TO: Local District Commissioners, Medicaid Directors, Temporary Assistance Directors, Legal Staff, Fair Hearing Staff, Staff Development Coordinators

FROM: Judith Arnold, Director
Division of Coverage and Enrollment

SUBJECT: Revised Medicaid Eligibility Income Standards

EFFECTIVE DATE: April 1, 2008

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The purpose of this General Information System (GIS) message is to advise social services districts of the new income levels effective April 1, 2008, pursuant to Chapter 58 of the Laws of 2008. Income levels have been standardized statewide for Single Individuals and Childless Couples (S/CCs) and Low Income Families (LIF). This new income standard is called the Medicaid Standard. Also, the Medically Needy income levels have increased for households of 3 and higher. The new income levels, as well as CNS, will be programmed and available in early August 2008.

ELIGIBILITY LEVELS:

With the standardization of the levels for the S/CC and LIF populations, the PA Standard of Need will no longer be used for eligibility determinations after April 1, 2008. Disregards continue to be applicable ($90, 30 and 1/3, child care, etc), and additional allowances, including water costs, as appropriate. Also, the 185% maximum income test and the 100% test still apply.

The new Medicaid Standard also affects individuals living in a room and/or board situation. In the past, these applicants/recipients (A/Rs) were given the $45 PA Standard of Need, and instructions were previously given to determine if there was an unmet need. This GIS cancels GIS 07 MA/021. Effective April 1, 2008, a person in this living arrangement will be given the new Medicaid Standard. Please see Attachment II, MBL Living Arrangement chart, for shelter types and settings when the new Medicaid Standard will be used.

Medically Needy A/Rs have their net income compared to the Medically Needy Level or the Medicaid Standard (and MBL Living Arrangement chart, as appropriate), whichever is most beneficial.

NOTE: If a family's countable income exceeds the Medicaid Standard, the family may not spend down to the income level of Medicaid Standard. However, eligibility may exist and should be evaluated under one of the Medically Needy or Expanded Eligibility (poverty level) Programs or Family Health Plus.

When an SSI-related individual is not fully eligible using SSI-related budgeting for a household of one, because the person is living with an applying S/CC spouse whose income is less than the allocation amount, the S/CC budget may be used for both A/Rs, if more advantageous. Individuals who would otherwise be SSI-related, but are eligible using the S/CC budget, must be given the S/CC individual categorical code 09.

BUDGETING PROCEDURES

Systems support for the new levels will be available in early August. Upstate districts that are determining LIF, S/CC or Medically Needy eligibility for budgets with a **"from"** date of April 1, 2008 or later, before systems changes are available, must take the following steps in instances when an A/R has income over the January 2008 levels: (New York City instructions are separate)

- First, review the Total Net Income amount on the LIF/S-CC, Medically Needy, budget or the Total FHP Income on the budget output screen.
- Second, compare the income amount to the revised income standards.
- Third, if the household is ineligible, has a spenddown or shows eligibility for Family Health Plus, due to income, the attached charts are to be used. The printed MBL budget output screen must be annotated with the appropriate level used for eligibility and the message "due to 4/1/08 change in State law." The worker must also sign and date budget.

  Note: MBL is currently programmed to generate the correct Medically Needy Income levels for households of one or two.

When an A/R is ineligible because income exceeds the new levels, workers will need to use manual notice LDSS 3622 - Notice of Decision on your Medical Assistance Application or LDSS 3623 - Notice of Intent to Discontinue/Change Medical Assistance. For applications that are Medicaid eligible using the new levels, workers are to use manual notice DOH 4321 - Notice of Acceptance of Your Medical Assistance Application (Community Coverage Without Long-Term Care).

REIMBURSEMENT

In situations where an A/R would have been fully eligible for Medicaid had his or her case been budgeted with the new income levels, the recipient should be reimbursed directly and in full for otherwise Medicaid covered out-of-pocket expenses. The recipient may also be reimbursed for the difference between the co-pay for FHPlus and Medicaid, if there is proof that the recipient paid the co-pay. Local districts have the option of directly issuing reimbursement to eligible individuals, or having the New York State Department of Health process the reimbursements. Requests for reimbursement must be handled in accordance with the procedures set forth in the New York State Fiscal Reference Manual for Local Departments of Social Services, Volume I, Chapter 7, pages 15–18, dated February 10, 2002, and Volume II, Chapter 5, pages 10-15, dated May 10, 1999.