are also applying for Medicaid with a spenddown, or they do not know what program to apply for, they must apply using the DOH-4220.

The Low Income Subsidy (LIS) program, also known as “Extra Help”, is administered by the Social Security Administration (SSA) to help low income Medicare beneficiaries pay for prescription drug costs associated with their Medicare Part D benefits. (See **RESOURCES THIRD PARTY RESOURCES**) Section 113 of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) states that an application to SSA for the LIS program for Medicare Part D benefits will be used to initiate an application for benefits under the MSP.

CATEGORICAL FACTORS

MEDICARE SAVINGS PROGRAM

To comply with this requirement, eligible applications transmitted from SSA with a net income below 135% of the current Federal Poverty Level (FPL) will be accepted through an automated process.

AUTOMATED APPLICATIONS ACCEPTED:

Eligible applications from SSA that have net income below 135% of the Federal Poverty Level (FPL) will be automatically opened as a Qualifying Individual (QI) case; those with net incomes below 120% of the FPL will be opened as a Specified Low Income Medicare Beneficiary (SLIMB) case and those with net incomes below 100% FPL will be opened as a Qualified Medicare Beneficiary (QMB) case. All cases will be opened with an effective date based on the date of application to SSA.

- The begin date for Medicare Part A and B coverage will be the first day of the month of application to SSA for LIS
- The MSP begin date for SLIMB and QI will be the first day of the month of application to SSA for LIS.
- The MSP begin date for QMB will be the first day of the month following the month of application to SSA for LIS.

All individuals determined eligible through the automated process will be sent an acceptance notice by the State through the Client Notice System (CNS). The acceptance notice will inform the individual of their MSP category and will include the revised "Medicare Savings Program Request for Information" form. This form is designed to: collect additional demographic and financial information not collected on the LIS application; to collect information about other health insurance premiums; report income information; report a change in circumstance; and, request consideration for retroactive MSP coverage as applicable. Individuals found eligible for QMB will be issued a non-photo Common Benefit Identification Card (CBIC). Individuals found eligible for SLIMB and QI are not issued a CBIC.

Financial information provided by the recipient may affect the MSP level of benefits the individual is entitled to receive. In such instances verification of income and/or value of health insurance premiums must be provided and evaluated prior to changing the MSP level.

CATEGORICAL FACTORS

MEDICARE SAVINGS PROGRAM

Retroactive MSP benefits are NOT available to persons eligible for QMB. Retroactive MSP benefits are available to otherwise eligible SLIMB and QI individuals for three months prior to the date of the LIS application. Retroactive MSP benefits for QI cases cannot be provided for a previous calendar year.

Should an individual indicate on the "Medicare Savings Program Request for Information" form that he/she would like to apply for full Medicaid benefits; the district must send the Access NY Health Care application and Supplement A, if applicable, to the MSP recipient. The recipient must comply with all current procedures for applying for Medicaid benefits.

NOTE: Completion of the "Medicare Savings Program Request for Information" form is optional. Failure to complete and return the form will not result in a discontinuance of benefits. LIS application data sent by SSA to the State has been verified by SSA and is sufficient for documentation of identity, income, residence and citizenship.

AUTOMATED APPLICATIONS DENIED

Applications denied through the automated process include: individuals reported on the SSA file as having income in excess of 135% of the FPL; and individuals who have been denied by SSA as not in receipt of Medicare.

These cases will be sent a denial notice by the State through CNS. Such notice will include contact information for the appropriate local district.

AUTOMATED APPLICATION EXCEPTED

Applications that appear on an Exception Report must be reviewed and necessary action taken as appropriate.

THIS PAGE IS INTENTIONALLY LEFT BLANK

THIS PAGE IS INTENTIONALLY LEFT BLANK

CATEGORICAL FACTORS**MEDICARE BUY-IN**

Description: Certain A/Rs who receive Medicare may be eligible for Medicaid to pay the Medicare premium, coinsurance and deductible amounts.

