



STATE OF NEW YORK DEPARTMENT OF HEALTH

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

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 04 OMM/ADM-5

TO: Commissioners of
Social Services

DIVISION: Office of Medicaid
Management

DATE: July 20, 2004

SUBJECT: Medicaid Buy-In Program for Working People With Disabilities (MBI-WPD): Transition of the MBI-WPD Program to Local District Staff

SUGGESTED DISTRIBUTION:	Medicaid Staff Fair Hearing Staff Staff Development Coordinators
CONTACT PERSON:	Bureau of Local District Support Upstate: (518) 474-8216 NYC: (212) 268-6855
ATTACHMENTS:	Attachment I - Explanation of the MBI-WPD Program Attachment II - Grace Period Request Form Attachment III - Sample Grace Period Letter For Medical Condition) Attachment IV - Sample Grace Period Letter For Job Loss Attachment V - Acceptance Notice (manual) - English Attachment VI - Acceptance Notice (manual) - Spanish Attachment VII - MBI-WPD Monthly Report Form

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
03 ADM-4 95 ADM-17			366(1)(a)(14) &(15) 367-a(15)	MRG pp. 65-67 178-79 195-98	GIS 04 MA/009 GIS 04 MA/004 GIS 03 MA/009 GIS 01 MA/036

Date: July 20, 2004

Trans. No. 04 OMM/ADM-5

Page No. 2

I. PURPOSE

The purpose of this Administrative Directive is to provide Local Departments of Social Services (LDSS) with the plan for transition of eligibility determinations and full data entry for the MBI-WPD program to LDSS staff effective July 1, 2004.

Sections 62-69 of Part A of Chapter 1 of the Laws of 2002 established the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD) that extends Medicaid coverage to working applicants/recipients (A/Rs) with disabilities who have net incomes at or below 250% of the Federal Poverty Level (FPL) and non-exempt resources at or below \$10,000.

Administrative Directive (ADM) 03 OMM/ADM-4, issued on June 9, 2003, advised LDSS of the interim implementation plan for the MBI-WPD program that began July 1, 2003. Under the interim plan, eligibility determinations have been made by staff at the New York State Department of Health. There has been no systems support for automated premium collection and tracking; therefore, a moratorium on premium payment has been in effect. Because the automated Premium Payment Collection and Tracking (PPCT) system is not yet operational, the moratorium on premium collection continues. Once the PPCT system is operational, further instructions will be forthcoming.

II. BACKGROUND

Chapter 1 of the Laws of 2002 enacted two new categorically needy Medicaid groups under the MBI-WPD program 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. The MBI-WPD program is intended as a work incentive for persons with disabilities (including blindness).

Since July 1, 2003, LDSS staff and the Inter-Agency Team (IAT) at the Office of Medicaid Management (OMM) Albany Central Office (ACO) have shared responsibility for implementation of the MBI-WPD program (see 03 OMM/ADM-4). LDSS staff accepts applications and performs undercare and re-certification functions and ACO staff performs eligibility determinations and full data entry. On July 1, 2004 the responsibility for implementation of the MBI-WPD program, including eligibility determinations and full data entry for new cases and spenddown conversion cases, will transition to the LDSS.

Negotiations with a vendor are underway to provide premium collection and tracking for the MBI-WPD program but the contract will not be complete at the time the transition takes place. Therefore, the moratorium on premium payment and tracking continues.

III. PROGRAM IMPLICATIONS

A. Eligibility Requirements for the Medicaid Buy-In Program for Working People with Disabilities: Two Groups

As stated in 03 OMM/ADM-4, effective July 1, 2003, two new eligibility groups were established for the MBI-WPD program: the

Date: July 20, 2004

Trans. No. 04 OMM/ADM-5

Page No. 4

Basic Coverage group and the Medical Improvement group. To be eligible for either group, an A/R must have a disability that meets

the medical criteria for Supplemental Security Income (SSI) established by the Social Security Administration (SSA) but have too much income to qualify for SSI.

