# STATE OF NEW YORK
# DEPARTMENT OF HEALTH

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**ADMINISTRATIVE DIRECTIVE**

**TRANSMITTAL:** 10 OHIP/ADM-2

**TO:** Commissioners of Social Services

**DIVISION:** Office of Health Insurance Programs

**DATE:** March 3, 2010

**SUBJECT:** Medicaid Buy-In Program for Working People with Disabilities Medical Improvement Group

**SUGGESTED DISTRIBUTION:**
Medicaid Staff
Disability Staff
Fair Hearing Staff

**CONTACT PERSON:**
Local District Liaison
Upstate (518)474-8887 NYC (212)417-4500

**ATTACHMENTS:**

I. Explanation of the Medicaid Buy-In Program for Working People with Disabilities
II. Basic Group Grace Period Request Form
III. Medical Improvement Group Grace Period Request Form
IV. Grace Period Approval Letter MI Group–Job Loss
V. Grace Period Approval Letter MI Group–Medical Condition
VI. Grace Period Approval Letter BC Group-Medical Condition
VII. Grace Period Approval Letter BC Group-Job Loss

**FILING REFERENCES**

| Previous ADMs/INFs | Releases Cancelled | Dept. Regs. | Soc. Serv. Law & Other Legal Ref. | Manual Ref. | Misc. Ref. |
|---|---|---|---|---|---|
| 03 ADM-04<br>04 ADM-05 | | | 366(1)(a), (12),(13) 367-a (12) Chapter 1 of the Laws of 2002 | Medicaid Reference Guide page 72, Self-Employment | GIS 08 MA/04<br>GIS 08 MA/013<br>WWMS/NYC Software Version 2006.1 WMS/CNS Coordinator Letter 07/10/03 |

## I. PURPOSE

This Administrative Directive (OHIP/ADM) provides direction to local Departments of Social Services (LDSS) regarding the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) Medical Improvement group. It also provides revised versions of the grace period request form and grace period approval letters for the Basic Coverage group. This ADM is a supplement to 04 ADM-05, "Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD): Transition of the MBI-WPD Program to Local District Staff."

## II. BACKGROUND

Chapter 1 of the Laws of 2002 enacted two Medicaid eligibility groups under the MBI-WPD program by adding two new subparagraphs (12) and (13) to Section 366(1)(a) of the Social Services Law (SSL). The two groups are the Basic Coverage group and the Medical Improvement group. On July 1, 2003, the MBI-WPD program was implemented and all new eligible applicant/recipients (A/Rs) were enrolled in the Basic Coverage group.

Eligibility for the Medical Improvement group is considered only if the individual is no longer eligible for disability under the Basic Coverage group by reason of medical improvement. This determination is made by the State Disability Review Team (SDRT) at the time of a regularly scheduled Continuing Disability Review (CDR). For the first few years following implementation of the MBI-WPD program, individuals participated in the Basic Coverage group. Recently, the SDRT has determined that some of these recipients now meet the disability requirements for the Medical Improvement group. This ADM advises LDSS of the eligibility requirements for participation in the Medical Improvement group.

## III. PROGRAM IMPLICATIONS

The Basic Coverage group and the Medical Improvement group share the following basic MBI-WPD program requirements:

- the A/R must be at least 16 but less than 65 years of age;
- the A/R must be a resident of New York State;
- the A/R must be engaged in a work activity;
- the A/R must have net available income at or below 250% of the Federal Poverty Level (FPL) and countable resources that do not exceed the Medicaid resource level; and
- the A/R must pay a monthly premium, if net available income is at least 150% FPL but at or below 250% FPL.

**Note:** There is currently a moratorium on premium payments.

To be eligible for the Basic Coverage group, an individual must have certification of disability. To be eligible for the Medical Improvement group, the individual must first be in receipt of Medicaid coverage through the Basic Coverage group and then lose eligibility for that group as a direct result of medical improvement. These

individuals are no longer disabled by Social Security standards, but still have a severe impairment. These individuals are referred to as Medically Improved. The following sections contain the requirements for the Medical Improvement group that differ from the Basic Coverage group.

**A. Medical Improvement**

Individuals who are no longer eligible for disability under the MBI-WPD Basic Coverage group by reason of medical improvement, as determined at the time of a regularly scheduled CDR, but who continue to have a severe medically determinable impairment, may be eligible for coverage under the Medical Improvement (MI) group. A severe medically determinable impairment exists if an acceptable medical source, as defined in the New York State Medicaid Disability Manual, documents that an individual has a physical or mental impairment that has been stabilized by any one of the care, services or supports listed below, the loss of which could result in the individual's inability to continue to function at his/her current level.

