STATE OF NEW YORK DEPARTMENT OF HEALTH

REC'D SEP 22 1999

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Commissioner

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Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 99 OMM/ADM-3

DIVISION: Office of Medicaid Management

TO: **Commissioners of Social Services**

DATE: August 10, 1999

SUBJECT: Implementation of the Medicaid and Title XXI Provisions of the Balanced Budget Act of 1997

SUGGESTED DISTRIBUTION:

Medical Assistance Staff
Income Maintenance Staff
Staff Development Coordinators
Fair Hearing Staff

CONTACT PERSON:

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Fiscal: Region I through IV - Roland Levie (User ID FMS001) at 1-800-343-8859; Region V - Marvin Gold (User ID OFM270) at 212-383-1733.

ATTACHMENTS:

Attachment I, Examples
Attachment II, Growing Up Healthy Application, (DOH-4133) (not available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
98 OMM/ADM-3 91 ADM-50 91 ADM-18 91 ADM-11 89 ADM-40		360-4.8	PHL 2510 & 2511 SSA 1902 (a)(17) PL 105-33 Chap.2 of Laws of 1998		GIS 98 MA/041 GIS 98 MA/031

DSS-296EL (REV. 9/89)

I. Purpose

The purpose of this Administrative Directive (ADM) is to provide districts with instructions to implement the Medicaid and Title XXI provisions of the Balanced Budget Act of 1997 and corresponding changes in State law, and to advise districts of changes to the Child Health Plus program that impact the Medicaid program.

II. Background

The federal Balanced Budget Act of 1997 (Public Law 105-33) contains numerous provisions affecting health care coverage for children. The Balanced Budget Act (BBA) created the State Children's Health Insurance Program as Title XXI of the Social Security Act.

The purpose of Title XXI is to provide targeted low-income children who are currently uninsured with health care coverage. Under Title XXI, states can offer health care coverage in one of three ways: through expansion of the Medicaid program; through a separate Children's Health Insurance Program (CHIP); or through a combination of both. New York State will utilize a combination of the two programs. New York's CHIP is Child Health Plus, established under Title I-A of Article 25 of the Public Health Law.

In addition to the creation of Title XXI, the BBA provides states with options for expanding Medicaid coverage for children.

In New York State, Chapter 2 of the Laws of 1998 was enacted to provide authority for the Department to implement certain provisions of the BBA.

Prior to the BBA, New York addressed the issue of uninsured low-income children by expanding Medicaid and by creating the Child Health Plus (CHPlus) program. In 1990 and 1991, Medicaid eligibility levels were expanded to 185% of the Federal Poverty Level (FPL) for infants, 133% FPL for children ages one through five, and 100% FPL for children born after 9/30/83, who were at least six years of age but younger than nineteen. CHPlus began in 1991 as a State-sponsored program designed to provide health care coverage through health insurance to children in low income families who were not eligible for Medicaid. Children who applied for CHPlus but who appeared to be Medicaid eligible were advised of their potential eligibility for Medicaid.

Although not a specific requirement of Title XXI, a new Growing Up Healthy application for Medicaid, WIC (the Special Supplemental Food Program for Women, Infants, and Children) and CHPlus is being piloted, which will eventually replace the DSS-2921-P, the shortened Medicaid/WIC application currently in use. This new application will facilitate linkages among these programs to ensure that children receive care and are enrolled in the appropriate program.

As part of the process of applying for CHPlus, children must be screened to ascertain whether they appear to be Medicaid eligible. Any applying children who appear to be Medicaid eligible will be encouraged to apply for Medicaid. This process also applies to children who are currently enrolled in CHPlus and appear potentially Medicaid eligible at the time of annual CHPlus recertification. The Department will make every reasonable effort to ensure that children being transitioned from CHPlus to Medicaid do not lose health care coverage in this process.

The new State law provides that significant outreach efforts for both CHPlus and Medicaid be implemented. These strategies will include public education campaigns, and the establishment of community based enrollers who will assist children applying for and enrolling in CHPlus or Medicaid, whichever is appropriate. Further, these outstationed enrollers will be available on evenings and weekends, in order to make it easier for working families to access services. In specified locations, an interview with the enroller will serve as the face to face interview for Medicaid. At local option, the enroller will submit application packets either by mail or in person to the local department of social services (LDSS). The packets will include the completed one page application and all required documentation.