Policy: Persons eligible to be on the Medicare Buy-In who are not otherwise eligible for one of the Medicare Savings Programs (MSPs) are eligible in what is referred to as the “Original Buy-In”.

References: SSL Sect.

Dept. Reg. NYCRR 360-3.3

ADMs 95 ADM-11
87 ADM-27

Interpretation: The majority of individuals on Medicare Buy-In qualify as MSPs, not the “Original Buy-In”. “Original Buy-In” individuals (those that are not otherwise eligible for the MSP) are:

- Individuals in receipt of SSI cash assistance who do not qualify for the QMB program;
- Individuals eligible for Medicaid under the Pickle Amendment (refer to 87ADM-27);
- Individuals eligible for Medicaid under the Disabled Adult Child (DAC) provision (refer to 95 ADM-11);
- Individuals eligible under Section 1619B of the Social Security Act, which states that any certified blind or certified disabled person who is a qualified severely impaired individual will continue to be eligible for Medicaid despite earnings that demonstrate his or her ability to engage in substantial gainful activity under the SSI program (refer to 18 NYCRR Section 360-3.3); and
- Individuals eligible for Medicaid under 249E of Public Law 92-603, which includes individuals who became ineligible for SSI cash assistance because of the 1972 increase in their OASDI benefit and who would continue to be eligible except for that increase (refer to 18 NYCRR 360-3.3).

CATEGORICAL FACTORS**MEDICAID EXTENSIONS/CONTINUATIONS**

Policy: Medicaid is authorized for certain persons after their eligibility has ceased. These extensions/continuations are based on the A/R's previous eligibility.

References:

SSL Sect.	366.4
Dept. Reg.	360-3.3(c)
ADMs	09OHIP/ADM-1 02 OMM/ADM-7 01 OMM/ADM-6 OMM/ADM 97-2 97 ADM-20 95 ADM-21 90 ADM-42 90 ADM-30 90 ADM-9
INF	90 INF-45
GISs	03 MA/010 02 MA/012 98 MA/041 91 MA/042
LCM	98 OMM LCM-002

Interpretation: The following persons are eligible for Medicaid extensions/continuations:

- (1) A person who was eligible for Medicaid in December, 1973 as the spouse of a recipient of old age assistance, assistance to the blind or aid to the disabled (AABD), if such recipient continues to meet the standards of eligibility for aid to the aged, blind, or disabled in effect at that time, and the person continues to be the spouse of such recipient and resides with the recipient.
- (2) A person who was eligible for Medicaid as an inpatient in a medical facility in December, 1973 and who would have been eligible for Aid to the Aged, Blind or Disabled (AABD) at that time, if s/he had not been in the medical facility, for as long as s/he remains eligible according the AABD standards in effect in December, 1973.

CATEGORICAL FACTORS**MEDICAID EXTENSIONS/CONTINUATIONS**

- (3) A person who was eligible for Medicaid under LIF in at least three of the six months immediately preceding ineligibility, when this ineligibility resulted from the collection or increase in child or spousal support. The person remains eligible for four calendar months, beginning with the month following the month in which s/he became ineligible.
- (4) Any certified blind or certified disabled person who is a qualified severely impaired individual will continue to be eligible for Medicaid despite earnings that demonstrate his or her ability to engage in substantial gainful activity under the SSI program. A person is a qualified severely impaired individual if:
- (i) s/he was eligible for Medicaid and received SSI benefits, State supplementary payments, or benefits under section 1619(a) of the Social Security Act in the month preceding the first month in which the provision of this paragraph are applied; and
 - (ii) the Social Security Administration has determined that:
 - (a) the person continues to be blind or to have a disabling physical or mental impairment;
 - (b) the person continues to meet all other requirements for SSI eligibility except for earnings;
 - (c) the lack of Medicaid coverage would seriously inhibit the person's ability to continue or to obtain employment; and
 - (d) the person's earnings are insufficient to provide a reasonable equivalent of the SSI, Medicaid, and publicly funded attendant care benefits that would be available to the person if s/he were not employed.
- (5) A woman eligible for Medicaid during any month of her pregnancy retains eligibility until at least 60 days after the termination of the pregnancy. The 60-day continuation of Medicaid eligibility begins on the last day of the pregnancy and ends on the last day of the month in which the 60th day occurs. To receive the 60-day post partum extension, the woman must have applied for Medicaid prior to the end of her pregnancy.

