STATE OF NEW YORK
DEPARTMENT OF HEALTH

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TRANSMITTAL: 10 OHIP/ADM-4

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: April 2, 2010

SUBJECT: Elimination of the Personal Interview Requirement for Medicaid and Family Health Plus Applicants

SUGGESTED DISTRIBUTION:	Medicaid Directors Managed Care Staff Staff Development Coordinators Legal Staff Fair Hearing Staff Audit Staff Facilitated Enrollers
CONTACT PERSON:	Local District Liaison Upstate: (518) 474-8887 NYC: (212) 417-4500
ATTACHMENTS:	Attachment I - Model Memorandum of Understanding Attachment II - Confidentiality Agreement Attachment III - Transmittal Form Attachment IV - Addresses of Child Health Plus Plans

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
01 OMM/ADM-06 10 OHIP/ADM-01	GIS 96 MA/015	360-2.2(f)(1)	Ch. 58 of Laws of 2009		GIS 07 MA/027

I. PURPOSE

This Office of Health Insurance Programs Administrative Directive (OHIP/ADM) advises local departments of social services (LDSS) of the elimination of the personal interview requirement for all Medicaid and Family Health Plus (FHPlus) applicants as a result of Chapter 58 of the Laws of 2009. This includes applicants for the Family Planning Benefit Program (FPBP) and the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD), and individuals applying for Medicaid coverage of nursing facility services.

The interview requirement was previously eliminated for applicants for the Medicare Savings Program (MSP) as advised in GIS 07 MA/027.

II. BACKGROUND

Section 366-a of the Social Services Law required that LDSS conduct a personal interview with anyone applying for Medicaid. Similarly, Section 369-ee of the Social Services Law required that LDSS conduct an interview with anyone applying for FHPlus.

Chapter 58 of the Laws of 2009 eliminates the requirement to conduct a personal interview as part of the process of determining eligibility for Medicaid and FHPlus. The elimination of the interview is intended to simplify the application process and eliminate barriers to obtaining public health insurance. This change will simplify the application process by allowing applicants to mail in or drop off applications to an LDSS without requiring the applicant to schedule or appear for an interview. Applicants may still request assistance in understanding the Medicaid program or completing an application; however, an LDSS cannot require that an interview takes place.

III. PROGRAM IMPLICATIONS

An interview for Medicaid and FHPlus must not be required as a condition of eligibility on or after April 1, 2010. If a Medicaid or FHPlus application was filed prior to April 1, 2010, but the LDSS was unable to schedule the interview until April 1, 2010, or later, an interview must not be scheduled and eligibility must be determined.

To obtain information that may have been provided or clarified during an interview, the Access NY Health Care application (DOH-4220) is being revised. Additional questions are being added, other questions are being revised and some questions are being deleted based on policy changes since the last revision of the application. These changes will be outlined in a forthcoming directive. The revised Access NY Health Care application will be used by individuals applying for public health insurance only, including those who are applying for Medicaid coverage of long-term care services. The one-page Medicare Savings Program application and the Family Planning Benefit Program application will also still be available. The LDSS-2921 can still be used for individuals applying for both Medicaid and other programs such as Temporary Assistance (TA) and Food Stamps.

Although certain procedures in LDSS will change as a result of the elimination of the interview, many LDSS responsibilities continue, such as providing application assistance and timely eligibility determinations. Local departments of social services will continue to have 30 days to determine Medicaid eligibility for children under the age of 19 and pregnant women, 90 days for applicants pending a disability review, and 45 days for all other applicants.

Information in this directive provides LDSS with guidance to facilitate timely Medicaid and FHPlus eligibility determinations in the absence of a personal interview.

A. Application Assistance

Local departments of social services must continue to provide applicants with application assistance. An applicant can request assistance in understanding and/or completing the application for public health insurance. Such assistance may be sought and must be provided by the LDSS in person, either as a walk-in or by appointment, over the telephone or in writing. Local departments of social services must obtain any information missing from the application, including necessary documentation.

