Access to Health Care Services for Low-Income New Yorkers

The Legal Aid Society
Health Law Unit
199 Water Street, 3rd Floor
New York, NY 10038
Health Law Unit Helpline:
212-577-3575 (New York City)
1-888-500-2455 (Upstate)

Many thanks to Valerie Bogart of Selfhelp Community Services, Inc. who wrote the definitive outline on Medicaid eligibility in New York.

Updated September 5, 2008

Introduction

This training focuses on access to health insurance and health care services for low-income New Yorkers. It includes a discussion of government-sponsored health insurance programs, options for obtaining health care services for individuals who are uninsured or under-insured, and a brief overview of patients' rights in New York State.

Briefly the outlined sections are:

Medicaid – a joint federal/state/locally run health insurance program for very low-income people.

Family Health Plus – an expanded Medicaid program that provides basic managed care coverage to adults who are typically over-income or over-resourced for Medicaid.

Child Health Plus – a health insurance program for children. CHPlus A is Medicaid for children and can be provided through a Medicaid managed care plan or through regular fee-for-service Medicaid. CHPlus B is health insurance for children who are not Medicaid eligible and is only provided through a managed health care plan.

Healthy New York – a government subsidized health insurance program for low-income workers who do not receive health insurance through their jobs.

Options for Uninsured/Underinsured – Describes access to free and low-cost care and two supplemental insurance programs for under-insured individuals.

Patients' Rights in Hospitals and HMOs – Describes some of the laws which govern patients' and enrollees' rights to health care in federal and New York State law.

Medicaid

Medicaid is a comprehensive health insurance program for low-income people. The Medicaid program is codified in federal law and New York Social Services law. See 42 U.S.C. §1396 et. seq; N.Y. Soc. Servs. L. §§363-369-ee; see also 18 N.Y.C.R.R. §§ 360, 505.

Medicaid pays for all medically necessary care, including: hospitalization, out-patient care, mental health care, physical therapy, diagnostic tests, durable medical equipment, and pharmacy. See N.Y. Soc. Servs. L. § 365-a(2). Children under the age of 21 are also entitled to a comprehensive benefits package called Early and Periodic Screening, Diagnosis and Treatment ("EPSDT"). See 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(43), 1396a(a)(62), 1396d(a)(4)(B), 1396d(r), 1396s; N.Y. Soc. Servs. L. § 365-a(3). Most, but not all, New York State residents who receive Medicaid are now required to join managed care plans. The Medicaid Managed Care Program law is set forth at N.Y. Soc. Servs. L. § 364-j.

Joint federal-state program. The federal government pays for 50% of New York State's costs ("federal financial participation" or "FFP") provided that the State's Medicaid program fulfills federal requirements. For example, the federal law outlines the coverage of certain categories of people, the provision of certain services, and the reimbursement rates for providers set according to minimum standards. The federal Medicaid program rules are codified at 42 U.S.C. §1396 et seq.; 42 C.F.R. § 430 et. seq.

For every dollar spent on a Medicaid recipient's care (whether for mandatory or optional services), the federal government's share is 50 percent. Until recently, the remaining 50% was generally split 25/25 between New York State and local districts (NYC and counties), except for long term care for which the State pays about 40% and local districts pay 10%.[1]

In 2005, acknowledging that local districts could no longer keep pace with rising Medicaid expenses, the state passed legislation that capped the share that counties must contribute to the Medicaid program. Counties are now only responsible for the costs they were accessed in 2005 plus a 3% annual increase. All costs, including administrative costs, incurred by local districts above the cap are now covered entirely by state funds.[2] As the state continues towards its goal of covering all eligible but uninsured individuals, the cap should help reduce resistance to enrollment increases by local districts.

Unlike Welfare, Medicaid is NOT a block grant – it is an entitlement.
This means that: (1) federal minimum standards remain binding on states; and (2) an eligible person is ENTITLED to Medicaid coverage. Once an applicant is found eligible, her Medicaid case is opened; there is no wait list.

[1] N.Y. Soc. Servs. L. § 368-a.

[2] L. 2005, Ch.58, Part C

Basic Medicaid Eligibility

Medicaid Applications

Applications can be made at a Medicaid office, with a community based facilitated enroller, at a hospital, or with a Medicaid managed care plan. Application forms can be downloaded from the New York State Department of Health's (SDOH) website at: http://www.health.state.ny.us/nysdoh/fhplus/application.htm. Application sites in New York City can be found on the Office of Citywide Health Insurance Access (OCHIA) website at: http://www.nyc.gov/html/hia/html/public_insurance/enroll.shtml.

People who receive SSI and public assistance are automatically eligible for Medicaid. 42 U.S.C. §1396a(a)(10)(A)(I); 42 U.S.C. §1396u-l; N.Y. Soc. Servs. L. §366(1). Although applicants for public assistance, must check the box indicating that they wish to have Medicaid or they will not automatically get it. Medicaid was supposedly "delinked" from public assistance, however as a practical matter, public assistance recipients who have problems with their Medicaid case must resolve them at their public assistance center.
Children in foster care with rare exceptions are also automatically eligible for Medicaid and do not have to file separate applications. 18 N.Y.C.R.R. § 360-2.2(b)-(c).

Applicants may be entitled to retroactive Medicaid coverage for the three months prior to the date of application if they are eligible in the month that the medical service was received. 42 U.S.C. § 1396a(a)(34); 18 N.Y.C.R.R. § 360-2.4(c).

Application Processing Time

The time frame to process Medicaid applications depends on the applicant's Medicaid category (See "Categories" section below). 18 N.Y.C.R.R. § 360-2.4(a). Decisions on applications should be issued within the following time frames:

- Pregnant women & children – 30 days
- Adults – 45 days
- Disability based applications – 90 days

Recertification: Medicaid has a mail-in renewal/recertification process. Anyone on Medicaid without a Surplus (Spenddown) and without Long-Term Care can now attest to their income, resources and residence by signing the renewal forms. This is also true for recipients of Family Health Plus and the Medicare Savings Programs. Recipients must still document some changes, including letters of support if income is listed at $0, payment of health insurance premiums, and pregnancy (if pregnant). Recipients with a Surplus or receiving Long-Term Care must still document income and the current month's resources at renewal. See 08ADM-04 - Renewal Simplification for Medicaid and Family Health Plus Recipients which can be found on the SDOH website at: http://www.health.state.ny.us/health_care/medicaid/publications/pub2008adm.htm.

Eligibility tests for Medicaid

Category

It is important to figure out which category an applicant falls into because income and resource limits vary by category. There are four categories that are relevant to this inquiry: (1) age; (2) disability; (3) caretaker relative of a child under 21; or (4) single or childless couple. N.Y. Soc. Servs. L. §366(1). After you figure out the applicant's category, determine the household size, the income and its source.

Income

Income is any earned or unearned money entering the household. If the money is earned, Medicaid uses the amount before taxes (gross income) to determine eligibility. If the applicant receives income on a weekly basis, their monthly income is 4.33 multiplied by the weekly salary.

Single and Childless couples.[3]

Single people between the ages of 21 and 64 (who do not have disabilities) cannot earn more than $673 a month to qualify for Medicaid.[4] Childless couples cannot earn more than $840. These income limits are in Section 7 of MAPDR-01, referred as "Medicaid Chart." N.Y. Soc. Servs. L. § 366(2). See Section 7 of the Medicaid chart, found on HRA's website at: http://www.nyc.gov/html/hra/downloads/pdf/income_level.pdf.

Pregnant women living alone are not considered single, they are counted as a household of two. See Section 1 of the Medicaid Chart.

Applicants/recipients are entitled to some disregards when determining income. For example, for working people the first $90 is disregarded from their income. For a complete list of disregards, see MRG at 210 - 217. If you do not have a hard copy, the MRG is on the NYSDOH website: http://www.health.state.ny.us/nysdoh/medicaid/mrg/index.htm.

People With Disabilities, People Over 65, Caretaker Relatives for Children Under 21

These applicants have higher income limits, which are found in Section 3 of the Medicaid Chart. In addition, depending on the source of income, people with disabilities may benefit from disability budgeting rules which disregard significant amounts of earned income. See MRG at pp 174 – 209 for disregards and budgeting methodology.

---

[3] In addition to raising income levels, this year's state budget legislation removed several barriers to accessing Medicaid for single and childless couples. Also removed were drug and alcohol testing requirements and the requirement that an applicant show unmet needs. See 08MA013 - Increase in Medicaid Eligibility Resource Standards; Elimination of Drug/Alcohol Requirement for Medicaid found SDOH's website at: http://www.health.state.ny.us/health_care/medicaid/publications/pub2008gis.htm

[4] Single people who earn less than $867 a month in 2008 may be eligible for Family Health Plus ("FHPlus"), described in the next section of this outline. Childless couples who earn less than $1,167 may also qualify for FHPlus. See also Medicaid Chart, Section 4(b).