CATEGORICAL FACTORS**MEDICAID EXTENSIONS/CONTINUATIONS**

(6) A woman eligible for Medicaid during any month of her pregnancy is eligible for 24 months of coverage under the Family Planning Extension Program (FPEP). The 24-month extension is applied at the end of the 60-day postpartum continuation. Women who qualify may receive a full range of family planning services, exclusive of abortions, from one of the participating providers (Title X Clinics) for 26 months after the end of their pregnancy regardless of changes in income. If a woman does not recertify for Medicaid after the 60-day postpartum extension, she is still eligible for FPEP for 24 months. Eligibility for the FPEP is based on the woman's self-declaration of pregnancy and evidence of Medicaid coverage at the time of her pregnancy. Claims payment is made outside of the Medicaid Management and Information System (MMIS). FPEP coverage is not reflected on WMS. All women being considered for FPEP must first be considered for eligibility under the FPBP/MA programs. FPEP is only for the women defined above who are ineligible for FPBP/MA due to unsatisfactory immigration status and/or income in excess of 200%.

(7) An infant, born to a woman eligible for and receiving Medicaid at the time of the infant's birth, is eligible for Medicaid until the end of the month in which the child turns age one. When a woman applies for Medicaid within three months after giving birth and it is determined that she was eligible at the time of the birth, the infant is eligible for this one-year extension.

An infant born to a woman eligible for and receiving FHPlus on the date of the infant's birth is eligible for Medicaid until the end of the month in which the child turns age one.

(8) An infant eligible for Medicaid, based on his/her household income being equal to or below 200% of the poverty level, and receiving medically necessary inpatient care and services on his/her first birthday will remain eligible for inpatient coverage until the end of his/her inpatient stay.

(9) A child eligible for Medicaid, based on his/her household income being equal to or below the poverty level standard for his/her age, and receiving medically necessary inpatient care and services on his/her nineteenth birthday will remain eligible for inpatient coverage until the end of his/her inpatient stay.

CATEGORICAL FACTORS

MEDICAID EXTENSIONS/CONTINUATIONS

- (10) A person overcoming a certified disability or certified blindness remains categorically SSI-related through the second month following the month in which the disability or blindness ends. This is a categorical extension only. These persons must meet the financial eligibility requirements for Medicaid as SSI-related recipients.
- (11) A family overcoming an ADC deprivation factor remains categorically ADC-related for three months following the month in which the deprivation ended. The deprivation can end due to any of the following changes in circumstances: a parent is no longer incapacitated; or b) absent parent returns to the home. This is a categorical extension only. The family must meet the financial eligibility requirements for ADC-related Medicaid recipients.
- (12) An individual under the age of 22, if the individual attained the age of 21 while receiving psychiatric services in a State hospital for the mentally disabled, is entitled to a one year extension.
- (13) A child who was in receipt of SSI on August 22, 1996, and whose SSI payment was discontinued on or after July 1, 1997 due to the change in disability criteria as defined by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, will continue to be eligible in the SSI-related category until the earliest event occurs:
- a) the child reaches 18 years of age;
 - b) the child no longer meets the income and/or resource levels of the SSI program;
 - c) the child no longer meets the definition of disabled that was in effect prior to the PRWORA; or
 - d) the child fails to meet another Medicaid eligibility requirement.

