

Access to Health Care Services for Low-Income New Yorkers

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

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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.

Brief descriptions of the outlined sections are below:

- I. **Medicaid** – a joint federal/state/locally run health insurance program for very low-income people.
- II. **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.
- III. **Child Health Plus** – a health insurance program for New York State 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.
- IV. **Healthy New York** – a government subsidized health insurance program for low-income workers who do not receive health insurance through their jobs.
- V. **Options for Uninsured/Underinsured** – Describes access to free and low-cost care and two supplemental insurance programs for under-insured individuals.
- VI. **Patients' Rights in Hospitals and HMOs** – Describes some of the various laws which govern patients' and enrollees' rights to health care in federal and New York State law.

I 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. The remaining 50% is 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 NYC and counties pay 10%. N.Y. Soc. Servs. L. § 368-a. This division has changed to 37.5% State and 12.5% local under the federal managed care waiver, but it is not clear for which recipients.

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.

A. 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 NYC 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.

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

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).

SSI recipients and children in foster care with rare exceptions are automatically eligible for Medicaid and do not have to file separate applications. 18 N.Y.C.R.R. § 360-2.2(b)-(c).

Immediate Needs Medical Assistance. A State Supreme Court has found that under SSL §133, the state must adopt a system for providing temporary pre-investigative medical assistance to meet immediate, not just emergency, needs while an applicant's Medicaid application is pending. *Pastore v. Sabol*, 611 N.Y.S.2d 755, rev'd and dismissed as moot, 646 N.Y.S.2d 708 (2d Dep't 1996). However, since the *Pastore* decision was dismissed on appeal, it has been difficult to enforce this obligation.

Currently, local districts do not appear willing to address pre-investigation medical needs. Some districts will provide "temporary Medicaid cards" after preliminary investigations of eligibility. Others will issue "Medicaid pending" letters, which can be useful with providers.

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-1; N.Y. Soc. Servs. L. §366(1).

Applicants for public assistance, must check the box indicating that they wish to have Medicaid or they will not automatically get it. Although Medicaid was supposedly "delinked" from public assistance, as a practical matter, public assistance recipients who have problems with their Medicaid case must resolve them at their public assistance center.

Medicaid now has a mail-in **renewal/recertification** process. If no changes have occurred, recipients are only required to send in one pay stub with their signed renewal form.

Eligibility tests for Medicaid

1. 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.

2. 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.

- a. **Single and Childless couples.** Single people between the ages of 21 and 64 (who do not have disabilities) cannot earn more than \$352 a month to qualify for Medicaid.¹ Childless couples cannot earn more than \$468. These income limits are in Section 7 of MAPDR-01, referred to as “Medicaid Chart.” N.Y. Soc. Servs. L. § 366(2). Please note that these income limits can be lower if a single person’s rent is below \$215 or a childless couple’s rent is below \$250 a month. See Section 7 of the Medicaid chart, 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 NYSDOH Medicaid Reference Guide (“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>.

- b. **People with disabilities, and/or who are over 65, or are the caretaker relative for children under the age 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.

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/spenddownOUTLINE.pdf>.

The Community Services Society’s Public Benefit Resource Center also offers a guide for consumers at

¹ Single people who earn less than \$851 a month in 2007 may be eligible for Family Health Plus (“FHPlus”), described in the next section of this outline. Childless couples who earn less than \$1,141 may also qualify for FHPlus. See FHPlus section later in this outline.

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 income of \$2128 per month; Couples are eligible with income of \$2853 per month in 2007). 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 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.

- c. **Pregnant Women and Children Under Age 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 income limits at Section 3.

When determining income, remember 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.

3. Resources

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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 home equity 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 – Long-Term Care Medicaid Eligibility Changes, 06 ADM-5 http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/06adm-5.pdf

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

Community Medicaid without long-term care services – attestation

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 now and the look back period for all resources begins to increase to new 60 month look back in January 2009)

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

- a. **Single and Childless couples.** Single people between the ages of 21 and 60 (who do not have disabilities) cannot have more than \$2000 in resources. Folks who are over 60 can have up to \$3000 in resources. See Medicaid Chart, Section 7(b). Applicants with resources above these limits should consider applying for FHPPlus which has higher resource limits. See Medicaid Chart, Section 4.
- b. **People with Disabilities, and/or who are over 65, or are the caretaker relative for children under the age 21.** These people have higher resource limits. See Medicaid Chart, Section 3. They can also spend-down their resources to qualify for Medicaid.
- c. **Pregnant Women and Children Under Age 19.** No resource limits. See MRG at 305.