Spenddown Program

People in this category who have incomes that are higher than the Section 3 income limits can spend-down their income to qualify for Medicaid. The spend-down program is also called the Excess Income Program. Beneficiaries can participate in the spend-down program by accruing paid or unpaid medical bills to qualify for Medicaid or they can pay Medicaid the difference between their income and the Medicaid income limit to become eligible. For more information on the spend-down program, see Medicaid Spend-down Program in NYS - Training Outline by Valerie Bogart, Selfhelp Community Services, Inc.
http://onlineresources.wnylc.net/healthcare/docs/spendownOUTLINE.pdf.
The Community Services Society's Public Benefit Resource Center also offers a guide for consumers at www.cssny.org/pbrc/consumerbenefits/meip.pdf.

PRACTICE TIP: If an applicant is disabled but does not receive SSI or SSDI, she may apply for Medicaid under the disability related category by requesting that Medicaid certify her as disabled. The applicant must submit the following forms to Medicaid: DSS-486T (Medical Report for Determination of Disability - to be completed by treating physician) and DSS 1151 (Disability Interview - to be completed by the applicant or case worker). These forms are available at:
http://www.wnylc.net/pb/docs/DSS_486-New.pdf
http://www.wnylc.net/pb/docs/DSS_1151-New.pdf
It is the Medicaid eligibility worker's responsibility to observe and note if the applicant is disabled. See NYS DOH Medicaid Disability Manual - Policy 5, http://www.health.state.ny.us/health_care/medicaid/reference/mdm/index.htm#toc.

Working people with disabilities may be eligible for a program called the **Medicaid Buy-In for Working People with Disabilities** (MBI-WPD). This program offers full Medicaid coverage for people with incomes significantly above the traditional Medicaid levels (Individuals are eligible with calculated income of $2167 per month; Couples are eligible with income of $2917 per month in 2008). MBI-WPD applicants benefit from the disability budgeting rules and may actually be eligible with gross incomes of $53,028 for an individual and $71,028 for a couple, considerably higher than those listed in the Medicaid Chart. MBI-WPD applicants benefit from the disability budgeting rules and may actually be eligible with gross incomes that are considerably higher than those listed in the Medicaid Chart. Section 6 of the Medicaid Chart. See MRG at p. 209.1.
For more information on this program see NYS DOH website at:
http://www.health.state.ny.us/health_care/medicaid/program/buy_in/index.htm.

Pregnant Women and Children Under 19

Applicants in this category can earn or live in households with even higher income limits. See Medicaid Chart Section 1. There is **no spend-down** for these expanded income limits.

However, applicants who are above the income limits and need services provided by Medicaid can still spend-down to the regular Medicaid income limits in Section 3 of the Medicaid Chart.

When determining income, pregnant women are always counted as two people. Example: a household with a pregnant woman and two children is counted as a household of four for Medicaid purposes.

Income disregards for caretaker relatives of children under the age of 21 and for children under the age of 21 are found in MRG at 129 - 138 and at 150 - 165.

Resources

Resources are items like bank accounts, IRAs, life insurance policies (that have a cash value), cars, and so forth. See MRG at 250 - 363 for a detailed list of resources and disregards.

How resources are counted may depend on the type of care the applicant requires. Example: The home an applicant lives in (not a second home), is generally not a resource for Medicaid purposes. However, if the applicant's equity in their home is more than $750,000, except in limited circumstances, she will not be eligible for Medicaid coverage for long term care services. See Deficit Reduction Act of 2005 (DRA) – Long-Term Care Medicaid Eligibility Changes, 06 ADM-5
http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/06adm-5.pdf.

Whether documentation of resources is required for applications is dependent on the type of care the applicant needs. Coverage types and documentation requirements are as follows:

- Community Medicaid without long-term care services – attestation of resources
- Medicaid with community based long-term care services– documentation of resources in the month of application
- Institutional and waiver long-term care services – documentation of resources for past 36 months (60 months for trusts). The look back period was increased to 60 months for all resources under the DRA. However, the look back period remains at 36 months until January 2009 when it begins to increase monthly until it reaches 60 months in January 2011. (For more information on the DRA and its effect on long-term care, see Medicaid Provisions in the Deficit Reduction Act of 2005, Valerie Bogart, Selfhelp Community Services, Inc.
  http://onlineresources.wnylc.net/healthcare/docs/OutlineDRA.pdf

See Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources), 04 OMM/ADM-6
http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/04adm-6.pdf.

Single and Childless Couples

As of April 1, 2008, resource limits in Medicaid are the same as the Family Health Plus levels. All single Medicaid and Family Health Plus recipients can now have $13,050 in resources.

Families of two can have $19,200; resource levels increase with each additional family member. See Medicaid Chart, Sections 3, 4(a) and 4(b), 6, and 7(b).

People With Disabilities, People Over 65, Caretaker Relatives for Children Under 21

These people have the same resource limits as other adults, but they can also spend-down their resources to qualify for Medicaid. See Medicaid Chart, Section 3. See also MRG at 340.

Pregnant Women and Children Under 19

No resource limits. See MRG at 305.

Citizenship/Immigration Status

Documentation requirements for citizens. The federal Deficit Reduction Act of 2005, requires states to maintain documentary evidence of **citizenship** and **identity** for applicants and recipients who claim to be citizens. New York implemented these rules on July 1, 2006.

Since NY was one of the few states to require citizenship documentation prior to the enactment of the DRA, the new rules have been somewhat less burdensome here. However, there are some significant changes under the federal rules. The biggest change is that birth certificates cannot be used to document both citizenship and identity – they are now only good for documenting citizenship. Previously NY accepted them as evidence of both. Under the federal rules the only documents that can be used to satisfy both requirements are US passports, Certificates of Naturalization and Certificates of Citizenship. Since many Medicaid applicants/recipients cannot afford to get passports, many will be required to submit two forms of documentation – one proving citizenship and another proving identity. In addition to these documentation changes, eligibility workers must now note in the file that they have seen an original document from the applicant/recipient. A list of documents that can be used to satisfy this requirement can be found in 08 OHIP/INF-1 Citizenship and Identity Documentation Requirements of the Deficit Reduction Act (DRA) of 2005: Final Guidelines found on SDOH's website at: http://www.health.state.ny.us/health_care/medicaid/publications/pub2008inf.htm

Pregnant women, SSI recipients, Medicare recipients and children in foster care are exempt from the documentation requirements for citizens. A pregnant woman, regardless of her immigration status in the U.S., can be fully covered from the time her pregnancy is verified up to the second month after delivery. Recipients of SSI, Medicare and foster care services are exempt because they have already proven their status under those programs. http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/07ma004.pdf.

Everyone else's Medicaid eligibility is subject to the citizenship/immigration test. Regular Medicaid and Family Health Plus coverage in New York State is available to the following immigrant groups. See Aliessa v. Novello, 96 N.Y.2d 418, 730 N.Y.S.2d 1 (2001)(declaring unconstitutional immigration limits in N.Y. Soc. Servs. L. §122); GIS 01 MA/033 (10/2/01); 04 OMM/ADM-7.

- U.S. citizens;
- Qualified aliens (no matter what their date of entry into the U.S.), including:

- Lawful Permanent Residents,5 conditional entrants, persons paroled into US for at least one year, certain battered aliens, their parents and/or children (if batterer is LPR or citizen and not in household)
- Refugees and Asylees (including Cuban/Haitian entrants and Amerasian immigrants)
- Immigrants who have had their deportation withheld
- Qualified aliens who are on active duty in the U.S. armed forces, or honorably discharged veterans, their spouses, widows and dependent children

Persons who are Permanently Residing Under Color of Law (or "PRUCOL" immigrants) – are eligible for Medicaid and Family Health Plus. On August 4, 2008, SDOH issued clarification on establishing eligibility for some PRUCOL applicants. Both formal applications for change of status and some informal applications can establish a non-citizen as PRUCOL. See 08INF-04 - Clarification of PRUCOL Status for the Purposes of Medicaid Eligibility, found on SDOH's website at: http://www.health.state.ny.us/health_care/medicaid/publications/docs/inf/08inf-1.pdf

There are NO immigration status requirements for Medicaid for the treatment of an emergency medical condition, PCAP, or CHPlus B (see their respective sections below).

PRACTICE TIP:

Generally, only non-immigrants (visitors, tourists) and undocumented immigrants are ineligible for Medicaid and Family Health Plus, unless they are under the age of 19, pregnant or seeking emergency treatment. See separate handout on Immigrant Eligibility for Medicaid and Family Health Plus which describe immigrant coverage and Medicaid. (See also, SDOH ADM on immigrant eligibility – 04 OMM/ADM-7 http://www.health.state.ny.us/health_care/medicaid/publications/pub2004adm.htm)

Although most Medicaid offices, public assistance centers and out-stationed Medicaid staff at hospitals and other providers are now familiar with the Aliessa decision and immigrant eligibility, since the enactment of the DRA, some eligibility workers have mistakenly denied or rejected immigrant applicants based on the new documentation requirements for citizens.

