



STATE OF NEW YORK DEPARTMENT OF HEALTH

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LOCAL COMMISSIONERS MEMORANDUM

Transmittal No: 08 OHIP/LCM-1

Date: April 8, 2008

Division: Office of Health
Insurance Programs

TO: Local District Commissioners

SUBJECT: Continued Medicaid Eligibility for Recipients Who Change Residency (Luberto v. Daines)

ATTACHMENTS: Attachment I - Relocation Referral Form (available on-line)
Attachment II - Managed Care Plans by District (available on-line)
Attachment III - OHIP-0014 Manual County A Notice (available on-line)
Attachment IV - OHIP-0014S Manual County A Notice Spanish (available on-line)
Attachment V - OHIP-0015 Manual County B Notice (available on-line)
Attachment VI - OHIP-0015S Manual County B Notice Spanish (available on-line)
Attachment VII - Verification of New Address Form (available on-line)

I. PURPOSE

The purpose of this Local Commissioners Memorandum (LCM) is to advise local departments of social services (LDSS) of the settlement agreement reached in the Luberto v. Daines class action lawsuit. This case concerns Medicaid eligibility for recipients who notify their LDSS of a change in residency to another district and have no changes in circumstances material to Medicaid eligibility. This LCM provides interim procedures that must be followed to insure that otherwise eligible individuals who report their move from one district to another within New York State have their Medicaid case transitioned to the new district without the need for a new application or face-to-face interview.

II. BACKGROUND

In December, 2000, the Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, issued a reminder to all states that in a county-administered Medicaid program, when a recipient moves within the State, the State and counties are responsible for transferring the case record to the new county of residence so that Medicaid can continue without interruption. The State was reminded by CMS that it could not require the recipient to reapply for Medicaid or comply with a Medicaid redetermination solely based upon a move to a new county. If there is a change in circumstances (beyond just a move to a new county) that might affect eligibility, the county is to perform an ex parte redetermination to determine whether Medicaid eligibility continues.

General Information System (GIS) message 02 MA/001, dated January 9, 2002, advised local districts of a change to Social Services Law Section 62.5 (a) that required districts to provide coverage to an individual who moves from one district to another for the month in which the move takes place and the following month. This change in law supported the Department's efforts to provide Medicaid coverage without interruption when an otherwise eligible individual moved from one county to another within the State.

In 2005, a class action lawsuit, Luberto v. Daines, Index No. CV-05-5421 (USDC, EDNY) was filed. The lawsuit alleged that New York State was out of compliance with the December, 2000 letter issued by CMS. In settling the lawsuit, the Department agreed to modify existing policies and procedures to provide for the transition of a Medicaid case for an otherwise eligible recipient who moves from one district to another within the State.

III. PROGRAM IMPLICATIONS

Medicaid recipients who report their move from one district to another within the State will be provided coverage for the month in which the move is reported and the following month. Coverage will be established in the new district of residence effective the first day of the second month following the month the move was reported. Eligibility will continue for the duration of the originating county's authorization period, or four months, whichever is greater. If a recipient advises the district of a move, in advance of his or her actual relocation, the district is responsible for providing coverage through the month of actual move and the following month. For example, an individual whose existing Medicaid authorization period is June through May advises his or her current Medicaid district in November that he or she has leased a new apartment in another county beginning in January. Assuming a new address is provided in the new district of residence, coverage must be provided by the originating district through the month of actual move (January) and the following month (February).

The new policies and procedures apply to Medicaid recipients who notify their district of a move to another county on or after December 28, 2007. In order to apply the new procedures, the recipient must notify his or her district of the move and provide the district with his or her new address in writing. If a recipient provides their district with additional information at the time of notification of the move

that may affect the individual's ongoing eligibility, a redetermination of eligibility must be made before the case is transitioned to the new district, barring certain exceptions.

The policy changes in this letter apply to all Medicaid recipients in a Case Type 20 (Medicaid) or 24 (Family Health Plus/FHP), as well as those recipients who receive Medicaid through a Temporary Assistance (TA) Case (Case Types 11, 12, 16 or 17). The new policies do not apply to Medicaid recipients who are institutionalized in a medical facility as defined in Department Regulations at 18 NYCRR, Section 360-1.4 (j). As a result, Medicaid eligibility will not be transitioned for individuals who relocate to another district from a hospital, nursing home, Intermediate Care facility, inpatient psychiatric center or inpatient alcohol treatment facility.

Individuals who report a move but who do not provide an address in the new district of residence must continue to be provided coverage for the month of move and following month, as provided for under existing requirements. Such cases should be closed, but NOT with a Luberto designated Reason Code, as described in this LCM.

