



# STATE OF NEW YORK DEPARTMENT OF HEALTH

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**ADMINISTRATIVE DIRECTIVE**

**TRANSMITTAL:** 03 OMM/ADM-4

**TO:** Commissioners of  
Social Services

**DIVISION:** Office of Medicaid  
Management

**DATE:** June 9, 2003

**SUBJECT:** Interim Implementation of the Medicaid Buy-In Program for  
Working People with Disabilities

<b>SUGGESTED DISTRIBUTION:</b>	Medicaid Staff Fair Hearing Staff Staff Development Coordinators
<b>CONTACT PERSON:</b>	Bureau of Local District Support Upstate: (518) 474-8216 NYC: (212) 268-6855
<b>ATTACHMENTS:</b>	Attachment I - MBI Outreach and Education Contractor List Attachment II - BPA&O Cooperative Agreement Awards List Attachment III - Explanation of the MBI-WPD Program Attachment IV - MBI Batch Transmittal Form Attachment V - Acceptance Notice (manual) Attachment VI - MBI-WPD Disability Transmittal Form Attachment VII - Grace Period Request Form

**FILING REFERENCES**

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
95 ADM-17			366(1)(a)(14) & (15) 367-a(15)	MRG pp. 65-67 178-79 195-98 320	GIS 01 MA/036 GIS 03 MA/009

**I. PURPOSE**

The purpose of this Administrative Directive (ADM) is to advise local departments of social services (LDSS) of the provisions of Chapter 1 of the Laws of 2002 regarding Medicaid coverage for working people with disabilities. Sections 62-69 of Part A of Chapter 1 of the Laws of 2002 establish a new Medicaid Buy-In program to extend Medicaid coverage to working disabled applicants/recipients (A/Rs) who have net incomes at or below 250% of the Federal Poverty Level (FPL) and non-exempt resources at or below \$10,000. This directive provides districts with interim implementation requirements for this new program. An additional administrative directive will be issued at a later date to explain the transition of the MBI-WPD program to the LDSS and the operations of the automated premium payment system. New York City case processing instructions will follow under separate cover.

**II. BACKGROUND**

The concern expressed most frequently by people with disabilities who want to work is the fear of losing coverage for health care should their employment cause them to lose eligibility for benefits such as Medicare and Medicaid. Often these individuals are unable to get private health insurance that will cover all of their medical needs. The loss of Medicare and Medicaid leaves them without a way to pay for medical expenses and for basic supports they require to live. Therefore, many do not work, as it may result in the loss of their Medicare or Medicaid coverage. Others may be employed but are careful to limit their earnings to the very low levels that will not jeopardize such coverage.

Historically, individuals with disabilities who receive Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) may utilize work incentive provisions within the Social Security Act (the Act) to help them retain health care. These provisions include Section 1619(a) of the Act that allows an individual to continue to receive SSI and Medicaid even when their earned income reaches the substantial gainful activity (SGA) limit. Section 1619(b) of the Act provides for continued Medicaid coverage for an individual whose earnings make him or her ineligible for a SSI cash payment. For Medicaid coverage to continue under Section 1619(b), the individual must be otherwise eligible for SSI except for their earnings. The individual must continue to meet SSI disability and resource criteria, and the individual's earnings must not be sufficient to replace the value of the SSI and Medicaid benefits he/she would receive (called the "threshold amount"). These work incentive provisions were designed to help a federal disability beneficiary transition to work.

The Balanced Budget Act of 1997 allows states to establish Medicaid Buy-In programs for the working disabled. The Federal Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999 further allows states the option of establishing two new optional categorically needy Medicaid eligibility groups. The first group, called the Basic Coverage Group, consists of those disabled individuals age 16 or over, but under age 65, who, except for their earned income, would be eligible to receive SSI benefits (regardless of whether they have ever received SSI cash benefits). The second group, the Medical Improvement Group, consists of individuals with a medically improved disability who lose Medicaid eligibility under the Basic Coverage Group because their medical condition improves to the point where they are no longer disabled under the SSI definition of disability but who still have a severe impairment. The TWWIIA allows states to eliminate or set their own income limit (up to 450% FPL) and resource limitations. States can require payment of

premiums or other cost-sharing charges set on a sliding scale based on net income.

Chapter 1 of the Laws of 2002 enacted the two new categorically needy Medicaid groups in New York State, by adding two new subparagraphs (12) and (13) to Section 366.1(a) of the Social Services Law (SSL). A new subdivision (12) to Section 367-a of SSL provides for the payment of premiums for certain participants based on net available income. This new program, known as the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD), is intended as a work incentive for persons with disabilities (including blindness).