State Residence

Applicants must be New York residents, or, while temporarily in the state, require immediate medical care not otherwise available. An out-of-state resident is not eligible if they enter New York solely to obtain medical care. N.Y. Soc. Servs. L. § 366(1)(b); 18 N.Y.C.R.R. § 360-3.2(g),

NYSDOH MRG at 400 - 412. There is no minimum time limit to establish state residency, however applicants must intend to stay in New York.

Emergency Medicaid for Non-Immigrants and Undocumented Immigrants

All non-immigrants and undocumented immigrants who meet the other four eligibility requirements (category, income, resource and state residency test) for Medicaid are eligible for Medicaid to cover treatment for an emergency medical condition (often referred to as Emergency Medicaid). N.Y. Soc. Servs. L. §122. Citizens and lawful immigrants must apply for regular Medicaid; they cannot get Emergency Medicaid.

Emergency Medicaid covers the care and services necessary to treat an emergency medical condition. An emergency medical condition is a condition that, after sudden onset, has acute severe symptoms (including severe pain, labor and delivery) which if left untreated could place the applicant's health in jeopardy. N.Y. Soc. Servs. L. §122(1)(e); 00 OMM/ADM-9 at 3; 04 OMM/ADM-7 at 6.

Emergency Medicaid covers hospital stays, an emergency room visit, lab and other diagnostic tests, medications, and care in a clinic or doctor's office. Emergency Medicaid will not cover organ transplants, transplant services, or people who came to the United States in order to get medical care.

A doctor must certify that the applicant has an emergency medical condition on a form that is submitted with their Medicaid application. These forms are called a DSS-3955 or a MAP 2151. See 04 OMM/ADM-7 pp 31-33
http://www.health.state.ny.us/health_care/medicaid/publications/pub2004adm.htm
and GIS 07MA-0006
http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/07ma006.pdf.
The doctor can certify an applicant for Emergency Medicaid for 60 days at a time. Every six months Emergency Medicaid recipients have to fill out a full application for Emergency Medicaid and re-prove their eligibility.

Emergency Medicaid is only used for people without satisfactory immigration status, like undocumented immigrants and non-immigrants. All other legal immigrants should be provided regular Medicaid since the income and other eligibility requirements are the same for Emergency Medicaid and regular Medicaid. Immigrants here on medical visas may not be eligible for Emergency Medicaid because of the restrictions on these visas and because they are not New York State residents.

Pregnancy and Family Planning

Prenatal Care Assistance Program (PCAP)

PCAP is a Medicaid program for pregnant women who live in New York State. See N.Y. Pub. Health L. §2520 et. seq; see also N.Y. Soc. Servs. L. §365-a(6). All pregnant women, who earn less than 200% of the federal poverty line are eligible for PCAP. See Section 1 of the Medicaid Chart; see also N.Y. Pub. Health L. §2521(3). PCAP pays all prenatal care and up to 60 days of post-natal care. N.Y. Pub. Health L. §2522 (listing benefits). For some women with income below

100% of the FPL, PCAP pays for even non-pregnancy related care. See Section 1 of the Medicaid Chart.

Qualified PCAP health care providers are allowed to determine that a pregnant woman is "presumptively" eligible for PCAP assistance. N.Y. Pub. Health L. §2529. This means that pregnant women can begin to get Medicaid covered health services immediately when they apply for PCAP. A qualified PCAP provider can issue a PCAP/Medicaid "pending letter" so that eligible women can get the health care they need while they wait for their Medicaid card to come in the mail. The local Medicaid agency (HRA/MICSA in New York City) has 30 days to approve a PCAP Medicaid application. 18 N.Y.C.R.R. §360-2.4(a)(4)(I).

A baby born to a PCAP recipient is automatically eligible for Medicaid for the first year of his or her life. N.Y. Soc. Servs. L. §366-g; see also 00 OMM/INF-01.

The Medicaid Family Planning Extension Program (FPEP)

FPEP extends Medicaid family planning benefits to women who lose their Medicaid eligibility after the end of their pregnancy and have no other insurance coverage. FPEP provides women with up to 24 months of coverage for a full range of family planning services. Coverage begins when the beneficiary loses her PCAP/MA (60 days postpartum).

To be eligible, a woman must meet the following criteria:

- Patient was pregnant within past two years.
- Patient had full Medicaid for PCAP when pregnancy ended. It does not matter how the pregnancy ended (live birth, miscarriage, termination).
- Patient lost Medicaid after pregnancy ended and has no other health insurance coverage.
- Women and adolescents, regardless of their immigration status, are eligible.

Documentation required to determine eligibility includes proof of pregnancy and either a Medicaid card, a Medicaid managed care plan card, a Medicaid client identification number (CIN) or a Notice of Discontinuance of Medical Assistance. A PCAP recipient is not automatically transferred into this program, she must apply for FPEP services.

FPEP covers the following services: gynecological care, birth control, emergency contraception, pregnancy testing, STD testing, counseling and treatment, HIV testing and counseling and colonoscopy. Abortion services are not covered. See MRG Medicaid Update February 2005, http://www.health.state.ny.us/health_care/medicaid/reference/mrg/updates4/042-046.1extcont.pdf; see also a description of the program on SDOH's website at: http://www.health.state.ny.us/health_care/medicaid/program/longterm/familyplanbenprog.htm

Medicaid Family Planning Benefit Program (FPBP)

FPBP provides family planning services to men and women who are not otherwise financially eligible for Medicaid. The income limit in 2008 is $1734 for an individual and $2334 for a family of 2. (See Medicaid Chart, Section 5).

The program includes most forms of birth control, emergency contraception, male and female

sterilization, preconception counseling and preventive screening and family planning options before pregnancy. Other services are provided within the context of family planning visits, like physicals, pregnancy testing, STI (including HIV) testing, and cervical cancer screening. Mammograms are not covered. See 02 OMM/ADM-7 Family Planning Benefit Program at http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/02adm-7.pdf See also a description of this program on SDOH's website at: http://www.health.state.ny.us/health_care/medicaid/program/longterm/familyplanbenprog.htm

Transitional Medical Assistance (TMA)

Federal law provides a grace period for receipt of Medicaid benefits, known as transitional medical assistance (TMA), when a parent gets a job or a salary increase that triggers ineligibility for Medicaid. See 42 USC §§ 602(a)(37), 1396r-6. The primary purpose of the TMA program as established by Congress in the 1980s was to ensure that families who find jobs and leave welfare should not have to worry that they or their children will lose health insurance.

TMA is available to families who are cut off of public assistance because of new or increased earnings (or loss of an earnings disregard), and meet the following criteria:

- Eligibility for Medicaid based on the low–income eligibility thresholds for family assistance, for at least thee of the six months preceding the increased earnings;
- Dependent children living with or temporarily absent from the family.

See, SSL § 366(1)(a)(8)-(10)

TMA provides qualified families with full Medicaid services for up to 12 months. See SSL § 366(4)(a)-(b),; 18 NYCRR § 360-3.3(c)(1)-(2); 90 ADM-30; 97 OMM/ADM 97-2. The first six-month period is automatic and has no income limit. The second 6 month period is available only to those with income below 185% of the federal poverty level. An application is required for the second six-month period; quarterly reports of income are also required.

TMA can also be based on increased child support income, but only one four-month extension is available. The family must have received public assistance for three of the six months preceding the increase that triggered ineligibility.

The Second Circuit clarified that TMA must also be made available to recipients whose Medicaid benefits are terminated due to earnings as a result of state legislation lowering eligibility limits for the program. Rabin v. Wilson-Coker, 362 F.3d 190 (2d Cir. 2004). Before the end of TMA, notice must be given with the opportunity to recertify for regular Medicaid.

Ex parte Re-determinations of Eligibility

Federal Medicaid regulations require that states continue to provide Medicaid to eligible recipients until they are found to be ineligible. 42 C.F.R. § 435.930. States are required to include assessments for eligibility for CHPlus B for those recipients under age 19 undergoing a change in eligibility status. 42 C.F.R. §431.636(b)(4).

Federal courts have held that when a recipient is no longer automatically eligible for Medicaid through eligibility for SSI or AFDC, states must make an *ex parte* determination of eligibility for Medicaid via other eligibility pathways, provide notice to recipients of other options, and discontinue Medicaid only after a finding that no other basis for eligibility exists. See, Stenson v. Blum, 467 F.Supp 1331 (SDNY 1979), aff'd wo. opinion, 628 F.2d 1342 (2d Cir. 1980); Massachusetts Ass'n of Older Americans v. Sharp, 700 F.2d 749 (1st Cir. 1983); Crippen v. Kheder, 741 F.2d 102 (6th Cir. 1984).

