

## **2. ELIGIBLE POPULATIONS**

This chapter provides a complete description of The Partnership Plan populations eligible for participation on a voluntary or mandatory basis and those populations excluded from participation. The chapter is organized in the following sections:

- Mandatory Populations
- Voluntary (Exempt) Populations
- Excluded Populations
- Local District Optional Populations
- Medicaid Eligibility Quality Control (MEQC)

### **Overview**

The Partnership Plan encompasses most of the non-elderly, non-institutionalized Medicaid population in the State, as well as the expanded Title XIX population who were previously eligible for state-only medical assistance through the Home Relief (now Safety Net) program.

### **Mandatory Populations**

The following populations are required to enroll in an MCO on a mandatory basis unless they are eligible for an exemption or an exclusion, as described in the remaining sections of this chapter:

- Singles/Childless couples - cash and Medicaid only
- Low income families with children - cash and Medicaid only
- Aid to Families with Dependent Children (AFDC) - Medicaid only
- Pregnant women whose net available income is at or below 200 percent of the federal poverty level for the applicable household size
- Effective 4/1/02, children aged one (1) year or below whose family's net available income is at or below 200 percent of the federal poverty level for the applicable household size.
- Children between ages one (1) and five (5) whose family's net available income is at or below 133 percent of the federal poverty level for the applicable household size.
- Effective 4/1/02, children aged six (6) up to nineteen (19) whose family's net available income is less than or equal to 133 percent of the federal poverty level for the applicable household size. Effective 4/01/05, children ages 6-18 with family incomes between 100% and 133% FPL are no longer Medicaid (CHPlus A) eligible. Such recipients must be moved to CHPlus B at Recertification. These children must be screened for disability (SSI-related eligibility) when appropriate.
- Transitional Medical Assistance beneficiaries
- Supplemental Security Income (Cash) and Supplemental Security Income Related (Medicaid Only).

## **Voluntary (Exempt) Populations**

While the majority of the Title XIX populations are ultimately enrolled in managed care under The Partnership Plan, there are a number of population groups that are eligible for an exemption from mandatory enrollment in a mainstream MCO. (Information on the exemption criteria and process are included in the enrollment materials sent to all potential eligibles. SDOH has produced a pamphlet that includes this information.) Individuals who fall into one of the following categories are enrolled in MCOs only on a voluntary basis:

1. Individuals who are HIV+ or who have AIDS except in areas where program features are in place to mandatorily enroll this population. HIV Special Needs Plans have been established in certain areas of the State, and individuals with HIV disease may enroll in a managed care arrangement (either mainstream MCOs or SNPs where accessible).
2. Individuals who are diagnosed seriously and persistently mentally ill or seriously emotionally disturbed except those individuals whose behavioral health benefits are provided through the Medicaid fee-for-service program. This exemption does not apply to recipients with SSI or who are certified as aged, blind and/or disabled.
3. Individuals for whom a Medicaid Managed Care Provider is not geographically accessible so as to reasonably provide services. To qualify for this exemption, an individual must demonstrate that no participating MCO has a provider located within thirty minutes(30)/thirty(30)miles travel time from the individual's home who is accepting new patients, and that there is a fee-for-service Medicaid provider available within the thirty minutes/thirty miles travel time.
4. Pregnant women who are already receiving prenatal care from a provider authorized to provide such care not participating in any managed care plan that is in the Partnership Plan in the service area (note: this status will last through a woman's pregnancy and sixty (60) days post partum and will end on the last day of the month in which the 60th day occurs; after that time, she will be enrolled mandatorily into an MCO if she belongs to one of the mandatory aid categories).
5. Individuals with a chronic medical condition who, for at least six months, have been under active treatment with a non-participating specialist physician who is not a network provider for any MCO participating in the Medicaid managed care program service area. This status will last as long as the individual's chronic medical condition exists or until the physician joins a participating MCO network. Upon the request of an LDSS, the Division of Managed Care (DMC) in consultation with the Office of Health Insurance Programs (OHIP) Medical Director, will review cases of individuals with unusually severe chronic care needs for a possible exemption from mandatory enrollment in managed care if such individuals are not otherwise eligible for an exemption (i.e., meet one of the nineteen criteria listed here). The OHIP

Medical Director may also authorize a plan disenrollment for such individuals. Disenrollment requests should be made in a manner consistent with the overall disenrollment request process for “good cause” disenrollment.