- On-going, impairment-related monitoring (including psychotherapy and counseling) by a health care provider, which is essential to sustain the individual's current level of function.
- Medications, prescribed and necessary for control of the disabling condition, that enable the individual to maintain the current level of function. Control refers to reducing or eliminating symptoms or slowing down the progression of disease.
- Medical equipment and supplies including, but not limited to, prostheses and other impairment-related equipment, such as one-handed keyboards and typing aids, vision and sensory aids, telecommunication devices, and special tools designed to accommodate the individual's impairment.
- Medical services related to the control of a disabling condition, including physical or occupational therapy, which enable the individual to perform at the current level of function.
- Impairment-related support services including assistant care services, supportive living programs, and subsidized employment, as defined in the New York State Medicaid Disability Manual.

**Note:** The State Disability Review Team (SDRT) performs all new and Continuing Disability Reviews for the MBI-WPD program.

## B. Work Requirement for the Medical Improvement Group

For participation in the Medical Improvement group, the recipient must be engaged in a work activity of at least **40 hours per month** and **earn at least the applicable federal minimum wage** (currently $7.25).

### 1. Monitoring Work and Wages

Local districts are responsible for reviewing an individual's work activity and wage rate every six months for participation in the Medical Improvement group. Examples of proof of work and wages include: current pay stub(s); pay check(s) or a detailed written statement from the employer. If these documents are not available, the individual's income tax return, W-2 form, or records of bank deposits may be used. The Medicaid Reference Guide (MRG) may be used for guidance regarding self-employment verification. In order to compute hourly wages, individuals who are self-employed may attest to the number of hours worked. (See Section B.2 below.)

If the individual's income has increased or decreased at the time of a six-month work and wage review, the local district is responsible for re-determining eligibility for the MBI-WPD program and taking the appropriate action. If an individual falls below 40 hours of work a month or falls below the minimum wage requirement, the individual may be eligible for a grace period. (See Section C below.)

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

### 2. Determining Hourly Wage for Self-Employed Recipients

To determine the hourly wage for a self-employed individual in the Medical Improvement group, the *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.

For example: Mr. Frasier owns a business that made $725 in May, for which he worked 100 hours. The gross income of $725 is divided by the number of hours worked (100) to give an hourly wage rate of $7.25, which is equal to the federal minimum wage, thus meeting the minimum wage requirement.

If it is determined that a recipient does not meet the hourly work and/or wage requirement of the Medical Improvement group and is ineligible for a grace period, eligibility must be determined for other Medicaid programs. A medically improved individual, by definition, is not disabled; therefore, the individual is not eligible for SSI-related budgeting.

**Note:** Individuals in the Medical Improvement group may attest to resources if not requesting Medicaid coverage of long term care services.

## C. Grace Periods

Grace periods for the Medical Improvement group may be given for the following two reasons.

### 1. Job Loss/Reduction

The grace period policy for the Medical Improvement group is essentially the same as for the Basic Coverage group, in that the individual may request up to six months grace period in a twelve-month period. Additionally, for the Medical Improvement group the grace period is available if, *through no fault of his or her own,* the individual loses employment or falls below the 40 hours per month or minimum wage work requirement. Documentation is required from the employer that the individual was laid off or work hours or wages were reduced. If the individual is self-employed, a detailed explanation for the loss of work, reduction of work hours or wages is required.

The individual will be required to resume work for no less than the federal minimum wage and work for at least 40 hours per month at the end of the six-month grace period.

If an individual quits a job, falls below 40 hours per month or below minimum wage *by choice*, a grace period is denied and the individual is discontinued from the MBI-WPD program.

### 2. Change in Medical Condition

A grace period of up to six months in a twelve-month period may be requested if an individual in the Medical Improvement group loses a job or falls below 40 hours per month or earns less than minimum wage, and *states that the loss or decrease is related to his/her medical condition or to the worsening of his/her medical condition.* Documentation is required from an acceptable medical source and must include a statement indicating when the individual is reasonably expected to return to work.

At the end of a six-month grace period, if the individual is working less than 40 hours per month and/or earning less than the federally required minimum wage, the MBI-WPD CDR process is initiated to determine if the individual is eligible for re-instatement in the Basic Coverage group.