Consistent with federal law, local districts in New York are required by regulation to continue Medicaid assistance for recipients whose eligibility for Medicaid was linked to receipt of public assistance, SSI or Title IV-E assistance (foster care benefits), until the district determines that no other basis for eligibility is available. 18 N.Y.C.R.R. §360-2.6(b).

Thus, local districts have a duty to perform ex parte re-determinations of eligibility; inform Medicaid recipients undergoing a change of eligibility status of their options for continued coverage, including coverage through CHPlus B and/or the spend down program; and continue coverage until the district makes a determination of ineligibility under any available pathway.
.

Medicaid Managed Care

Most, but not all Medicaid beneficiaries in New York State must now join a Medicaid managed care plan. N.Y. Soc. Servs. L. §364-j. In regular Medicaid beneficiaries can go to any doctor who takes Medicaid. This is called fee-for-service because the doctor or provider gets a fee every time the beneficiary gets a service. In Medicaid managed care, beneficiaries must join a managed care plan and can only see the doctors and other health providers in their plan's network. In addition, they will be assigned a primary care provider and must go to this provider in order to get a referral for specialty care and hospitalizations. In managed care, the plan gets a flat monthly fee to provide for nearly all of the beneficiary's health care needs.

Beneficiaries must keep their regular Medicaid card. They will need it to get prescriptions and other important benefits that are not covered by their Medicaid managed care plan. See 364-j(3)(e).

Medicaid recipients in 42 upstate counties and New York City are generally required to join a managed care plan. In New York City, recipients who receive mandatory enrollment packets from New York Medicaid Choice, Medicaid's enrollment broker, generally must join a plan. If they do not choose a plan within 60 days (90 days for SSI recipients) of receiving a mandatory enrollment packet, they will be randomly assigned into a Medicaid managed care plan.

Once enrolled in a plan, recipients have 90 days to change plans. If they do not switch within 90 days, they are **"locked-in"** the assigned plan and cannot get out for the following 9 months, unless they have good cause to do so. After the lock-in period ends, recipients can change plans for any reason at any time. Enrollees are supposed to receive notice of this right 60 days prior to the end of the lock-in period.

Who Does Not Have to Join a Managed Care Plan?

Two groups of people do not have to join. People who are exempt or excluded. See N.Y. Soc. Servs. L. §364-j(3); NYS DOH Operational Protocol, Chapter 2. (NYSDOH Website: http://www.health.state.ny.us/health_care/managed_care/partner/operatio/)

Exempt

People who can decide if they want to join are exempt from Medicaid managed care. See N.Y. Soc. Servs. L. §364-j(3)(a)-(c), (g).

Excluded

People who cannot join a Medicaid managed care plan are excluded. See N.Y. Soc. Servs. L. §364-j(3)(d), (f).

Who Is Exempt from Medicaid Managed Care?

There are four categories of exemptions from managed care. Some recipients do not have to join managed care plans if they can prove joining will impose **barriers to accessing care**. Recipients in this category must prove one of the following to obtain an exemption:

- a managed care provider is not geographically accessible;
- if pregnant, their provider does not participate with any Medicaid managed care plans;
- they have a chronic medical condition and are being treated by a specialist who does not participate with any Medicaid managed care plans; or
- they cannot be served by a managed care provider due to a language barrier.

See N.Y. Soc. Servs. L. §364-j(2)(b)

The following recipients are statutorily exempt because of the treatment programs they participate in or they are in a special category:

- live in an alcohol/substance abuse program or a facility for the mentally retarded;
- are mentally retarded and get care from an intermediate care facility (or have health needs like a person in a facility);
- have a developmental or physical disability and receives home and community based waiver services (or have health needs like a person receiving these services) ;
- are in the "Care-at-Home" program (or have health needs like a person in that program);
- are Native American; or
- are enrolled in the Medicaid Buy-in Program for Working People with Disabilities (MBI-WPD) and are not required to pay premium.

See N.Y. Soc. Servs. L. §364-j(2)(c).

Recipients who are homeless and living in a shelter and children in foster care are **automatically exempt** if their participation is voluntary in their local district.[6] Finally, some recipients are **exempt until the commissioner of health and, in some instances, the commissioner of**

[6]N.Y. Soc. Servs. L. § 364-j(2)(f). Treatment of children in foster care is not uniform throughout the state. Some counties mandate enrollment in Medicaid managed care while others exclude this population entirely.

mental health determines that the managed care program is ready for them to be mandatorily enrolled.[7] This group includes:

- individuals who are dually eligible for Medicaid and Medicare if they are enrolled in a Medicare managed care plan;
- SSI recipients (this exemption no longer applies in 16 counties and New York City)[8];
- HIV+ recipients; and

adults with serious and persistent mental illness and children with serious emotional disturbances (this exemption no longer applies in 16 counties and New York City)[9].

New mandatory categories – **SSI recipients**, including adults with serious and persistent mental illness (**SPMI**) and children with serious emotional disturbance (**SED**), are no longer exempt from Medicaid managed care.
http://www.health.state.ny.us/health_care/medicaid/program/update/2008/2008-05.htm#upd
The State's Medicaid Director has also recommended mandatory enrollment for **recipients who are HIV + or have AIDS.** http://www.hwupdate.org/update/2008/08/bachrach_speaks.html

Who Is Excluded from Medicaid Managed Care?

Excluded people **cannot** join a Medicaid managed care plan even if they would like to. Beneficiaries are excluded if they:

- are in foster care.
- are in the Medicaid Spend-Down or Excess Income program.
- live in a nursing home or a hospice, or are in a long-term home health care program, state-operated psychiatric facility, or residential treatment facility for children.
- get Medicare and are in a long-term care program.
- are an infant living with a mother in jail.
- will get Medicaid for less than 6 months (for example, they get Emergency Medicaid).
- only use Medicaid for tuberculosis (T.B.) related services.
- are a blind or disabled child and live away from their parents.
- are in Medicaid's Restricted Recipient program.
- have other insurance.
- are an infant who weighs less than or equal to 1200 grams at birth and other infants meeting the SSI-related categories.

[7] N.Y. Soc. Servs. L. § 364-j(2)(g)

[8] For the most up to date list of the counties mandating enrollment of SSI recipients in Medicaid managed care, see SDOH OMC website at: http://www.health.state.ny.us/health_care/managed_care/mmc_counties/

[9] Id.

Enrolling and Disenrolling from Medicaid Managed Care.

Enrolling Voluntarily

Beneficiaries can enroll in a Medicaid managed care plan voluntarily at any time. They can join by calling a community based facilitated enroller, a Medicaid managed care plan directly or by calling **New York Medicaid Choice** at **1-800-505-5678**. This is a private company which has been contracted by many local districts including New York City to help enroll people in managed care. NY Medicaid Choice has response standards it is required to meet. They are required to answer the phone quickly and have operators who speak many languages. In counties that have not contracted with NY Medicaid Choice, recipients are enrolled into managed care plans by the local department of social services.

Disenrolling, transferring and Exemptions

People who would like to disenroll or transfer out of their Medicaid managed care plan, or who think they should be exempt or excluded from Medicaid managed care, should call New York Medicaid Choice at: 1-800-505-5678. New York Medicaid Choice also has a designated telephone number for SSI beneficiaries: 1-800-774-4241; TTY: 1-888-329-1541.

Issues Facing Medicaid Managed Care Enrollees

Loss of Services

Although Medicaid managed care enrollees are entitled to all services they would receive under fee-for-service, many enrollees lose access to medically necessary services upon enrollment. Soc. Servs. Law § 364-j(13)(a). New enrollees have experienced loss of coverage of private duty nursing services, Certified Home Health Agencies services, access to specialists, transportation services and durable medical equipment. The Department of Health is currently drafting transitional policies for managed care plans, which require the plans to maintain existing services until the enrollee receives assistance with plan navigation, disenrollment from the plan and enrollment into a plan that meets their needs or the exemption process.

Accessing Medically Necessary Care

Medicaid managed care, like fee-for-service Medicaid, covers all medically necessary care. Medically necessary care is care that is "…necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap…" See Soc. Servs. Law § 365-a(2); Operational Protocol, Chapter 4; Medicaid Model Contract, Sec 1
http://www.health.state.ny.us/health_care/managed_care/docs/medicaid_managed_care_and_family_health_plus_model_contract.pdf.
Although enrollees are entitled to all the services they received in regular Medicaid, enrollment in Medicaid managed care can impose barriers to accessing services in the form of prior authorization requirements, requirements to exhaust in-network options and utilization review.