System support to transition Medicaid coverage of individuals who move from one Upstate district to another Upstate district is operational for relocations reported on or after December 28, 2007. System support to transition Medicaid coverage of individuals who move into or out of New York City (NYC) is under development. Until such time as system support can be implemented, individuals who report a move are being identified by the Department and cases are being opened manually in the new district of residence.

The court order and stipulation in Luberto v. Daines does not change existing exceptions to the "where found" district of fiscal responsibility (DFR) rule as discussed in OMM/ADM 97-1 and GIS message 02 MA/006. Districts should be certain that a case does not meet one of the DFR exceptions before choosing to transition a case due to a move out of district. Individuals who report a move out of New York State are not subject to the new transition policies. Existing MA closing Reason Code E63 (for both Upstate and NYC) should be used to close cases due to a move out of State. Existing TA closing codes of E66 and M63 (Upstate and NYC) should continue to be used to close the TA case of an individual who moves out of New York State.

When a Supplemental Security Income (SSI) recipient reports a move to another district, it is important that the move be reported to the Department so the State SSI recipient Master File can be changed. Districts should continue to follow the instructions in 95 ADM-5 "SSI Case Correction Procedure: Use of Form SSA-3911" and Medicaid Director letter dated May 22, 2006 concerning the electronic filing of this change form, to report the move of an SSI recipient from one county to another county within the State. If there is a change in the SSI recipient's mailing address, the Social Security Administration (SSA) must also be notified of the change. Eligibility for SSI recipients is determined by the SSA. SSI recipients are not required to file a separate Medicaid application. Districts must coordinate any closing for an SSI recipient with the opening of a case by the new district. This coordination may be required in instances where the district learns of the move prior to the change being made via the State Data Exchange (SDX) system.

For purposes of the remainder of this letter, the term "County A" shall refer to the LDSS from which a recipient changes address. "County B" will be used to describe the LDSS to which a recipient is moving.

IV. PROCEDURES TO BE FOLLOWED WHEN A RECIPIENT MOVES FROM ONE UPSTATE DISTRICT TO ANOTHER UPSTATE DISTRICT

A. County A Required Action

The following actions must be taken when a Medicaid/FHP recipient reports a move to another district and provides his or her district with the address in their new district of residence in writing (documentation of the new address is not required):

1. Initiate a closing transaction, using closing Reason Code C65 (Not A Resident of District-New Address Provided). Use of this Reason Code will generate the Medicaid Coverage "TO" Date as the last day of the month following the month in which the closing transaction is done. Client Notice Subsystem (CNS) notice language, associated with Reason Code C65, will inform the recipient that his or her Medicaid case will be transitioned to the new district of residence effective the first day of the second month following the month in which the closing transaction is made.
2. The Residence Address on screen 1 of WMS must be changed to the newly reported address. Data appearing in the Care Of and/or Mailing Address fields that is not applicable to the move should be deleted.
3. Appropriate changes are required to be made to the Pre-Paid Capitation (PCP) subsystem. If the managed care/FHP plan an individual is currently enrolled in is available in the new district of residence, or if County B has only one FHP plan, no changes to the PCP subsystem are necessary. If the plan is not available in the new district of residence, a disenrollment may need to be processed. For further information regarding managed care/FHP, see Section IV.C., of this LCM.
4. Provide the new district of residence with copies of the following documents from the existing case record:
 - (a) proof of Identity, of all relocated individuals;
 - (b) proof of date of birth, of all relocated individuals;
 - (c) proof of Marital Status, if relevant to establishment of eligibility;
 - (d) proof of citizenship or immigration status;
 - (e) the most recent LDSS-3209;
 - (f) the current LDSS-639, Disability Review Team Certificate, if the eligibility of any case member is based on disability; and
 - (g) a copy of the Relocation Referral Form (Attachment I).

NOTE: Documentation of Income and Resources is not required to be provided to County B.

The documents listed above must be provided to County B so that the new district of residence, in the absence of an application, will have the basic documentation necessary to support eligibility in the event of an audit. The Relocation Referral Form, (Attachment I) is to be used when forwarding the case record documentation to the new district. Documents that are not in County A's possession should be noted on the Relocation Referral Form. Districts may include any additional information that may be important for the new district to be aware of for a particular case. An example of information that should be forwarded to County B would be information concerning any remaining medical bill(s) submitted to County A that can be used to meet the recipient's spenddown liability in County B. Districts should also forward any trust documents that may be applicable to the case, including information regarding any income being placed in an existing Exception trust.

B. County B Required Action

Effective February 29, 2008, a system-generated opening will occur for cases that have been closed using Reason Code C65.

1. The day following County A's closing transaction, a system-generated pending opening transaction, with Reason Code 898 (District Transfer Opening) will be received by County B. The receiving district will be determined through a zip code and address match based on the Residence Address fields, as entered by County A.