### III. PROGRAM IMPLICATIONS

#### A. Medicaid Buy-In Program for Working People With Disabilities

Effective July 1, 2003, two new eligibility groups are established for the Medicaid Buy-In program for Working People with Disabilities: the Basic Coverage Group and the Medical Improvement Group. To be eligible for the Basic Coverage Group, an A/R must have a disability that meets the medical criteria for SSI established by the Social Security Administration but have too much income to qualify for SSI. In addition to the usual Medicaid rules, the specific requirements are:

- Age - the A/R must be at least 16 years of age, but under the age of 65
- Work - the A/R must be engaged in a work activity for which they receive financial compensation and pay all applicable state and federal income and payroll taxes
- Disability - A/R must have certification of disability
- Income - the A/R must have total net income at or below 250% of the FPL. If net income is at or above 150% of the FPL but does not exceed 250% of the FPL, a premium payment will be required (see note #1 below)
- Resources - non-exempt resources cannot exceed \$10,000
- Premium Payment: The premium is 3% of net earned income plus 7.5% of net unearned income. Individuals with net income below 150% of the FPL pay no premium (see note #2 below).

**Note #1:** SSI-related budgeting, including allocation and deeming, is used for determining net available income and resources.

**Note #2:** A moratorium on premium payments has been instituted until such time as systems support for an automated premium collection and tracking is available. The anticipated implementation date for this system is Spring 2004. Once the automated premium payment and tracking system is available, premium payment will be required for those eligible for the MBI-WPD program who have net income between 150% and 250% of the FPL. Also, at that time, administration of the program will be transitioned to the LDSS to be administered consistent with other Medicaid programs.

A recipient in the Basic Group must be engaged in a work activity, for which they receive financial compensation and pay all applicable state and federal income and payroll taxes. Documentation of earned income will be required.

A recipient is eligible for Medicaid coverage under the Medical Improvement Group if, in addition to meeting the above criteria, she/he is in receipt of coverage through the Basic Group, is no longer determined disabled, but continues to have a severe medically determined impairment. A recipient in the Medical Improvement Group must be employed at least 40 hours per month and earn at least the federally required minimum wage. Loss of eligibility under the Basic Coverage Group must be the direct and specific result of loss of disability status because of medical improvement.

It is not likely that the first year of operations will include participants in the Medical Improvement Group because of the requirement that a recipient be a participant in the Basic Group prior to being eligible for the Medical Improvement Group.

For the MBI-WPD program, the responsibility for case processing and the Medicaid eligibility determination are shared between the LDSS and the State Inter-Agency Team (IAT).

The State Disability Review Team conducts all disability determinations and Continuing Disability Reviews (CDR) for the MBI-WPD program. If an applicant is not in receipt of SSDI benefits or is not currently determined disabled or is in the MBI-WPD program and continuing disability review is indicated, the determination will be made by the State Disability Review Team in Albany.

MBI-WPD applicants who wish to participate in Managed Care may opt to enroll if their net income is less than 150% FPL. MBI-WPD participants with income between 150% and 250% FPL are excluded from Managed Care even in districts with mandatory Managed Care programs.

Cost shares for MBI-WPD participants will be at the regular cost share rate of 50% federal, 25% State and 25% local and 50% federal, 40% state and 10% local for Long Term Care costs, with no local administrative costs.

This is an interim implementation plan. The MBI-WPD program will be transitioned to the LDSS to be administered consistent with all other Medicaid programs when the automated premium collection and tracking system becomes operational in spring 2004. At that time, districts will be responsible for all case processing, including premium payment and collection.

#### **B. Outreach, Education and Client Representation**

Fifteen contractors have been selected to assist MBI-WPD applicants with education, outreach and client representation. These contractors are required to work cooperatively with local department of social services in this endeavor (see Attachment I to this ADM for the list of Outreach and Education contractors).

In January 2002, New York State received a Medicaid Infrastructure Grant (MIG) from the Centers for Medicare and Medicaid Services (CMS). MIG committees developed educational materials that will be used by the contractors for education and outreach purposes.