Facilitated Enrollers (FEs) and other designated staff at outreach sites such as family planning providers, providers who determine presumptive eligibility and hospitals with out-stationed workers may also provide application assistance. Although the role of FEs will not change greatly with the elimination of the interview, they may continue to be relied upon to provide application assistance in seeing and copying original identity and citizenship documentation. However, an LDSS may not require that individuals apply through an FE or other outreach site, nor may they require that applicants seek application assistance from these entities. More details on the role of FEs are provided in Section IV, REQUIRED ACTION, of this ADM.

With the elimination of the interview, individuals may mail the application to the wrong LDSS. If the LDSS believes that the applicant is the fiscal responsibility of another district, the LDSS where the individual is applying may take a “courtesy application” and forward it to the district of fiscal responsibility. Guidelines for “courtesy applications” can be found in 97 OMM/ADM-1. The agreed upon district of fiscal responsibility shall obtain any information missing from the application.

B. Application Date

The policy regarding the application date has not changed. The application date is the date that a signed and dated application is received by the LDSS, either by mail, or by an applicant dropping the application off at the LDSS. The application date for individuals applying with an FE or other outreach site is the date on which the application is started. For children under 19 and

pregnant women applying through the presumptive eligibility process, the application date is the date of the screening.

C. Complete Applications

With the elimination of the interview, applicants will be able to mail their applications directly to the LDSS. If an applicant did not seek assistance in completing the application, an application with incomplete sections may be received by the LDSS. An application is considered to be filed with the LDSS when an applicant submits a signed and dated application that includes his/her name and address. The LDSS may need more information to make a Medicaid eligibility determination but the application date is protected.

The LDSS must contact the applicant to get additional information that is needed to make an eligibility determination. Local departments of social services have options regarding how to obtain missing information. The LDSS may call the applicant to get information over the phone and notate findings on the application. If information is missing from the various sections of the application, or if the LDSS prefers, a photocopy of the incomplete pages of the application may be mailed to the applicant to complete and return to the agency.

Local departments of social services must allow applicants at least 10 days to provide requested documentation. The applicant may request additional time when attempting to obtain required documentation. If an applicant is requested to provide documentation necessary to make an eligibility determination and does not do so within the required time period and does not ask for more time or assistance in obtaining documentation, his/her application may be denied.

It is important to reiterate that even if information is missing from the application, the application date must be protected while seeking to obtain more information. In addition, if an application is submitted and all necessary information is included, an application should not be denied because inconsequential information has not been provided. For example, LDSS examiners should not deny an application because supporting documentation of a water expense or childcare expense is not submitted, if the applicant can be determined eligible without this deduction. However, the examiner should not give an additional allowance or a deduction without the documentation. If the applicant is otherwise eligible, coverage in the appropriate program must be authorized.

D. Screening When Determining Eligibility

In providing application assistance, some LDSS offices may offer to screen an application when it is brought to the LDSS by the applicant. While screening an application may be useful, an LDSS cannot require that an application be screened. Screening of an application is more informal than a personal interview. During a screening, the LDSS examiner or other district personnel may review an application to ensure that all appropriate sections of the

application are complete and required documentation is included. The individual screening the application may also view and copy the original identity and citizenship documents. A screening may take less time than a formal interview would have, but it may reduce the need for further follow-up by the LDSS.

Note: If an LDSS screens an application and sees that the case will be ineligible based on income, the district must continue to process the application, request income documentation and provide the proper decision notice.

E. Identity and Citizenship Documentation

Applicants are still required to provide all necessary documentation to establish eligibility. Federal regulations that require applicants to show original or certified copies of identity and citizenship documentation continue to apply. To assist LDSS in making accurate and timely Medicaid eligibility determinations, these original documents may be presented at the LDSS, to an FE, designated staff at an outreach site including deputized workers, or to designated staff at an entity in the community with which the LDSS has established a Memorandum of Understanding (MOU) for purposes of verifying that original documents have been seen. Examples of other community entities include, but are not limited to, hospitals, physicians' offices, senior centers or town clerks. An FE may review original documentation for an applicant without processing the application. If an FE views original documents but does not provide application assistance, he/she should make copies of the original documents, stamp the copy indicating the date the original was seen, include the lead name and the FE name on the copy, and return the original documents and copies to the applicant.