4. Citizenship/Immigration Status

New documentation requirements for citizens. The federal Deficit Reduction Act of

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2005, requires states to maintain documentary evidence of **citizenship** and **identity** for applicants and recipients who claim to be citizens. New York implemented these new 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. A list of documents that can be used to satisfy this requirement can be found in GIS 06/MA021, Attachment http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/06ma021att.pdf.

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. This change could present significant burdens on the local districts during recertification of recipients.

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 NYS 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.

- a. U.S. citizens;
- b. Qualified aliens (no matter what their date of entry into the U.S.), including:
 - Lawful Permanent Residents,² 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

² N.B.: NYS gets federal financial participation for individuals who entered prior to August 22, 1996, but must provide Medicaid (100% state funded) to all legal immigrants.

- a qualified alien who is on active duty in the U.S. armed forces, or honorably discharged veterans, their spouses, widows and dependent children
- c. Persons who are Permanently Residing Under Color of Law (or “PRUCOL” immigrants) – are eligible for Medicaid and Family Health Plus.

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 TIPS:

1. 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 - <http://www.wnyc.net/onlineresources/pb/showquestion.asp?faq=64&fldAuto=1650>)
2. Proving citizenship or legal immigration status can be difficult for elderly people born in the South or rural areas, or who immigrated decades ago. See 00 OMM/ADM-9 (<http://www.wnyc.net/pb/showquestion.asp?faq=4&fldAuto=181>) While the ADM pre-dates the Aliessa decision and is incorrect about lawful immigrants’ eligibility for Medicaid, the attachments have good ideas for primary and secondary verification.

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. Because these requirements are often short-handed as “Citizenship documentation”, workers incorrectly believe that now only citizens are eligible.

5. 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.

B. 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/pub2007gis.htm. 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 able to get Emergency Medicaid because of the restrictions on these visas and because they are not New York State residents.

C. Prenatal Care Assistance Program

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 the Medicaid-funded Prenatal Care Assistance Program or “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 who earn less than 100% of poverty, 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
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“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)** 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:

1. Patient was pregnant within past two years.
2. Patient had full Medicaid for PCAP when pregnancy ended. It does not matter how the pregnancy ended (live birth, miscarriage, termination).
3. Patient lost Medicaid after pregnancy ended and has no other health insurance coverage.
4. 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 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.

D. 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:

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1. Eligibility for Medicaid based on the low-income eligibility thresholds for family assistance, see, SSL § 366(1)(a)(8)-(10), for at least three of the six months preceding the increased earnings or child support that triggered ineligibility;

2. Dependent children living with or temporarily absent from the family.

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.

E. 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.

F. Dual Eligibles

Dual eligibles are beneficiaries who have both Medicaid and Medicare. Generally seniors over the age of 65 and people who have been determined eligible for SSDI for more than two years are eligible for Medicare. Medicare now has 4 parts. Part A covers hospitalization and some long term care and certified home health attendant services. Part B covers physician visits, durable medical equipment, lab work, etc. Part D is prescription drug coverage. Part C offers Parts A, B and D along with some additional benefits not generally covered by Medicare through managed care organizations, generally known as “Medicare Advantage Plans”.

For services covered by Medicare it is the primary payer and Medicaid provides secondary coverage for any cost-sharing (e.g. deductibles and co pays). For non-Medicare covered services, Medicaid provides complete coverage. For many duals Medicaid also covers Part B premiums. The most common services dual eligibles rely on Medicaid to cover are personal care services.