Problems with the Exemption Process

Many clients do not discover they are enrolled in a managed care plan until they try to use their regular Medicaid card and it doesn't work because the client has been enrolled in managed care. Because this can be a life threatening occurrence for someone with a disability, the Department

of Health has begun modifying the exemption process. Currently the process often requires multiple forms to be completed by the recipients' providers. Since most recipients don't know which form to ask for, further complicating this process has been the issuance of incorrect forms. In response to complaints, especially on behalf of children, the Department has now authorized New York Medicaid Choice to grant immediate exemptions to children under 18 who seem to meet the criteria. Their parents or guardians have 120 days to submit documentation of their exemption.

The Department of Health is also modifying the exemption application process for those facing mandatory enrollment. SSI recipients will have 120 days to complete the exemption application process. During this time, they will not be mandatorily enrolled. In addition, the Department is working on streamlining the required exemption forms so that multiple submissions will no longer be required.

Access Rights of Medicaid Managed Care Enrollees

Case Management

One of the benefits of Medicaid managed care enrollment is supposed to be case management. The objective of case management is to provide medically necessary quality care and to assure access and continuity of care for a patient. This responsibility includes identification of a health risk, diagnosis of disease, and development of a treatment plan. See Operational Protocol, Definitions and Acronyms.

The provision and execution of case management varies widely from plan to plan. Enrollees often experience case management as utilization review instead of assistance in obtaining medically necessary care. Acknowledging that accessing case management services has been difficult for enrollees, SDOH formed a Case Management Work Group to establish requirements for implementing case management and more uniformity across plans in its delivery.

Right to Specialty Care

In addition to the rights Medicaid managed care recipients have under Medicaid law, they also have rights as managed care enrollees under the Public Health and Insurance Laws. These laws include the right to:

- have their specialist serve as their PCP
- get a standing referral to see their specialist
- go to a non-participating doctor if their managed care plan does not have a specialist in its network who can meet their medical needs
- continue seeing their doctor for up to 90 days (or through delivery if pregnant) if she leaves the plan's network while undergoing a course of treatment.

N.Y. Pub. Health L. § 4403(6)

Disclosure

Managed care plans must tell their patients about the coverage offered, benefit packages, prior authorization rules, how to file grievances and utilization review appeals, reimbursement policies, how to change providers, get referrals, specialty care, any use of formularies and so forth.

Enrollees also have a right to receive written notice of service and payment denials and of their Fair Hearing rights. N.Y. Pub. Health L. § 4408

Problem Solving in Medicaid

Whenever someone is denied Medicaid eligibility or a benefit or service in the Medicaid program, they have the right to request a **Fair Hearing**. See 42 C.F.R. § 431.200 et. seq.; N.Y. Soc. Servs. L. §22. A Fair Hearing is the applicant/beneficiary's chance to tell her side of the story before a State administrative law judge. The City representative (or Medicaid managed care plan representative) will also have a chance to explain why they took the adverse action against the applicant/beneficiary.

Fair Hearing requests should be made immediately whenever someone receives a notice they disagree with (like a Notice of Intent to Discontinue or a denial notice). If a Fair Hearing is requested within 10 days of the issuance date on the Notice of Intent, beneficiaries can continue getting their Medicaid benefit or service until a decision is rendered. This is called **aid continuing**.

Applicants/beneficiaries have only 60 days to request a Fair Hearing to challenge a notice that they disagree with. N.Y. Soc. Servs. L.§22(4). If benefits are terminated or reduced without notice, beneficiaries still have the right to request a fair hearing to challenge the termination or reduction and should request aid continuing. They can also ask for an agency conference. Note: requesting an agency conference does not preserve an individual's Fair Hearing rights or stop the 60 day clock. Applicants/recipients can request both. To get an agency conference, call the Medicaid Conference Unit at 212-630-0994.

Applicants/beneficiaries have the right to get copies of their Medicaid case record. See 18 N.Y.C.R.R. §358-3.7; see also Annunziata v. Blum, 81 Civ. 302 (S.D.N.Y. Apr. 4, 1983). Agencies representing recipients can call the conference unit to see the file (212-630-0995) or ask the caseworker to mail the documents. Evidence packet requests can also be faxed to the Fair Hearing Liaison, Nadine Lopez-Flores at 212-630-9897. Evidence packets must be mailed within a "reasonable time." If a request is made less than 5 days before the hearing, the district does not have to mail copies of the documents, and can instead provide them to the requestor at the hearing.

Family Health Plus

Family Health Plus ("FHPlus") is a Medicaid expansion program for adults. It covers adults without children at 100% of the FPL and adults with children at 150% of the FPL. The eligibility tests are the same as for regular Medicaid with two additional requirements: applicants must be uninsured[10] and they must be between the ages of 19 and 64. See N.Y. Soc. Servs. L. § 369-ee et. seq. When applying, applicants should be informed about whether they are eligible for Medicaid and/or FHPlus. If the applicant is eligible for regular MA she cannot enroll in FHPlus. However, if the applicant is only eligible for MA with a spend-down, she can choose to enroll in

[10] There are some exceptions to this rule. See GIS 08 MA/007 Family Health Plus: Excepted Benefits (http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/08ma007.pdf) for a list of exceptions to this rule.

FHPlus. N.Y. Soc. Servs. L. §369-ee(2)(a)(2); 01 OMM/ADM-6 at 11-12. Applicants with pre-existing conditions can still get FHPlus coverage; the plans must enroll them!

In July 2007, an amendment was passed extending Family Health Plus coverage to low-income workers under the **Family Health Plus Premium Assistance Program**. This amendment allows employers to buy-in to FHPlus to provide health insurance to their workers. Implementation of this program is beginning with members of Union 1199 and will expand to other workers. For more information on this program see the SDOH website at: http://www.health.state.ny.us/nysdoh/fhplus/who_can_join.htm

What Does FHPlus Cover?

All FHPlus enrollees must enroll in a FHPlus managed care plan and most services, including family planning,[11] are provided through the plan. As of October 2008, pharmacy benefits are provided outside of the managed care context; recipients will receive a NY State Benefit card to use at the pharmacy. See GIS 08 MA/021 Family Health Plus: Pharmacy Carve-Out at: http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/08ma021.pdf FHPlus enrollees receive primary, preventive, specialty and inpatient care. FHPlus dental benefits are optional which means the health plans determine whether they will cover dental care (those plans that do get rate adjustments from the Department of Health). For enrollees, this means if they chose a plan that does not cover dental benefits, they have no dental care. There is no fee-for-service coverage for dental services.

Although FHPlus enrollees, like all Medicaid recipients, have a duty to report changes that affect their eligibility, FHPlus enrollees have **guaranteed coverage for their first six months[12] of enrollment**, even if their income goes above the guidelines.

FHPlus will not pay for long-term care services for the chronically ill, like nursing home stays, personal care services, hospice care, intermediate care facilities for developmentally disabled and private duty nursing. FHPlus does cover up to 40 home care visits in lieu of hospitalization. FHPlus also does not cover non-emergency transportation, medical supplies, non-prescription medications (other than diabetic supplies and equipment). See N.Y. Soc. Servs. L. §369-ee(1)(E); 01 OMM/ADM-6 (Attachment VI describes FHPlus benefit package); see also Medicaid Managed Care/Family Health Plus Model Contract, Appendix K, http://www.health.state.ny.us/health_care/managed_care/pdf/mafhpcontr05.pdf.

FHPlus has co-payment requirements for many services. However, although providers can bill, as with Medicaid these services cannot be denied if the enrollee cannot afford to pay the co-pay. See Family Health Plus Program Changes Required by Chapter 58 of the Laws of 2004, Chapters 58 and 63 of the Laws of 2005, 05 OMM/ADM-4 http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/05adm-4.pdf

---

[11] Under Medicaid Managed Care, family planning can be acquired out of the managed care plan's network.

[12] Pursuant to N.Y. Soc. Servs. L. §369-ee(3)(c), the state has requested approval from the federal government to extend guaranteed eligibility from six months to 12 months. To date this request has not been approved.

How to Apply for FHPlus

FHPlus coverage does not begin until the applicant is enrolled in a FHPlus plan. If they have large hospital bills for the three months prior to their enrollment date, they can try to use the Medicaid Excess Income program; if they are eligible, Medicaid will pay for these bills for the three months prior to their enrollment date. In addition, if applicants have bills that they incurred more than 90 days after their date of application (the date the applicant submitted all documentation and signed the application) she can request reimbursement. See GIS 02 MA/033.

Applicants join a FHPlus managed care plan for a 12-month period, with the right to switch plans without cause for the first 90 days. An enrollee may change plans for good cause during the next 9 months. Family members do not have to join the same FHPlus plan.

New Applicants

People can apply for FHPlus at their local Medicaid office, with a community based facilitated enroller, or with a FHPlus managed care plan. The enroller will submit the completed application within 5 days of the signature on the application. The local Medicaid office must make a determination on eligibility within 30 days from the date of the application for households with pregnant women and/or children and 45 days for all others.