Basic Coverage Group

In addition to the usual Medicaid rules, the requirements that apply to the Basic Coverage group 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 (see Required Action section for verification of Sheltered Workshop employees work).
- **Disability** - The 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. **Note:** SSI-related budgeting, including allocation and deeming, is used for determining net available income and resources.
- **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 (after SSI-related budgeting methodology is applied). Individuals with net income below 150% of the FPL pay no premium. **Note:** A moratorium on premium payments is effective until such time as systems support for an automated premium collection and tracking become available.

Medical Improvement Coverage Group

In addition to the usual Medicaid rules, the requirements that apply to the Medical Improvement group are:

- A new applicant is **NEVER** placed in the Medical Improvement Group. The individual must first be in receipt of coverage through the Basic Group and lose eligibility for that group as a direct and specific result of medical improvement (see Disability requirement below).
- **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 financial compensation is received and all applicable state and federal income and payroll taxes are paid (see Required Action section for verification of Sheltered Workshop employees work). 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.
- **Disability** - The recipient's disability determination (performed by the State Disability Review Team in Albany as a Continuing Disability Review) indicates that the individual is no longer disabled but retains a severe medically determined impairment.

- **Income** - The A/R must have a total net income that is 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.
Note: SSI-related budgeting, including allocation and deeming, is used for determining net available income and resources.
- **Resources** - The A/R's non-exempt resources cannot exceed \$10,000.
- **Premium Payment** - The premium is 3% of the net earned income plus 7.5% of net unearned income (after SSI-related budgeting methodology is applied). Individuals with net income below 150% of the FPL pay no premium.
Note: A moratorium on premium payments is effective until such time as systems support for an automated premium collection and tracking is available.

B. Managed Care

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.

C. Cost Shares

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. Local districts must use the revised schedule D-4 to claim administrative costs for the MBI-WPD program.

D. Premium Payment Collection and Tracking (PPCT) System: A New WMS Subsystem

A new Welfare Management System (WMS) subsystem is under development to hold data specific to premium collection and tracking for the MBI-WPD program. A systems interface is also under development to supply necessary information to the selected Premium Payment Collection and Tracking System vendor, who will be responsible for mailing premium bills/coupons, some notices and letters and for the necessary tracking functions for the MBI-WPD program. Once the automated PPCT system is operational, the contracted PPCT system vendor will report to the OMM and LDSS according to a prearranged schedule. Information regarding this system will follow at a later date.

E. Application Process

This section addresses application forms, the face-to-face interview and coverage codes for the MBI-WPD program.

Application Forms

The following application forms are accepted for the MBI-WPD program:

- LDSS-2921 "Application for Public Assistance/Medical Assistance/Food Stamps/Services"
- Medicaid Renewal (Recertification) Form
- Access New York Health Care Form DOH-4220

Local district staff is reminded that an MBI-WPD application form, whether the applicant is new or currently on spenddown, must be accompanied by current documentation of items subject to change, such as employment. If an applicant is currently on spenddown, the client's most recent application or renewal form will be accepted as long as it was filed within the last six months. If it has been more than six months since the application was completed, a new form must be submitted.

Face-to-Face Interview

The LDSS must schedule and conduct the face-to-face interview with the applicant or his/her representative and during the interview:

- Discuss the availability of Impairment Related Work Expenses (IRWEs) deductions and Plan for Achieving Self-Support (PASS) accounts with the A/R.
- Provide the applicant with a copy of the "Explanation of the MBI-WPD Program" (see Attachment I of this ADM).
- Verify age, work and disability status (see Required Actions for each of these requirements).
- Determine if disability certification is needed. If a disability determination is needed, local district staff must request medical documentation from the applicant's medical providers (see Required Actions for disability determinations process).

Coverage Codes That Apply Based on Resource Documentation

The August 2004 systems migration for Attestation of Resources will include new coverage codes that will apply to the MBI-WPD program based on resource documentation provided. These coverage codes will appear in a separate ADM that will be released in the near future. See the Systems Implications section of this ADM for coverage codes that apply until attestation of resources is implemented.