It is not necessary for the LDSS to enter into a separate agreement from those that currently exist with entities such as community based organizations (CBO) or plan FEs, family planning providers, presumptive eligibility qualified entities or Article 28 prenatal care providers. Although the LDSS is not required to use other entities, some may choose to do so as a way to provide applicants with more options than coming into the LDSS office. If the LDSS chooses to use such entities for this purpose, they will need to enter into formal agreements with them. Although these community organizations may assist in the process of seeing and copying original documents, they will not validate the authenticity of the documents, nor will they determine if the identity and/or citizenship documentation requirement has been satisfied; they will make copies of documents and sign and notate on the copies that they saw an original. The documents and copies made by the community entities should be given to the applicant to submit to the LDSS.

The revised Access NY Health Care application will instruct applicants to contact the LDSS to find out where he/she may bring original or certified copies of identity/citizenship documentation. Local departments of social services are responsible for informing applicants of locations where they can take original documents to be reviewed and copied.

To facilitate agreements with community organizations, a model MOU and Confidentiality Agreement are included with this ADM (Attachments I and II). These documents must be used as written, without modification. If an LDSS requires a modification to one of the documents, approval must be obtained from the State Department of Health, Office of Health Insurance Programs, prior to any changes being made. Local departments of social services are instructed to contact their local district liaison for approval.

IV. REQUIRED ACTION

The receipt and processing of Medicaid applications will change with the elimination of the personal interview. Local department of social services will need to evaluate current procedures to ensure that accurate and timely Medicaid eligibility determinations continue to be made. Local department of social services examiners will need to be aware of the need for separate determinations for TA/Medicaid applicants who fail to comply with the TA interview requirement, the need to provide managed care education, and the distribution of informational materials (e.g. Books 1-3).

A. Separate Determinations

If an individual applies for both TA and Medicaid and fails to appear for a TA interview, the LDSS must conduct a separate determination of Medicaid eligibility. This may include requesting documentation necessary to establish eligibility. See Section V, SYSTEM IMPLICATIONS, for additional information on separate determinations.

B. Managed Care Implications

Applicants for FHPlus must choose a health plan for their coverage. In counties that have more than one FHPlus health plan, choosing a plan continues to be an eligibility requirement. Most applicants for Medicaid must choose a plan; mandatory managed care is operational in 38 counties and is scheduled to expand. Choosing a Medicaid plan is not a condition of eligibility; however, failure to choose a plan in these counties will result in an applicant being assigned to one, also known as auto-assignment.

Local departments of social services are required to educate applicants about their choice of managed care plans for FHPlus and for Medicaid in mandatory counties. Education includes providing basic information about the managed care program, plans available in each county and their optional benefits. The goal of education is to increase the number of applicants who select a plan and who

are able to identify a health plan that includes their current doctor, and to decrease the need for auto-assignment. Managed care education can be conducted by mail, in person, by telephone or through FEs.

All districts need to provide managed care education packets, which will include county specific information (e.g., what plans are available, optional benefits, etc.) and a managed care contact for more detailed information. For counties with Medicaid Managed Care, brochures can be ordered by contacting the State Department of Health (SDOH) Distribution Center by calling (518) 465-8170 or writing to their address at 21 Simmons Lane, Albany, New York, 12204. These brochures describe mandatory/voluntary managed care and managed care for SSI recipients, and should be included in the education packet. Packets can be mailed with the application or made available at the LDSS.

Revisions are being made to the language on the Access NY Health Care application (the application instructions and the enrollment section) to inform applicants about what managed care is, who must enroll, and how applicants can get information on the plans available in their district. Applicants will be instructed in Section I of the application to call the New York Medicaid CHOICE (managed care enrollment broker for New York State, also known as Maximus) hotline at 1-800-505-5678 for more information.

