



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

INFORMATIONAL LETTER

TRANSMITTAL: 10 OHIP/INF-1

DIVISION: Office of Health
Insurance Programs

TO: Commissioners of
Social Services

DATE: July 26, 2010

SUBJECT: Questions and Answers: Elimination of the Personal Interview Requirement for Medicaid and Family Health Plus Applicants; Revised DOH-4220, Access NY Health Care Application; Release of DOH-4495A, Access NY Supplement A; and Financial Maintenance

SUGGESTED

DISTRIBUTION: Medicaid Staff
Temporary Assistance Staff
Fair Hearing Staff
Legal Staff
Staff Development Coordinators

CONTACT PERSON: Local District Liaison
Upstate: (518)474-8887
New York City: (212)417-4500

ATTACHMENTS: None

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
10 OHIP/ADM-6	GIS 96 MA/015	360-2.2	366-a(2)(a)	MRG pgs. 386-387	GIS 07 MA/027 GIS 06 MA/015
10 OHIP/ADM-5		360-2.2(f)(1)	366-a(4)		
10 OHIP/ADM-4		360-2.3(c)(5)	Chapter 58		
10 OHIP/ADM-1			of the Laws		
03 OMM/ADM-6			of 2009		
01 OMM/ADM-06					
09 OHIP/INF-2					
06 OMM/INF-1					

The Office of Health Insurance Programs (OHIP) recently issued policy directives regarding the elimination of the personal interview for Medicaid and Family Health Plus (FHPlus) applicants (10 OHIP/ADM-4); the revised Access NY Health Care application (DOH-4220) and DOH-4495A, Access NY Supplement A (10 OHIP/ADM-5); and policy guidance concerning financial maintenance (10 OHIP/ADM-6).

The purpose of this release is to provide answers to questions raised by local departments of social services (LDSS) relating to these topics.

Application

1. **Question:** When should the Access NY Health Care application (DOH-4220) be used? When should the LDSS-2921 (green and white common application) be used?

Answer: The Access NY Health Care application must be used when an applicant is applying for Medicaid only, including applicants seeking Medicaid coverage of long-term care services and nursing home care. The LDSS-2921 must be used when an applicant is applying for Medicaid and another program, such as Temporary Assistance or Food Stamp benefits. While it is the LDSS responsibility to provide the applicant with the DOH-4220 for Medicaid only applications, the LDSS must accept the LDSS-2921 if submitted by an applicant for Medicaid only.

2. **Question:** Should a LDSS continue to accept the older version (5/08) of the Access NY Health Care application (DOH-4220) after the revised version (2/10) is available?

Answer: The revised Access NY Health Care application must be in use by all LDSS by June 11, 2010, approximately 60 days from its anticipated date of availability. After this date, all older versions of the Access NY Health Care application should be discarded by the LDSS. However, if an LDSS receives a 5/08 version of the Access NY Health Care application after June 11, 2010, the district must accept the application.

3. **Question:** What constitutes a complete application?

Answer: An application is considered to be "complete" or filed with the LDSS when an applicant submits a signed and dated application that includes his/her name and address. The LDSS may need more information to make a Medicaid eligibility determination, but the application date is protected.

4. **Question:** How is the application date determined?

Answer: The policy regarding application date has not changed. The application date is the date that a signed and dated application is received by the LDSS. The application may be received either by mail, or by an applicant dropping the application off at the LDSS. The application date for individuals applying with a Facilitated Enroller (FE), Family Planning Benefits Program (FPBP) provider or other outreach site is the date on which the application is started. For children under 19 and pregnant women applying through the presumptive eligibility process, the application date is the date of the screening.

5. **Question:** Should Books 1, 2 and 3 still be given to applicants? How should these materials be provided with the elimination of the personal interview? Are there other ways to provide these materials to applicants without the LDSS incurring the expense of mailing?