County B will be alerted to this pending transaction via a BICS WINR 4648, "Case Control Transfer Report". The report will be received one business day before the case is set to open in County B. The case will be in FDE/ERR status for the day the report is received, during which the district may modify the system-generated Case Number. Modifications to other system generated fields of Local Office, Unit, Worker and Coverage Code may be made while the case is in FDE/ERR status or subsequent to the opening transaction being processed.

2. The day following the receipt of a pending opening transaction and WINR 4648, a case will be established in the new district of residence. The Authorization and Medicaid Coverage "FROM" Dates of this opening will be the day following County A's Medicaid Coverage "TO" Date. The Authorization and Medicaid Coverage "TO" Dates will be generated to equal the balance of the Authorization period that had been authorized by County A, or four months, whichever is greater. CNS notice language, associated with the system-generated opening, will inform the recipient that his or her case has been transferred to the new district of residence.

Example: County A does a closing transaction on April 21, 2008, using Reason Code C65. The Medicaid Coverage TO Date will be generated in County A as May 31, 2008. On April 22, 2008, County B will receive the WINR 4648 "Case Control Transfer Report" and the case will appear in FDE/ERR status. County B may change the system generated Case Number, as well as other limited fields on April 22. On April 22, 2008, the case will be established in County B, with an Effective FROM Date of June 1, 2008.

- 3. The case will be authorized using the same Coverage Code that existed prior to the move, with the following exceptions: individuals who were authorized in County A with Coverage Code 30 (PCP Full Coverage) will be authorized for fee-for-service coverage. The fee-for-service coverage will be based on the Resource Verification Indicator (RVI) Code from the County A case:

<u>Resource Verification Indicator</u>	<u>Fee-For-Service Coverage</u>
1 (Resources Verified for 36 months)	01 (Full coverage)
2 (Resources Verified only for current Month)	19 (CC w/LTC)
3 (Resources Not Verified)	20 (CC w/o LTC)
4 (Transfer of Resources)	10 (Limited coverage)

NOTE: Pregnant women, Expanded eligible children and LIF eligible children authorized in County A with coverage code 30 will not have their coverage converted to fee-for-service based on the RVI. Regardless of the RVI value on the County A case, these individuals will be provided with coverage for all care and services. (see Section IV.C. below for further information regarding managed care/FHP).

FHP individuals (Coverage Code 34) will be authorized with Coverage Code 06 (Provisional Coverage), until enrollment to a FHP plan can be accomplished.

NOTE: Pregnant women who are authorized with Coverage Code 34 on a CT 20 (Individual Categorical codes 58 or 59), will have their coverage converted to Full coverage (01) or Perinatal coverage (15), respectively. In this instance a FHP disenrollment must be processed so that the pregnant woman may access fee-for-service coverage in the new district of residence.

- 4. In the event that County B does not receive adequate case record documentation from the former district, the documentation is to be requested from the recipient at the time of renewal.
- 5. Schedule the renewal of transitioned cases, based on the new Authorization period.

C. Managed Care/Family Health Plus Implications

- 1. Medicaid Managed Care

Medicaid managed care individuals who have moved to a new district should be re-enrolled in the same managed care plan in their new district of residence if the plan is available in the new district. Although the case will transition to the new district with fee-for-service coverage, that coverage should be changed to Managed Care Coverage (Coverage Code 30) if the plan the individual was enrolled in in the former district is available in the new district of residence. This change in Coverage Code, which can be made while the case is in pending opening status, will afford the individual uninterrupted access to plan services. A future enhancement to the WINR 4648 "Case Control Transfer Report", discussed in Section VI.A of this LCM, will include populating the PCP/FHP Indicator to assist districts

in identifying cases that are transitioned with an active managed care enrollment. If the same plan is available in the new district of residence, the Coverage Code must be changed and re-enrollment to the same managed care plan processed.

If the Medicaid managed care plan that an individual is enrolled in is NOT available in the individual's new district, County A's managed care disenrollment should be coordinated with the last date of coverage in County A (end of the month following the month in which the closing transaction was made). Consideration may be made to disenroll the individual earlier if the individual has moved out of the plan's service area and cannot access services. The disenrollment would enable the individual to receive fee-for-service coverage in order to access services. The decision to disenroll earlier should be made based on a discussion with the individual. Reason Code 97 (Moved Out of Service Plan Area) should be used for the disenrollment. The case will transition to the new district with fee-for-service coverage. Future managed care enrollment should proceed according to local district requirements.