New York City and the following counties utilize the services of Maximus: Nassau, Suffolk, Westchester, Putnam, Sullivan, Ulster, Dutchess, Orange, Schenectady, Fulton, Montgomery, Washington and Otsego. When an applicant residing in one of the above counties calls the toll-free number for managed care information, education and information on choosing and enrolling in a health plan can be provided. The enrollment choice is “pended” until the district opens the case on WMS. The Prepaid Capitation Plan (PCP) subsystem is updated for enrollment after that transaction. This process is currently in operation in the districts utilizing the enrollment broker.

In LDSS that do not utilize the enrollment broker, applicants who call the hotline will be referred to the managed care unit in the appropriate LDSS office. The Division of Managed Care at SDOH will maintain a listing with Maximus of the designated managed care contacts’ phone numbers for referral purposes.

Local departments of social services are reminded that enrollment information must be accepted from Section I. Recipients cannot be required by districts or plans to complete a separate enrollment form. If recipients provide a choice of primary care doctor on enrollment information, this information must be sent to the plan by the LDSS.

Applicants may be referred to managed care workers or Maximus counselors at the time they choose to come into the LDSS to conduct such business as copying documents, requesting application assistance, or to bring in required documentation. Managed care and eligibility staff should develop procedures to make these important referrals at such times.

C. Role of Facilitated Enrollers

The role of FEs will largely continue as it has in the past. The application date for applications received by FEs will continue to be the date the FE starts the application with the applicant. Medicaid coverage will continue to start on the first day of the month in which the application start date occurs or in one of the three months prior if the applicant is seeking and is determined eligible for retroactive coverage. The FE will still have 15 business days to submit the application to the LDSS.

While an interview with the LDSS or an FE cannot be required, FEs and LDSS examiners are required to provide application assistance, as appropriate, to an applicant who seeks assistance in understanding the application process or with completing the application. As stated previously, applicants are still required to provide all necessary documentation and in some cases, original documentation. When an applicant is seeking application assistance from an FE, the FE can make copies of necessary documents for submission to the LDSS with the application, annotate that they have seen the original, and return the original documents to the applicant.

It is anticipated that FEs will experience different scenarios when accepting applications in an environment without an interview. In the first scenario, the application process for the FE will continue in the same way as it has in the past; an applicant or authorized representative meets with an FE and receives application assistance, and submits an application. In this situation, the FE must get the application to the LDSS for an eligibility determination within 15 business days.

In the second scenario, an applicant completes an application on his/her own, and then submits the application to the FE or asks the FE to review the application. The FE should not submit the application without first reviewing it to ensure that it is complete and all necessary documentation has been presented. Since this is now an FE application, the FE should then date stamp the application on the day he/she meets with the applicant, which starts the 15-business day clock. In this scenario, the FE must have the applicant resign/date the application and collect current documentation.

Local departments of social services cannot forward applications submitted directly to the LDSS by an applicant to an FE and require the FE to follow up in obtaining the necessary documentation.

D. Applications That Screen Medicaid Eligible Sent to Non-FE CHPlus Plans

When an application is mailed directly to a Child Health Plus (CHPlus) plan that is not an FE, the application will be mailed by the plan directly to the LDSS if the child appears Medicaid eligible, whether it is complete or incomplete. In such cases, the original application should be sent to the LDSS. The application date in this scenario is the date that a signed and dated application is received by the LDSS. Documentation of income in this scenario must be for the most recent four weeks preceding the application date. Non-FE CHPlus plans will no longer be referring these applicants to an FE for application assistance. If the application is incomplete, the LDSS must work directly with the applicant, not the health plan, to complete the application. Non-FE plans should use the transmittal form attached to this ADM (Attachment III) when sending applications to the LDSS. If the CHPlus plan is an FE, the plan should review the application as they normally would to ensure that it is complete and all necessary documentation has been provided before it is forwarded to the LDSS. In this instance, the application date is the date the FE receives the complete application. The FE would have 15 business days from the date the application was received to get the application to the LDSS.