Answer: Applicants must be given Books 1, 2 and 3 (LDSS-4148A, LDSS-4148B and LDSS-4148C) at the time of Medicaid application. If an applicant comes into an LDSS for application assistance or to drop off the application, the Books must be given to him/her at that time. If an applicant mails an application to the LDSS, the LDSS must send the applicant Books 1, 2 and 3, if not already provided. If an applicant applies through an FE, the FE should provide Books 1, 2 and 3. Outreach sites (FPBP providers, Presumptive Eligibility (PE) providers, FEs etc.) may order these Books from the OTDA warehouse by emailing forms.orders@otda.state.ny.us. Book 1, LDSS-4148A is available in boxes of 200; Book 2, LDSS-4148B is available in boxes of 175; and Book 3, LDSS-4148C is available in boxes of 700.

6. **Question:** Can the Access NY Health Care application be printed from the internet?

Answer: Yes, the revised Access NY Health Care application and Supplement A are available on the internet. The online versions are read-only. The application and Supplement A can be printed and completed, but cannot be completed on-line. The application can be found at: <http://www.health.state.ny.us/nysdoh/fhplus/application.htm>.

7. **Question:** If more than seven household members are applying, instead of using another application, would a copy of Section B, Household Information, listing the additional household members be acceptable?

Answer: Yes, copies of the additional pages are acceptable.

Incomplete Applications

8. **Question:** How should the LDSS handle contacting an applicant to obtain information missing from the application?

Answer: The LDSS must contact the applicant to get additional information that is needed to make a Medicaid eligibility determination. Local departments of social services have options regarding how to obtain missing information. The LDSS may call the applicant to get information over the phone and fill in missing answers on the application, initial those areas of the application and annotate the date the information was obtained. A dated note should also be made in the case record that a telephone call with the applicant occurred and the information obtained. If information is missing from various sections of the application, the LDSS may photocopy the incomplete pages of the application and mail these pages to the applicant to complete and return to the agency.

9. **Question:** If an Upstate LDSS sends out a letter that an application is incomplete and the LDSS does not receive a response from the applicant, will there be a new CNS code for incomplete applications?

Answer: No new code is being developed at this time. Upstate CNS Reason Code U20 should be used in this circumstance. Reason Code U20 is used as a denial or discontinuance code when the applicant/recipient fails to provide requested documentation. Selection "Other" should be used with the following language, "You or your representative did not complete sections of the application necessary to determine your eligibility."

10. **Question:** If an applicant does not provide documentation necessary to make an eligibility determination within the required timeframe and does not ask for additional time, his/her application may be denied. Regarding applicants seeking Medicaid coverage of nursing facility services, if they do not meet the documentation deadline or ask for additional time, should the case be opened as Medicare Savings Program (MSP) or community Medicaid coverage, or should the application be denied?

Answer: If the applicant is eligible for community Medicaid coverage and/or QMB or SLIMB, the case should be opened. If an applicant is eligible for QI, the case should be opened for QI only.

11. **Question:** If an LDSS receives an application in the mail without necessary documentation and the LDSS determines the case is another county's responsibility, should the application be sent to the correct district, or should the application be held until all necessary information has been collected and then sent to the appropriate district?

Answer: With the elimination of the personal interview, applicants may mail the application to the wrong LDSS. If an LDSS receives an application and determines that the applicant is the fiscal responsibility of another district, the LDSS must contact the county of fiscal responsibility to obtain their agreement regarding fiscal responsibility and forward the application to the district. The date of application is protected as the date the first district received the application. The agreed upon district of fiscal responsibility shall obtain any documentation missing from the application.

Documentation

12. **Question:** How will citizenship and identity guidelines be maintained?

Answer: Applicants are still required to provide all necessary documentation to establish eligibility. Federal regulations that require applicants to show original or certified copies of identity and U.S. citizenship documentation continue to apply. To assist the LDSS in making accurate and timely Medicaid eligibility determinations, these original documents may be presented at the LDSS, to an FE, to designated staff at an outreach site, including deputized workers, or to designated staff at an entity in the community with which the LDSS has established a Memorandum of Understanding (MOU) for purposes of verifying that original documents have been seen.

13. **Question:** Are community organizations aware that requests could be coming from the LDSS for help with original documentation?