#### **C. Benefits Planning, Assistance and Outreach (BPAO)**

Pursuant to the provisions of TWWIIA, the Social Security Administration (SSA), awarded cooperative agreements to seven community organizations in New York State, called Benefits Planning, Assistance and Outreach (BPA&O) projects. These BPA&O projects provide all SSA beneficiaries with disabilities (including transition-to-work aged youth) access to benefits planning and assistance services. Benefits Counselors assist persons with disabilities to make informed choices about work. Attached is the list of organizations that received cooperative agreement awards from the Social Security Administration. LDSS staff should make referrals to these Benefits Counselors as needed (see Attachment II to this ADM). If a person with a disability wishes the services of a Benefits Counselor but is not a recipient of Social Security Disability and/or Supplemental Security Income benefits, a referral to the office of Vocational and Educational Services for Individuals with Disabilities (VESID) may be made.

#### IV. Required Action

To be eligible for the MBI-WPD program, an individual must meet age, work, disability, and income and resources requirements. If an individual is under 16 or over 64 years of age, she/he is not eligible for this program. If an individual is not certified disabled but alleges a disabling condition, a disability review is required prior to an eligibility determination for the program. All disability reviews for the MBI-WPD program will be conducted by the State Disability Review Team.

##### A. Program Administration

The following details the roles and responsibilities for local district and Inter-Agency Team (IAT) staff. It is anticipated that by Spring 2004, program operations, with the exception of disability reviews, will be transitioned completely back to districts, allowing MBI-WPD cases to be processed like any other Medicaid case. An administrative directive will be issued at that time to provide the details of the transition process and instructions for the automated premium payment system.

##### **Inter-Agency Team staff processes cases at the Office of Medicaid Management (OMM) Albany Central Office (ACO) with LDSS Assistance:**

##### **LDSS staff will:**

1. Provide information and application for the program. Provide Applicant/Recipient (A/R) with a copy of the "Explanation of the MBI-WPD Program" (see Attachment III of this ADM)
2. Schedule and conduct the face-to-face interview with A/R or his/her representative. Discuss the availability of Impairment Related Work Expenses (IRWEs) deductions and Plan for Achieving Self-Support (PASS) accounts with A/R
3. Photocopy documentation; verify employment, age and disability status (If applicant is not age appropriate or is not working, LDSS will conduct a regular MA eligibility determination and follow usual procedures)
4. Determine if a disability determination is required; if so, request medical documentation from the applicant's medical providers (486T, revised 9/91)
5. Register the application in Welfare Management System (WMS) and assign a case number
6. If additional documentation is required, give applicant a 10 day pending letter listing all documents which must be provided to determine eligibility

7. When documentation is received, or on the 11<sup>th</sup> day, complete the "MBI-WPD Batch Transmittal" form (see Attachment IV to this ADM) and overnight mail copies of the application, transmittal, medical release forms and copies of documentation to ACO (LDSSs are required to retain the original application and copies of all documentation for their records)

**Inter-Agency Staff will:**

1. Log-in applications received from LDSS
2. Assign cases to Inter-Agency Team (IAT) for eligibility determination
  - a. If the case is complete, IAT staff will perform an eligibility determination, including consideration of Impairment Related Work Expenses (IRWEs) and Plan for Achieving Self-Support (PASS) accounts
  - b. If the case is incomplete, IAT staff will follow-up with A/R and LDSS, if needed, on both outstanding documentation and disability review if required
3. Run MBL budget, including all applicable IRWEs and PASS deductions
4. Perform full data entry.
  - a. If income and resources eligible, supervisory signoff is obtained, case is authorized for 12 months and acceptance notice (manual notice, see Attachment V to this ADM) is sent to applicant
  - b. If ineligible, IAT staff obtains supervisory signoff and sends denial notice to applicant
5. Complete Bi-Weekly Case Processing Report and send to LDSS, indicating the status of those cases opened or denied during the reporting period

**Co-op Cases:**

For mixed households (households with other applying family members) new applicants for MBI-WPD eligibility will be processed at the ACO by IAT staff but the eligibility determination for the rest of the household must be completed by the local department of social services staff.

If the MBI-WPD individual is already on a case with his/her family and is requesting participation in the MBI-WPD program for him/herself, the district must send proof of work, disability status, PASS and IRWEs documentation and other applicable documents to the ACO so that the eligibility determination may be made and the case processed for the MBI-WPD program. If the A/R is determined eligible for the MBI-WPD program, IAT staff will coordinate with LDSS staff to set up a separate case for the MBI-WPD recipient.