E. Child Health Plus

If an LDSS receives an application for a child who is ineligible for Medicaid due to excess income or immigration status, the LDSS must mail the application and documentation, including a copy of the ineligible Medicaid budget for cases denied for excess income, directly to the CHPlus plan on a daily basis, if a plan selection has been made. In cases where a plan selection has not been made and there is only one CHPlus plan in the county, the application and supporting documentation can be mailed directly to that plan. A list of health plans by county with their addresses is included in Attachment IV of this ADM. Updates to this list will be sent as needed. In cases where a plan selection was not made and there are multiple CHPlus plans available in the county, the LDSS must send the application and supporting documentation to the **Bureau of Child Health Plus Enrollment, Corning Tower, Room 1619, Empire State Plaza, Albany, NY 12237.** Staff from the Bureau will assist the individual in making the plan selection and then will forward the application directly to that plan.

F. Role of Presumptive Eligibility Screeners and FPBP Providers

Applicants for presumptive eligibility (PE) must continue to be screened in person for PE coverage to be authorized since presumptive eligibility is determined for children or pregnant women who present for treatment/services at a medical facility. Additionally, applicants for family planning only services will apply through FPBP providers when they present at a facility for covered services. Family planning clinics with an MOU for FPBP must continue to pursue confidentiality and explain to the

applicant that FPBP is not an application for Medicaid or FHPlus. Applicants must also be told that they may apply for Medicaid or FHPlus at any time. A separate MOU does not need to be signed with PE screeners and FPBP providers to assist in the process of reviewing original documentation.

G. Referrals

The requirement for an interview has been eliminated as a condition of Medicaid and FHPlus eligibility; however, occasionally it may be necessary for the LDSS to make referrals to other units and departments. For example, a referral may need to be made from the Medicaid Unit to the Child Support Enforcement Unit (CSEU) for a IV-D interview for a non-exempt individual to obtain medical support and/or establish paternity for his/her child(ren).

Such referrals may be used as opportunities to obtain a Client Benefit Identification Card (CBIC) photo if it is required for that individual. The requirement for certain non-exempt individuals to be photographed at the LDSS so their picture may appear on their CBIC for Medicaid-only cases remains the same. In addition, the current policy regarding how this requirement is handled by the LDSS has not changed. Local departments of social services are reminded that individuals who are required to have a photo on their CBIC, as described in 09 GIS/MA-021, may not be called into the LDSS only to obtain this photograph. In addition, Medicaid-only applications may not be denied for the sole reason that the applicant failed to obtain a photograph for his/her CBIC. The applicant should be photographed the next time there is client contact.

H. Informational Materials

The LDSS-4148A, “What You Should Know About Your Rights and Responsibilities”, LDSS-4148B, “What You Should Know About Social Services Programs”, and LDSS-4148C, “What You Should Know if You Have an Emergency,” also known as Books 1, 2 and 3, must continue to be given to all applicants.

With the elimination of the interview, LDSS will have to change the way they provide these booklets to applicants. Local departments of social services may either include these informational booklets with the application package that is either mailed or handed to applicants or the LDSS may send the booklets to applicants after they receive an application. However, LDSS may not wait until eligibility is determined to send Books 1, 2 and 3. If an LDSS chooses to provide the booklets in the application package and they receive an application printed from the internet, the examiner should not assume the booklets have been seen and the examiner should mail Books 1, 2 and 3 to the applicant.

I. Disability Determinations

Identification of potentially disabled individuals and assistance with medical evidence gathering for disability reviews continues to be the responsibility of the LDSS. The revised Access NY Health

Care application (DOH-4220) contains questions that will help district workers identify potentially disabled individuals. Further information about the revised application will be forthcoming. As in the past, if an individual does not have current, acceptable certification of disability, but indicates a possible disability on the application, the LDSS must assist the individual in gathering a medical evidence packet for a Medicaid disability determination by the State or local Disability Review Team.