Answer: Facilitated enrollers have been notified that the LDSS will give applicants the option of presenting their original documents to them. It is the responsibility of the LDSS to reach out to organizations or providers that can facilitate verifying that original documents have been seen when the district determines that this service would be of assistance to area residents. If an organization agrees to participate and signs an MOU, the LDSS must educate the organization about its procedures for verifying that original documents were seen.

14. **Question:** Will separate agreements be necessary for Article 28 prenatal care providers?

Answer: No, separate agreements are not necessary for Article 28 prenatal care providers who do Presumptive Eligibility. It is also not necessary for the LDSS to enter into a separate agreement with a Community-Based Organization (CBO) or plan FE, family planning provider or presumptive eligibility qualified entity.

15. **Question:** Can an applicant go to an FE to present his/her original documents, but not submit a completed application with the FE?

Answer: Yes, if an FE views original documentation but does not provide application assistance, the FE will make copies of the original documents, stamp the copy indicating the date the original was seen, add the lead name and the FE name on the copy, and return the original documents and copies to the applicant for submission to the LDSS.

Managed Care

16. **Question:** How will applicants be educated on managed care?

Answer: This topic is covered in 10 OHIP/ADM-4, Section IV.B.

Mandatory Medicaid Managed Care (MMC) counties are required to educate applicants about MMC. Voluntary counties are not required to educate applicants about MMC; however, they are encouraged to do so. The Family Health Plus (FHPlus) program requires that applicants be given information about managed care plans. Managed care education/enrollment can be done in person, by mail, or by telephone. In counties that utilize Maximus (enrollment broker), Maximus is responsible for developing a managed care packet. In non-Maximus counties, the LDSS is responsible for developing a managed care packet, and may utilize the managed care materials available at the State Health Department Distribution Center by calling (518) 465-8170 to order.

As a reminder, FHPlus applicants in counties that have more than one plan are still required to make a plan choice as part of the eligibility process. This is not part of the eligibility process for those found eligible for Medicaid. If a Medicaid recipient does not make a plan choice in a mandatory county, the auto assignment process will take place.

17. **Question:** What has to be included in a non-Maximus county packet?

Answer: Education packets are to include, at a minimum, a brochure ("60 days to choose"), a fact sheet about what plans are available in the county for both Medicaid and FHPlus, and information as to whether the plan includes optional benefits such as dental coverage. If a district is aware that a family includes a member receiving SSI cash benefits or who is SSI-Related, the SSI brochure, "You have 90 days to choose", should also be sent. (At the time of this INF release, there is a brochure being printed that will combine the current 60 and 90 days to choose brochures. Once it is available, this brochure should be given out regardless of SSI cash, SSI-Related or non-SSI-Related category.) Packets can be mailed with the application or made available at the LDSS. Including the enrollment form is optional. The completion of a separate enrollment form cannot be required by plans or LDSS, as plan selection can be made in Section I of the Access NY Health Care application. If a recipient provides a choice of a primary care doctor, this information must be sent to the plan by the LDSS. A suggested insert to packets is the Managed Care Regional Consumer Guides, which can be viewed online at: http://www.nyhealth.gov/health_care/managed_care/consumer_guides/ or can be ordered by calling New York State Health Department at (518) 486-9012. It is not a requirement to send out provider booklets. Managed care packets can be mailed when a completed Medicaid application is received, or when an individual appears on the potential auto assignment report.

18. **Question:** How should Maximus counties handle managed care packets?

Answer: A full education packet is mailed out from Maximus' mailing house at the time a case is opened, reopened, renewed, or a change transaction occurs. Maximus can enroll/educate at the LDSS or through the call center. If a person is educated by a Maximus staff person at the LDSS at application, he/she is given all required managed care materials.

Section I of the revised Access NY Health Care application (2/10) instructs applicants to call the New York Medicaid CHOICE hotline at 1-800-505-5678 for more information.

19. **Question:** How should the LDSS educate applicants on managed care?

