TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Eligibility and Marketplace Integration

SUBJECT: Medicaid Eligibility Determinations for Immediate Medical Needs

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
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The purpose of this General Information System (GIS) message is to inform local departments of social services of the policy for processing Medicaid eligibility applications for individuals who appear at a local district office with an immediate medical need i.e., with an apparent need for a medication and/or other medical care or services on that day.

With the exception of Presumptive Eligibility programs, there is no provision in federal or State statute or regulation to authorize Medicaid coverage prior to a determination of eligibility. Whenever possible, districts should determine Medicaid eligibility for an individual with an immediate medical need on the same day the coverage is requested. If an individual completes a Medicaid application or Temporary Assistance and Medicaid application, attests to residency, documents current income, attests to United States citizenship or provides documentation of citizenship/alien status, and provides a Social Security Number (SSN) or states that an SSN has been applied for, eligibility can be determined. An SSI-related applicant must also attest to current resources for community coverage with no long-term care.

If eligibility can be determined, and the individual is at or below the applicable Federal Poverty Level or Medicaid level/Standard, coverage is authorized. In cases where an eligible applicant has an immediate medical need, the district issues the individual a Temporary Medicaid Authorization form (LDSS-CS-19/2831A) which includes the individual's Client Identification Number. This temporary authorization is intended for use between the time of the eligibility determination and the receipt of a Common Benefit Identification Card (CBIC). When issued, the temporary authorization (up to a maximum period of 15 days) guarantees Medicaid payment to enrolled providers for medically necessary services covered under the program.

Beginning January 1, 2014, Medicaid applications for individuals in a Modified Adjusted Gross Income (MAGI) category of assistance (with certain exceptions as noted in 13 OHIP/ADM-4) are required to be submitted to New York State of Health (NYSOH), New York's Marketplace, for a determination of eligibility. Although Medicaid eligibility may be determined when an application is submitted, NYSOH does not have the capability of issuing a Temporary Medicaid Authorization. For this reason, the Department is requiring local districts to continue to determine Medicaid eligibility for any individual who appears at a local district office with an immediate

medical need even if the individual is in a MAGI categorical group and would otherwise be required to apply for coverage through NYSOH. If a district is unable to make an eligibility determination on the same day the request for coverage is made, the applicant should be instructed to return to the agency the following day or, if the individual declares the situation is an emergency, the individual should be referred to the nearest hospital emergency room.

To determine eligibility for an individual in a MAGI eligibility group who is seeking coverage for an immediate medical need, districts must use pre-Affordable Care Act (ACA) rules. Once MAGI-like rules are available on WMS (February 18, 2014), those rules must be used to determine eligibility. Parents and Caretaker Relatives who are determined to be eligible for Family Health Plus (FHPlus) under pre-ACA rules, can not be issued a Temporary Medicaid Authorization since FHPlus coverage is only available prospectively following enrollment in a plan.