**Spenddown Cases:**

1. **In which the individual has a certification of disability and meets the age requirements, has earned income and requests MBI-WPD:**

Documentation of disability and all income and resources are to be sent to the ACO for eligibility determination and case processing. IAT staff will:

- a. Recode in WMS
- b. Evaluate for MBI-WPD eligibility, including consideration of IRWEs and PASS accounts
- c. Run and store a new MBL budget
- d. Coordinate case processing with the LDSS staff
- e. Send a notice informing A/R "No spenddown - switched to MBI-WPD"

- 2. In which the individual is not certified disabled:** The case remains on spenddown until State Disability Review Team completes the disability determination. LDSS sends complete disability package and documentation of all disability, income and resources to the ACO.

**Undercare Maintenance of MBI-WPD Cases:**

LDSS staff is responsible for the following:

- Lost cards
- Address changes, etc.
- COLAs
- Mass rebudgeting
- Fair hearings (with input from IAT staff)
- Recertification
- Continuing Disability Review (CDR) initiation (with actual CDR done by State Review Team)
- PASS account approvals

**B. Application Process**

Individuals applying for the MBI-WPD program must complete the LDSS-2921, "Application for Public Assistance/Medical Assistance/Food Stamps/Services." In addition, during the application process, districts must include information about the simplified resource review option if the district has elected to offer this option to its Medicaid population. As advised in 95 ADM-17, "Community Coverage Option", applicants who choose to have a simplified resource review must be provided with a copy of Attachment I to 95 ADM-17. The applicant must sign the attachment indicating the coverage for which he or she is applying. A copy of the signed form must accompany a submitted application.

At the face-to-face interview, it is important that the eligibility worker screen the applicant to insure that they meet the basic MBI-WPD program requirements. If the applicant is under 16 or 65 years of age or over, she/he is not eligible for the MBI-WPD program. Provided an individual is age 16-64, working, certified disabled and has income and/or resources above the SSI income/resource levels, she/he may be eligible for the MBI-WPD program. If an applicant is not currently working, LDSS staff should offer a referral to VESID or BPA&O (see Attachment II of this ADM). Until the applicant is working, he/she cannot participate in the MBI-WPD program and must instead be evaluated for Medicaid under other programs, such as spenddown.

Acceptable proof of work may include an A/R's: pay stub(s); pay check(s); a written statement from the employer; or when these are not available the A/R's income tax return, W-2 form, or records of bank deposits may be used. For self-employment, employment records and related materials concerning self-employment earnings and expenses, or current income tax return can be used to document earnings.

Applicants must provide proof of disability. In those instances when an applicant has not been previously certified disabled, the LDSS must assist the applicant in establishing proof of disability. LDSS staff must assist the applicants by having them sign the appropriate consent for release of medical information forms and must send requests for medical information to all relevant medical providers. These forms must be modified to include the New York State Department of Health Office of

Medicaid Management in the statement of release of information. The form must also include instructions to the provider indicating the address to which the medical evidence is to be sent (see address below). Copies of the release form and all requests for medical evidence are to be sent to the ACO with the application and necessary documentation.

The LDSS is to provide the individual with a copy of the "Explanation of the MBI-WPD Program" (see Attachment III of this ADM). The LDSS should also inform the applicant that they will receive a notice of the decision on the application from the IAT staff.

Completed application packages include copies of the application, the signed "Consent for Community Eligibility Determination" (if appropriate), all required documentation for eligibility and consent for release of medical information form, as well as copies of all requests for medical records. Current procedures for packaging and sending disability review cases to Albany will apply, with the exception of the transmittal form. A revised transmittal form for disability review cases, specific to the MBI-WPD program, must be used for MBI-WPD disability review cases (see Attachment VI of this ADM). The application package must be sent via overnight mail to the ACO in Albany at the following address:

MBI-WPD Coordinator  
Division of Consumer and Local District Relations  
NYS Department of Health  
Office of Medicaid Management  
One Commerce Plaza, Room 728  
Albany, New York 12260

**Note:** Districts should not hold applications for more than 10 days pending receipt of the individual's documentation. If an applicant fails to provide requested documentation within the 10 day time period, the LDSS should forward the application package to the ACO for appropriate action.

### C. Disability

Individuals must be certified blind or disabled in order to be considered eligible for Medicaid under the MBI-WPD program. An applicant who shows proof of disability from the Social Security Administration is considered disabled for the MBI-WPD program and may be included in the Basic Coverage Group, if otherwise eligible. An applicant whose disability has not previously been certified by SSA or a Local or State Disability Review Team requires a disability review by the State Medicaid Disability Review Team. Continuing disability reviews for recipients participating in the MBI-WPD program will be performed by the State Disability Review Team, regardless of the team (State or Local) who performed the initial disability review.