Prior to January 1, 2006, Medicare did not offer prescription drug coverage, this service was paid for by Medicaid for duals. The Medicare Prescription Drug Improvement and Modernization Act (MMA) established Medicare Part D which provides prescription drug coverage for all Medicare beneficiaries including duals. Soc. Sec. Act § 1860D-1, *et seq.*, 42 U.S.C. § 1395w-101, *et seq.* Part D has had a major impact on the way dual eligibles receive their prescriptions. Under Medicaid, duals were able to go to any pharmacy that accepted Medicaid to have their prescriptions filled. They also had the right to receive their prescriptions even if they could not afford to pay their co pay. Most importantly, duals received prescriptions based on their doctor’s diagnosis and opinion that they were medically necessary to treat their condition.

Under Part D, duals are randomly assigned to one of 13 prescription drug plans (PDP) in NYS. PDPs are supposed to cover all medically necessary prescriptions, however they are not required to have all prescriptions on their formularies and some drugs have been excluded from Medicare’s coverage. For a list of the excluded drugs and whether they are covered by Medicaid, see NYFAHC’s RX tip sheet at http://onlineresources.wnyc.net/healthcare/docs/NYFAHC_Fact_Sheet.pdf.

PDPs have different formularies, different rules about prior authorization and different pharmacy networks. It is up to duals to decide whether their prescription drug needs are met by the plan they have been assigned to and to change to a more appropriate plan if they are not.

Since many drugs prescribed to duals are not be covered by the PDPs’ formularies, NYS provided wrap-around coverage to fill in the gaps. However, because prescription drugs are now supposed to be covered by Medicare, New York does not receive any federal financial participation for providing this extra coverage. As a result, the full wrap expired on January 1, 2007. NYS now offers very limited wrap around for duals for prescriptions in four drug classes – 1) Atypical antipsychotics; 2) Antidepressants; 3) Antiretrovirals used in the treatment of HIV/AIDs; and 4) Anti-rejection drugs used in the treatment of tissue and organ transplants.

For the most recent information on Part D coverage for duals in NYS, see the Western NY Law Center’s Health Resource Page, http://onlineresources.wnyc.net/healthcare/part_D.asp.

Updated April 16, 2007

G. 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 their Medicaid card. 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 health 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 23 upstate counties and New York City are generally required to join a managed care plan. In NYC, 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 recipients in receipt of SSI) of receiving a mandatory enrollment packet, they will be randomly auto-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 can not 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.

All New York State Medicaid applicants and recipients, **including SSI recipients**, must join Medicaid Managed Care plans unless the beneficiary is exempt or excluded.

1. 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).

a. Who Is Exempt from Medicaid Managed Care?

Beneficiaries are statutorily exempt from Medicaid Managed Care if they:

- are homeless.
- 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 are in a special treatment program.
- are in the “Care-at-Home” program (or have health needs like a person in that program).
- are Native American.
- are enrolled in the Medicaid Buy-In Program for Working People with Disabilities (MBI-WPD) and are not required to pay a premium.

Beneficiaries are also exempt from Medicaid Managed Care if they can **prove** joining will impose barriers to accessing care:

- have a chronic medical condition or have a major operation scheduled and get care from a specialist doctor who is not in any Medicaid Managed Care Plans (they should ask their doctor to fill out an Exemption Form).
- managed care provider is not geographically accessible i.e., recipient has to travel more than 30 minutes to get to a doctor in a Plan.
- are pregnant and get care for their pregnancy from a doctor who is not in a Plan. This exemption only lasts for 60 days after their baby is born.
- cannot get a doctor in a Plan who speaks their language.
- are temporarily living outside of New York City.
- have a *good cause* for not wanting to enroll.

Others recipients are exempt until the commissioner of health determines that the managed care program is ready for them to be mandatorily enrolled. This group includes recipients who:

- receive both Medicaid and Medicare. Dual eligibles are only allowed to join Medicaid Advantage plans which is a health plan with coordinated Medicaid and Medicare services.
- are HIV + or have AIDS or have End Stage Renal Disease (they should ask their doctor to fill out an Exemption Form).

New mandatory categories – SSI recipients including adults with Serious and Persistent Mental Illness and children with Serious Emotional Disturbance, are no longer exempt from Medicaid managed care!

