OTHER ELIGIBILITY REQUIREMENTS
STATE RESIDENCE AND RESPONSIBILTY FOR ASSISTANCE

ASSISTANCE TO PERSONS WHO CHANGE RESIDENCY

Description: Medicaid recipients who notify their district of residence of a change in residency to another district in New York State will have their Medicaid case transitioned to the new district without the need for a new application or face-to-face interview.

Policy: Medicaid recipients who report their move from one district to another within the State will be provided coverage by their originating district for the month in which the move is reported and the following month. Coverage will be established in the new district of residence effective the first day of the second month following the month the move was reported. Eligibility will continue for the duration of the originating county's authorization period, or four months, whichever is greater. If a recipient advises the district of a move, in advance of his or her actual relocation, the originating district is responsible for providing coverage through the month of the actual move and the following month.

References:

SSL Sect.	62.5 (a)
ADM	99 OMM/ADM -3 OMM/ADM 97-1 95 ADM-5 89 ADM-2
Dept. Reg.	360-1.4 (j)
LCM	08 OHIP/LCM-1
GIS	02 MA/006 02 MA/001

Interpretation: Recipients in Case Types 20 (Medicaid), 24 (Family Health Plus), and recipients who receive Medicaid through a Temporary Assistance (TA) Case (Case Types 11, 12, 16 or 17) who notify their district of a move to another county, and provide their new address in writing will have their Medicaid case transitioned to the new district of residence without the need for a new application or face-to-face interview.

NOTE: This policy does **not** apply to Medicaid recipients who are institutionalized in a medical facility as defined in Department

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Regulations at 18 NYCRR, Section 360-1.4 (j). This means that eligibility will not be transitioned for individuals who relocate to another district from a hospital, nursing home, Intermediate Care facility, inpatient psychiatric center or inpatient alcohol treatment facility.

When a Supplemental Security Income (SSI) recipient reports a move to another district, it is important that the move be reported to the Social Security Administration following the instructions in 95 ADM-5. Districts must coordinate any closing for an SSI recipient with the opening of a case in the new district.

For recipients who report their move and provide the address in the new district in advance of his or her actual relocation, the district is responsible for providing coverage through the month of the actual move and the following month and coverage is established in the new district the first day of the succeeding month.

If a district discovers a recipient has moved out of county (the recipient has reported the move), coverage must be provided for the month of and the month following the move at which time the case must be closed.

Recipients who do not report their move in advance of his or her actual relocation will have their coverage provided by the originating district for the month in which the move is reported and the following month. Coverage is established in the new district effective the first day of the second month following the month the move was reported.

NOTE: The District of Fiscal Responsibility (DFR) rules, with the exception of the Transition Rule, remain unchanged.

CONSIDERATIONS:

Changes in Circumstances- In situations where the recipient reports their move AND other changes relative to eligibility and the information is sufficient to complete a re-determination before the case is transitioned, such re-determination should be made. Changes that result in ineligibility should be handled in accordance with existing procedures, including the discontinuance or change of coverage as appropriate. However, in no instance should a district

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delay the transition of coverage pending receipt of further information regarding items that may change as a result of the individual's reported relocation (i.e. a change of job, which may result in a change in earned income).

Cases for which the district has not completed the eligibility determination, (i.e. a pregnant woman authorized for Presumptive Eligibility) must have such determination of eligibility completed prior to the transition of the case to the new district of residence.

Similarly, if the case is in the process of being renewed, the district must complete the renewal before transitioning the case to the new district of residence.

Not All Case Members Moving- The eligibility of the moving household members must be determined. If determined ineligible, they must be closed, and the case is not transitioned. If eligibility continues, a new case must be opened for them and transitioned to the new district of residence. Eligibility for the remaining household members must be re-determined and appropriate action taken.

Returned Agency Correspondence- Returned correspondence, including the Medicaid/FHP renewal that is returned to the district by the U.S. Postal Service with a change of address must be re-mailed to the new address with a copy of Attachment VII of 08 OHIP/LCM-1 which will provide the individual the opportunity to confirm the new address. Individuals who respond in the prescribed time frame (minimally 10 days) to the follow-up correspondence shall be considered to have reported their re-location and new address and will have their case transitioned after continued eligibility is determined. Individuals who do not respond to the follow-up correspondence will have their case discontinued having failed to renew or comply with a request for additional information.

