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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	***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.

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(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.

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(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.***

(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.

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(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.

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(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 page 485).

(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 Services re-determines and confirms eligibility.

(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 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;

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dies; moves out of State or the LDSS is unable to locate; was fraudulent during the application process; 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 page 115); or is a single adult or member of a childless couple and is not pregnant, aged, blind, or disabled and commits an Intentional Program Violation (IPV) prior to the first month enrolled in the managed care plan. Recipients receiving coverage under a guarantee who have excess income/resources spend down to gain Medicaid eligibility for services outside of their plans (see pages 239 and 339).

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).