OTHER ELIGIBILITY REQUIREMENTS

MAINTAINING MEDICAID ELIGIBILITY FOR INDIVIDUALS ADMITTED TO A PSYCHIATRIC CENTER

Description: Generally, Medicaid coverage must be suspended for recipients age 21-64 admitted to a psychiatric center and reinstated at the time of release from such facility.

Policy: When a district is notified that a Medicaid recipient age 21-64 is a resident of a psychiatric center, the district must suspend Medicaid coverage, barring certain exceptions. Upon notification of discharge from the psychiatric center, Medicaid coverage must be reinstated in the district of fiscal responsibility immediately prior to admission.

NOTE: Districts will be notified of admissions and discharges from State Operated Psychiatric Centers by the State Department of Health in conjunction with the Office of Mental Health (OMH). However, should a district become aware that an individual age 21-64 has entered a private (non-state operated) psychiatric hospital, Medicaid coverage must also be suspended and re-instated.

References:

SSL Sect.	365.2 (a) & (b) 366 (1) (c) & (d)
Dept. Regs.	360-3.4 (a) (2)
ADMs	11 OHIP/ADM-3
INFs	89 INF-43

Interpretation: Suspension of Medicaid**:**

On a monthly basis DOH will run a file provided by OMH to identify individuals age 21-64 who have been in a State psychiatric center for at least 30 days and have an active Medicaid/FHPlus case**.**

Medicaid must be suspended for Case Type 20 (MA) recipients with one of the following Coverage Codes: 01 (Full), 02 (Outpatient), 06 (Provisional), 10 (All Services Except Nursing Facility Services), 11 (Legal Alien), 15 (Perinatal), 18 (Family Planning Services Only), 19 (Community Coverage With Community-Based Long-Term Care), 20 (Community Coverage Without Long-Term Care), 22 (Outpatient Coverage Without Long-Term Care), 21 (Outpatient Coverage With Community-Based Long-Term Care), 23 (Outpatient Coverage With No Nursing Facility Services), 24 (Community Coverage Without Long-Term Care, Legal Alien During Five-year Ban, NYC only), and 30 (Pre-paid Capitation Plan). Also, Family Health Plus (FHPlus) coverage will

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be suspended for Case Type 24 (FHPlus) recipients who at the time of admission have Coverage Code 06 (Provisional, not yet enrolled, Upstate only), Coverage Code 20 (Community Coverage Without Long-Term Care) or 34 (FHPlus).

In situations where the individual was part of a multi-person household, a determination of the remaining household's ongoing eligibility must be performed. The psychiatric center resident shall remain in the household count unless the district receives notification from OMH that the resident's stay is other than temporary.

Medicare Part A and /or B premium payments and payments for third-party health insurance coverage must be discontinued and the Buy-In closed. If the individual is enrolled in a managed care plan, he/she must be dis-enrolled. NOTE: It may not be appropriate to discontinue payment of third-party health insurance premiums which cover other Medicaid/FHPlus household recipients.

Medicaid coverage will not be suspended for Temporary Assistance (TA)/Medicaid recipients if the individual continues to receive TA benefits based on the individual's temporary admission to a psychiatric center. For these individuals, Medicaid coverage will continue. Also, Supplemental Security Income (SSI) beneficiaries will continue to receive Medicaid coverage based on the receipt of SSI.

Exceptions to Suspension:

1. Medicaid Coverage must be discontinued for recipients with Coverage Code 07 (Emergency Services Only).
2. Individuals with Coverage Code 31 or 36 (Active for Guarantee Coverage Only) must have their managed care guarantee coverage discontinued with appropriate notice.
3. Individuals authorized for Medicare Savings Program (coverage code 09) must have their coverage discontinued.
4. Individuals with coverage code 17, Health Insurance Continuation Only- COBRA, AHIP must have their coverage discontinued. **NOTE**: If the COBRA/AHIP policy covers other eligible household members, it may not be appropriate to discontinue payment of health insurance premiums.

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5. Case Type 20 (MA) recipients with Coverage Code 09 who are participating in the spenddown program must have their case suspended and their premium payment discontinued. Recipients who have been authorized for MSP-only must have their MSP Buy-in span end-dated in eMedNY.

Re-Instatement of Medicaid

Upon notification from DOH/OMH that an individual whose Medicaid or FHPlus authorization had been placed in suspend status is being discharged from the psychiatric center such individual must have their Medicaid coverage reinstated with the coverage they had immediately prior to their admission to the psychiatric center. Medicaid coverage must be reinstated for five months (the month of discharge, plus four months) with appropriate notice at the individual's current address.

In situations where the releasee is residing with family members who are not in receipt of Medicaid or FHPlus, his/her ongoing eligibility shall be redetermined at renewal as a member of the household, after the five month reinstatement period. If the releasee is a member of a currently eligible Medicaid/FHP household, eligibility for the other household member(s) must be reviewed at renewal.

Exceptions to Re-Instatement

1. Medicaid eligibility must be redetermined for individuals who are being discharged to an SNF. While a new application is not required, Supplement A to the DOH-4220 is required if resource information must be captured.

2. Coverage for individuals who are being discharged to the custody of the United States Immigration and Customs Enforcement (ICE) must be discontinued.

3. Individuals who are being discharged to a NYS or local correctional facility will continue to have their coverage suspended.

4. Coverage must be discontinued for individuals who are being discharged to another state's law enforcement.

5. Coverage for individuals who are being discharged to the Federal Bureau of Prisons must have their coverage discontinued.

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6. Coverage for individuals who are being discharged to an OMH operated living arrangement (i.e. a State operated family care home, community residence or residential care center for adults) must be discontinued. Once the county case is closed, OMH will open a case in District 97.

7. Coverage must be discontinued for individuals who have died in the psychiatric center.

8. The DFR prior to admission to the psychiatric center must discontinue coverage for individuals who turn 65 and remain in the psychiatric center. Once the district closes its case, OMH will determine eligibility for the individual.

9. Coverage for an individual discharged to an Office for People with Developmental Disabilities (OPWDD) must be discontinued. Once the district has closed its case, OPWDD will open a case in District 98.

10. Medicaid and FHPlus must be discontinued for individuals who have moved to another state.

11. Medicaid and FHPlus must be discontinued for individuals who are discharged to an out-of-state psychiatric center.