Districts that previously mailed the Disability Interview form (LDSS-1151) and the district-specific Release of Medical Information form to the applicant may continue to initiate the medical evidence packet in this manner. When the LDSS-1151 form is returned to the district, it is important that the information on the form be reviewed by a district worker for completeness and the form signed by the worker. If the form is not complete, it is the responsibility of the worker to contact the applicant and obtain the information.

Districts that previously scheduled a disability interview to complete the Disability Interview and Release of Medical Information forms may no longer require an individual to come in for an interview. Districts may choose to complete the Disability Interview form (LDSS-1151) by telephone or they can mail the required forms to the applicant. If the district chooses to complete the form by mail, at least three attempts by telephone need to be documented before a letter is mailed to the individual requesting the completion of the Disability Interview and the Release of Medical Information forms. As stated previously, forms received from an applicant via the mail must be reviewed for completeness and signed by the worker. Incomplete forms must be addressed by the worker and all information obtained before the packet is submitted for a disability review.

Whether the district chooses to obtain completed disability forms by mail or via the telephone, if the individual requests assistance or wishes to have an interview in person, the district must accommodate the request.

V. SYSTEM IMPLICATIONS

A. Client Notices

1. Upstate

Medicaid: Client Notices System (CNS) Reason Codes/Paragraph Numbers V10/D0012-“Failure to Appear for Interview Appointment with Agency” and F27/D0100-“Failure to Complete Interview, MA/FHP” will be eliminated as a result of the elimination of the personal interview as a condition of Medicaid/FHPlus eligibility with the June 2010 systems migration. Although these codes will be available until the system migrates, LDSS examiners must not deny any Medicaid applicants for failure to appear for or complete a personal interview.

Temporary Assistance (TA): Prior to April 1, 2010, when a TA/Medicaid application was denied for failure to keep/complete a personal interview, Medicaid was denied for the same reason. Due to the elimination of the personal interview requirement as a condition of Medicaid eligibility, the Medicaid Separate Determination Insert Reason Code, which is system generated when denying all category types for TA, has been changed. When TA is denied using reason codes E10-"Failure to Keep/Complete Interview: No Scheduled Appointment"; or N10-"Failure to Keep/Complete Appointment", the Medicaid Separate Determination Insert Reason Code will change from 754-"Combined TA/MA Denial" to 753-"TA Denial, MA Separate Determination".

The Separate Determination Insert Reason Code produces a CNS notice informing the TA applicant of the status of his/her Medicaid eligibility decision. The language in the notice will read as follows: "If you are not already receiving Medical Assistance/Family Health Plus, we will review your application to see if the following person(s) may be eligible for Medical Assistance/Family Health Plus. We will send you our decision separately in the mail. You will not receive another notice if you are already receiving Medical Assistance/Family Health Plus."

2. New York City

Medicaid: Effective with the June systems migration, the Medicaid WMS case denial code "200-Eligibility interview" will be disabled. Although this code will be available until the system migrates, Human Resource Administration (HRA) examiners must not deny any Medicaid applicants for failure to appear for or complete a personal interview.

Temporary Assistance (TA): The TGIF matrix will be modified as follows: the TA CNS reason codes E10-"Failure to Keep/Complete Interview: No Scheduled Appointment," F10-"Failed to Keep Appointment for Initial Eligibility Interview," and N10-"Failure to Keep/Complete Eligibility Appointment" will change to enable a separate determination effective with the June migration.

B. <u>Electronic Eligibility Decision Support System (EEDSS)</u>

Even though the interview requirement for Medicaid and FHPlus eligibility is being eliminated, the format of the EEDSS will not change. The EEDSS will be in "maintenance mode", which means that it will be updated to reflect current policy.

VI. EFFECTIVE DATE

The provisions of this ADM are effective for all Medicaid and FHPlus applications filed on or after April 1, 2010. If a Medicaid or FHPlus application was filed prior to April 1, 2010, but the LDSS was unable to schedule the interview until April 1, 2010, or later, an interview must not be scheduled and eligibility must be determined.

Donna Frescatore

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