Answer: Applicants may be referred to managed care workers or Maximus counselors if they choose to come into the LDSS to conduct such business as requesting application assistance, copying original documents, or to bring in required documentation. Managed care and eligibility staff should develop procedures to make these important referrals at such times. A face-to-face managed care encounter must be made available upon request by an applicant/recipient.

The SDOH managed care website has a great deal of information plus a directory of managed care plans for each county. Counties could also include the website address in the education packet which is: http://www.nyhealth.gov/health_care/managed_care/mmc_counties/.

20. **Question:** If a Medicaid applicant called Medicaid CHOICE and chose a managed care plan in the process of completing his/her application, how would the LDSS know which plan the applicant chose?

Answer: When the applicant calls Medicaid CHOICE and picks a plan, Maximus will instruct the applicant to write his/her plan choice on his/her application. If the applicant does not list his/her plan choice on the application after speaking with Medicaid CHOICE and the eligibility is for FHPlus, the LDSS examiner should check with the Maximus site counselor if/when the examiner is ready to open the case. The plan choice would show up in the Maximus system as a pending enrollment. The LDSS examiner could also contact the Maximus call center to access the same information.

Child Health Plus

21. **Question:** Will Child Health Plus (CHPlus) accept both the DOH-4220 and the LDSS-2921 from LDSS?

Answer: Please see GIS 10 MA/015.

22. **Question:** How should a district handle an application when the applicant is eligible for CHPlus and has picked a plan, or when an applicant is eligible for CHPlus but has not picked a plan?

Answer: Please see GIS 10 MA/015.

23. **Question:** When an LDSS receives an application and the children are denied Medicaid eligibility, should the LDSS send a copy of the application and copies of all additional documents to CHPlus, or does CHPlus require the original application and additional documents?

Answer: Copies of the application (DOH-4220) and copies of all additional documents may be sent to CHPlus. The LDSS should retain the original application and any documentation. (See GIS 10 MA/015.)

24. **Question:** Are non-FE plans going to be required to send LDSS the application when they determine a child is Medicaid eligible instead of CHPlus eligible?

Answer: Effective July 1, 2010, non-FE plans (e.g., Empire) will be forwarding original applications for children that appear Medicaid eligible to the LDSS. They will not be referring these families to an FE.

NOTE: Some CHPlus plans scan all of the DOH-4220 applications and do not keep original copies. If a district receives a scanned copy of the DOH-4220 from a CHPlus plan, the district must accept the application and determine Medicaid eligibility.

25. **Question:** If a district receives an application that indicates income is over the Medicaid level and there are children under age 19 on the case, can the district use the stated income and deny Medicaid for the case/children and send the application to CHPlus? Or does the district have to verify income first?

Answer: If the income is clearly over the applicable Medicaid income level(s) and there is no evidence that the applicants are eligible for Medicaid coverage with a spenddown, a denial may be sent based on the stated income. A copy of the application should be forwarded to CHPlus.

26. **Question:** If an LDSS has confirmed income through SOLQ, UIB, SDX or the Child Support Collection Unit, should they include the information when forwarding an application to CHPlus?

Answer: Yes, if the LDSS has confirmed income through SOLQ, UIB, SDX or the Child Support Collection unit, they should include it with the application when it is sent to CHPlus.

27. **Question:** When sending an application to CHPlus, districts have been instructed to include a copy of the MBL budget if the child(ren) was denied based on excess income. Does NYC need to include the child's budget?

Answer: Yes, when sending an application to CHPlus, all districts, including NYC, should include a copy of the child's budget and the denial notice.

Family Planning Benefit Program and CHPlus

28. **Question:** If a child is excess income for Medicaid but is determined eligible for the Family Planning Benefit Program (FPBP), should the LDSS refer the child to CHPlus?

Answer: Yes, the child should be authorized with FPBP coverage and referred to CHPlus.

29. **Question:** If an applicant indicates that he/she is interested in receiving coverage for family planning services (DOH-4220, Question #6, Page 3 of 9) if he/she is ineligible for Medicaid or FHPlus, would everyone applying on that application automatically receive an FPBP eligibility determination if ineligible for Medicaid or FHPlus?