SSI recipients including, adults with serious and persistent mental illness and children with serious emotional disturbance have an extended time period – 90 days – to join a plan. If they do not join a plan or request an exemption during the 90 enrollment period, they will be randomly auto-assigned to a managed care plan.

b. Who Is Excluded or Cannot Join a Medicaid Managed Care Plan?

Excluded people cannot join a Managed Care Plan even if they would like to. Beneficiaries are excluded and **cannot** join a Medicaid Managed Care Plan if they:

- are in fostercare.
- are in the Medicaid “Spend-Down” or “Excess Income” program.
- live in a nursing home or a hospice, or 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.

3. 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 (Maximus) at 1-800-505-5678**. This is a private company which has been contracted by the New York State Department of Health to help enroll people. 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.
- 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 number for SSI beneficiaries: 1-800-774-4241; TTY: 1-888-329-1541.

4. Issues Facing Medicaid Managed Care Enrollees

A. 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). Loss of coverage has been especially problematic for enrollees who receive services from Certified Home Health Agencies. 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.

B. 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.

Access Rights of Medicaid Managed Care Enrollees

A. 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.

B. 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 that 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 they are undergoing a course of treatment.

N.Y. Pub. Health L. § 4403(6)

C. 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

I. 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 only have 60 days to request a Fair Hearing to challenge a notice that they disagree with. N.Y. Soc. Servs. L. §22(4).

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: 212-630-0996.

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). 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 212-643-3697. The pertinent regulation was amended in November 1997, eliminating the requirement that the agency mail the documents within 3 business days of a request. Now, they must mail them in a "reasonable time." If a request is made less than 5 days before the hearing, they do not have to mail copies of the documents, and can instead provide them to the requestor at the hearing.

II. FAMILY HEALTH PLUS

Family Health Plus ("FHPlus") is a Medicaid expansion program for adults. It covers

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adults without children at 100% of the FPL and adults with children at 150% of the FPL. FHPlus also has resource levels that are three times the Medicaid resource levels. See Section 4 of the Medicaid Chart. The eligibility tests are the same as for regular Medicaid with two additional requirements: applicants must be uninsured 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 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!

A. What Does FHPlus cover?

All FHPlus enrollees must enroll in a FHPlus managed care plan and all services, including pharmacy and family planning,³ are provided through the plan. FHPlus enrollees receive primary, preventive, specialty and inpatient care. The FHPlus plan gets to determine if it will cover dental care (those plans that do get rate adjustments from the Department of Health).

FHPlus Enrollees have their **first 6 month's of coverage guaranteed**, even if their income goes above the guidelines (enrollees have a duty to report if their circumstances change). In September 2005, the FHPlus program implemented cost sharing. See 05 OMM/ADM-4 Attachment II, http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/05adm-4att2.pdf. However, as with regular Medicaid and Medicaid Managed Care, if a beneficiary cannot pay her co-pay, the provider cannot deny services. See 05 OMM/ADM-4 at 4.

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, like 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

³ Under Medicaid Managed Care, pharmacy must be and family planning can be acquired out of the managed care plan's network.

B. 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 eligible to 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 her 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.

1. **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 for households with pregnant women and/or children** and **45 days for all others from the date of the application**.
2. **Transitioning households.**
 - A. Public assistance recipients with children under 21 in their household should be offered transitional Medicaid when their work income makes them ineligible for PA. 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.
 - B. **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.
 - C. **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 mom’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 the mom’s choice. If there is no Medicaid Managed Care Plan in mom’s district, baby will enroll in fee-for-service Medicaid.
3. **Recertification.** FHPlus uses an annual mail-in recertification process, not a face-to-face appointment in order to maintain eligibility and enrollment.

C. 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.

III. 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 Section 1-2) and there is no resource test. Children enrolling in CHPlus A (Medicaid Chart at Section 1) receive benefits through a Medicaid managed care plan unless they are exempt or excluded. (See Section H, Medicaid Managed Care 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. Like 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 MA with a spend-down, they can enroll in CHPlus B). Cf. 01 OMM/ADM-6 at 14.