6. Individuals with end stage renal disease (ESRD).
7. Individuals who are residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MR).
8. Individuals with characteristics and needs similar to those who are residents of ICF/MRs based on criteria cooperatively established by the State Office of Mental Retardation and Developmental Disabilities (OMRDD) and the SDOH.
9. Individuals already scheduled for a major surgical procedure (within thirty (30) days of scheduled enrollment) with a provider who is not a participant in the network of a Medicaid MCO under contract with the LDSS. This exemption will only apply until such time as the individual’s course of treatment is complete.
10. Individuals with a developmental or physical disability who receive services through a Medicaid Home-and-Community-Based Services waiver or Medicaid Model Waiver (care-at-home) through a Section 1915c waiver, or individuals having characteristics and needs similar to such individuals (including individuals on the waiting list), based on criteria cooperatively established by OMRDD and DOH.
11. Individuals who are residents of Alcohol and Substance Abuse or Chemical Dependence Long Term Residential treatment programs.
12. Medicare/Medicaid dually eligible individuals who enroll in a Medicare Advantage plan may also enroll in the same plan’s Medicaid Advantage product (these persons may **only** join a qualified Medicaid Advantage Plan). These and other individuals with Medicare are precluded from enrolling in any mainstream Medicaid managed care plan.
13. In New York City, all homeless individuals are exempt. In areas outside of NYC, exemption of homeless individuals residing in the shelter system is at the discretion of the local district (see below, section Local District Optional Populations, for more information).
14. Native Americans.
15. Individuals who cannot be served by a managed care provider due to a language barrier which exists when the individual is not capable of effectively communicating his or her medical needs in English or in a secondary language for which PCPs are available within the managed care program. Individuals with a language barrier will be deemed able to be served if they have a choice, within time and distance standards, of three PCPs who are able to communicate in the primary language of the eligible

individual or who have a person on his/her staff capable of translating medical terminology. Individuals will be eligible for an exemption when:

(i) The individual has a relationship with a Medicaid fee-for-service primary care provider who:

- (a) has the language capability to serve the individual;
- (b) does not participate in any of the Medicaid managed care plans contracted for a service area which includes the eligible individual's residence;
- (c) is located within a thirty (30) minute/thirty (30) mile radius of the eligible individual's residence;

**AND**

(d) there are fewer than three (3) participating PCPs available within or outside the thirty (30) minute/thirty (30) mile radius who are able to communicate in the primary language of the eligible individual or who have a person on his/her staff capable of translating medical terminology.

**OR**

(ii) The individual has a relationship with a Medicaid fee-for-service primary care provider who:

- (a) has the language capability to serve the individual;
- (b) does not participate in any of the Medicaid managed care plans contracted for a service area which includes the individual's residence;
- (c) is located outside a thirty (30) minute/thirty (30) mile radius of the eligible individual's residence;

**AND**

(d) there are fewer than three (3) participating PCPs available within or outside the thirty (30) minute/thirty (30) mile radius who are able to communicate in the primary language of the eligible individual or who have a person on his/her staff capable of translating medical terminology.

16. Individuals temporarily residing out of district, (e.g., college students) will be exempt until the last day of the month in which the purpose of the absence is accomplished. The definition of temporary absence is set forth in Social Services regulations at Title 18 Section 360-1.4(p).

17. *Non-institutionalized SSI and MA-SSI not in receipt of Medicare until program features are in place, and then exemption status is eliminated.*

18. Individuals with a County of Fiscal Responsibility code of 98 (OMRDD in MMIS) are exempt in counties where program features are approved by the State and operational at the local district level to permit these individuals to voluntarily enroll in Medicaid managed care.
19. Effective July 1, 2003, individuals who are eligible for Medical Assistance pursuant to the “Medicaid buy-in for the working disabled” (subparagraphs twelve or thirteen of paragraph (1) of subdivision one of Section 366 of the Social Services Law), and who, pursuant to subdivision 12 of Section 367a of the Social Services Law, are not required to pay a premium.

Determination of an individual’s eligibility for exemption will be conducted by the local districts upon the request of the individual or his/her designee. Local districts (or the enrollment and benefits counselor) follow state guidelines in determining eligibility for exemption. When exemption status is unclear, the District may request assistance from the SDOH DMCPE.