If, at the end of a six-month grace period, the individual is not working, the individual is no longer eligible for the MBI-WPD program. Eligibility under other Medicaid programs must be determined. If the individual needs a disability determination, a CDR must be performed using the most recent favorable Aid to Disabled (AD) decision as a point of comparison.

**Note:** Recipients may be granted multiple grace periods during a twelve-month period; however, in no event may the sum of the grace periods exceed six months in a twelve-month period. The start date for the twelve-month period is the first day of the first grace period authorized.

**D. Managed Care**

As with the Basic Coverage group, Medicaid Managed Care is a voluntary option only for those Medical Improvement group individuals who are income eligible under 150% of the FPL. In districts where enrollment in a Managed Care plan is mandatory, these individuals cannot be required to enroll.

Pursuant to statute, MBI-WPD recipients with income at or above 150% FPL but below 250% FPL are excluded from Managed Care. Such recipients may voluntarily participate in Managed Long Term Care.

## IV. REQUIRED ACTION

**A. SDRT Responsibilities**

- The SDRT is responsible for notifying the local district when it is determined that an individual meets the medical requirements for the Medical Improvement group. The district will be notified via the "Disability Review Team Certificate" (LDSS-639) with a "Notice of Medical Assistance Disability Determination – MBI-WPD MI Group."

- Upon receipt of a CDR packet from the LDSS, the SDRT is responsible for determining if an individual continues to meet the medical requirements for the Medical Improvement group.

**B. LDSS Responsibilities**

- When the LDSS receives the Disability Review Team Certificate (LDSS-639) indicating that the individual meets the medical requirements for the Medical Improvement group, eligibility for the MBI-WPD program is evaluated using the Medical Improvement group work and wage requirements. If the individual does not meet the eligibility requirements for the Medical Improvement group, eligibility must be determined as a non-SSI-related recipient.
- If the individual is eligible for the Medical Improvement group, the Individual Categorical Code must be changed from 70 to 71.
- If the individual's income has changed, it is necessary to determine if Managed Care should be offered to the individual or if necessary, discontinued and the appropriate Restriction/Exemption code entered in WMS.
- The LDSS must complete the "Notice of Medical Assistance Disability Determination – MBI-WPD MI Group" received from the SDRT with the LDSS-639. Copies of the notice and the LDSS-639 must be filed in the case record and the originals sent to the recipient with a copy of the revised "Explanation of the MBI-WPD Program". (See Attachment I to this ADM.)
- The LDSS must send the recipient the CNS notice "Continue MBI-WPD, Medically Improved with a Severe Impairment," (Reason Code U05) to inform the recipient that Medicaid coverage continues under the Medical Improvement group of the MBI-WPD program.

- The LDSS is responsible for requesting work and wage information from the recipient every six months.
- At the time of the six-month work and wage review, if the individual's income has increased or decreased but still meets the minimum requirements, the local district is responsible for re-determining eligibility for the MBI-WPD program. If the individual's work and/or wages fall below the minimum requirements, the district must determine whether the individual meets the requirements for a grace period. To obtain additional information necessary to determine whether a recipient qualifies for a grace period, districts must send the recipient a copy of the "Medical Improvement Group Grace Period Request Form." (See Attachment III of this ADM.)
- When sending a "Grace Period Request Form," the LDSS must add the LDSS' address, fill in the client's identifying information and the LDSS' contact name and phone number.
- When a recipient completes a grace period request form (see Attachment III) and submits it with supporting documentation to LDSS, the LDSS staff reviews and, if appropriate, approves the request. The signed decision is copied and placed in the recipient's file, the original is sent to recipient with a letter listing the steps to take when the grace period draws to a close. (See Attachments IV and V to this ADM. Also see Attachments II, VI and VII for revised versions of the grace period request form and approval letters for the Basic Coverage group.)
- If the recipient fails to return the "Grace Period Request Form," eligibility must be determined as a non-SSI-related recipient and the appropriate notice sent to the recipient.
- The LDSS must track grace periods to insure that the recipient does not exceed six months in a twelve-month period.
- The LDSS must track the expiration of the LDSS-639. Two to three months before the expiration, a Continuing Disability Review Packet must be compiled and sent to the SDRT.

## C. Recipient Responsibilities

- Comply with all requests for information and documentation.
- Notify the local district immediately of any changes in address, income, resources, employment or medical condition.
- Return a grace period request form, when applicable.
- If premium eligible, pay the monthly premium.