CHPlus A Enrollees get **one year of guaranteed coverage**, even if their income goes above the guidelines. 42 U.S.C. §1396a(e)(12). CHPlus B enrollees, however, have a duty to report if their circumstances change.

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.

A. Who is Eligible for CHPlus B?

1. **Age.** All enrollees must be under the age of 19.
2. **Income.** All children who are not eligible for CHPlus A are eligible for CHPlus B. However, if their income is above a certain level, they may have to pay a monthly premium. See Medicaid Chart Section 2.
4. **No resource/assets test.**
5. **Citizenship/Immigration Status.** CHPlus B is available to all children regardless of immigration status.

6. **Residency.** All CHPlus enrollees must be New York State Residents.

B. 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,⁴ 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.

C. 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.

D. 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.

⁴ 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.

IV. HEALTHY NEW YORK

Healthy NY is a reduced cost health insurance program available to uninsured workers whose monthly income is above the limits for Medicaid and Family Health Plus. See N.Y. Ins. L. § 4326; 11 N.Y.C.R.R. § 362-1.1, et seq. The program is offered throughout the state through HMOs. HMOs are required to offer the same benefit package without any additions or subtractions. 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>.

A. Who is Eligible for Healthy NY?

Working uninsured individuals who meet the following eligibility requirements:

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

B. 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 coverage; 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.

D. 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/hnyhmo.htm>. In addition to filling out an application, applicants will have to provide documentation of their residence, household income, and employment status.

V. RESOURCES FOR THE UNINSURED

A. 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/community/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-book-05.pdf>.

B. 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 FPL. 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 hospital's financial assistance policy.
- Installment payment plans are required and can not 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-emergent care deposits must be made in accordance with the financial assistance policy.

C. 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 separate programs for uninsured or under-insured persons living with HIV:

- New York's regular ADAP program, which provides access to a comprehensive formulary of drugs for uninsured or under-insured 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>.

VI. PATIENTS' RIGHTS IN THE HEALTH CARE SYSTEM

A. 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.

1. **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. See N.Y. Pub. Health L. §4408.
2. **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).
3. **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 that they disagree with. N.Y. Pub. Health L. § 4903(1)(a)- (c)). There are strict time frames for these appeals. N.Y. Pub. Health L. §§ 4903-4904.
4. **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).
5. **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).
6. **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. <http://www.ins.state.ny.us/extappqa.htm> The State will ask independent health care professionals, who are not related to the Plan, to review the enrollees case. The Plan must comply with the external review decision. N.Y. Pub. Health L. §4910.

B. 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:

1. **Confidentiality.** For example, 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).
2. **Respect.** Patients have the right to receive courteous, fair and respectful care and treatment. N.Y. Pub. Health L. §2803(3)(g).
3. **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).
4. **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).
5. **Appropriate Discharge Plan.** Patients have the right to receive an appropriate discharge plan and information about how to appeal said discharge. 10 N.Y.C.R.R. §405.7(c)(14).
6. **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).

C. Patient's Right to Get Health Care 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:

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- free translation services
- written notice in the language they speak which 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 one percent of the hospital's catchment area. 10 N.Y.C.R.R. §405.7(a)(7).

New regulations effective September 1, 2006: New York State Department of Health (NYSDOH) adopted regulations setting 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 which 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: <http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm>

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).

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) who 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
New York, NY 10278
(212) 264-3313

To file a complaint with the State Department of Health about a hospital, contact:

New York State Department of Health
Hospital Complaint Section
Local Area Office/New York City
5 Penn Plaza
New York, NY 10001-1803
(212) 268-6477

To file a complaint with the State DOH about a managed care plan, contact:

Kathleen Shure, Director
Office of Managed Care
New York State Department of Health
Local Area Office/New York City
5 Penn Plaza
New York, NY 10001-1803
(212) 268-5977
(800) 206-8125

Disability Discrimination. People with disabilities who feel that they are being discriminated against by a health care provider should file a complaint, pursuant to Title II of the Americans with Disabilities Act, with the same individuals listed above. 42 U.S.C. § 12131.

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)

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Managed Care Consumer Assistance Program: 212-614-5400, <http://www.mccapny.org/> (for help with managed care questions)

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:

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)

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)

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>