Children in Continuous Coverage Status- Children who move to another district of residence will have their eligibility transitioned to the new district of residence. However, children who have lost eligibility fro reasons other than a move out of district will be provided continuous coverage through the continuous coverage period by their former district of residence.

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Individuals who Notify County B of their Re-location- In situations where the recipient notifies the new district of residence of their move, the new district of residence must direct the individual to put the new address in writing. The new district must forward the new address to the district currently providing coverage so that such district may take necessary action to transition the case.

If the individual wishes to make an application in the new district of residence, all aspects of the application process must be adhered to, including the face-to-face interview and documentation requirements. If the applicant(s) is found eligible, coordination in opening and closing the cases must occur between the two districts to avoid duplicate coverage.

NOTE: The Medicaid coverage of a TA case will be transitioned to the new district of residence in the event of a reported move. However, the individual must re-apply for TA in the new district of residence. If the individual also applies for Medicaid with the TA application and the determination is made prior to the transition of the Medicaid coverage, the TA/Medicaid case should be authorized.

Homeless Individuals- Homeless individuals who report a move to another district must have their case transitioned, even though they do not have a permanent address.

Admissions to District 97 (Office of Mental Health) and 98 (Office of Mental Retardation and Developmental Disabilities) Living Arrangements- Individuals who are admitted to certain District 97 and 98 living arrangements will not have their cases transitioned. When a district is contacted by a Patient Resource Office (OMH), or a Revenue Support Office (OMR) and advised that an individual has been admitted to a specified OMH or OMR living arrangement, the district must use manual notice OHIP-0014 to inform the individual that his or her Medicaid case is being transferred to District 97 or 98, effective with the date of admission to the facility.

When an individual is discharged from a specified OMH or OMR living arrangement, the district will be sent the Relocation Referral Form and accompanying documentation from the appropriate Patient Resource Office or Revenue Support Office. The District of

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Fiscal Responsibility must establish uninterrupted coverage for the case, and send notice OHIP-0015.

COVERAGE CONSIDERATIONS:

Managed Care- If available, individuals who have moved to a new district should be re-enrolled in the same managed care plan in their new district of residence.

If the same managed care plan is not available, the Managed Care disenrollment should be coordinated with the last date of coverage in the former district. Consideration may be made to disenroll the individual earlier if the individual has moved out of the plan's service area and can not access services. Such disenrollment would enable the individual to receive fee-for-service coverage in order to access services. Future managed care enrollment should proceed according to local district requirements.

Family Health Plus (FHPlus) - If available, individuals who have moved to a new district should be re-enrolled in the same managed care plan in their new district of residence.

Individuals who have moved to a district where only one FHPlus plan is available must be enrolled in that plan. If the FHPlus plan is not the same plan as the individual was enrolled previously, the county must take necessary steps to insure the enrollment is effective by the first day of the month following the closing in the former district of residence. This may include notifying the plan in writing if the enrollment is not processed by pull down dates.

If the same FHPlus plan is not available and more than one FHPlus plan exists in the new county of residence, the former county of residence must disenroll the individual effective the first day of the month following the second month in which the closing transaction is made. The new district of residence must provide the individual with plan selection information as soon as possible. In some instances, the former district of residence may need to delete a disenrollment to allow the new district of residence

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to process an enrollment.

NOTE: Managed Care and FHPlus recipients who are receiving Guaranteed Coverage (Coverage Codes 31 and 36 respectively) have been determined to be ineligible for Medicaid. If such an individual reports a move to another district, the individual is entitled ONLY to the balance of the six month guarantee from the original county of residence.

Third Party and Medicare- When a case opens in the new district of residence, any commercial insurance, Medicare coverage and Medicare Savings Program information must be reflected on eMedNY.

If the former district of residence has been paying a commercial health insurance premium, all necessary information regarding the payment of the premium must be forwarded to the new district of residence and annotated on the Relocation Referral Form.

The new district of residence should verify that the commercial policy remains in effect. Any changes to coverage or providers should be entered in the eMedNY Third Party subsystem and the district should assume the responsibility of making the premium payments. This should be done timely to ensure the commercial health insurance coverage is not jeopardized.

Disposition:

Local Social Services Districts must ensure that individuals who report their move to a new district and are otherwise eligible have their Medicaid/Family Health Plus case transitioned to such new district. Appropriate and timely transactions in the Welfare Management System (WMS) must be taken, and coordinated between the new and former districts to ensure appropriate access to Medicaid and Family Health Plus coverage.