STATE OF NEW YORK
DEPARTMENT OF HEALTH

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INFORMATIONAL LETTER

TRANSMITTAL: 08 OHIP/INF-3

DIVISION: Office of Health Insurance Programs

TO: Commissioners of Social Services

DATE: June 11, 2008

SUBJECT: Disability Determinations for Medicaid Applicants/Recipients

SUGGESTED DISTRIBUTION: Medicaid Staff
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Staff Development Coordinators

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ATTACHMENTS: None

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
DSS 86 ADM-27		370.2 (b) (5 (ii) 351.2 351.30(f) 352.23	42 CFR 435.541 Section 158(2)	NYS Disability Manual Section II C.1.a. & I.4.a. & b.	GIS 06 MA/005

I. Purpose

The purpose of this Informational Letter is to clarify the Department's policy regarding the referral of potentially disabled individuals to the State or local Disability Review Team (DRT) for a determination of disability for Medicaid. This letter also describes the action to be taken by local districts when the Social Security Administration (SSA) issues a determination of disability, including unfavorable determinations.

II. Background

Responsibility for detecting disability rests primarily with the local district. Efforts must be made to identify disability-relatedness at the time of application and at renewal for Medicaid. All individuals who claim an impairment, disability or unemployable status that has lasted, or is expected to last for at least twelve months, and do not have certification of disability, (e.g., SSA disability certification), must be informed about the advantages of disability certification and in some cases, the requirement to comply with the disability determination as a condition of receiving Medicaid benefits.

Generally, Medicaid disability reviews are required if a determination of disability would yield a Medicaid benefit for the Applicant/Recipient (A/R) or a financial benefit for the Medicaid program. Examples of a Medicaid benefit to an A/R include:

- more favorable budgeting that would enable a single adult or member of a childless couple (S/CC) to obtain Medicaid if he/she does not meet the Medicaid standard;
- budgeting that would enable an A/R who is otherwise financially ineligible to obtain Medicaid benefits, with or without a spenddown;
- budgeting that would enable a Family Health Plus (FHP) A/R to access services that are available under the Medicaid program, but not under Family Health Plus.

An example of a financial benefit to the Medicaid program is the placement of an S/CC A/R into a federally participating category. Since the establishment of New York State's 1115 managed care waiver, such placement contributes to the State's ability to demonstrate and maintain budget neutrality. (Budget neutrality is the requirement that federal funds spent under the waiver, which includes S/CCs, not exceed the funds that would have been spent without the waiver. Expenditures for S/CCs who are determined disabled are considered funds that would have been spent without the waiver.) For this reason, identification of individuals with disabling impairments remains an important function of the local district worker. Workers are reminded of the importance of initiating a disability determination for these individuals despite the end of the Shares Reclassification and Upstate High Dollar Target Reporting program and the discontinued use of the Retroactive Aid Category Change form (DSS-3586).

Administrative Directive 86 ADM-27, "Retroactive Aid Category Changes," established the policy of referring potentially disabled individuals to the State or local DRT for a determination of disability at the same time a referral is made to SSA. This policy was established as a result of delays in the SSA disability determination process, the number of unfavorable determinations overturned upon completion of the appeals process, and the federal timeframe for claiming retroactive federal participation. Because there has been improvement in the SSA disability determination process, referral to the State or local DRT is no longer needed for Temporary Assistance (TA) A/Rs. Although application for SSI is not a condition of eligibility for Medicaid, Medicaid-Only A/Rs who are determined to be potentially disabled must be referred to SSA for a disability determination and possible entitlement to Social Security Disability Insurance (SSDI) benefits.

Disability determinations are completed for all Medicaid-Only A/Rs under the age of 65 who are citizens or qualified aliens not in the federal five year ban, and who appear to meet the SSA disability criteria. Disability determinations are completed for qualified aliens in the five year ban and Permanent Resident Under Color of Law (PRUCOL) aliens only if a determination of disability will provide a Medicaid benefit for the A/R. If determined to be disabled, the A/R is given an informed choice between SSI-related budgeting and any other appropriate category when he/she is eligible under more than one category.

For Medicaid-Only A/Rs referral to the State or local DRT is still appropriate in order to give an individual the benefit of SSI-related budgeting.

III. Temporary Assistance

Temporary Assistance (TA) A/Rs, who appear to be potentially eligible for SSI benefits must as a condition of TA eligibility and/or continued eligibility:

- apply to SSA for Supplemental Security Income (SSI) benefits;
- cooperate with the SSI disability process such as providing medical documentation or attending medical appointments;
- appeal an SSI eligibility denial when the local district determines such an appeal is required;
- accept SSI benefits.

If a TA A/R is unable to apply for SSI benefits without assistance, local district staff must provide any services that are necessary to ensure that the individual is assisted in applying for and following through with the application for SSI benefits, including helping the individual complete the application or filing for an appeal, as appropriate. In such instances, the TA benefits shall not be denied, reduced or discontinued for failure to apply for SSI benefits.

Since a disability determination is performed by SSA, TA staff should not submit these cases to the State or local DRT for a separate determination of disability.