IV. REQUIRED ACTION

As of July 1, 2004, the LDSS will be responsible for implementation of the MBI-WPD program. The application process will continue as directed in the Interim Implementation plan; however, as stated in GIS MA/004, the Access New York Health Care form DOH-4220 or the CNS generated Medicaid Renewal (Recertification) Form, if completed within six months of the request for participation in the MBI-WPD program, may now be used in addition to the LDSS-2921 "Application for Public Assistance/Medical Assistance/Food Stamps/Services" form. The face-to-face interview continues to be a requirement of application as does verification of the specific eligibility requirements.

A. Age Requirement

An applicant for the MBI-WPD program must be at least 16 years of age, but under the age of 65. If the applicant is under 16 or 65 years of age or older, she/he is not eligible for the MBI-WPD program. Documentation of age is necessary at the time of application or renewal.

Date: July 20, 2004

Trans. No. 04 OMM/ADM-5

Page No. 8

If the A/R's 65th birthday occurs within 12 months of the date of application or renewal, coverage under the MBI-WPD program must end on the last day of the month of the individual's 65th birthday. The worker

must discuss this with the individual at the time of application or renewal and shorten the authorization period accordingly.

B. Work Requirement

If an applicant is not currently working, LDSS staff should offer a referral to VESID or to a Benefits Planner. 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 includes an A/R's: current pay stub(s), pay check(s) or a written statement from the employer. When these are not available the A/R's income tax return, W-2 form, or records of bank deposits may be used.

Sheltered Workshop

03 OMM/ADM-4 states that, "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." However, some sheltered workshop employees are tax blocked and for these individuals, although they may have pay stubs or a detailed statement of earnings from their employer, taxes are not deducted from their pay. In this case the tax requirement is not applicable and the pay stubs or employer's detailed statement of work may be used to verify work. In these instances the detailed statement of earnings from the employer or current pay stubs is considered acceptable proof of work.

Self-Employment

The Medicaid Reference Guide (MRG) may be used for guidance regarding self-employment verification. The MRG contains information on verification of small business, farm income, partnerships and corporations, as well as instructions for estimating net earnings from self-employment and determining net profits. Applicants for the MBI-WPD program who are self-employed in their own business are not required to show a profit but must submit documentation as detailed in the MRG.

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. Grace periods are a way of recognizing the fact that persons with disabilities may have periods of increased or decreased ability to work for medically verifiable or other reasons that require special consideration. 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:

- 1. 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.
- 2. 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

Date: July 20, 2004

Trans. No. 04 OMM/ADM-5

Page No. 10

recipient is reasonably expected to return to employment, for example, a temporary layoff, or that the recipient is actively

seeking new employment. An individual who is in receipt of unemployment insurance, who was let go from a job related to behavior resulting from the individual's disability, is considered eligible for a job loss grace period as the individual lost employment through no fault of their own. Receipt of unemployment insurance implies that the individual is actively seeking new employment.

Note: MBI-WPD participants reporting job loss due to non-medical reasons should be referred to One-Stop Centers, Vocational and Educational Services for Individuals with Disabilities (VESID) and Benefits Planning Assistance & Outreach (BPA&O) services as applicable, so that assistance with employment may be sought prior to loss of eligibility in the program.

If an individual loses eligibility for the MBI-WPD program due to job loss or medical condition that exceeds the six-month allowable grace period, the individual may reapply for the program without completing a new application form for up to 30 days following discontinuance. However, verification of return to work is needed.

The current process for grace periods, which will carry over for the transition, is as follows:

- A recipient must complete a MBI Grace Period Request form (see Attachment II to this ADM).
- The recipient must return the form with the required documentation to the LDSS.
- The required documentation must support the request for a grace period by detailing why the recipient is out of work and how long they will be out.
 - Change in medical condition supporting documentation must detail the current health problem, treatment and the time period that the recipient will be out of work. It must be provided by a Medical Doctor or primary care practitioner.
 - Job Loss documentation includes a layoff notice or a statement from the Department of Labor, VESID, etc.
- Each grace period request is reviewed along with the supporting documentation.
 - The grace period is approved by the LDSS for the time period requested by the recipient, unless the approval would result in the recipient exceeding the six-month maximum grace period. Remember, the 12 month tracking period for grace periods starts with the first day of the first awarded grace period. At the end of the 12 months, a new 12 month tracking period starts. The 12 month tracking period is independent of the authorization period and is not tied to the authorization period.
- The signed notice of decision is sent to the recipient. The LDSS must return the completed request form to the recipient within 10 working days.

