TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Coverage and Enrollment

SUBJECT: Discontinuance of Retroactive Aide Category Changes and Disability Determinations for Otherwise Eligible Singles/Childless Couples

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Liaison
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The purpose of this GIS message is two-fold: it addresses the discontinuance of the DSS-3586 “Retroactive Aid Category Change” form and informs districts of a change in policy regarding disability determinations for otherwise eligible Singles/Childless Couples (S/CC).

Effective immediately, local social service districts statewide are no longer required to complete the DSS-3586 “Retroactive Aid Category Change” form. This form originally assisted with audit efforts to change certain Federally Non-Participating (FNP) claims to a Federally Participating (FP) status for recipients who were determined to be disabled during a retroactive period (up to two years from the payment date of the claim). The New York State Department of Health (NYSDOH) has determined that the continued reporting of these cases through the use of the DSS-3586 is no longer necessary. Local districts statewide are, therefore, instructed to stop submitting these forms to NYSDOH. Local districts are also reminded that the upstate Shares Reclassification System High Dollar Targeting reports are no longer being generated.

Regarding disability reviews for potentially disabled applicants/recipients (A/R), it has been the Department’s policy to require an otherwise eligible S/CC to comply with a disability review as a condition of Medicaid eligibility. Effective immediately S/CC A/Rs are no longer required to comply with a disability review as a condition of Medicaid eligibility. Since FP conversions are still an important part of cost neutrality for the Managed Care Waiver, if an individual states they are disabled on the application, or there is evidence of a disability, the disability review should still be pursued. If an S/CC individual does not comply with the process, and they are otherwise eligible, their eligibility should not be denied and coverage must be authorized. This revises instructions previously provided in GIS 06 MA/005 “Purposes of Medicaid Reviews” and 08 OHIP/INF-3 “Disability Determinations for Medicaid Applicant/Recipients.”