The new State law also provides that the State may contract with entities such as local government agencies and community based organizations to implement outreach strategies, including facilitated enrollment activities. The State has issued a joint Medicaid and CHPlus Request For Proposal (RFP) inviting such entities to submit plans detailing their enrollment strategies. Details regarding the RFP have been provided under separate cover.

III. Program Implications for Medicaid

As a result of the BBA and enactment of Chapter 2 of the Laws of 1998, there are changes to the Medicaid program, as well as changes to the CHPlus program. The Medicaid changes include 12 months of continuous Medicaid coverage for most children, and coverage to 100% of FPL for all children who are at least six but less than nineteen years of age. State legislation also contains a presumptive eligibility provision for children, and allows for coverage up to 133% of FPL for children up to age nineteen; however, these provisions are contingent upon certain managed care milestones and will be implemented at a later date. The Department will issue a separate ADM on these provisions prior to implementation.

The Medicaid provisions being implemented at this time are as follows:

A. Expanded Coverage of Children at 100% of Federal Poverty Level (FPL)

Consistent with section 4911 of the BBA, and pursuant to Social Services Law, section 366(4)(q)(1), effective January 1, 1999, full Medicaid coverage will be extended to children who are at

least 6 years of age but less than 19 years of age, and whose household incomes do not exceed 100% of the applicable FPL. There is no resource test for these children. This acceleration replaces the phase-in for children born after 09/30/83.

NOTE: When a family applies for Medicaid by means of the Common Application (Form DSS-2921), and the family is ineligible using Low Income Families (LIF) or Aid to Dependent Children (ADC)-related budgeting solely due to excess resources, children under the age of 19 must be rebudgeted using poverty level budgeting, with no resource test.

B. Continuous Eligibility

Consistent with section 4731 of the BBA, and pursuant to Social Services Law, section 366(4)(s), effective with determinations or redeterminations of eligibility made on or after January 1, 1999, children less than nineteen years of age whose family incomes do not exceed the appropriate FPL will be guaranteed coverage for 12 months from the date of eligibility, regardless of any changes in their family's circumstances, including income. This is true for both initial eligibility and for redeterminations. A child who is found to be no longer eligible during these 12 months will continue to receive Medicaid until the end of the 12 months.

NOTE: Children whose last eligibility determination was made at any time prior to January 1, 1999, are not entitled to this 12 month guarantee of coverage.

C. Local Share for Medicaid Expansion

For children who are **newly** eligible under the expanded category (i.e., children born **before** 9/30/83 and less than nineteen years of age), there will be no local share for program or administrative costs.

D. Growing Up Healthy Application, DOH-4133

The new Growing Up Healthy Application, DOH-4133 (Attachment II), has been created to help facilitate linkages among CHPlus, Medicaid, and WIC, and may be used to apply for all three programs. This form will eventually replace the DSS-2921-P, which cannot be used to apply for CHPlus. The new DOH-4133 has additional questions which reflect the needs of the CHPlus program, notably questions related to a child's access to other health insurance, whether a tax return was filed for the previous year, and current health care providers under CHPlus. There is a check-box in Section H for the applicant to give consent for sharing of information between the district and CHPlus. There are changes to the language on the back of the form as well. This form may be used only for children less than 19 years of age, and for pregnant women.

IV. Required Action

A. Expanded Coverage of Children

Effective January 1, 1999, for both new cases and recertifications, children less than nineteen who have birthdates on or before 9/30/83 and who are ineligible at the LIF level or at the ADC-related medically needy level should be redetermined at 100% of FPL before denying or establishing a spenddown for the case. Previously, children born after September 30, 1983 who were at least six years of age but less than 19 years of age were covered at 100% of FPL. As of January 1, 1999, this group was expanded to all children aged six but less than age 19. See 91 ADM-50, "Medical Assistance Coverage of Children up to 100% of the Federal Poverty Line", section IV, for instructions on determining eligibility under expanded levels.