2. Family Health Plus

FHP individuals who have moved to a new district should be re-enrolled in the same FHP plan in their new district of residence if the plan is available in the new district. Although the case will transition to the new district with Provisional Coverage (except pregnant women as noted in section IV.B.3 of this LCM), that coverage should be changed to FHP Coverage (Coverage Code 34) if the same plan operates in the new district of residence. This change in Coverage Code, which can be made while the case is in pending opening status, will afford the individual uninterrupted access to plan services. A future enhancement to the WINR 4648 "Case Control Transfer Report", discussed in Section VI.A of this LCM, will include populating the PCP/FHP Indicator to assist districts in identifying cases that are transitioned with an active FHP enrollment. If the same plan is available in the new district of residence, the Coverage Code must be changed from Provisional Coverage (Coverage Code 06) to FHP Coverage (Coverage Code 34) and re-enrollment to the same FHP plan processed.

Individuals who have moved to a district where only one FHP plan is available must be enrolled in that plan. If the FHP plan is not the same plan the individual was enrolled in when in the former district, County A should not process a disenrollment, which may cause a gap in coverage. County B must make appropriate entries in the PCP subsystem to enroll the individual in the new plan. The coverage code of the individual should be changed to 34 on the day the case is in pending status. In order to limit gaps in access to services, County B must take the necessary steps to insure the enrollment is effective by the first day of the month following the closing in County A. This may include notifying the plan in writing if the enrollment is not processed by pulldown dates.

If the FHP plan that an individual is enrolled in by their former district of residence is not available in the new district of residence and more than one FHP plan exists in the new county of residence, County A must disenroll the individual effective the first day of the month following the second month in which the closing transaction is made. The case will transition to the new district of residence with Provisional Coverage (Coverage Code 06). County B must provide the individual with plan selection information as soon as possible in order to provide the greatest opportunity to have FHP enrollment to the selected plan effective the first day the case becomes the responsibility of County B (the first day of the second month following the month in which the closing transaction was made in County A). If the individual selects a FHP plan in time for County B to enroll, County A will need to delete the disenrollment so that County B may enroll. The PCP subsystem will not support a disenrollment and enrollment line for the same date.

Attachment II of this LCM is a copy of a recent Monthly Medicaid Managed Care Enrollment Report. This report may be used by local district workers to determine whether a particular Medicaid managed care plan or FHP plan does business in another district. The report is sorted by Medicaid managed care, followed by managed long-term care, FHP and Medicaid Advantage. The most recent report may be found on the Department's website at:

http://www.health.state.ny.us/health_care/managed_care/reports/enrollment/monthly/

Managed care/FHP recipients who are receiving Guarantee Coverage (Coverage Codes 31 and 36, respectively) have been determined to be ineligible for Medicaid. If such individual reports a move to another district, the individual should receive the balance of the six month guarantee from County A. A WMS edit will prevent use of closing Reason Code C65 when any individual on the case has Coverage Code 31 or 36.

D. Temporary Assistance Cases

Individuals whose Medicaid is authorized in connection with a Temporary Assistance (TA) cash case are also affected by the settlement agreement reached in Luberto v. Daines. This creates a situation where the DFR Transition Rule for TA and Medicaid will differ when a recipient does not notify his or her district of a move to another county in the same month in which the move actually occurs. Temporary Assistance policy requires the former district of residence to provide cash assistance for the month of the move and following month. Medicaid must be provided for the month the move is reported to the county and the following month.

Due to the differences that can occur with TA and Medicaid policy for county-to-county moves, two TA closing Reason Codes are available to support Medicaid policy. TA closing Reason Code M62 (Moved Out of District) has been modified to generate the Medicaid Coverage "TO" Date on screen 5 of WMS as the last day of the month following the month in which the TA closing transaction is made. Reason Code M62 should be used to close a TA case when the report of move is made timely (either during the month of move or the

following month). The TA closing date and TA notice language associated with M62 has not been changed. The Medicaid language on the notice will inform the individual that his or her Medicaid coverage will be transferred to the new district of residence effective the first day of the second month following the month in which the TA closing transaction is made. As explained in the January 30, 2008 WMS/CNS Coordinator letter, TA workers should use M61 (Moved Out of District-Late Report) to close a TA case that moved out of the district two or more months in the past. The Medicaid Coverage "TO" Date on screen 5 of WMS will be generated as the last day of the month following the month in which the TA closing transaction is done. The Medicaid language associated with Reason Code M61 will inform the individual that Medicaid coverage will be transferred to the new district of residence effective the first day of the second month following the month in which the TA closing transaction was made.

For any transferred cases, the case record documentation, as outlined in Section IV.A.4., must be forwarded to the Medicaid Director in the new district of residence.

E. Third Party/Medicare Implications

When a case opens in the new district of residence, any commercial insurance, Medicare coverage and Medicare Savings Program information that is on eMedNY will automatically be associated with the new district of residence. It is not necessary to end-date the information in County A and re-open the information in County B. County A should only end-date commercial insurance if it knows that the insurance has ended. If the commercial insurance has not ended and County A has been paying the commercial insurance premium, all necessary information regarding the payment of the premium must be forwarded to the new district of residence and annotated on the Relocation Referral Form.