IV. Medicaid

In accordance with Federal Regulation 42 CFR 435.541, an SSA disability determination is **binding** on a Medicaid case until the determination is changed by SSA or there is a change in the individual's circumstances. The effect of this regulation on procedures for Medicaid eligibility is addressed in the following sections.

A. Disability Approvals by DRT and SSA

If a Medicaid-Only A/R applies concurrently to the State or local DRT and to SSA for disability certification, and the State or local DRT determines an individual disabled prior to notification of the disability determination by SSA, the decision may be used for the SSI-related category of assistance until such time as the SSA decision is received.

Once a favorable disability determination is made by the State or local DRT, the Individual Categorical Code must be changed to 11 (blind) or 12 (disabled) on WMS. In the case where SSA makes a determination of disability with an onset date earlier than the DRT effective date, the SSA onset date may be used when changing the Individual Categorical Code to 11 or 12, as long as the recipient is otherwise eligible for Medicaid.

B. Disability Approval by DRT and Subsequent Disapproval by SSA

If an individual is determined disabled by the State or local DRT and a subsequent SSA review determines that the individual is not disabled, the individual is encouraged to appeal the unfavorable SSA disability determination.

If the individual is eligible under another category of assistance, except Family Health Plus, s/he must be removed from the SSI-related category and the categorical code changed to reflect the appropriate category. If, at a later date, the unfavorable SSA disability determination is overturned on appeal, the Individual Categorical Code should be changed back to 11 or 12 on WMS to reflect the SSA disability approval period, as long as the individual is otherwise Medicaid eligible.

If the individual is ineligible for Medicaid on any other basis or is eligible under Family Health Plus, and appeals the unfavorable SSA disability determination within the allotted 60-day period, Medicaid coverage in the SSI-Related category must be continued throughout the appeals process until the final administrative decision is made by SSA.

If an individual is found ineligible by SSA for a **non-medical reason** and the DRT has made a favorable disability determination, the DRT determination stands. A Continuing Disability Review (CDR) must be performed prior to the expiration of the DRT certificate.

C. Individuals Applying for Medicaid-Only After an SSA Denial for Medical Reasons

The State or local DRT **must** make a disability determination for individuals applying for or receiving Medicaid who have received a disapproval by SSA for medical reasons if the individual:

- alleges a different or additional disabling condition than that considered by SSA in making its determination; or
- alleges less than 12 months after the most recent unfavorable SSA disability determination that his/her condition has changed or deteriorated, alleges a new period of disability which meets the duration requirement, and SSA has refused to reopen or reconsider the allegations or the individual is now ineligible for SSA benefits for a non-medical reason; or
- alleges more than 12 months after the most recent unfavorable SSA disability determination that his/her condition has changed or deteriorated since the SSA determination and alleges a new period of disability which meets the duration requirement, and has not applied to SSA regarding these allegations.

D. Disability Interview Form (LDSS-1151 (rev. 8/98))

In order to facilitate the proper processing of disability determinations by the State DRT, the Disability Interview form (DSS-1151) must be completed in its entirety and signed and dated by the interviewer. It is important that the following be clearly documented:

- Section E (SSI/SSD Disability History) – Month and year of all SSA applications, decisions (approvals/denials), and appeal filings. Documentation of SSA approvals must include effective date of eligibility and SSA denials must include the reason for denial (medical/non-medical). If additional space is needed, Part VI (Interviewer's Observations) of the LDSS-1151 form may be used. A copy of any available SSA decision letter should also be submitted.
- Section J (Applicant's Category at Referral) – The applicable category must be documented by checking the appropriate box. This information should be updated at the time of each submission if using the original LDSS-1151 form.
- Part VI (Interviewer's Observations) – Signature of worker and date signed must be entered at the time of each submission if using the original LDSS-1151 form.

E. Medical Evidence

The local agency, in cooperation with the A/R, shall attempt to obtain all available medical information from the A/R's treating sources, in order to help establish a longitudinal medical history. Information should cover the timeframe for which a disability determination is being considered and, at a minimum, should include the 12 months prior to the application date. The following forms are recommended for obtaining medical and non-medical evidence.

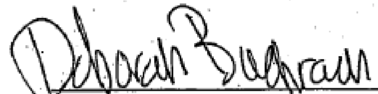
Adult cases:

- Form DSS-486T "Medical Report for Determination of Disability," pages 1& 2
- Applicable body system sections of the DSS-486T packet; in lieu of these sections, the provider may submit all progress notes and testing reports for the requested time period.

Child cases:

- Form OHIP 0005 "Childhood Medical Disability Report," completed by an acceptable medical source; in lieu of this form, the provider may submit all progress notes and testing reports for the requested time period.
- Form OHIP 0006 "Questionnaire of School Performance," completed by a teacher or school official, along with most recent IEP report, if applicable
- Form OHIP 0007 "Description of Child's Activities," completed by a parent or guardian
- In addition, the most recent evaluation by any involved therapies (i.e., physical, occupational, speech/language) is recommended.

Social Services districts should direct any questions regarding disability determinations to their Medicaid Local District Liaison.



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