Individuals who become eligible for exemption due to a change in eligibility status after they have enrolled in managed care may apply for exemption and be disenrolled within 30-60 days, depending on roster pull-down dates. All managed care enrollees receive information on the exemption criteria and process in the enrollment education process.

### **Excluded Populations**

The following population groups are not eligible for enrollment in Medicaid Managed Care<sup>1</sup>:

1. Individuals who become eligible for Medicaid only after spending down a portion of their income.
2. Individuals who are residents of State-operated psychiatric facilities or residents of State-certified or voluntary treatment facilities for children and youth.
3. Individuals who are residents of residential health care facilities (RHCF) at the time of enrollment and enrollees whose stay in an RHCF is classified as permanent upon entry into the RHCF or is classified as permanent at a time subsequent to entry.
4. Individuals enrolled in managed long term care demonstration programs authorized under Article 4403-f of the Public Health Law.
5. Medicaid eligible infants living with incarcerated mothers.

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<sup>1</sup> Dually eligible individuals are ineligible for enrollment in a mainstream Medicaid managed care plan. If eligible, they may only enroll in a qualified Medicaid Advantage Plan on a voluntary basis. (See #12 under exemptions.)

6. Infants weighing less than 1200 grams at birth and other infants under six months of age who meet the criteria for SSI or the SSI related category (shall not be enrolled or shall be disenrolled retroactive to date of birth).
7. Individuals with access to comprehensive private health care coverage including those already enrolled in an MCO. Such health care coverage, purchased either partially or in full by or on behalf of the individual, must be determined to be cost effective by the local social services district.
8. Foster children in the placement of a voluntary agency.
9. Youth in the care and custody of the Commissioner of the Office of Children and Family Services.
10. Certified blind or disabled children living or expected to be living separate and apart from the parent for thirty (30) days or more.
11. Individuals expected to be eligible for Medicaid for less than six (6) months, except for pregnant women (e.g., seasonal agricultural workers).
12. Foster children in direct care (unless LDSS opts to enroll them) (see below, section Local District Optional Populations, for more information).
13. Individuals in receipt of long-term care services through Long Term Home Health Care programs or Child Care Facilities (except ICF services for the Developmentally Disabled).
14. Individuals eligible for medical assistance benefits only with respect to tuberculosis-related services.
15. Individuals placed in State Office of Mental Health licensed family care homes pursuant to the New York State Mental Hygiene Law, Section 31.03.
16. Individuals enrolled in the Restricted Recipient Program.
17. Individuals who have a “County of Fiscal Responsibility” code of 99 in MMIS.
18. Individuals admitted to a Hospice program prior to the time of enrollment (if an enrollee enters a Hospice program while enrolled in an MCO, they may remain enrolled in the MCO to maintain continuity of care with the enrollee’s PCP). Hospice services are accessed through the fee-for-service Medicaid program.
19. Individuals with a “County of Fiscal Responsibility” code of 97 (OMH in MMIS).
20. Individuals with a “County of Fiscal Responsibility” code of 98 (OMRDD in MMIS) will be excluded until program features are approved by the State and operational at

the local district level to permit these individuals to voluntarily enroll in Medicaid managed care.

21. Individuals eligible for Medicaid pursuant to Title 11-D of the Social Services Law (Family Health Plus) are not eligible for enrollment in Medicaid managed care under the Partnership Plan.
22. Effective July 1, 2003, individuals who are eligible for Medical Assistance pursuant to the “Medicaid buy-in for the working disabled” (subparagraphs twelve or thirteen of paragraph (a) of subdivision one of Section 366 of the Social Services Law), and who, pursuant to subdivision 12 of Section 367-a of the Social Services Law, are required to pay a premium.
23. Effective October 1, 2002, individuals who are eligible for Medical Assistance pursuant to paragraph (v) of subdivision four of Section 366 of the Social Services Law (persons who are under 65 years of age, have been screened for breast and /or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early detection Program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable coverage as defined in the Federal Public Health Service Act).
24. Effective October 1, 2002, individuals receiving family planning services who are not otherwise eligible for Medicaid and whose net available income is 200% or less of the federal poverty level.
25. Effective April 1, 2007, individuals eligible for the Colorectal and Prostate Cancer Program.
26. Medicaid/Medicare dually eligible individuals who are not enrolled in a Medicare Advantage Plan.

A description of the process for identifying excluded populations is contained in Chapter 12.

