TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Health Care Reform and Health Insurance Exchange Integration

SUBJECT: Changes to Medicaid Coverage for the Treatment of an Emergency Medical Condition

EFFECTIVE DATE: February 25, 2013

CONTACT PERSON: Local District Liaison
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The purpose of this Office of Health Insurance Programs General Information System (GIS) message is to advise local departments of social services (LDSS) of changes to Medicaid coverage for the treatment of an emergency medical condition.

Medicaid payment is provided for the care and services necessary for the treatment of an emergency medical condition to an otherwise eligible temporary non-immigrant (e.g., foreign student, visitor/tourist) and undocumented (illegal) alien. To be eligible for Medicaid coverage for the treatment of an emergency medical condition, a temporary non-immigrant or undocumented alien must meet all eligibility requirements, including proof of identity, income and State residence. Temporary non-immigrants, who have been allowed to enter the United States temporarily for a specific purpose and for a specified period of time, do not have to meet the State residence requirement and are considered ”Where Found” for District of Fiscal Responsibility purposes.

The following changes will impact the application process, authorization and coverage periods as well as the billing process for individuals in receipt of Medicaid Coverage for the treatment of an emergency medical condition (Coverage Code 07 “Emergency Services Only”).

Application Process

Prior to this change, a temporary non-immigrant or an undocumented alien (Alien Citizenship Indicator Code E, or “ACI E”) was only eligible for 07 coverage if he/she had an emergency medical condition and submitted a DOH-4471, “Certification of an Emergency Medical Condition” form, to the local district. Effective February 25, 2013, this population may now apply for Emergency Services Only coverage prior to the onset of a medical emergency. A DOH-4471 is no longer required to be submitted in order to authorize Emergency Services Only coverage to an otherwise eligible individual. This change will streamline the application process and enable Medicaid eligibility to be determined prior to the onset of a medical emergency.

Authorization and Coverage

If a temporary non-immigrant or undocumented alien submits an application and is determined to be otherwise eligible for emergency services only, districts are instructed to authorize 07 coverage for a 12-month authorization period. If the applicant/recipient (A/R) requests retroactive coverage, and is determined to be otherwise eligible, the district must authorize 07 coverage for up to three months prior to the month of application. Districts will no longer enter Coverage Code 07 only for the dates of service of a medical emergency period.

> Example: A temporary non-immigrant applies for Medicaid coverage on March 23, 2013. The individual had an inpatient stay for a medical emergency that occurred on December 17, 2012. The individual is determined otherwise eligible, so the district authorizes Coverage Code 07 from December 1, 2012, through February 28, 2014 (15 months total). Although the medical emergency has ended, the individual continues to be authorized with Emergency Services Only coverage in case of a future medical emergency.

Generally, it is anticipated that districts will receive applications from temporary non-immigrants and undocumented aliens after an emergency medical condition has occurred, but this might not always be the case. This policy change allows a temporary non-immigrant or undocumented alien to apply for Medicaid coverage before the onset of an emergency medical condition.

Temporary non-immigrants and undocumented aliens are to be renewed prior to the end of their 12-month authorization period following standard renewal requirements. Temporary non-immigrants and undocumented aliens are to be issued a Client Benefit Identification Card (CBIC) and will remain excluded from Medicaid Managed Care and Family Health Plus.

Spenddown

The Medicaid spenddown provisions apply to temporary non-immigrants and undocumented aliens in the same manner as they apply to legal immigrants and U.S. Citizens. In most cases, an A/R will have an inpatient hospital bill that will meet the individual's six-month spenddown liability. Paid and unpaid medical bills for emergency and non-emergency services may be used to meet the A/R's spenddown for Emergency Services Only. In such situations, the district must authorize 07 coverage for the six-month spenddown period. Medicaid will only pay for care and services necessary for the treatment of an emergency medical condition during the 07 coverage period. The spenddown period can be monthly for emergency out-patient care. Districts should authorize 07 coverage whether the recipient meets a one-month spenddown or six-month spenddown.

