OTHER ELIGIBILITY REQUIREMENTS

DECISION AND NOTIFICATION

Description: A decision on an application, reapplication, or recertification is a determination that the applicant is either eligible or ineligible for Medicaid.

Policy: A decision as to the A/R's eligibility is made within specified time periods for each new application, reapplication and recertification. Upon reaching a decision, a written notification of acceptance, denial, withdrawal, discontinuance, reduction or change in the spenddown calculation is sent to the applicant.

The Notice of Intent sent to Public Assistance A/Rs who have also applied for Medicaid contains a separate statement concerning Medicaid eligibility. Where the reason for denying the PA case is also a valid reason for denying Medicaid, it is stated separately in the Notice of Intent.

New SSI beneficiaries will receive a letter from New York State informing them that they are automatically eligible for Medicaid. This letter also requests the A/R to supply information concerning third party health insurance, and information on paid or incurred medical bills for the three months prior to the month of application.

References:

SSL Sect.	366 366-a
Dept. Reg.	358-3.3 358-4.1 360-2.4 360-2.5 360-2.8 360-2.9
ADMs	89 ADM-21 82 ADM-5

Interpretation: A determination of eligibility is made within a 45-day time period. A determination of eligibility for persons eligible under the poverty based programs (pregnant women and children under age 19) is completed within 30 days. The only exception to this are cases awaiting a disability determination. A 90-day time limit is applied to situations when a disability determination is being

OTHER ELIGIBILITY REQUIREMENTS

DECISION AND NOTIFICATION

made (see page 26). If the eligibility determination process for a disabled applicant takes more than 90 days, on or before the 90th day, the A/R is sent a written statement stating the reasons for the delay. When the applicant is eligible under a different category, Medicaid is authorized for the interim period.

Each applicant for Medicaid is notified in writing of the local district's decision regarding his/her application. In the written notification, the applicant is informed of: the action taken, the effective date of the action, the specific reason(s) for the action whether positive or negative, including supporting regulations or laws; his/her right to a conference with a representative of the district; and of his/her right to a fair hearing including the method by which s/he may obtain a hearing. The applicant is also advised that s/he may be represented at any conference or fair hearing by someone such as legal counsel, or by a relative, friend or other person and of the availability of community legal services (Legal Aid), if any. A fair hearing request may be made on the basis of: denial of assistance; failure to determine the applicant's eligibility within the time period specified; inadequacy of the amount or manner of assistance; discontinuance or reduction of **coverage or** assistance; objection to State policy as it affects the applicant; or any other grounds affecting the applicant's entitlement to assistance. If a recipient requests a fair hearing within the time period specified in the notice, Medicaid is continued unchanged until a decision is issued on the Fair Hearing.

A separate Medicaid eligibility determination is completed for every PA case closed or denied where the A/R also applied for or was in receipt of Medicaid, except for cases when the reason for closing or denying PA is also a valid reason for closing or denying Medicaid. In all situations, the client is advised in a separate statement of the status of his/her Medicaid eligibility.

This section describes decision and notification in detail. It is organized as follows:

Acceptance;
Denial;
Withdrawal; and
Discontinuance or reduction.

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

ACCEPTANCE

Description: When an application for Medicaid is accepted, Medicaid is authorized for a stated person(s) for a specific period of time. The applicant is notified as to who was accepted or denied and the **effective date** of authorization.

Policy: When an application is accepted and Medicaid is authorized, notification in writing shall be sent to the applicant.

References:

SSL Sect. 366
366-a

Dept. Reg. 358-3.3
358-4.1
360-2.4
360-2.5

ADMs ***04 OMM/ADM-6***
97 OMM/ADM-2
96 ADM-15
89 ADM-21
87 ADM-41

Interpretation: Written notification to the applicant includes a copy of the applicant's budget and an explanation of what care or services are authorized. If limitations are placed upon care or services, the limitations are explained in the letter. A copy of the notice is also sent to the medical provider (e.g., nursing home or hospital), as appropriate.

When only certain members of the applying household (group applying) are accepted for coverage, the coverage is explained in the notice to the applicant. The notice also advises the applicant of his/her responsibility to inform the district of any changes in his/her financial situation and/or any other changes affecting eligibility.

In addition to the standardized notice, an A/R with excess income (see page 239) is given a copy of the "Explanation of Excess Income Program" letter. When appropriate, a copy of the “Provider/Recipient Letter” and the Optional Pay-In Program for Individuals with Excess Income” (see 96 ADM-15) is sent to A/Rs with excess income. The “Provider/Recipient Letter” lists incurred medical expenses for which the A/R is responsible or partially responsible. A copy of the “Provider/Recipient Letter” is

OTHER ELIGIBILITY REQUIREMENTS

ACCEPTANCE

also sent to the provider for billing purposes. When the medical expenses are for services from more than one provider, a separate form is completed for each provider to protect the A/R's confidentiality. When the A/R is a patient in a nursing facility or is approved for nursing home care, a letter of notification is sent to both the nursing home and the A/R clearly stating the A/R's liability toward the cost of care. When the A/R is an institutionalized spouse, the community spouse is also sent a copy of the notice.

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

DENIAL

Description: A denial is a determination that an applicant is not eligible ***for Medicaid.***

Policy: When an application for Medicaid is denied, a written notification is sent to the applicant.