### **Local District Optional Populations**

Medicaid eligible individuals in the following categories may be eligible for enrollment in the MCO at the LDSS’ option, as indicated below:

- Foster care children in the direct care of LDSS, pursuant to the LDSS foster care plan as approved by NYSDOH:
  - Mandatory county—children in LDSS direct care may be mandatorily enrolled.
  - Mandatory OR voluntary county—children in LDSS direct care may be enrolled on a case-by-case basis.

- Homeless persons living in shelters outside of New York City are eligible for enrollment if so determined by the LDSS:
  - Mandatory county—homeless persons may be mandatorily enrolled.
  - Mandatory OR voluntary county—homeless persons may be enrolled on a case-by-case basis.

At the LDSS option, Medicaid eligible individuals in the following categories are excluded from enrollment in the MCO, as indicated below:

1. Mandatory OR voluntary county - foster care children in the direct care of LDSS.
2. Mandatory OR voluntary county - homeless persons living in shelters outside of NYC.

### **Medicaid Eligibility Quality Control**

The State proposed a waiver of the traditional Medicaid Eligibility Quality Control process. Staff resources equivalent to those used for traditional Medicaid Eligibility Quality Control reviews were reassigned to waived projects. Over the five year span of this waiver, modified Quality Control procedures were used to examine sampled individuals for the following purposes:

- Reducing or defraying Medicaid expenditures
- Tracking issues to provide management information needed for policy clarification
- Obtaining data needed for legislative purposes
- Collecting information on client formation of trusts and transfer of assets
- Targeting areas for review of conformity to program rules and regulations

The review process was changed from a routine examination of all elements of eligibility for all categories or recipients to a flexible audit function with the ability to concentrate staff resources in the most significant areas of the Medicaid program. Accordingly, the above areas were not intended to limit options, but to represent a starting point for new methodologies of reviewing Medicaid.

## **2. FHPlus ELIGIBLE POPULATIONS**

Under the FHPlus program, an “Eligible Person” is an individual who meets the following criteria:

1. Permanent resident of New York State.
2. Age 19 through 64.
3. Citizen or qualified alien pursuant to the Personal Responsibility and Work Reconciliation Act of 1996.
4. Not eligible for Medicaid solely due to income and/or resources, or is eligible only through the application of excess income toward the costs of medical care and services.
5. Pursuant to a change in State law in 2004, a resource test is required. Resources are cash or those assets which can be readily converted to cash, such as financial institution accounts, life insurance, stocks, bonds, mutual fund shares and promissory notes. Resources include property not readily converted to cash (i.e., real property). A person may attest to the amount of their resources, however, in the event there is an inconsistency between the information reported by the person and any information obtained from other sources, and that information would affect the person’s eligibility, the person will be asked to provide documentation to verify the resources. The resource level for FHPlus will be 150% of the applicable allowable income amount permitted for Medicaid.
6. Not a federal, state, county, municipal or school district employee eligible for health care coverage through his or her employer, (Pursuant to a 2005 change in State Law).
7. Not in receipt of health care coverage or insurance, unless it is one of the excepted benefits listed below.
  - a) accident-only coverage or disability income insurance
  - b) coverage issued as a supplement to liability insurance
  - c) liability insurance, including auto insurance
  - d) workers compensation or similar insurance
  - e) automobile medical payment insurance
  - f) credit-only insurance
  - g) coverage for on-site medical clinics
  - h) dental-only, vision-only, or long-term care insurance
  - i) specified disease coverage
  - j) hospital indemnity or other fixed dollar indemnity coverage
  - k) prescription-only coverage

8. If the individual has or can get employer-sponsored health insurance available through his/her employer he/she may be eligible for help to pay for premiums, deductibles, coinsurance, and co-payments through the Family Health Plus Premium Assistance Program (federal, state, county, or school district health insurance plans are excluded).
9. Gross household income at or below the following federal poverty levels:
  - i) Parent(s) living with a child(ren) under the age of 21 will qualify with a gross family income up to 133% of FPL; this increased to 150% of FPL as of October 1, 2002.
  - ii) Individuals without dependent children in their households will qualify with a gross household income up to 100% FPL.
10. Applicants must comply with other Medicaid eligibility requirements, with the exception of the following requirements:
  - a) Photo ID
  - b) finger-imaging
  - c) face-to-face interview (may be delegated to the facilitated enrollment agent)
  - d) Enrollment in FHPlus is voluntary