Upstate

Effective March 4, 2013, Coverage Code 06 (Provisional Coverage), will be available in WMS for recipients coded with ACI E. The Coverage Code that is first entered for an individual will determine if the system will automatically change the Coverage Code at the end of an 07 coverage period or if the district must manually change the Coverage Code. If an individual is first authorized with Coverage Code 06, once the individual has met his/her

spenddown (Coverage Code changed to 07), at the end of the 07 coverage period, the system will automatically change the Coverage Code back to 06. However, if the individual is first authorized with Coverage Code 07, the system will not automatically change the Coverage Code to 06 at the end of the 07 coverage period. In this case, the district must manually change the Coverage Code to 06 at the end of the 07 coverage period.

New York City

Further information will be forthcoming.

Renewal Process

Current Medicaid recipients with Coverage Code 07 Emergency Services Only, who have an active case with an ongoing medical emergency (e.g., dialysis and chemotherapy patients), must have their authorization/coverage extended by the district for up to four months in order to get these individuals into a renewal cycle. At renewal, these cases should be processed according to the instructions outlined in this GIS.

Streamlining the Billing Process

Although treating physicians are no longer required to complete the DOH-4471 "Certification of an Emergency Medical Condition," the physician must continue to authorize on the electronic claim submitted through eMedNY that the treatment being billed is for an emergency medical condition (Admission Type 1 – Emergency).

Medicaid payment is available for care and services provided to temporary non-immigrants and undocumented aliens in order to treat an emergency medical condition. Under federal requirements, 42 USC 1396b(v), SSA 1903(v) and 42 CFR 440.255, the term "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

This definition must be met at the time the medical service is provided, or it is not considered to be an emergency medical condition. Not all services that are medically necessary meet the federal definition of an emergency medical condition. Emergency medical conditions do not include debilitating conditions (e.g., heart disease or other medical conditions requiring rehabilitation) that result from the initial event and that later require ongoing regimented care. Such debilitating conditions cannot be considered to be emergency in nature simply because the absence of medically necessary, ongoing care would have serious health consequences for the individual.

Systems Implications

The following changes have been made to improve access to Medicaid for the treatment of an emergency medical condition.

WMS (Upstate and NYC)

- Authorization for temporary non-immigrants and undocumented aliens (ACI E) will be allowed for 12 months plus a three-month retroactive period, if otherwise eligible (total 15 months).

- The edits (1583, 1584, 1585, 1586, 1587, 1588, 1589, 1597) limiting coverage periods for Emergency Services Only will be disabled. Medicaid Coverage Code 07 will continue to be used with ACI E.

Upstate

- As of March 4, 2013, Coverage Code 06 will be available for use with ACI E for cases with a spenddown requirement.

CNS (Upstate and NYC)
The following CNS notices have been disabled:

E06/D0060, E06/D0049, E06/D0181, E03/C0288, E02/C0121

Upstate CNS

Upstate notices have been revised to authorize Emergency Services Only coverage with no time period restrictions. For Reason Codes S77, S78 and S79, some of the system generated fields have been converted to "worker fill." The Medicaid coverage "To" date has been removed from the opening sentence.

Additional changes to the below Reason Codes have been made to support the changes referenced in this GIS. These codes are detailed in Attachment III of the February 2013 WMS/CNS Coordinator Letter.

C22/Y0052, S77/Y0051, S78/Y0057, S79/Y0058, U63/X0127, U73/D0065

New York City WMS

Instructions for the New York City Human Resources Administration will follow separately.

NYC Notices

Manual notice MAP 2151b(E), "Notice of Acceptance for Medicaid Coverage for the Treatment of an Emergency Medical Condition," will be revised in accordance with the policies described in this GIS.

The following NYC manual notices are no longer applicable and are now obsolete:

MAP-2151A- Letter to Attending Physician

MAP-2151k- Notice of Decision to Close Your Emergency Medical Assistance Coverage Case

MAP 2151- Certification of Treatment of Emergency Medical Condition

MAP-2151g- Notice of Decision Regarding Your Emergency Medical Assistance Coverage