NOTE: If a child is determined to be ineligible using the LIF, ADC-related and poverty level budgeting methodologies, a disability determination should be considered for children who appear potentially disabled before referring such children to CHPlus. This will ensure that all possibilities of Medicaid eligibility have been explored and that certified blind/disabled children have access to Medicaid services such as inpatient rehabilitative therapy and waivered services.

NOTE: Prior to passage of the BBA, the CHPlus program was totally State funded, and as such, was considered a State public program for purposes of Medicaid spenddown. The portion of the premium paid on a recipient's behalf by the CHPlus program was an allowable expense for Medicaid spenddown. With the availability of federal funding for CHPlus, the program no longer meets the definition of a State public program, and premium payments paid by CHPlus must no longer be used to meet Medicaid spenddown.

B. Continuous Eligibility

Effective with determinations or redeterminations of eligibility made on or after January 1, 1999, most children less than age 19 will be guaranteed coverage for 12 months. Each time eligibility is determined, (i.e., at initial determination, and at every recertification or redetermination), children less than age 19 who are found **fully** eligible for Medicaid will be entitled to 12 months of continuous coverage regardless of any changes in income or circumstances. This period of continuous coverage applies to children who are eligible under LIF budgeting, **fully** eligible under ADC-related medically needy budgeting, or whose household income is less than the appropriate Expanded Eligibility level, (i.e., 100%, 133%, or 185% of FPL). It also applies to children in families who are in Public Assistance cases and receiving Medicaid.

The continuous coverage provisions do not apply to children who must spend down to the medically needy income level, or to children who are fully eligible only by applying the SSI-related budgeting methodology. Further, children who are non-qualified aliens only eligible for coverage for emergency medical treatment are not entitled to continuous coverage after the end of the medical emergency.

NOTE: In GIS 98 MA/041 and in regional training in the fall of 1998, local districts were advised that continuous coverage did not apply to children whose eligibility was determined using the ADC-related budgeting methodology. However, children fully eligible using ADC budgeting have incomes which are below the FPL. Therefore, the Department has determined it is appropriate to provide continuous coverage to these children. Until systems modifications are in place to accomodate this population, fully eligible ADC-related medically needy children should be coded using the appropriate poverty level Categorical Code (44, 46, or 47) as determined by the age of the child. (See Section V.A.1. of this directive.)

This policy interpretation is effective August 30, 1999. Any child who was determined eligible using ADC-related budgeting methodology on or after January 1, 1999 and who has subsequently lost eligibility prior to this effective date is entitled to have his/her Medicaid coverage reinstated from the date of closing through the end of the child's continuous coverage period. This does not apply to children closed for reasons which bypass continuous coverage edits, as explained in Section V.A.2.b. of this directive.

Children eligible for continuous coverage (in any district **except** New York City) will have a system-generated continuous save date (CSD) in their records. This date will be 12 months from the date eligibility was last established. This date is defined further in Section V.A.2. See Attachment I for examples.

If a child moves to another district in New York State during a period of continuous coverage, the child remains the responsibility of the originating district until such time as a Medicaid application is filed for the child, and the child is determined eligible in the new district. At that time, a new period of continuous eligibility begins, and the new district becomes responsible for the child's Medicaid. If no application is filed in the new district, or if the child is determined ineligible for Medicaid, the child remains the responsibility of the originating district for the balance of the period of continuous eligibility.

However, if a family applies in the new district, and a child or children in that family are determined to be ineligible, the new district assumes responsibility for the balance of the continuous coverage period for any such children in order to avoid a circumstance in which household members have Medicaid coverage from different districts. For example, a family with a two year old child in receipt of Medicaid moves. They advise the

former district, which makes the necessary systems changes to give the child continuous coverage. When the family applies in the new district, the mother is pregnant. Their net income now exceeds 133% of the FPL, therefore, the two year old child cannot be determined fully eligible, but the mother is found eligible under 185% of the FPL. The new district should add the child to the mother's case using a "continuous coverage" categorical code for the balance of the continuous coverage period (See Section V).