References:

SSL Sect. 366
366-a

Dept. Reg. 358-3.3
358-4.1
360-2.3
360-2.4
360-2.5
360-2.8
360-2.9

ADMs ***04 OMM/ADM-6***
97 OMM/ADM-2
96 ADM-15
89 ADM-21
87 ADM-4

Interpretation: An application for requested Medicaid coverage may be denied because the applicant is ineligible or because the applicant's eligibility cannot be determined due to his/her failure to cooperate in establishing eligibility.

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

DENIAL

When a decision is reached, a letter is sent to the applicant, including a copy of the budget, when applicable, informing him/her of the reason for the denial and of his/her right to: a conference with a representative of the local district; and a fair hearing as outlined on page 375, "Decision and Notification." A copy of the notice is also sent to the Medical provider (e.g. nursing home and hospital) as appropriate.

When an applicant is denied due to excess income and the applicant is ADC-related, SSI-related, a pregnant woman, or under 21, the letter explains how excess income may be utilized to "spend down" to the medically needy income level or PA Standard of Need (whichever is higher) (see pages 114 and 121). The letter further explains local district procedures regarding the applicant's use of the excess income, including the ”Optional Pay-In Program for Individuals with Excess Income.”

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

WITHDRAWAL OF APPLICATION

Description: After the submission of a written application, but before the applicant is notified by the local social services district of his/her eligibility determination, the applicant may withdraw his/her request for Medicaid.

Policy: When an application is withdrawn by the applicant, the district registers it as withdrawn.

References:

SSL Sect. 366
366-a

Dept. Reg. 358-3.1
358-3.3
358-4.1

Interpretation: The decision to withdraw an application can only be made by the applicant or by the person making the application on behalf of the applicant. When the withdrawal is made in person, the applicant or representative is asked to sign the application as appropriate or sign a statement declaring his/her desire to withdraw the application. When the request is by phone, a notation is made on the application. **In addition, an adequate notice is issued to the applicant/representative confirming the voluntary withdrawal.** No further action is taken on the application; however, the applicant may reapply at any time. Original documents, such as birth certificates, are returned to the applicant, but any photo static copies and the application remain with the district and are not returned to the applicant.

OTHER ELIGIBILITY REQUIREMENTS
DECISION AND NOTIFICATION

DISCONTINUANCE OR REDUCTION

Description: A discontinuance of Medicaid is a termination of all benefits under the program. The reduction of Medicaid is a change of benefit coverage from more extensive coverage to less extensive coverage or to an increase in the **recipient's** liability, ***i.e., a change from Community Coverage with Community-Based Long-Term Care to Community Coverage without Long-Term Care, or*** a change from full coverage to a spenddown.

Policy: A determination by the district to discontinue or reduce a recipient's Medicaid ***coverage*** is communicated to the recipient in a letter of intent to discontinue or reduce Medicaid. Generally, the notice is sent at least ten days in advance of the proposed action. Under certain circumstances, it is not necessary to send a notice of intent ten days in advance of the action (see page 382). Where the A/R is in receipt of both Medicaid and Public Assistance, any notice to discontinue or reduce Public Assistance also includes a statement advising the client of the status of his/her Medicaid eligibility.

References:

SSL Sect.
366
366-a

Dept. Reg.
358-3.3
358-4.1
360-2.3
360-2.6
360-2.7
360-2.8
360-2.9

ADMs
04 OMM/ADM-6
97 OMM/ADM-2
89 ADM-21
83 ADM-27
81 ADM-55
80 ADM-19

Interpretation: A Medicaid case is discontinued because of the recipient's ineligibility for continued assistance, failure to cooperate, permanent removal from the district or other factors which affect continued eligibility. Generally, a letter of notification

OTHER ELIGIBLITY REQUIREMENTS

DISCONTINUANCE OR REDUCTION

is sent (see page 374), at least 10 days in advance of the proposed action, to the recipient advising him/her of: the action to be taken; the effective date of the action, the reason(s) why the action(s) is/are being taken; the supporting law or regulation; the client's right to request a conference with a representative of the district; and the right to a fair hearing. If the recipient requests a fair hearing between the date of the notification and the date of the proposed action, Medicaid is continued without reduction until the fair hearing decision is rendered.

A reduction in Medicaid coverage also requires that a letter of notification be sent at least 10 days in advance of the proposed reduction. The letter of notification advises the client: that his/her Medicaid is being reduced; the effective date of the action; the reason why the action is being taken; the supporting law or regulations; the recipient's right to a conference with a representative of the district; and the right to a fair hearing. If the recipient requests a fair hearing between the date of receiving the notice and the date of the proposed reduction, Medicaid is continued without reduction until the fair hearing decision is rendered.

When an A/R is in receipt of Public Assistance and Medicaid or SSI cash and the cash benefit is discontinued, a separate determination for Medicaid is completed by the end of the calendar month following the month in which cash assistance is terminated. The Notice of Intent to Discontinue Public Assistance contains a separate statement advising the client of the status of his/her Medicaid: continued until a separate determination can be made; discontinued and the reasons why; or continued until the next recertification. When an SSI cash benefit is discontinued, and there is adequate information in the local district’s records, the recipient's eligibility is determined without contacting the recipient. The recipient is notified of the eligibility decision. When Medicaid eligibility can not be determined due to inadequate information, the recipient is contacted and required to provide the necessary information. Medicaid is continued pending the receipt of the information. The recipient is given 30 days to provide this information.