**Note:** Disability determinations for A/Rs who are not working and/or not applying for the MBI-WPD program will continue to be performed by the responsible (state or local) review team.

### D. Grace Periods

A grace period is a time period during which a MBI-WPD program participant is not working but remains eligible for the program. Recipients may be granted multiple grace periods during a 12-month



period, however, in no event may the sum of the grace periods exceed six months in the 12-month period.

Two types of grace periods may be granted:

- **Change in Medical Condition:** A grace period of up to six months will be allowed if, for medical reasons, the MBI-WPD participant is unable to continue working. Medical verification will be required. When an applicant requests this type of grace period, LDSS must request medical verification.
- **Job Loss (through no fault of participant):** A grace period of up to six months will be allowed if, through no fault of the participant, job loss is suffered, i.e., due to layoff, etc. Verification is required. Districts must verify that the recipient is reasonably expected to return to employment, for example, a temporary layoff, or that the recipient is actively seeking new employment.

**Note:** MBI-WPD participants reporting job loss due to non-medical reasons should be referred to One-Stop Centers, VESID and BPA&O services as applicable, so that assistance with employment may be sought prior to loss of eligibility in the program.

To request a grace period, an A/R must complete a MBI-WPD request form (see Attachment VII of this ADM). When an A/R requests a grace period the LDSS must provide the A/R with a grace period request form and instruction sheet. The A/R must complete the form and return it, with required documentation to the local social services office for processing. The required documentation will vary depending on the type of grace period requested. A/Rs requesting a grace period due to a change in medical condition will be required to provide a physician statement detailing the current health problem, treatment and the time period that the A/R will be out of work. For A/Rs requesting a grace period due to job loss, acceptable forms of verification include a lay-off notice, statement from the Department of Labor, VESID, etc.

LDSS must review each grace period request and documentation to determine that the documentation supports the request. The district must approve the grace period for the time period indicated on the request form unless approval would result in the recipient exceeding the six-month maximum grace period. The LDSS completes the decision section of the grace period request form. A copy of the completed form is then sent to the ACO for tracking purposes. LDSS must return the completed request form to the recipient within 10 working days.

Because the Albany Central Office will be tracking recipients in a grace period during the interim implementation of the MBI-WPD program, it is essential that a copy of the completed grace period request form be sent by the LDSS to the ACO. A monthly report will be sent to the LDSS identifying all recipients approved for a grace period, the date they were approved and the authorization period.

#### **E. Financial Eligibility**

Regular SSI-Related budgeting rules will be used to determine an individual's net available monthly income and countable resources. This includes applying all SSI-Related income and resource disregards and allocation and deeming, when applicable. As for all SSI-Related cases,

the individual's Impairment Related Work Expenses (IRWEs) may be disregarded (see Medicaid Reference Guide pages 195 -198). We anticipate that some of the applicants will be seeking Plans to Achieve Self Support (PASS) accounts, which are disregarded for purposes of determining SSI-Related A/R's Medicaid eligibility (see Medicaid Reference Guide pages 178-179, 200-201 and 320).

The household size for FPLs will be the same as regular SSI-Related budgeting. The individual's net available income, after applying all disregards and exemptions, will be compared to 150% or 250% of the FPL. If an A/R's income exceeds 250% of the FPL, the A/R is determined ineligible for the MBI-WPD program. If an A/R's net available monthly income is at or below 250% of the FPL and countable resources are at or below the \$10,000 resource standard (regardless of household size), the A/R will be financially eligible for Medicaid coverage under the MBI-WPD program. A/Rs cannot spenddown income to 250% of the FPL and qualify for coverage under the MBI-WPD program. Additionally, countable resources must be at or below the \$10,000 resource standard as of the first of the month in which coverage is sought. Medical bills cannot be used to offset resources in excess of the \$10,000 resource standard. Individuals will however, be allowed to set resources aside in an irrevocable pre-need funeral agreement.

Eligible individuals will be entitled to reimbursement of paid or unpaid medical bills in the three-month period prior to the month of application, if eligibility under the MBI-WPD program can be established for this time period. However, retroactive coverage will not be given prior to July 1, 2003; the start date for the MBI-WPD program. In addition, eligible participants will be subject to photo identification and finger imaging requirements.