If a child turns age 19 during a period of continuous eligibility, the guarantee of continuous eligibility will end as of the last day of the month of the child's nineteenth birthday. However, if the child is receiving medically necessary inpatient services at that time, Medicaid coverage continues through the end of the hospitalization.

Prior to the expiration of a period of continuous eligibility, a recertification notice should be sent to the family, in the event that circumstances have changed which could effect eligibility.

C. Local Shares for Medicaid Expansion

There will be no local share for the acceleration of the on-going Medicaid expansion to 100% of FPL for children born before 09/30/83 and less than age 19. This applies to continuous coverage for this group as well. Correct calculation of the local share is dependent upon the selection and input to WMS of the correct categorical code for each child. See Section V for these codes. Further instructions regarding this were transmitted in WMS/CNS Coordinator letters dated February 9, 1999 and March 2, 1999, and in MBL transmittals as well.

D. Growing Up Healthy Application, DOH-4133

As the new Growing Up Healthy application is phased in, districts will need to assure that applicants complete the DOH-4133 in full. This includes completion of those sections which pertain to CHPlus and WIC, since children are allowed to apply for these other programs on the same application. This would allow the application to be forwarded to other programs without having the applicant complete a separate application for CHPlus and/or WIC. The applicant should be encouraged to check "Yes" on the consent in Section H, which allows sharing of information between CHPlus and the district, as needed. If persons in the household other than children under the age of 19 and pregnant women are applying, they must use the full application (DSS-2921).

V. **Systems Implications:**

A. Upstate

1. MBL - The MBL system currently calculates the 100% FPL. The Expanded Eligibility Code field (EEC) should be input with a "D" - children age 6 up to age 19, or a "B" - EEC for "C", "D", "I", "P" whichever is appropriate to calculate the case

FPL eligibility. The "D" code has been redefined to include children age 6 and older, but less than age 19. The MBL Expanded Eligibility Code screen has been updated to include children age 6 up to age 19.

2. WMS changes to support Title XXI have been made in the following areas: 1) new and revised Individual Categorical Codes, 2) system generation of a Continuous Save Date and 3) changes to the PA Closing/MA Extension Process.

a) **INDIVIDUAL CATEGORICAL CODES**

The definition of Individual Categorical Code 44 has been changed and new Individual Categorical Codes have been added. These Individual Categorical Codes should be entered to identify children eligible under the various FPLs used to determine Expanded Eligibility and to identify those children receiving Medicaid based on the Continuous Coverage requirement of Title XXI.

The new definition of Individual Categorical Code 44 is:

44 100INFNT EXPANDED INFANT 0 UP TO 1 UNDER 100% FPL.

The new Expanded Eligible Individual Categorical Codes are:

45 185INFNT EXPANDED INFANT 0 UP TO 1 - 100%-185% FPL
46 133CHILD EXPANDED CHILD(REN) 1 UP TO 6 - 133% FPL
47 100CHILD EXPANDED CHILD(REN) 6 UP TO 19 - 100% FPL

NOTE: Children with household income above LIF but under ADC-related levels should be coded with Individual Categorical Codes 44, 46 or 47. ADC-related categorical codes 22 and 25 should only be used in excess income cases, when a child has spent down to the MA level.

The following Individual Categorical Codes should be entered to identify children who are no longer eligible for Medicaid but who are entitled to Medicaid under the Continuous Coverage provisions of Title XXI:

53 CONT-LIF CONTINUOUS COVERAGE - LIF CHILD 0 UP TO 19.
54 CONT-EXP CONTINUOUS COVERAGE - All EXPANDED CHILDREN EXCEPT INFANTS 0 UP TO 1 (100%-185 FPL).
55 CONT-185 CONTINUOUS COVERAGE -EXPANDED INFANT 0 UP TO 1 -100%-185% FPL.

These Categorical Codes have been edited based on age.