F. Conversion of Cases

On February 29, 2008, closing transactions done in January, 2008 using Reason Code C65 (Case Types 20 and 24) and TA Reason Code M62 (Case Types 11, 12, 16 and 17) were converted to cases in the new district of residence. On February 29, 2008 Upstate districts received the first "Case Control Transfer Report" (WINR 4648) listing cases in FDE/ERR status, pending opening. Cases were in pending status for the day the report was received. Districts could make changes to the system-generated Case Number while in FDE/ERR status. Changes to other system-generated fields of Local Office, Unit, Worker and Coverage Code could also be made while in FDE/ERR status or subsequent to the case becoming active. As a result of this conversion, closing transactions done in January, 2008, had coverage established in the new district of residence with an Authorization and Medicaid coverage "FROM" date of March 1, 2008. This initial WINR 4648 report included case closings that were done throughout the month of January. Therefore, this initial report may contain more cases than future regular installments of the report.

Closing transactions done during February, 2008 were converted on March 21, 2008. Upstate districts received the WINR 4648 on March 24, 2008. As a result of this conversion, closing transactions done in February, 2008 have coverage established in the new district of residence with an Authorization and Medicaid coverage "FROM" date of April 1, 2008. Processing of these cases should proceed as explained in this LCM.

V. MOVES TO OR FROM NEW YORK CITY

System support is being developed to automatically transition the case of an individual who moves from New York City to an Upstate district or from an Upstate district to New York City.

Currently, the closing transaction performed by County A, using the specified Reason Codes noted below, will result in the case appearing on a monthly transfer file. The transfer file will contain certain data from the originating district's WMS record. This data will be used to manually open cases in the new district of residence.

A. New York City to Upstate Moves

1. Medicaid Only/FHP Cases

When a New York City Medicaid recipient reports a move to an Upstate district, NYC will initiate a closing transaction using Reason Code G61 or G62. Use of these Reason Codes will generate the Medicaid Coverage "TO" Date as the last day of the month following the month in which the closing transaction is made. Cases closed with these Reason Codes will appear on a monthly transfer file. The Residence Address and Zip Code of the newly reported Upstate address will be used to determine the Upstate district where the manual opening is to occur. Use of closing Reason Codes G61 or G62 will require an Amplification Date (date of actual move).

Individuals enrolled in managed care or FHP in NYC will be automatically disenrolled from the plan at the pulldown date following the month in which eligibility ends. The effective date of the disenrollment will be the day following the last day of eligibility in NYC.

2. Temporary Assistance Cases

Closing Reason Code G62 should be used to discontinue the TA case of a NYC resident who reports a move to an Upstate county. An Amplification Date is required. The Medicaid coverage associated with the closing TA case will be discontinued effective the last day of the month following the month in the TA closing transaction is made. As described above, cases closed with Reason Code G62 will appear on a monthly transfer file and the case is to be manually opened in the Upstate district based on the new address and zip code.

Individuals enrolled in managed care in NYC will be automatically disenrolled from the plan at the pulldown date following the month in which eligibility ends. The effective date of the disenrollment will be the day following the last day of eligibility in NYC.

To notify Upstate districts of cases that require a manual opening, Upstate districts have been and will continue to be provided with an Excel spreadsheet containing specific case information from the transfer file. This information is being forwarded by the district's Local District Support Liaison. As districts receive this information, a Medicaid case is to be opened as soon as possible and the appropriate manual notice sent (Attachment V or VI). Districts will be notified when the processing of the transfer file is automated.

NYC staff should forward the required documentation to support the new case, as outlined in Section IV.A.4 of this LCM, to the attention of the Medicaid Director in the new Upstate district of residence.

B. Upstate to New York City Moves

1. Medicaid Only/FHP Cases

When a recipient reports that he or she has moved to NYC, the Upstate district will be responsible for providing coverage for the month of notification and the following month. In closing the Upstate case, districts should follow the instructions for Upstate to Upstate moves, as explained in Section IV.A., with the exception of the PCP changes, which will be automatically ended at the pulldown date following the month eligibility ends. The effective date of the disenrollment will be the day following the last day of eligibility in the Upstate district. The closing transaction, using Reason Code C65 (Moved Out of District- New Address Provided) will result in the case appearing on the monthly transfer file. This monthly transfer file will be used to open a case on NYC WMS with an opening Reason Code of 853 (Case Type 20) or 856 (Case Type 24), effective the first day of the month following the Upstate Medicaid Coverage "TO" Date.