Transitioning Households

Public assistance recipients with children under 21 in their household should be offered transitional Medicaid when their work income makes them ineligible to continue to receive public assistance. When their transitional Medicaid is ending, the family should receive a separate redetermination for MA/FHPlus eligibility. A seamless transition should occur from Medicaid to FHPlus for these families. See 01 OMM/ADM-6 at 20-22.

Medicaid/FHPlus for Singles/Childless Couples

Single and childless couples who are deemed ineligible for Safety Net Assistance because of income and/or resources below 100% of poverty will continue to receive Medicaid pending a separate determination. A similar seamless transition should occur from FHPlus to Medicaid for individuals whose earnings dip. See 01 OMM/ADM-6 at 20-22.

Newborns

All babies born to a woman who is enrolled in FHPlus will be provided 1 year's automatic Medicaid coverage. N.Y. Soc. Servs. L. §366(4)(1); 01 OMM/ADM-6 at 15-17. The baby will either be placed in the mother's plan (on Medicaid managed care if her county is a mandatory county), or if her plan does not participate in Medicaid, in the Medicaid managed care plan of her choice. If there is no Medicaid managed care plan in the mother's district, baby will enroll in fee-for-service Medicaid.

Recertification. FHPlus uses an annual mail-in recertification process, not a face-to-face appointment in order to maintain eligibility and enrollment.

Appeals in FHPlus

FHPlus beneficiaries can request Fair Hearings (see Fair Hearing discussion in Medicaid section, above) or seek to resolve their problems through internal plan grievance, N.Y. Pub. Health L. §4408-a, and/or utilization review procedures, N.Y. Pub. Health L. §4900.

Child Health Plus

Child Health Plus (CHPlus) is a health care program for uninsured children under the age of 19. It is broken into two parts, A and B. CHPlus A is the regular Medicaid program for children. This program operates on expanded Medicaid income eligibility levels (see Medicaid Chart at Sections 1 and 2) and there is no resource test. Children enrolling in CHPlus A receive benefits through a Medicaid managed care plan unless they are exempt or excluded. (See, Medicaid Managed Care section, above).

CHPlus B offers health care to children who are above the CHPlus A income levels or who are ineligible for Medicaid because of their immigration status. As with CHPlus A, there is no resource test. However, enrollees in CHPlus B must enroll in a managed care plan. See N.Y. Pub. Health L. § 2511. CHPlus B enrollees cannot be eligible for Medicaid (but if they are only eligible for Medicaid with a spend-down, they can enroll in CHPlus B). Cf. 01 OMM/ADM-6 at 14.

All CHPlus enrollees receive **one year of guaranteed coverage**, even if their income goes above the guidelines. 42 U.S.C. §1396a(e)(12). Enrollees do have a duty to report changes that affect their eligibility. N.Y. Pub. Health L. § 2511(4).

There is **no per service cost sharing** (i.e. no co-pays or co-insurance) in the CHPlus program**.** Although enrollees will not have to pay co-pays or exhaust deductibles, they may have to pay a monthly premium depending on their income level to receive CHPlus B coverage. See Medicaid Chart at Section 2 for a listing of CHPlus B income limits.
Note: On September 1, 2008, eligibility for CHPlus B expanded to 400% of the FPL, the current Medicaid Chart has not been updated to reflect this expansion. See income section below.

Who Is Eligible for CHPlus B?

- **Age**. All enrollees must be under the age of 19.
- **Income**. In general, all children who are not eligible for CHPlus A are eligible for CHPlus B. Families with incomes below 160% of the Federal Poverty Level (FPL) can receive free insurance; families with incomes over that pay on a sliding scale from about $9-$40/month. If the family income is above 400% of the Federal Poverty Level (about $70,000 for a family of 3), they will have to pay full price for the monthly premiums, or about $156/month. See Medicaid Chart Section 2, also see CHPlus ADM#53 and a description of the program on SDOH's website at: http://www.health.state.ny.us/nysdoh/chplus/who_is_eligible.htm
- **No resource/assets test**.
- **Citizenship/Immigration Status**. CHPlus B is available to all children regardless of immigration status.[13]
- **Residency**. All CHPlus enrollees must be New York State residents.
- **Other Health Insurance Coverage**. Children cannot be covered under other health insurance to receive CHPlus B, and cannot be eligible for coverage under the public employees' state health benefits plan. Some children who were covered by employer-

[13] The only children who may not be eligible are those on visitors visas or other short-term visas because they may not be able to show they are New York state residents.

based health insurance within the past six months may be subject to a waiting period before they can be enrolled in Child Health Plus. See http://www.health.state.ny.us/nysdoh/chplus/who_is_eligible.htm

What Does CHPlus B cover?

All applicants/recipients must enroll in a CHPlus B managed care plan and all services, including pharmacy and family planning,[14] are provided through the plan. Enrollees receive primary, preventive, specialty and inpatient care. Unlike CHPlus A, CHPlus B will not cover orthodontia treatment, long-term care services for the chronically ill, like nursing home stays, personal care services, hospice care, intermediate care facilities for developmentally disabled and private duty nursing. CHPlus B also does not cover non-emergency transportation, medical supplies and over-the-counter drugs not prescribed by a doctor.

How to Apply for CHPlus

Applicants for CHPlus A and B can apply by filling out the DOH-4133, Growing Up Healthy application form or the Access New York Health application form. Forms can be obtained from community based organizations that have been designated as facilitated enrollers for the program, participating managed care plans and local Medicaid offices. To find out what managed care plans are available and where to apply, call Child Health Plus B, at 1-800-698-4KIDS or visit the NYSDOH website at: http://www.health.state.ny.us/nysdoh/chplus/where_do_i_apply.htm.

Applicants for CHPlus B are required to provide documentation of the child's age, that they live in New York State and proof of their monthly income.

Presumptive Eligibility. When an application is submitted directly with a health plan, a child is presumptively eligible for benefits for up to 60 days while her application is being processed. Once approved for CHPlus B, eligibility lasts for 12 months.

Recertification Process. CHPlus B beneficiaries must recertify annually. Recertification can be done by mail or by going in person to the managed care plan or community based facilitated enrollment site.

Appeals in CHPlus

CHPlus A beneficiaries have the same appeals rights as beneficiaries of regular Medicaid. If they are in a managed care plan they can request a Fair Hearing or seek to resolve their problems through the CHPlus plan's internal grievance and/or utilization review procedures. Children enrolled in CHPlus B have the same rights as commercial managed care consumers (see Managed Care Patients' Bill of Rights Section, below), but they do not have Fair Hearing rights.

Healthy New York

Healthy NY is a reduced cost health insurance program available to uninsured workers with monthly incomes above the limits for Medicaid and Family Health Plus. See N.Y. Ins. L. § 4326;

[14] This is different than Medicaid Managed Care for CHPlus A beneficiaries, where pharmacy must be, and family planning can be, acquired out of the managed care plan's network.

11 N.Y.C.R.R. § 362-1.1, et seq. The program is offered throughout the state through HMOs. All HMOs are required to offer the same benefit package. However the HMOs are allowed to charge different premiums. Therefore, it is necessary to shop and compare between the different insurers. To find out which HMOs are available in a particular area and their premium rates, call toll free at 1-866-HEALTHY NY (1-866-432-5849) or visit the Healthy New York website at http://www.ins.state.ny.us/website2/hny/english/hny.htm.

Who Is Eligible for Healthy NY?

Working uninsured individuals who meet the following eligibility requirements:

- **Health Insurance**. Employer does not currently provide applicant with health insurance and has not provided group health insurance during the 12-month period preceding application.
- **Medicare**. Applicant must be ineligible for Medicare.
- **Residency**. Applicants must be New York State residents.
- **Employment**. Applicants must be employed on a full-time, part-time or episodic basis.
- **Income**. Gross household income level is at or below 250% of the gross federal poverty level.

What Does Healthy NY Cover?

Healthy NY covers essential health needs including inpatient and outpatient hospital services, physician services, maternity care, preventive health services, diagnostic and x-ray services, emergency services, and a limited prescription benefit. Many services are not covered. The following services are not covered; Mental health services, including treatment and medication for ADHD, depression, and anxiety; alcohol and substance abuse treatment; chiropractic services; hospice care; ambulance; dental care; vision care; durable medical equipment.

Covered services are subject to a co-payment. All care is provided in-network only, except for emergency services or where care is not available through a health care plan's providers. Otherwise, the health care plan's network of providers must be used. Unlike Medicaid, CHPlus A and B, and FHPlus, coverage pursuant to the Healthy NY program is provided subject to a pre-existing condition waiting period. Applicants who have been uninsured for more than 63 days should check with the individual health plans to find out how long the waiting period is for coverage of pre-existing conditions. See N.Y. Ins. L. §§ 4318, 3232.