CATEGORICAL FACTORS

MEDICAID EXTENSIONS/CONTINUATIONS

(14) A refugee or a Cuban-Haitian entrant eligible under the Refugee Assistance Program (RAP) who becomes ineligible as a result of increased earnings from employment remains Medicaid eligible for the duration of the RAP eligibility period (currently eight (8) months from the date of entry into the United States). (See **OTHER ELIGIBILITY REQUIREMENTS STATE AND FEDERAL CHARGES REFUGEES AND CUBAN-HAITIAN ENTRANTS**)

(15) Children under the age of 19 are guaranteed coverage for up to 12 months. Each time eligibility is determined, (i.e., at initial determination, and at every recertification or redetermination), children up to the age of 19 who are found fully eligible for Medicaid will be provided coverage for 12 months from the date of the determination or redetermination or until their 19th birthday, whichever is sooner, regardless of any changes in income or circumstances. This also applies to children in families who are in Public Assistance cases and receiving Medicaid. It does not apply to children whose immigration status entitles them only to coverage for emergency medical treatment, to children eligible with a spenddown; or to children only eligible using the SSI-related budgeting methodology.

IV-E Foster Care children are also eligible for continuous coverage, including children in the custody of the Office of Children and Family Services (OCFS) in IV-E eligible settings. Medicaid for all children in Foster Care should be authorized for 12 months from the initial determination, or 12 months from re-determination. State regulations require that Services review Foster Care cases every 6 months. Medicaid should be re-authorized for 12 months each time a Service case is re-determined and eligibility is confirmed.

(16) An individual enrolled in a Managed Care Organization (MCO) is guaranteed six months of Medicaid coverage for the capitated benefits offered through the MCO even if he or she loses Medicaid eligibility. The six-month period of eligibility starts on the recipient's effective date of enrollment in an MCO and continues through the end of the sixth month. Enrollees who are no longer Medicaid eligible and are in guaranteed eligibility status receive pharmacy services through the fee-for-services program and family planning services through free

CATEGORICAL FACTORS

MEDICAID EXTENSIONS/CONTINUATIONS

access policy which allows recipients to access services on a fee-for-service basis as well as in the plan (if capitated). This guarantee does not apply to a recipient who: is incarcerated; dies; moves out of State or requests that his/her case be closed; is a pregnant woman with a net available income in excess of the medically needy income, but at or below 200% of the poverty level. (See **REFERENCE MEDICALLY NEEDY INCOME LEVELS**) Recipients receiving coverage under a guarantee who have excess income and SSI-related recipients who have resources spend down to gain Medicaid eligibility for services outside of their plans. (See **INCOME EXCESS** and **RESOURCES EXCESS RESOURCES**)

- (17) Children age 18 up to age 21 who are final-discharged from foster care and remain in New York State are eligible for Medicaid until the end of the month in which they turn 21. The Medicaid case for the child must contain necessary documentation including identity, citizenship/immigration status, residency, etc..

If it is determined, based on the address received from the foster care worker, that the child is residing in a different county, the “from district” must authorize Medicaid coverage for an initial 12 month period following the foster care discharge. Once authorized, the child’s case can be transferred to the new district of residence using the provisions outline in 08 OHIP/LCM-1, “Continued Medicaid Eligibility for Recipients Who Change Residency (Luberto v.Daines)”.

If it is beneficial, a child who moves back into the Medicaid household of his/her legally responsible parent(s) after discharge from foster care may be included in the household budget of the other family members. However, if including the child in the household is not beneficial, the child must remain eligible on his/her own case until his/her 21st. birthday.

This section also describes the following Medicaid provisions:

- Separate Medicaid Determinations (Rosenberg/Stenson);
- Section 249E of the Public Health Law 92-603;
- Pickle Eligible (formerly 503 cases);
- Disabled Adult Children (DAC); and
- Transitional Medicaid (TMA).