  **Note:** There is currently a moratorium on premium collection.

## V. SYSTEMS IMPLICATIONS

### A. Upstate and New York City

The following System modifications have been made to support the MBI-WPD's Basic Coverage group and the Medical Improvement group.

#### 1. WMS

a. Two Individual Categorical Codes are available for identification and Federal/State/Local claiming purposes:

70 Medicaid Buy-In – Basic Coverage group
71 Medicaid Buy-In – Medical Improvement group

If the Individual Categorical Code is 70 or 71:

- The individual must be at least 16 but less than 65 years of age.
- Only Case Type 20 may be used.
- The Medicaid Coverage Code for **Upstate** must be 01, 06, 10, 11, 19, 20, 30 or 31.
- The Medicaid Coverage Code for **New York City** must be 01, 10, 11, 19, 20, 24, 30 or 31.

**Note:** The Individual Categorical Code 71 may only be used when the State Disability Review Team determines an individual medically improved.

b. Restriction/Exception codes for Managed Care apply as follows:

Code 90 (Managed Care Excluded) is to be used for individuals with net income at least 150% FPL but at or below 250% FPL (who do not request enrollment in a Managed Long Term Care plan).

Code 91 (Managed Care Exempt) is to be used for individuals with net income below 150% FPL who choose not to be enrolled in Managed Care.

c. Corresponding Recipient AID Categories:

Code 82 MBI-WPD Basic Coverage group
Code 83 MBI-WPD Medical Improvement group

These AID Categories are for reporting purposes and are system generated.

**2. MBL**

**Expanded Eligibility Codes (EEC)**

a. Upstate:

Code V – MBI-WPD (SSI–Related budgeting prior to MBI-WPD). This code will not show MBI-WPD eligibility if the individual is fully Medicaid eligible.

Code W – MBI-WPD (MBI-WPD budget only). This code will show MBI-WPD eligibility.

The EEC Codes are valid for Budget Types 04, 05 and 06. In addition, a field entitled "PASS" is available on MBL to enter income that is to be disregarded in accordance with an approved Plan for Achieving Self-Support.

b. New York City:

Code W – This code is used with Budget Type 04 to determine MBI-WPD eligibility only.

**Note:** A request has been made to Systems that would eliminate the use of EEC codes for determining MBI-WPD eligibility. The MBL budgets 04, 05 and 06 will be changed to reflect MBI-WPD eligibility on the SSI-related output screen. When this change is made, information will be forthcoming.

**3. CNS - Upstate**

CNS Reason codes available to use for the Medical Improvement group include:

- U05 Continue MBI-WPD, Medically Improved with a Severe Impairment
- U03 Discontinue MBI-WPD, No Longer Meets Requirements of the Medical Improvement group, MA Ineligible Due to Excess Income, FHP Ineligible Due to Excess Income, Equivalent Health Insurance or Public Employee, S/CC
- U06 Discontinue MBI-WPD, Medical Improvement group Not Working 40 Hrs, Not Working at Federal Minimum Wage, MA Ineligible Due to Excess Income, FHP Ineligible Due to Excess Income, Equivalent Health Insurance or Public Employee, FP
- U07 Discontinue MBI-WPD Medical Improvement group Not Working 40 Hrs, Not Working at Federal Minimum Wage, MA Ineligible Due to Excess Income, FHP Ineligible Due to Excess Income, Equivalent Health Insurance or Public Employee, FNP Parent
- U08 Discontinue MBI-WPD No Longer Meets Requirements of the Medical Improvement group, MA Ineligible Due to Excess Income, FHP Ineligible Due to Excess Income, Equivalent Health Insurance or Public Employee, FNP Parent

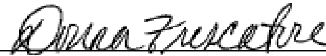
- U09 Discontinue MBI-WPD No Longer Meets Requirements of the Medical Improvement group, MA Ineligible Due to Excess Income, FHP Ineligible Due to Excess Income, Equivalent Health Insurance or Public Employee, FP
- U16 Discontinue MBI-WPD Medical Improvement group Not Working 40 Hrs, Not Working at Federal Minimum Wage, MA Ineligible Due to Excess Income, FHP Ineligible Due to Excess Income, Equivalent Health Insurance or Public Employee, S/CC

### 4. Manual Notices - New York City

Manual notices for New York City will be issued under separate cover.

## VII. EFFECTIVE DATE

The provisions of this Administrative Directive are effective March 1, 2010, retroactive to July 1, 2003.



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