Answer: Yes, if the application indicates a request that eligibility for FPBP be determined if he/she is ineligible for Medicaid or FHPlus, all ineligible household applicants age 10-64 will also receive an FPBP determination. In addition, children under age 19 are to be referred to CHPlus. In future revisions of the application, lines may be added to indicate which applicants would like eligibility for FPBP determined.

Supplement A

30. **Question:** If a client has active community based coverage (with or without long term care) and subsequently is admitted to a nursing facility on a permanent basis, would the applicant need to complete a new application or Supplement A?

Answer: Supplement A must be completed and resource documentation must be submitted for the period back to February 8, 2006, or the past 60 months, whichever is less. If there is a trust, documentation of trust assets must be submitted for the past 60 months. The applicant is not required to complete the Long-Term Care Change in Need Resource Checklist (Attachment I of 06 OMM/ADM-5). Please refer to 10 OHIP/ADM-5, pages 11 and 14 for further information regarding when Supplement A is required to be completed.

31. **Question:** The Resources/Assets section of Supplement A states, "On a separate piece of paper, provide an explanation of each transaction of \$2,000 or more." Can districts still look at transactions for less than \$2,000?

Answer: The \$2,000 amount was chosen as a set dollar amount for bank transactions statewide. Once a district screens bank account information and explanations for transactions of \$2,000 or more, the district has discretion on a case by case basis to review transactions and request explanations for transfers of less than \$2,000. Supplement A does state that, "Medicaid retains the right to review all transactions made during the transfer look-back period."

32. **Question:** If an applicant uses the older version of the DOH-4220 when applying for Medicaid coverage of nursing facility services, will they also have to complete Supplement A?

Answer: Yes, Supplement A must be completed if the individual is applying for Medicaid coverage of nursing facility services.

33. **Question:** Section IV.B.10 of 10 OHIP/ADM-05 states that the spouse must sign both the application and Supplement A. We are assuming that the applying spouse must sign, not the non-applying spouse, correct?

Answer: Each applying adult must sign the Access NY Health Care application and Supplement A. A non-applying spouse cannot be required to sign the application (DOH-4220) or Supplement A. An applicant cannot be denied if the non-applying spouse refuses to sign either of these.

Financial Maintenance

34. **Question:** Can financial maintenance be evaluated for an applicant of the Family Planning Benefit Program (FPBP)?

Answer: There is no financial maintenance test for the Family Planning Benefit Program or the Medicare Savings Program (MSP). Also, financial maintenance does not apply to child-only cases or to A/R's subject to post-eligibility treatment of income.

35. **Question:** If an applicant does not list a shelter expense on the application, can eligibility be determined? Can the application be denied?

Answer: An application cannot be denied for failure to provide a shelter expense. The LDSS must review the reported income and consider the average cost of housing in their district. If the income is sufficient to support average housing costs, the application can be processed. If the income does not pass the applicable 60% or 70% maintenance test, the district can send the Financial Maintenance form (DOH-4443) and allow a minimum of 10 days for the applicant to return the form.

36. **Question:** If there is additional income in the household used to meet housing expenses, such as a child's income, should it be used as part of the gross income when calculating financial maintenance?

Answer: Yes, the income should be used.

37. **Question:** If an individual returns the Financial Maintenance form and explains that someone gives them money to pay their bills, is it necessary to document this particular explanation since letters of support are still required per the "Documents Needed When You Apply for Health Insurance" of the Access NY Health Care application (DOH-4220)?

Answer: If an individual fills out the Access NY Health Care application and answers Section C, Questions 1 and 2, or they fill out the Financial Maintenance form and provide an explanation of support, an additional statement of support is not required. We are looking into revising the "Documents Needed When You Apply for Health Insurance" and possibly making it into a stand alone document with a form number.

Miscellaneous

38. **Question:** What should the LDSS do if an Upstate recipient wants to add a child to his/her case in between renewal periods?