2. Temporary Assistance Cases

A TA recipient who is also authorized for Medicaid will have his or her Medicaid coverage transferred to NYC by the Upstate district. In closing the Upstate TA case, districts should follow the instructions for Upstate to Upstate moves, as explained in Section IV.D. of this LCM. Managed care enrollment of individuals moving to NYC will automatically be ended at the pulldown date following the month in which eligibility ends. The effective date of the disenrollment will be the day following the last day of eligibility in the Upstate district. The closing transaction, using Reason Code M61 or M62 will result in the case appearing on the monthly transfer file.

Until the monthly transfer file can be automated, NYC staff will process NYC openings for cases identified on the monthly transfer file. The appropriate notice will also be sent to the individual.

NOTE: Upstate districts should be aware of differences in editing on the CARE OF and MAILING ADDRESS fields that exist between Upstate and NYC WMS. The NYC WMS considers the CARE OF and MAILING ADDRESS to be one field. Therefore, when data is entered in either the CARE OF or MAILING ADDRESS field of the Upstate case, both fields must be completely filled. Data appearing in either of these fields that is not applicable to the case once it transfers to NYC should be entirely deleted before closing the case.

Upstate districts should forward the required documentation to support the new case, as outlined in Section IV.A.4. of this LCM, to:

Susan Pelham
330 West 34th Street, Room 922
New York, New York 10001
Telephone Number: (212) 630-1606
Email: pelhams@hra.nyc.gov

C. Transfer File Processing

Once automated, on a monthly basis, cases that are set to close due to a reported move, either from NYC to an Upstate district or from an Upstate district to NYC will become part of the monthly transfer file. Prior to the opening of a case in the new district, as determined by an address and zip code match, a search will be performed to establish whether any members of a relocating case have an active case in the new district of residence or any other district. For any case member found to have an active case in another district, a transitioned case will not be established, and the individual will appear on the new district's Case Control Transfer Report, as explained below.

The transfer file will be created on the first day of each month and will capture all reported cases that have coverage ending the previous day. Cases to be established in NYC will be opened with a system-generated opening Reason Code of 853 (Case Type 20) or 856 (FHP). Other system-generated fields on the NYC opening transaction will be:

MA Center-Local Office: 549
MA Responsible Area Code: LB
Unit Worker: NYSLB

Cases to be established in an Upstate district will appear on the Case Control Transfer Report (WINR 4648) that will be available on the second day of each month (excluding weekends and holidays). The cases will be in FDE/ERR status on the day the report is received, during which the district may modify the system generated Case Number. Modifications to other system-generated fields may be made while the case is in FDE/ERR status or subsequently. The day following the receipt of the report, cases to be established in an Upstate district will be opened with a system generated opening

Reason Code of 898 (District Transfer Opening). Such cases will be identified on the Case Control Transfer Report with the following system generated fields:

CASE NUMBER: NT, Followed by Julian Date and Sequence Number
UNIT: MA
WORKER: NYNTR

A case opening will be system-generated in the new district of residence with coverage beginning the day following the last day of coverage in the former district's case. The Authorization and Medicaid coverage "TO" dates of this opening transaction will be system-generated and will equal the months remaining in the former district's original Authorization period, or four months, whichever is greater.

As part of the automated transition process, the newly opened case will be established with the same Coverage Code that appeared in the former case with the following exceptions: Individuals enrolled in Medicaid managed care (Coverage Code 30) will be opened with fee-for-service Medicaid, based on the RVI Code (see Section IV.B.3 for a chart identifying the Coverage Code associated with each RVI Code). FHP individuals (Coverage Code 34) will be transitioned to the new district of residence with Provisional Coverage, with the exception of pregnant women, as noted in Section IV.B.3. The district receiving the case must take steps to initiate Medicaid managed care or FHP enrollment, as appropriate.

D. Third Party/Medicare Implications

Since individuals moving from an Upstate district to NYC, or from NYC to an Upstate district, will receive a new Client Identification Number (CIN), commercial insurance, Medicare coverage and Medicare Savings Program information that is in eMedNY will not automatically be associated with the new county of residence. Until an automated process can be developed, the Third Party Liability Unit, within the State Office of Health Insurance Programs, will enter commercial insurance, Medicare coverage, and Medicare Savings Program information under the new CIN in eMedNY. If an individual's commercial insurance will be available in the new district and the former district had been paying the commercial insurance premium, all necessary information regarding the payment of the premium must be forwarded to the new district of residence.