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

SEPARATE HEALTH CARE COVERAGE DETERMINATIONS

Policy: Recipients of Temporary Assistance (TA) and Medicaid who are closed on Temporary Assistance and who are pregnant, under 21 years of age, parents residing with children under age 21, certified blind/disabled, or age 65 and over, are provided a separate determination for Medicaid /Family Health Plus/Family Planning Benefit Program Benefit eligibility. Single adults/childless couples determined ineligible for Safety Net Assistance based on income and whose income is at or below 100% of the federal poverty level will have Medicaid continued pending a separate determination.

References: Dept. Reg. 360-2.2

ADMs 01 OMM/ADM-6
90 ADM-30
82 ADM-5
80 ADM-84
80 ADM-19

Interpretation: When an SSI recipient loses eligibility, Medicaid is continued until a separate Medicaid determination is made.

When a TA recipient loses eligibility, the reason for the TA closing will:

- (1) Allow Medicaid to continue unchanged if the reason for closing the TA case does not apply to Medicaid;
- (2) Prompt a separate determination of Medicaid eligibility if the reason for the TA closing may affect Medicaid eligibility; or
- (3) Close the Medicaid case if the reason for closing the TA case also applies to Medicaid.

The separate determination for Medicaid is completed by the end of the calendar month following the month in which cash assistance was terminated. A separate statement is made in the Notice of Intent advising the recipient of the action to be taken on his/her Medicaid case, the reasons for the action and the supporting regulations.

When the TA case is closed, the separate determination is made from information in the TA case record. If additional information is required, the district requests it from the recipient (Rosenberg court decision).

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

SEPARATE HEALTH CARE COVERAGE DETERMINATIONS

When a SSI cash benefit is discontinued, a separate determination is made from information provided by the Social Security Administration on the SDX. If additional information is required, the local district requests the information from the recipient (Stenson court decision). (See **OTHER ELIGIBILITY REQUIREMENTS RENEWAL**)

NOTE: When an application for both TA and health care coverage is made and TA is denied, a separate health care coverage determination is completed, unless the reason to deny TA is also a proper basis for the denial of health care coverage.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

SECTION 249E OF THE PUBLIC LAW 92-603

Description: Under Section 249e of Public Law 92-603 A/Rs are entitled to have the amount of their October 1972 social security increase disregarded in the determination of eligibility if they meet the following criteria:

- (1) in August of 1972, they were entitled to Retirement, Survivors and Disability Insurance (RSDI) benefits and eligible for or in receipt of cash assistance under ADC or AABD; or
- (2) in August of 1972, they were entitled to RSDI benefits and would have been eligible for ADC or AABD, except that they were in a medical institution or intermediate care facility; and
- (3) they currently meet the categorical requirements for SSI (aged, certified blind/disabled) or ADC-related persons.

Policy: To determine if an A/R is eligible under 249e:

- (1) determine the amount of the A/R's RSDI benefit in August 1972. This is done by multiplying the A/R's current RSDI benefit by a figure derived from the present and prior percentage increases in RSDI since August 1972. This figure will change each time there is an RSDI cost of living increase. The figure to use to calculate the amount of A/R's RSDI benefit can be found in **REFERENCE SECTION 249E**.
- (2) using the amount of the August 8, 1972 RSDI benefit and other information provided by the A/R, determine if s/he was eligible for ADC or AABD in August 1972 and was terminated due to the 20% SSA increase of October 1972; if yes,
- (3) determine the A/R's current eligibility, disregarding the 20% Social Security increase received in October 1972. To determine the amount of the current Social Security benefit being considered, multiply the A/R's current RSDI benefit by a figure computed from the present and prior percentage increases in RSDI since 1972. This figure will change each time there is an RSDI cost of living increase. This factor can be found in **REFERENCE SECTION 249E**.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

SECTION 249E OF THE PUBLIC LAW 92-603

References:	SSL Sect.	366.2(b) 363-b
	Dept. Reg.	360-3.3(c)(14)
	ADMs	04 OMM/ADM-2 85 ADM-3
	GIS	04 MA/031