Answer: Separate applications are not required when adding a child to a case mid-renewal. A recipient can call the LDSS to request that his/her child be added to the Medicaid case. Documentation for the child, if needed, must be provided in this situation. The LDSS must send the recipient a notice of decision regarding the child's Medicaid eligibility.

39. **Question:** What should the LDSS do if an Upstate recipient wants to add an adult to his/her case mid-renewal?

Answer: When adding an adult to an existing case mid-renewal, the adult being added to the case must complete an application.

40. **Question:** Will FEs be notified that a separate application is not needed when a recipient wants to add a child to his/her case mid-renewal?

Answer: If a recipient wants to add a child to his/her case between authorization periods, the recipient may seek application assistance at an FE. Facilitated enrollers will assist the individual with completing an application for the child. The LDSS should be aware of this and should accept the application sent from an FE to the LDSS.

41. **Question:** Are the new applications being drop shipped to the FEs as well, or will LDSS need to deliver new applications to the FEs in their district?

Answer: Community-Based FEs have received a drop shipment of applications. Only LDSS and CBOs may order applications directly from the Department of Health (DOH) warehouse. Health plans performing facilitated enrollment activities are responsible for printing their own supplies of the DOH-4220. It is the responsibility of the LDSS to provide supplies of the DOH-4220 to all other outreach organizations (e.g., hospitals, PE providers, etc.).

42. **Question:** Is the use of an acknowledgement letter advised when applications are received by the LDSS through the mail?

Answer: An acknowledgement letter may reduce the number of phone calls a district receives from applicants inquiring about the status of their application. It may also be an opportunity for the district to provide other district specific information to the applicant.

43. **Question:** Can DOH release a document containing a list of the most frequently asked eligibility application questions?

Answer: Such a document was discussed in the Elimination of the Face-to-Face Workgroup and is currently being developed. This document will contain the most frequently asked questions that LDSS examiners receive from Medicaid applicants. Local departments of social services will be able to use this document as a reference guide, and/or to post on their website for informational purposes.

44. **Question:** What is a deputized worker?

Answer: The term "deputized" means to stand in for/act in place of. For Medicaid purposes, a deputized worker is a non-district worker given authority to accept applications, obtain documentation and complete other standard initial eligibility procedures at an outstationed location (i.e., hospitals). Options for such staff are outlined in 91 ADM-28, "Medical Assistance Applications at Hospitals and Federally-Qualified Health Centers", specifically in Section IV.C.2.

45. **Question:** Is there a standardized manual for deputized workers?

Answer: No, there is not a standardized manual for deputized workers and there are no plans to develop one at this time. It is the responsibility of the LDSS to choose who can be authorized to act as a deputized worker. It is also the responsibility of the LDSS to train such individuals.

46. **Question:** What is an authorized representative?

Answer: An authorized representative is an individual authorized by the applicant to apply for Medicaid on his/her behalf. The Access NY Health Care application allows the applicant to choose what actions his/her authorized representative is permitted to do on his/her behalf. When the applicant is incompetent or incapacitated, an individual acting responsibly on behalf of the applicant may apply for Medicaid, discuss the application/case and receive notices for the applicant as explained in 10 OHIP/ADM-5, "Revised DOH-4220: Access NY Health Care Application and Release of DOH-4495A: Access NY Supplement A", specifically in Section IV.A.1.

47. **Question:** If an individual is applying for funds to cover a burial, can the LDSS-2921 be used?

Answer: The LDSS-2921 is the application to be used for burials.

48. **Question:** Can DOH have a monthly statewide question and answer session similar to OTDA where LDSS can ask questions and have everyone hear the question and answer all at once?

Answer: OHIP will consider this suggestion. Currently OHIP conducts quarterly M-TAG conference calls which provide districts an opportunity to raise questions and receive answers.

49. **Question:** On the Notice of Responsibilities and Rights for Support (LDSS-4279), who should sign the "Signature of Worker"? Is this the FE or the LDSS worker?

Answer: The person providing the applicant with the LDSS-4279 should sign the form.



Donna Frescatore, Deputy Commissioner
Office of Health Insurance Programs