Co-payments and Deductibles for Covered Services. There is significant cost sharing for enrollees in this program. Covered services are subject to a co-payment at the time services are received. Additionally, for prescription drugs there is an annual deductible. The amounts of the co-payments and deductible are the same for each health plan. The applicable co-payments are *:

- Inpatient hospital services: $500 co-pay.
- Surgical services: 20% or $200 co-pay.
- Outpatient surgical facility: $75 co-pay.
- Emergency services: $50 co-pay, waived if admitted to the hospital.
- Prescription drugs: Maximum benefit of $3,000 per individual per year; $100

deductible per calendar year; generic drugs have a $10 co-pay; brand name drugs have a $20 co-pay plus the difference in cost between the brand name drug and generic equivalent.

- Prenatal services: $10 co-pay
- All other services: $20 co-pay

*There are no co-payments for routine well-child visits and necessary immunizations.

How to Apply for Healthy NY

Applicants for Healthy NY coverage apply directly to a health plan. All HMOs licensed in New York State are required to offer Healthy NY coverage; other insurers may choose to offer it. Application forms are provided by participating insurers. To find out what HMOs are in a particular area and how much the monthly premiums are, go to the Healthy NY website at http://www.ins.state.ny.us/website2/hny/english/hny.htm. In addition to filling out an application, applicants will have to provide documentation of their residence, household income, and employment status.

Resources for the Uninsured

Public Hospitals and Clinics

Public hospitals and community based clinics often provide discounted or free medical care and medication. Many of these providers treat uninsured individuals for free or at a reduced rate, called a sliding fee scale. In New York City, the public hospital system is run by the New York City Health and Hospitals Corporation (HHC). There are HHC facilities throughout the city except Staten Island. http://www.nyc.gov/html/hhc/html/home/home.shtml.

HHC offers a sliding fee scale program for uninsured and underinsured patients called HHC Options. Information on how to access this program and fees charged is available at http://www.nyc.gov/html/hhc/html/access/hhc_options.shtml. The Commission on the Public's Health System published a booklet on HHC Options. It can be found on HHC's website at http://www.nyc.gov/html/hhc/downloads/pdf/hhc-options-01-2008-en.pdf.

Patient Access to Hospital Charity Care Funds

Beginning January 1, 2007, all general hospitals must establish written policies and procedures for the provision of financial assistance to reduce the hospital bills of low income New Yorkers who are uninsured or underinsured.

The new patient financial assistance section in New York's Charity Care law establishes a sliding fee scale rate for all patients living at or below 300% of the federal poverty level. Under this provision hospitals cannot charge more than $150 to patients with incomes at or below the FPL and charges for patients with income up to 300% of the FPL cannot exceed the Medicaid rate for services received. N.Y. Pub. Health L. § 2807-k(9-a).

In addition to limiting charges, the new patient financial assistance law requires the following:

- Hospitals must establish financial assistance policies and procedures which include the above sliding fee scale limits on charges, contain specific application and appeal processes and provide for the training and supervision of staff to implement the policy.
- Hospitals must provide notice of the existence of financial assistance policy and applications through signage upon intake and on bills in language appropriate manner.

- Notice of the hospital's financial assistance policy and applications must be provided in languages spoken during more than 5% of hospital visits or by non-English speaking individuals comprising more than 1% of the population in the hospital's service area.

- Applicants must be provided with a financial assistance application, upon request within 90 days of the date of service or discharge and must be given 20 days to complete the application. Hospitals can require that patients apply for public health insurance as a condition of eligibility for financial assistance.

- Decisions on financial assistance applications must be made within 30 days of the complete application and must notify patients of appeal rights.

- Hospitals may take no action to collect on bills until the financial assistance application is processed in accordance with the hospitals' financial assistance policy.

- Installment payment plans are required and cannot exceed 10% of the patient's gross monthly income. Under special circumstances a patient's assets may be considered, with the exception of a primary residence, retirement plans, college savings accounts and a vehicle.

- Acceleration clauses on installment payment plans are prohibited, and non-emergency care deposits must be made in accordance with the financial assistance policy.

SDOH has posted the requirements of the law and information on hospitals on its website at: http://hospitals.nyhealth.gov/.

Targeted Insurance Programs

Elderly Pharmaceutical Insurance Coverage (EPIC) Program

EPIC is a prescription drug benefit plan for New York residents who are over the age 65. The EPIC program has modest co-pays. A single person must earn less than $35,000 a year to qualify. Couples must earn less than $50,000. To get an application or ask questions about EPIC, call 1-800-332-3742 or visit their website at http://www.health.state.ny.us/nysdoh/epic/faq.htm.

AIDS Drug Assistance Program (ADAP)

ADAP has four programs for uninsured or underinsured persons living with HIV:
New York's regular ADAP program, which provides access to a comprehensive formulary of drugs for uninsured or underinsured persons with HIV infection.

The ADAP Plus program, which covers primary care, including early intervention and ongoing treatment for HIV disease.

The HIV Home Care program, created in 1991 and moved into ADAP in 1993.

The ADAP Plus Insurance Continuation program (APIC), which pays for commercial health insurance premiums for ADAP-eligible clients who have existing private coverage.

To be eligible for ADAP, the household income must be at or below $44,000/year for households of one, $59,200/year for a household of two and $74,400/year for households of three or more. The resource limit for all households is $25,000.

For more information on the services available in these ADAP programs, visit http://www.health.state.ny.us/diseases/aids/resources/adap/index.htm.

Patients' Rights in the Health Care System

Managed Care Bill of Rights

New York State has a fairly progressive managed care bill of rights which is found in both the Public Health and Insurance laws.

Disclosure

Managed care plans must tell their patients about the coverage offered, benefit packages, prior authorization rules, how to file grievances and utilization review appeals, reimbursement policies, how to change providers and get referrals and specialty care, any use of formularies and so forth. See N.Y. Pub. Health L. §4408.

Grievance Procedures

All managed care plans must let enrollees file grievances when they have a problem with their plan or the care they are receiving. N.Y. Pub. Health L. §4408-a. These procedures follow strict time lines. N.Y. Pub. Health L. §4408-a(4). The procedures also provide for appeals. N.Y. Pub. Health L. §4408-a(8)-(1). A plan cannot retaliate against someone if they file a grievance. N.Y. Pub. Health L. §4408-a(13).

Utilization Review Appeals

Whenever a managed care plan denies medical care because it is not medically necessary the enrollee has the right to seek an appeal of that utilization review decision. N.Y. Pub. Health L. §4900(8). This is an internal process. The enrollee has the right to have clinical peer reviewers on contract with the plan review medical denials. N.Y. Pub. Health L. § 4903(1)(a)-(c). There are strict time frames for these appeals. N.Y. Pub. Health L. §§ 4903-4904.

Right to Go to the Emergency Room

Managed care plans must pay for visits to the emergency room if the enrollee felt that they urgently needed the medical care. This is known as the prudent-layperson standard. N.Y. Ins. L. §3216(9).

Right to Specialty Care

Enrollees have the right to go to a non-participating doctor if their managed care plan does not have a specialist in its network that can meet their medical needs. N.Y. Pub. Health L. § 4403(6)(a). Enrollees have the right to get a standing referral to see their specialist. N.Y. Pub. Health L. § 4403(6)(b). They have the right to have their specialist serve as their PCP. N.Y. Pub. Health L. §4403(6)(c). If their doctor leaves the plan's network while they are undergoing a course of treatment, the plan must pay for the enrollee to keep seeing the doctor for up to 90 days (or through delivery if pregnant). N.Y. Pub. Health L. §4403(6)(e)(1).

Right to External Review

Enrollees have the right to get an external review -- or independent review – of their Plan's decision to deny a health care service because it was not medically necessary (i.e., if they lose a utilization review appeal). They can also get an external review when a plan denies an experimental or investigational treatment. An external review appeal is filed with the State Insurance Department. The external review appeal forms can be obtained online at http://www.ins.state.ny.us/extapp/extappqa.htm. The State will ask independent health care professionals, who are not related to the plan, to review the enrollee's case. The plan must comply with the external review decision. N.Y. Pub. Health L. §4910.

Hospital Patients' Bill of Rights

Patients in hospitals, nursing homes and other residential facilities have a bill of rights which govern the way they are to be treated. See N.Y. Pub. Health L. §2903-c. These rights must be posted in the hospital and provided to patients upon admission. 10 N.Y.C.R.R. §405.7(a). These rights include:

Confidentiality

Patients have the right to have confidential conversations with their doctors and privacy in the treatment of their medical records. N.Y. Pub. Health L. §2803(3)(b), (f).

Respect

Patients have the right to receive courteous, fair and respectful care and treatment. N.Y. Pub. Health L. §2803(3)(g).

Freedom From Arbitrary Restraint

Patients have the right not to be restrained either physically or chemically unless a physician orders such restraint for a specific period of time (nurses in some circumstances). N.Y. Pub. Health L. §2803(3)(h).