Disposition: The current year RSDI benefit amount is multiplied by the current year RSDI percentage increase based on cost of living increases since August 1972 (both amounts can be found in **REFERENCE SECTION 249E**) to derive the amount used to determine eligibility for AABD in August 1972. If the person would have been eligible in August 1972, the current RSDI amount is multiplied by the factor representing the increases since August 1972 (factor can be found in **REFERENCE SECTION 249E**) to determine the amount, which is considered as income effective for the current year. This also addresses the need to disregard the 20% Social Security increase of October 1972.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

PICKLE ELIGIBLE (FORMERLY 503 CASES)

Description: Section 503 of Public Law 94-566, referred to as the Pickle Amendment, protects Medicaid eligibility for all recipients of Retirement Survivors and Disability Insurance (RSDI) who were previously eligible for RSDI and SSI benefits concurrently. These recipients are individuals who would be eligible for SSI, if all RSDI COLAs received since they were last eligible for and receiving RSDI and SSI benefits concurrently, were deducted from their countable income. The RSDI beneficiary may have lost his/her SSI benefit for reasons other than COLAs and still be considered a Pickle eligible.

References:

SSL Sect.	366.2(b) 363-b
Dept. Reg.	360-3.3(c)(10)
ADMs	87 ADM-27 85 ADM-35

Interpretation: To be eligible under the Pickle Amendment, an A/R must meet the following criteria:

- (1) On or after April 1977, were eligible for and receiving SSI and RSDI benefits concurrently;
- (2) is currently eligible for and receiving RSDI;
- (3) is currently ineligible for SSI, and
- (4) would be eligible for SSI, if the RSDI COLAs received by the A/R and his/her spouse, since the last month that the A/R received both RSDI and SSI benefits, are disregarded.

A person eligible under the Pickle amendment must meet the SSI income and resource criteria. An A/R cannot spend down to attain Pickle eligibility.

Eligibility for all individuals who meet the Pickle criteria is initially determined by deducting all COLAs received since SSI eligibility was lost. (See **REFERENCE REDUCTION FACTORS FOR CALCULATING MEDICAID ELIGIBILITY UNDER THE PICKLE AMENDMENT**) If the individual's total income (less COLAs) and resources are below current SSI standards, the individual is eligible under the Pickle Amendment.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

PICKLE ELIGIBLES (FORMERLY 503 CASES)

A notation is made in the case record to identify potential Pickles for future action. A potential Pickle is someone who:

- (1) concurrently received SSI and RSDI after April 1977;
- (2) loses SSI eligibility; and
- (3) was not found eligible for Pickle treatment at the time SSI eligibility was lost.

Disposition:

Anyone who concurrently receives RSDI and SSI and loses their eligibility for SSI is potentially eligible under the Pickle Amendment, except for persons who:

- (1) currently have a recoupment taken against them by SSI for money incorrectly paid or SSI is in the process of making a recoupment effort, even if no money is recouped;
- (2) are closed because they moved out of New York State; or
- (3) received SSI in error.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

WIDOWS/WIDOWERS

Policy: There are two separate disregards that can apply to widows/widowers.

- A. A person 60 years of age or older who applies for and receives early widow's or widower's insurance benefits under section 202(e) or (f) of the Social Security Act, or receives other benefits under section 202 of such Act but is eligible for widow's/widower's insurance benefits, and who becomes ineligible for SSI as a result of receiving such benefits, will remain eligible for Medicaid so long as:
- (1) s/he would be eligible for SSI payments if s/he were not receiving such benefits; and
 - (2) s/he is not entitled to Medicare Part A benefits.
- B. Certified disabled widows or widowers who lost SSI and Medicaid benefits due to an actuarial adjustment authorized under the Social Security Amendments of 1983 are eligible for Medicaid providing they meet all of the following criteria:
- (1) in December 1983, the potential eligibles were entitled to monthly insurance benefits under Title II of the Social Security Act;
 - (2) the potential eligibles were entitled to widows' or widowers' benefits based on a disability under Title II for January 1984 and also had SSI benefits paid with respect to them in that month;
 - (3) the potential eligibles lost their SSI Benefits because of the increase in the amount of their widow(er)'s benefits for which they became entitled prior to age 60;
 - (4) the potential eligibles have continued to receive their widow(er)'s benefits since January 1984; and
 - (5) the potential eligibles would continue to be eligible for SSI if the amounts of the January 1984 adjustment and any subsequent cost of living adjustments were disregarded in determining their eligibility.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