#### **F. Medicaid Managed Care**

Medicaid Managed Care is a voluntary option *only* for those MBI-WPD recipients who are income eligible *under 150% of the FPL*. Pursuant to statute, all other recipients are excluded from managed care. In districts where enrollment in a managed care plan is mandatory, individuals in the MBI-WPD program cannot be required to enroll. It should be noted that individuals in receipt of Medicare, regardless of income level, are excluded from enrollment in managed care.

#### **G. Premium Payments**

MBI-WPD participants with net (earned and unearned) income between 150% and 250% of the FPL shall be required to pay a monthly premium for Medicaid coverage based on a percentage of their earned and unearned income. However, due to the unavailability of an automated premium collection and tracking system for the MBI-WPD program, a *moratorium exists on premium collection until the automated system is completed (approximately spring 2004)*. An ADM will be issued prior to implementation of the automated system for premium collection and tracking in 2004, which will address the details of that system as well as the policy for the long term implementation of the MBI-WPD program.

#### **H. Co-Pays**

All applicable Medicaid co-pays continue to apply for MBI-WPD program participants. In 2004, when the automated premium collection and

tracking system is in place, co-pays will continue to apply *in addition* to any premium payment the participant makes.

**I. Notices**

CNS and manual notices have been developed. IAT staff will be responsible for sending notices of initial Medicaid eligibility determinations to applicants.

**IV. SYSTEM IMPLICATIONS**

**A. Downstate**

New York City systems instructions will follow under separate cover.

**B. Upstate**

Systems codes and edits have been modified to support the interim implementation of the MBI-WPD program. A description of the items below can be found in the WMS/CNS Coordinator Letter and the MBL transmittal to support the July 21, 2003 WMS migration. The following is a summary of the changes:

1. WMS Changes

Effective with the July 21, 2003 migration:

- a. Two new Individual Categorical Codes have been added for identification and Federal/State/Local claiming purposes:
  - 70 Medicaid Buy-In - Disabled Basic Group
  - 71 Medicaid Buy-In - Medically Improved

Codes 70 and 71 are allowed in Case Type 20 only.

If the Individual Categorical Code is 70 or 71, the Medicaid Coverage Code must be 01, 10 or 30.

If the Individual Categorical Code is 70 or 71, the Individual must be between 16 and 64 years of age.

- b. Restriction/Exception codes for Managed Care will apply as follows:

90 Managed Care Excluded will be used for those individuals with a net income between 150% and 250% FPL.

91 Managed Care Exempt will be used for those individuals with a net income that is below 150% FPL who choose not to be in managed care.

- c. Corresponding AID Categories:

- 82 Medicaid Buy-In Disabled Basic Group
- 83 Medicaid Buy-In Medically Improved Group

These AID Categories have been added for reporting purposes

2. MBL Implications

Effective for MBL budgets with a From Date of July 1, 2003 or after, two new EEC Codes will be available for the MBI-WPD program:

"V" - MBI-WPD(SSSI -Related budgeting prior to MBI-WPD)

"W" - MBI-WPD(MBI budget only)

The new EEC codes are valid for Budget Types 04, 05 and 06. In addition, a new field entitled "PASS" will be available to enter income that is to be disregarded in accordance with an approved Plan for Achieving Self-Support.

When an EEC Code of V or W is entered, the SSI-Related Total Net Income minus PASS amount will be used to calculate eligibility for the MBI-WPD program. The FPL table used will be based on the Living Arrangement Codes of 1 or 2 (not number in case) and whether a non SSI-related spouse has sufficient income remaining after allocation to any non-disabled children in the household.

MBI-WPD total net income after applying all SSI-Related income disregards will be compared to 150% of the FPL and 250% of the FPL.

The second EEC screen will display the Net Income and a Medicaid Buy-In section with one of the following messages:

Eligible	150%	\$ Amount
Eligible	250%	\$ Amount
Ineligible Income	250%	\$ Amount
Ineligible Resources		\$ 10,000
Ineligible Income/Resources	250%	\$ Amount/\$10,000

For an EEC of "V" or "W", the Resource test is \$10,000.

3. CNS Changes

Numerous additions to the CNS Denial, Closing and Undercare codes will be implemented to accommodate the MBI-WPD program. The notices will be available for the July 1, 2003 implementation.

**V. EFFECTIVE DATE**

The interim provisions contained in this directive are effective July 1, 2003.

Kathryn Kuhmerker, Deputy Commissioner  
Office of Medicaid Management