Two model notices, one for each type of grace period, are included as Attachments III and IV of this ADM. One of these letters should be sent to a recipient when the district sends the signed grace period decision to the recipient. The letters inform the recipient of the necessary steps that will be required of them as the grace period draws to a close.

Beginning July 1, 2004 local districts will need to keep track of grace periods by either using a "tickler file" or database to make sure the recipient doesn't exceed the six month grace period limit. The Office of Medicaid Management has a database that may be used for this purpose. If your district would like a copy of this database, you may e-mail a request to:

Emt04@health.state.ny.us

C. Disability Requirement

Proof of Disability

Applicants must provide proof of disability. Acceptable proof of disability for initial application in the MBI-WPD program include:

- An award letter from the Social Security Administration for Social Security Disability Insurance (SSDI) benefits or other proof of receipt of SSDI benefits, such as a check or bank deposits listing the benefit. A Medicare card is also considered acceptable proof.
- An existing State or Local Disability Review Team certification at initial application for the MBI-WPD program.

Note: If the individual does not have existing certification of disability at the time of initial application, a disability determination must be performed by the State Disability Review Team in Albany.

New Disability Determinations

Local districts are reminded of their continuing responsibility to assist an A/R in establishing proof of disability or continuing disability. Medicaid applicants with an alleged disability, who are working and earning Substantial Gainful Activity (SGA) must be considered for a disability determination and informed of the MBI-WPD program. It is not appropriate to exclude these individuals from the first step of the sequential evaluation for disability.

If an individual is working and alleges a disability but does not have acceptable proof of disability, the LDSS must:

- Discuss the MBI-WPD program with the individual and give them the written explanation of the program.
- Have the individual sign the appropriate release of medical documentation forms.

Note: During the interim implementation period, counties requested that medical providers send evidence directly to the Albany Central Office. Beginning July 1, 2004, medical evidence is to be sent to the local district. The letter requesting medical evidence from treating sources should be modified to include the appropriate local district address to insure that medical evidence is sent to the local district and not to the Albany Central Office. Only a complete disability package will be sent to the State Disability Review Team in Albany. In the case of No Actions, the LDSS will be sent the completed DSS-639 with details of medical documentation needed. The district must make every effort to assist in obtaining the requested information and

Date: July 20, 2004

Trans. No. 04 OMM/ADM-5

Page No. 13

carefully document the efforts in the applicant's file. If the medical provider is unwilling or unable to provide the requested

documentation, a consultative exam will be required (see Consultative Exam section below). If the requested documentation is not received after several attempts or if the applicant fails to comply with two consultative examination dates, the local district will deny the MBI-WPD application for failure to provide documentation.

Note: It is important that attempts to obtain medical documentation and contacts with the applicant regarding consultative examination dates be carefully documented by local district staff.

- Complete the DSS-1151 interview form during the face-to-face interview and create a list of all treating sources (physicians, psychologists, hospitals, therapists, counselors, etc.).
- Utilize the DSS-486T forms and a copy of the release of medical evidence form to obtain medical evidence from all treating sources for a period up to 12 months prior to the date of application and cover the timeframe for which the disability determination is being sought. Be sure to send the treating physician a Functional Capacity Assessment form (page 2 of the DSS-486T).
- As medical evidence is received, a disability package is created consisting of:
 - The completed DSS-1151
 - Applicable portions of the DSS-486T, signed by a Medical Doctor or qualified Psychologist (as applicable)
 - All requested medical evidence
- Complete a MBI-WPD Transmittal sheet with 2 copies placed on the front of the disability packet.
- Mail the complete disability packet to:

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

When the disability determination is complete, the State Disability Review Team in Albany will send a copy of the Disability Review Team Certificate (DSS-639), along with a copy of the submitted disability packet, to the local district. A DSS-4141 "Notice of Medical Assistance Disability Determination" will be included with the completed disability determination package that is returned to the LDSS. The State Disability Review Team will complete the determination portion of the form. Local district staff is responsible for filling in district-specific information, including county name, address telephone number.