WIDOWS/WIDOWERS

References: SSL Sect. 366
 Dept. Reg. 360-3.3(c)(9)
 ADM 87 ADM-27

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

DISABLED ADULT CHILD (DAC) BENEFICIARIES

Description: Section 6 of Public Law 99-643 (42 U.S.C. 1383c(c)), provides that individuals who lose SSI eligibility because of the receipt of Social Security Disabled Adult Child (DAC) benefits, or because of an increase in the amount of these benefits are eligible for Medicaid if certain criteria are met.

Policy: DAC Social Security benefits are received upon the disability, retirement or death of a parent. An individual is eligible for Medicaid as a DAC beneficiary if all of the following criteria are met:

- (1) the individual is at least 18 years old;
- (2) the individual became certified blind or certified disabled before reaching the age of 22;
- (3) the individual was receiving SSI benefits on the basis of blindness or disability;
- (4) the individual lost SSI benefits on or after July 1, 1987; and
- (5) the individual's loss of SSI benefits was the result of entitlement to a DAC benefit, or an increase in the benefit.

When the criteria are met, and the individual would be eligible for SSI benefits if the amount of the initial entitlement or an increase in the DAC benefit were disregarded, the individual is eligible for Medicaid.

References: ADMs 95 ADM-11

LCMs 92 LCM-41 (February 28, 1992)

Interpretation: For an individual who lost SSI eligibility because of the initial entitlement to a DAC benefit, the entire amount of the DAC benefit is disregarded in the determination of countable income, including any subsequent increases in the benefit. When ineligibility for SSI was due to an increase in the DAC benefit, the amount of DAC benefits received in the month prior to the termination of SSI is the amount of DAC benefits that are counted in determining eligibility. Any subsequent increase(s) in DAC benefits is disregarded. If the

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

DISABLED ADULT CHILD (DAC) BENEFICIARIES

individual would be eligible for SSI (SSI income and resource levels) by disregarding the DAC benefit or increase(s) in the benefit, s/he remains eligible for Medicaid under the DAC provision.

NOTE: When determining Medicaid eligibility for individuals who have been identified as DACs, districts first determine eligibility under the DAC provision, even if the individual appears to have income under the medically needy level. If eligibility cannot be established under the DAC provision, SSI-related budgeting procedures apply.

When a Medicaid recipient eligible under the DAC provision has an increase in either income (other than the DAC benefit) or resources that would have resulted in a loss of SSI eligibility, the recipient will also lose DAC status for Medicaid. By budgeting the DAC benefit, the individual may be subject to a spenddown requirement. If the income and/or resources are reduced to the point where the individual would again be entitled to SSI benefits except for the increase in or entitlement to the DAC benefit, the individual would again become eligible for Medicaid under the DAC provision.

Individuals who are eligible for Medicaid under the DAC provision are evaluated for QMB eligibility. The individual's actual gross income (without disregarding the DAC benefit) is used when determining QMB eligibility (See 89 ADM-7). Regardless of QMB eligibility, individuals who are eligible for Medicaid under the DAC provision are eligible for Medicaid payment of Medicare Part B premiums as is done for the original buy-in groups including SSI recipients and persons qualifying under Sections 503 (Pickles) and 1619(b) of the Social Security Act (Public Law 99-509).