VI. CASE CONTROL TRANSFER REPORT

A. Upstate Districts

Each Upstate district will receive a daily "Case Control Transfer Report" (WINR 4648) through BICS that identifies cases that have been transferred (to an Upstate district) as a result of the automated county-to-county move process. Cases that are transferred from NYC to an Upstate district will be included in the WINR 4648 when the transfer file between NYC and Upstate is automated. The WINR 4648 will include the following information:

Section I: Pending Cases - will list cases that are in FDE/ERR status for one day (excluding weekends and holidays) to alert the district that a case is in pending status in the district. This section of the report will contain the system-assigned Case Number, Case Name, Case Type, CIN, former Coverage Code, new Coverage Code, and Restriction/Exception Indicator. Changes to the system generated Case Number may only be made while the case is in FDE/ERR status. Changes to other system generated fields can be made while in FDE/EFF status or subsequent to the case being opened. Districts should use this report to identify FHP cases that will require plan selection information. A future enhancement to this report will include populating the PCP/FHP Indicator to assist districts in identifying cases that are transitioned with an active managed care enrollment.

Section II: Exception Cases - will list cases in which one or more members were found to have an active case in County B or elsewhere. A transitioned case will not be created. Districts should review the cases appearing in this section of the report in order to make decisions regarding the best resolution of the information. This may include contacting other districts to better establish where the individual(s) is actually residing. This section of the report will contain the following information: District, Case Number of existing case found in the clearance process, Existing Case Name, Case Type, Coverage Code and Restriction/Exception Indicator and CIN.

B. New York City

In addition to the regular WMS disposition and error report, a new report identifying the disposition of each case transferred to NYC will be created. The report will include the following information: Case Name, Upstate Case Number, Upstate CIN, NYC Case Number if issued or found, NYC CIN if issued or found, Client Name and DOB, if present. The report will also identify any Errors such as invalid Case Type or Active CIN on NYC. This report will be available when the transfer file between Upstate and NYC is automated.

VII. ADDITIONAL INFORMATION THAT RELATES TO CERTAIN MOVES

A. Report of Changes Affecting Eligibility

In the course of a Medicaid/FHP recipient reporting his or her move, other changes relevant to eligibility may also be reported. If the district is provided with sufficient information to make a redetermination of eligibility based on reported changes, a redetermination is to be completed before transitioning the case to the new district of residence. Changes resulting in ineligibility should be handled in accordance with existing procedures, including the discontinuance or change of coverage, as appropriate. However, districts should NOT delay the transitioning of coverage pending receipt of further information regarding items that may change as a result of the individual's reported relocation. For example, an individual who informs the district he has moved to take a new job, but does not know his new income, would have his case transitioned. When the change in income is known by the recipient, the recipient

is expected to report the change to the new district. Income information will also be reported to the new district when the case is renewed. Another example of when a case should be transitioned is if a parent reports her child has moved to another district to live with her father. The case should be transitioned to the new district of residence. The new district will evaluate the child's ongoing eligibility at renewal.

It should also be noted that Single Individuals and Childless Couples (S/CCs) are not required to document their new shelter expenses as a condition for transitional coverage. County B will review these changes at renewal.

Individuals who report a move, for whom the district has not yet done a determination of eligibility (i.e. a pregnant woman authorized for Presumptive Eligibility), must have a determination of eligibility completed before the case is transitioned to the new district of residence.

If a case is in the process of being renewed and an individual reports a move to another district, County A must complete the renewal before transitioning the case to the new district of residence.

B. Not All Case Members Are Moving

When a district receives information regarding an existing case in which only some members are relocating, the impact of the move must be assessed on both those who are remaining in County A and those members who have relocated. If those case members who have moved continue to be eligible, County A must provide coverage to those individuals for the month of notification of the move and the following month. However, because applicable closing codes to transition coverage are only case level Reason Codes, when only some case members of a household are relocating, a new case must be established for those individuals moving. The new case is to be subsequently closed with the appropriate Moved Out of District closing Reason Code. This will allow the individuals to be transitioned to the new district. If the result of the redetermination is that the relocating household members are ineligible, they should be deleted from the case and provided with timely and adequate notice based upon the reason for their ineligibility (i.e. not moved out of district).

C. Returned Agency Correspondence

District correspondence, including the Medicaid/FHP renewal, that is returned to the district by the U.S Postal Service with a change of address indicating the individual may have moved out of the district must be forwarded to the new address. In order to get confirmation from the recipient of a move, Attachment VII of this LCM must be included when the returned mail is forwarded to the individual. Individuals who respond to this follow-up correspondence in the time frame provided by the district (minimally 10 days should be given) shall be considered to have reported their relocation and new address. The case is then eligible to be processed under the new transition provisions. Failure to respond to the follow-up correspondence will result in a discontinuance for reasons other

than a move out of district such as failure to renew or comply with a request for additional information.

If a Medicaid/FHP renewal (and Attachment VII) is forwarded based on a change of address identified by the U.S. Postal Service, the renewal and Attachment VII to this LCM must be returned by the recipient and processed by County A before the case is transitioned to County B.