Note: The local district must fill in a telephone number that the applicant may call to request a copy of the DSS-639 disability determination decision. The local district must send a copy of the completed DSS-4141 form to the applicant and retain a copy of the completed notice in the client's record.

Consultative Exams

If an applicant does not have a medical treating source or the treating source is unwilling or unable to provide necessary medical information for a disability determination, the local district must arrange a consultative exam. Regulations at 18NYCRR 360-5.5 provide that the local district must pay for the cost of such examinations, consultations

and tests required by the disability review team when they indicate that more information is needed. These costs are subject to reimbursement as an administrative expense, whether or not the applicant is subsequently determined disabled. Federal financial participation shall be claimed for such expenditure even if the client is subsequently determined not disabled. However, as previously stated, there are no local administrative costs for the MBI-WPD program.

Continuing Disability Review

All Continuing Disability Reviews (CDR) for all working individuals, regardless of their participation in the MBI-WPD program, must now be performed by the State Disability Review Team, even if the local district performs its own disability determinations. This applies to all such individuals, even those not currently participating in the MBI-WPD program.

The local district prepares the CDR packet by contacting all known medical providers for current medical evidence. District workers will use the existing Disability Review Team Certificate (DSS-639) and the Disability Interview (DSS-1151) form as a guide in preparing the continuing disability review packet. Once the new medical evidence is received, the CDR packet is sent to the State Disability Review Team in Albany, MBI-WPD Coordinator (see instructions and address under "New Disability Determinations" section above).

Upon completion of the continuing disability review, the State Disability Review Team will send the district a copy of the Disability Review Team Certificate (DSS-639), the medical evidence package and the DSS-4141. The DSS-4141 will be completed by the LDSS and sent to the recipient. The LDSS retains a copy of the DSS-4141 in the client record.

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

Assignment of Applicant to Basic or Medical Improvement MBI Group

The only instance in which the local district may assign an individual to the MBI-WPD **Basic Group** is if a new applicant is in an existing approval period for disability certification at the time of application. If, at the time of new application, the individual is in receipt of SSDI or if the individual is in a disability approval period that was determined by the State or Local Disability Review Team, the individual may be placed in the MBI-WPD Basic Group by the local district if otherwise eligible for the program and working. In **all** other instances, the State Disability Review Team assigns the MBI group for which the A/R is eligible. If an applicant is not in receipt of SSDI benefits or is not currently determined disabled or is in the MBI-WPD program and a CDR is indicated, the disability determination must be made by the State Disability Review Team in Albany. The State Disability Review Team will notify the local district if the applicant is to be considered for eligibility in the Medical Improvement Group.

D. Financial Requirements: Income and Resources

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. Local district staff is reminded that as for all SSI-related cases, the individual's non-medical Impairment Related Work Expenses (IRWEs) may be disregarded (see Medicaid Reference Guide pages 195 -198 and the December 10, 2003 video-teleconference on IRWEs and PASS). 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 and the December 10, 2003 video-teleconference on IRWEs and PASS).

Procedures for establishing household size for MBI-WPD will be the same as for 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 for a household of one or two. 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.

E. Social Security Administration Programs: Supplemental Security Income (SSI) 1619(a) and 1619(b) Programs

The LDSS is reminded that if an individual is active on a Supplemental Security Income (SSI) case, the individual receives automatic Medicaid and is not eligible for the MBI-WPD program. If the individual is notified by the Social Security Administration that their SSI case will terminate, that individual must have a separate Medicaid eligibility determination, including a determination of eligibility under the MBI-WPD program. Medicaid coverage must continue until a separate eligibility determination for Medicaid is made. All criteria must be met for the MBI-WPD program in order for an individual to be found eligible for the program. The most likely scenario will be that the individual has been participating in SSA's 1619(b) program and has reached the income threshold for participation in that program. Another likely scenario would be one in which the individual exceeds the resources amount allowed by SSI. The LDSS is reminded that the resources level for the MBI-WPD program is \$10,000 for an individual or a couple.