Interpreters

Patients have the right to have skilled interpreters and persons skilled in communicating with people who have visual and/or hearing impairments assist them in the hospital. 10 N.Y.C.R.R. §405.7(a)(7).

Appropriate Discharge Plan

Patients have the right to receive an appropriate discharge plan and information about how to appeal it. 10 N.Y.C.R.R. §405.7(c)(14).

Medical Records

Patients have the right to get copies of their medical records, although the hospital can charge up to 75 cents per page. N.Y. Pub. Health L. §2803-c(3)(l).

Patients' Right to Receive Health Care Services in a Language They Speak

Federal and State laws bar discrimination based upon race, color, national origin and disability. These laws have been interpreted to require that health care providers must provide patients with health care in the language that they speak. See 42 U.S.C. 2000d; see also 10 N.Y.C.R.R. §405.7(a)(7) (hospital patients' bill of rights, n.b. similar provision exist for clinics and nursing homes).

Most New York State hospitals, clinics and nursing homes must provide limited English proficient patients with:

- free translation services
- written notice in the language they speak that tells them of their right to free translation services
- qualified and trained interpreters

Health care providers should not ask patients to use family and friends to translate except as a last resort and only with their informed consent. A medical provider should not use a patient's minor child to translate. A health provider should limit the use of a phone interpreter.

The New York State Patients' Bill of Rights requires that interpreters must be available for limited-English-proficient patients where the language group composes more than 1% of the hospital's catchment area. 10 N.Y.C.R.R. §405.7(a)(7).

SDOH adopted regulations that became effective September 1, 2006 which establish basic standards for hospitals' communications with limited-English-proficient patients, as well as hearing and vision-impaired New Yorkers.
The new regulations apply to all public and private hospitals in New York State and require that all hospitals:

- Develop a language assistance program that designates a language assistance coordinator responsible for maintaining hospital language assistance services, and training all staff involved in direct patient care on how to access such services on behalf of patients.

- Provide materials to patients summarizing how to access the hospitals' free language assistance services. These forms and notices must be in the languages of the community each hospital serves.

- Interpreter services must be available to patients in the inpatient and outpatient setting within 20 minutes, and to patients in the emergency service within 10 minutes of a request to the hospital administration by the patient.

Hospitals are not permitted to use a patient's family members or friends as interpreters, unless free interpreter services have been explicitly offered by the hospital to the patient and the patient does not agree to use these services. The hospital must assure the appropriateness of any interpreter used in a hospital setting. 10 NYCRR § 405.7 and § 751.9.

Medicaid beneficiaries cannot be required to enroll in a Medicaid managed care plan if the plan cannot serve them due to a language barrier. N.Y. Soc. Servs. L. §364-j(3).

Filing Complaints

If patients are not provided an interpreter at their hospital, medical provider or managed care plan, they can file a complaint with the federal Office of Civil Rights or the New York State Department of Health. The federal Office of Civil Rights is supposed to monitor agencies and health providers (including managed care plans) that receive federal funds. The New York State Department of Health is supposed to monitor all health providers (including managed care plans) in New York State.

To file a complaint with the federal Office of Civil Rights, contact:
Michael Carter
Regional Director
Office of Civil Rights, HHS, Region II
26 Federal Plaza, Room 3312
New York, NY 10278
(212) 264-3313

To file a complaint with the State Department of Health about hospital care, contact:
New York State Department of Health
Centralized Hospital Intake Program
433 River Street, Suite 303
Troy, NY 12180
(800) 804-5447

To file a complaint with the State Department of Health about a managed care plan, contact:
Mark Adler, Director
Office of Managed Care
90 Church Street, 13th Floor
New York, NY 10007
(212) 417-5222
(800) 206-8125

Disability Discrimination

Title II of the Americans with Disabilities Act requires that people with disabilities have equal access to government programs that receive federal funds. 42 U.S.C. § 12131. People with disabilities who have difficulties accessing health care services under Medicaid, Medicaid

managed care, Family Health Plus or Child Health Plus because of their disability can request accommodations from HRA or Local Social Services District, the managed care plans, and New York Medicaid Choice. Complaints can be filed with the same individuals listed above.

Useful Phone Numbers and Websites

STATEWIDE RESOURCES

ADAP (AIDS Drugs Assistance Program): 1-800-542-2437,
http://www.health.state.ny.us/diseases/aids/resources/adap/index.htm

Centers for Medicare and Medicaid Services (Federal agency that administers these programs):
http://www.cms.hhs.gov/default.asp?

Child Health Plus A & B: 1-800-698-4KIDS (1-800-698-4543),
http://www.health.state.ny.us/nysdoh/chplus/index.htm,
http://www.nyc.gov/html/hia/html/places.html
(to find out where you can sign up for CHPlus in NYC)

Empire Justice Center, formerly Greater Upstate Law Project (updates on Medicaid issues in the Legal Services Journal, Medicaid-related postings): http://empirejustice.org/

EPIC: 1-800-332-3742, (Prescription drug program for seniors)
http://www.health.state.ny.us/health_care/epic/index.htm

Family Health Plus Information Line: 1-877-934-7587, (Medicaid program with expanded income eligibility for adults) http://www.health.state.ny.us/nysdoh/fhplus/index.htm

Gay Men's Health Crisis: 212-367-1300 or 800-243-7692 or e-mail to hotline@gmhc.org (hotline), 212-367-1040 (legal services), http://www.gmhc.org/ (assist with services for people who are HIV-affected)

Health Resource Page (information on health access issues and programs throughout NYS hosted by Western NY Law Center): http://www.wnylc.net/onlineresources/health_care.asp

Healthy New York: 1-866-HEALTHY NY (1-866-432-5849),
http://www.ins.state.ny.us/website2/hny/english/hny.htm or
http://www.ins.state.ny.us/website2/hny/spanish/hnys.htm (a limited insurance package for working New Yorkers)

The Legal Aid Society's Health Law Unit Helpline: 212-577-3575 (NYC); 888-500-2455 (Upstate)

Medicare Rights Center: 1-800-333-4114, http://www.medicarerights.org/Index.html (for assistance with Medicare problems)

Neighborhood Legal Services (Medicaid/Medicare & Disability-related postings, Statewide and National Assistive Technology Advocacy Project): http://www.nls.org

New York Medicaid CHOICE : 1-800-505-5678 (Handles Medicaid managed care enrollment, disenrollment, exemptions and exclusions. Also handles complaints about managed care plans)

New York State Department of Health: http://www.health.state.ny.us/

- ADMs, GISs, INFs, http://www.health.state.ny.us/health_care/medicaid/publications/
- Medicaid Reference Guide, http://www.health.state.ny.us/nysdoh/medicaid/mrg/index.htm
- Operational Protocol, http://www.health.state.ny.us/health_care/managed_care/partner/operatio/
- Office Managed Care, http://www.health.state.ny.us/health_care/managed_care/index.htm

New York State Office of the Aging: 212-333-5511, http://www.aging.state.ny.us/
(Help for low-income Medicare beneficiaries - provides information on Medigap Plans, Medicaid's Medicare Savings Plan Program, and the Low-Income Subsidy for Medicare Part D) http://hiicap.state.ny.us/medicare/lowincome.htm

New York State Office of Temporary and Disability Assistance, Office of Administrative Hearings: 518-474-8781 http://www.otda.state.ny.us/oah/default.asp

New York State Medicaid Helpline: 1-800-541-2831 (handles problems and complaints)

Social Security Administration: 1-800-772-1213, (for information on Low-Income Subsidy for Medicare Part D) http://www.ssa.gov/SSA_Home.html

Western New York Law Center (Posts daily updates on public interest law issues; hosts online discussion listserves for advocates; Online Resource Center posts Fair Hearing decisions; ADMs, INFs, GISs): http://www.wnylc.net/web/news/XcNewsPlus.asp

NEW YORK CITY SPECIFIC RESOURCES

Commission on the Public's Health System: 212-246-0803, http://www.cphsnyc.org/
(For questions about services for the uninsured in New York City)

Health Information Tool for Empowerment: http://www.hitesite.org/Default.aspx
(Web-based tool to locate health care services and programs for people who are uninsured or underinsured)

HRA Infoline: 1-877-472-8411 (provides information on all public assistance benefits including Medicaid eligibility and where to apply)

HRA Medicaid Helpline: 1-888-692-6116 (provides information on Medicaid, and FHPlus eligibility)

NYC Managed Care Consumer Assistance Program: 212-614-5400, http://www.mccapny.org/
(for help with managed care and eligibility for public insurance programs)

Office of Citywide Health Insurance Access, http://www.nyc.gov/html/hia/html/home/home.shtml
(Information on public and private health insurance programs including eligibility and enrollment information)

Public Benefits Resource Center: 212-614-5552 http://www.cssny.org/pbrc/index.html