D. Continuous Coverage for Children

Under the provisions of continuous coverage for children, as outlined in 99 OMM/ADM-3, "Implementation of the Medicaid and Title XXI Provisions of the Balanced Budget Act of 1997," children who moved from one district to another and did not have an application filed on their behalf in the new district or were determined ineligible by the new district, remained the responsibility of the former district of residence for the balance of the period of continuous coverage. With the implementation of the Luberto court order, children who move to another district will have their eligibility transitioned to the new district of residence. Continuous coverage for children, as provided by their former district of residence will be limited to children who lose eligibility for reasons other than a move out of district.

E. Individuals Who Notify County B of Their Relocation

When County B is advised of a change in address by an individual who has an active Medicaid case in another district, County B is directed to have the individual put the new address in writing. County B is instructed to send the new address information to County A so that the individual's Medicaid coverage can be transitioned by County A. The individual may choose to file an application in the new district of residence. However, in doing so, all aspects of the application process must be adhered to, including the face-to-face interview and documentation requirements. In order to avoid duplicate coverage in this instance, County B will need to coordinate the closing of the former district's case with their opening.

Although the Medicaid coverage of a TA recipient will be transitioned to the new district of residence when a move is reported, TA rules require that a new application for cash benefits be filed. When the TA applicant also files for Medicaid in the new district, the TA application should be processed according to existing procedures. If a TA and Medicaid determination are made before the Medicaid coverage transitions to the new district of residence, the TA/Medicaid case should be authorized. The transfer file will recognize the active case and not process a Medicaid only case in the new district.

F. Homeless Individuals

Homeless individuals who report a move to another district must have their Medicaid/FHP case transitioned under the procedures outlined in this LCM even though they lack a permanent address. Residency is based on an individual's expression of intent to reside in a particular district, not on any duration of residency or proof of a residential address. See 89 ADM-2 for a list of mailing address options for homeless individuals.

G. Admissions to District 97 (Office of Mental Health) and District 98 (Office of Mental Retardation and Developmental Disabilities) Living Arrangements

An individual who becomes the Medicaid responsibility of the State, as a result of an admission to certain living arrangements under the jurisdiction of the Office of Mental Health (OMH) or the Office of Mental Retardation and Developmental Disabilities (OMRDD) will have State Medicaid eligibility effective with the date of admission. Local districts must close an individual's Medicaid case so that District 97 or 98 may open a case. Local districts will generally learn of the need to close their case in these instances when contacted by the Patient Resource Office (OMH) or the Revenue Support Field Office (OMR). In these circumstances, districts are advised NOT to use closing Reason Codes that will transition the case the month following the month the closing transaction is made. Until such time as a unique closing Reason Code can be created to address this situation, Upstate districts may use closing Reason Code E61 (Not a Resident of District) and NYC may use G77. Districts must use the manual County A notice (OHIP-0014), Attachment III to this LCM, to inform the individual that his or her Medicaid case is being transferred to OMH/OMRDD. The use of these alternate closing Reason Codes will also help to ensure that the case is transitioned to OMH or OMRDD instead of the district where the OMH or OMRDD living arrangement is located.

Systemic support of transitioning cases is not able to accommodate situations where the district to where an individual is moving is not the district of fiscal responsibility, as is often the case with OMH and OMRDD discharges. In such cases, the DFR must be sent the Relocation Referral Form and accompanying documentation, but the case will not be systemically transitioned. The DFR district is required to establish uninterrupted coverage for such cases. When opening such cases, the individual is to be sent the manual County B notice (OHIP-0015), Attachment V to this LCM.

VIII. NOTICE REQUIREMENTS

A. CNS Upstate

Revised language has been developed to be used with closing Reason Codes M61 and M62 (TA cases Upstate) and C65 (MA/FHP Upstate). These notices advise the recipient that Medicaid/FHP coverage will continue through the "TO" Date that will be pulled from the Medicaid Coverage "TO" Date and that the individual's case will be transferred to the new district of residence effective the date following the Medicaid Coverage "TO" Date.

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The system generated Opening Reason Code 898 will generate a notice that advises the recipient that his or her case will be opened in the new district of residence and the effective date of the opening.

B. CNS NYC

Appropriate language has been developed for use with NYC closing Reason Codes G61 (MA/FHP) and G62 (TA and MA). These notices will advise the recipient who reports his or her relocation that Medicaid coverage will be provided by NYC through the end of the month following the month in which the closing transaction was made and coverage will transferred to the new district of residence.

System generated opening Reason Codes 853 (Case Type 20) and 856 (FHP) will generate a notice advising the recipient that a case has been established in NYC and the effective date of the opening.

Please contact your Local District Support Liaison at (518) 474-8887 (Upstate) or (212) 417-4500 (New York City) if you have any questions.

Judith Arnold, Director
Division of Coverage and Enrollment
Office of Health Insurance Programs