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 MBI-WPD 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

Date: July 20, 2004

Trans. No. 04 OMM/ADM-5

Page No. 17

should be noted that individuals in receipt of Medicare, regardless of income level, are excluded from enrollment in managed care at this time.

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.*

H. Co-Pays

All applicable Medicaid co-pays continue to apply for MBI-WPD program participants. Co-pays apply *in addition to* any premium payment the participant makes.

I. Notices

The LDSS is to provide the individual with a copy of the "Explanation of the MBI-WPD Program" (see Attachment I of this ADM). CNS and manual notices have been developed. Manual Acceptance notices in English and Spanish are Attachments V and VI of this ADM. These manual notices must be used until further instructions are issued. CNS notices are in development and instructions for use will be forthcoming.

J. Reimbursement of Spenddown

Individuals transitioned from spenddown to the MBI-WPD program are eligible for reimbursement of any spenddown amount paid in the three months prior to the MBI-WPD application if the eligibility determination indicates that the individual was eligible for the MBI-WPD program during that retroactive period. The usual procedures for retroactive coverage apply.

K. Third Party Health Insurance

All Third Party Health Insurance rules that are used for Medicaid apply for the MBI-WPD program.

L. MBI-WPD Recertification/Renewal

MBI-WPD recertifications/renewals must be carefully screened to insure that all MBI-WPD eligibility requirements are met. Current employment must be verified. District workers must see current pay stubs or other acceptable verification of work (per the MRG) or the case cannot be recertified for the MBI-WPD program. The district worker must also attend to the applicant's current age and remember to discuss the age requirement if the individual's 65th birthday will be attained within 12 months from recertification. The authorization period must be adjusted accordingly. Disability certification must also be verified. If the expiration date on the certification falls within 12 months of the date of recertification, a Continuing Disability Review (CDR) is necessary and a disability packet must be initiated for review by the State Disability Review Team in Albany. Individuals recertifying/renewing for the MBI-WPD program must continue to be income and resource eligible.

M. Co-Op Cases

There is no longer a need for separation of an MBI-WPD individual from other members of the household on a co-op case. Use of the appropriate Individual Category Code (see Systems Implications) when performing data entry for an MBI-WPD individual allows identification of MBI-WPD participants for DOH OMM federal reporting purposes. Therefore, it is no longer imperative that the SSI-related budget be stored separately from any other budget(s) for the household.

N. LDSS Reporting Requirements

Due to federal reporting requirements, select MBI-WPD data must be reported monthly by all local districts. Local district staff must use the MBI-WPD Monthly Report form (see Attachment VII) to report necessary data. The report form must be received in the Albany Central Office by the fifth day of every month and cover data for the previous month. The form may be submitted via U.S. mail to the MBI-WPD Coordinator or by e-mail to:

Emt04@health.state.ny.us

V. SYSTEMS IMPLICATIONS

A. New York City

New York City systems instructions will follow under separate cover.

B. Upstate

Systems codes and edits which were modified to support the interim implementation of the MBI-WPD program are available to LDSS. A description of the items below can be found in the WMS/CNS Coordinator Letter and the MBL transmittal that we issued that describes the July 21, 2003 WMS migration of the MBI-WPD program.

Note: In the near future, Resource Attestation codes will apply for the MBI-WPD program. A separate Administrative Directive will be issued to address resource attestation.

1. WMS Changes

A. Effective with the July 21, 2003 Migration

Individual Categorical Codes

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.

Restriction/Exception Codes

Two Restriction/Exemption codes for Managed Care will apply:

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.

Corresponding AID Categories

Two AID category codes apply:

- 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 are available for the MBI-WPD program:

- "V" - MBI-WPD(SSI-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" is 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 is used to calculate eligibility for the MBI-WPD program. The FPL table used is 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 is 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 were implemented to accommodate the MBI-WPD program. The notices are available and may be found in the WMS/CNS Coordinator Letter and the MBL transmittal that were issued to describe the July 2003 WMS migration of the MBI-WPD program.

VI. EFFECTIVE DATE

July 1, 2004

Kathryn Kuhmerker, Deputy Commissioner
Office of Medicaid Management