NOTE: In determining the amount of income available for the cost of care under chronic care budgeting, (See **INCOME CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSES** and **CHRONIC CARE BUDGETING METHODOLOGY FOR INDIVIDUALS**) DAC benefits are considered available income and added to all other sources of available income.

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

TRANSITIONAL MEDICAID (TMA)

Policy:

In order to assist families in making the transition from Medicaid under the Low Income Families (LIF) category of assistance to self-sufficiency as a result of employment, a twelve (12) month extension of Medicaid benefits is mandated under certain circumstances. Twelve (12) months of Transitional Medicaid (TMA) is available if the household: (1) is ineligible under LIF due to new or increased earned income of the parent/caretaker relative, or the loss of an income related disregard; (2) includes a dependent child (under age 21) living in the household; and (3) was receiving Medicaid under LIF in one out of the last six (6) months prior to the termination of eligibility. Earnings may be in combination with unearned income. When the household's income consists solely of unearned income, the household is not eligible for TMA. There is no requirement for continued employment during the TMA authorization period.

NOTE: Members of a household may be eligible for TMA when the parent/caretaker relative is not in receipt of Medicaid under the LIF category of assistance, if all other TMA criteria are met. For example: A mother receives SSI cash assistance and has Medicaid. Her two children receive Medicaid under LIF in a separate case. When she becomes employed, she loses her eligibility for SSI. When the new, earned income is counted, the family becomes ineligible for Medicaid under LIF. However, the children meet the TMA criteria and are authorized for the twelve month TMA extension. The mother's eligibility for Medicaid is determined applying appropriate rules.

References:

SSL Sect.	366
Dept. Reg.	360-3.3(c) 369.1 385.14(d)
ADMs	11 OHIP ADM-05 OMM/ADM 97-2 90 ADM-30
GIS	09 MA/023

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

TRANSITIONAL MEDICAID (TMA)

Interpretation: The TMA extension is for twelve (12) full months. If the recipient is entitled to TMA, the twelve months of TMA begins the first of the month immediately following the month in which the recipient lost eligibility under LIF in either a Temporary Assistance or Medicaid case. However, if the recipient becomes ineligible for Medicaid under LIF at the end of the month and, because of the ten-day notice requirement, his/her case is closed during the first ten (10) days of the following month, the twelve (12) month TMA extension begins the first day of the month in which the notice period ends.

NOTE: Eligibility is not evaluated under FHPlus, Medically Needy or expanded levels until the twelve month authorization period has ended.

Generally, there are only three (3) reasons for terminating the TMA extension prior to the end of the full twelve (12) months:

- (1) There is no longer a dependent child in the household. For TMA purposes, a dependent child is a person under the age of 21 who is living with his/her parent/caretaker relative. This child may or may not be an active member of the Temporary Assistance or Medicaid case. This also includes children temporarily living outside of their home; or
- (2) A court of law has found that the person received social services benefits fraudulently; or
- (3) The family no longer resides in New York State.

Disposition: When terminating TMA because there is no longer a dependent child in the household, a timely and adequate notice is sent. (See **OTHER ELIGIBILITY REQUIREMENTS DECISION AND NOTIFICATION DISCONTINUANCE OR REDUCTION TIMELY NOTICE**) If the end of the notice period occurs during the month in which the local district learned that the dependent child is no longer in the household, TMA is terminated at the end of that month. If the notice period extends into the following month, TMA is discontinued at the end of the notice period.

The availability of third party health insurance (TPHI) coverage is pursued. Enrollment in employer group health insurance is not a condition of eligibility for TMA. However, if a TMA recipient is enrolled

**CATEGORICAL FACTORS
MEDICAID EXTENSIONS/CONTINUATIONS**

TRANSITIONAL MEDICAID (TMA)

in an employer-sponsored health insurance plan, the local district must offer to pay the recipient's health insurance contribution to the premium, if the policy is determined to be cost effective,

Before the end of a household's 12-month TMA authorization period, the full renewal process is completed to determine eligibility for continued Medicaid, FHPlus or FPBP coverage.