Details on the age edits and other edits for these Categorical Codes are contained in the February 9, 1999 WMS/CNS Coordinator letter, Attachment I page 2 of 2.

b) **CONTINUOUS ELIGIBILITY SAVE DATE LOGIC**

Children up to age 19 with income under the appropriate FPL are entitled to 12 months of continuous Medicaid coverage following each determination or redetermination of eligibility, regardless of any change in income or circumstances. WMS will calculate and store a Continuous Save Date (CSD) for each qualifying individual to ensure that Medicaid coverage is not closed prior to the end of the 12 month Continuous Coverage period. The CSD will be displayed in the upper right hand corner of the MA Coverage History screen under the heading Cont Cov Date.

The CSD is calculated only when the following conditions exist:

- Case Type = 11, 12, 14, 16, 17, or 20, and;
- Individual Categorical Code = 01-09, 13, 15, 26, or 43-48 (these are the LIF or Expanded Categorical Codes), and;
- MA Coverage Code = 01, 10, 16, 30, or 32, and;
- MA Coverage To-date is greater than 12/31/98, and;
- Transaction Type (TT) = 02, 10, 06; or 05 during the circumstances described in c) or d) below.

or

- Sex = U, and;
- Case Type = 11, 12, 14, 16, or 17, and;
- Individual Categorical Code is blank, and;
- MA Coverage Code = 01, 10, 16, 30, or 32, and;
- MA Coverage To-date is greater than 12/31/98, and;
- TT = 02, 10, 06; or 05 during the circumstances described in c) or d) below.

The CSD is set equal to one full year from:

i) the first day of the application month at Application Registry or the MA Coverage From-date whichever is greater at Opening (TT=02) or Reopening (TT=10).

ii) the MA Coverage From-date at Recertification (TT=06).

iii) the greatest MA Coverage From-date of the added individual(s) or the first day of the transaction month whichever is greater at Undercare (TT=05) when an individual has been added.

iv) the greatest MA Coverage From-date of the individual(s) whose Individual Categorical Code has

been changed (or the 1st day of the transaction month if the MA Coverage From-date is not changed) at Undercare when the Categorical Code has been changed **from**:

1) non-LIF **to** LIF or Expanded
2) LIF **to** Expanded
3) Expanded **to** LIF
4) 44 **to** 45 or 46
5) 45 **to** 44 or 46
6) 46 **to** 47
7) non Continuous **to** Continuous (53, 54 or 55)

Since the individuals with Categorical Code 53, 54 or 55 do not meet the qualifying conditions in the CSD logic, a new CSD will be calculated only for the qualifying individuals.

(See above for listing of LIF and Expanded Categorical Codes.)

When either iii) or iv) above occurs, a CSD will be calculated or recalculated for all qualifying children in the case.

NOTE: In no event will the CSD extend beyond the end of the month of the 19th birthday.

NOTE: If a recalculation of the CSD results in a lesser CSD, the existing CSD will remain in effect. Exception: Date of Birth is changed in WMS to reflect an earlier 19th birthday. (A DOB change will not in itself result in a recalculation of the CSD; the conditions listed above must be met. If a recalculation is desired because the 19th birthday month is changed, entry of Transaction Type 06 will result in a recalculation.)

NOTE: Extending the MA Coverage period during a TT05 will not generate a CSD except under conditions described in c) and d) above.

WMS edits related to the CSD are listed and explained in Attachment II pages 2-3 of 3 of the February 9, 1999, WMS/CNS Coordinator letter.

Individuals may not be closed prior to the CSD. Any attempt to close an individual prior to the CSD will result in an error. The error message will be: MA COVERAGE TO-DATE MUST NOT BE LESS THAN THE CSD. The following closing reason codes will bypass this edit:

E95 died
E60 unable to locate

E63 not a state resident
E79 MA not provided in current living arrangement
E90 client request
U77 concurrent benefits, intrastate
U78 concurrent benefits, interstate
E01 non-qualified PRUCOL alien, ineligible for full MA
E02 non-qualified alien, end of medical emergency
E05 qualified alien, 5 year ban, end of medical emergency
E65 eligible for continuous coverage, moved out of district, accepted in new district
H32 TMA discontinuance, receiving PA, MA continues.

Any attempt to delete an individual prior to the CSD will result in a warning.

c) **PA CLOSING/MA EXTENSION PROCESS**

The PA Closing/MA Extension process has been modified: Children under 19 whose PA closes and who would not otherwise be opened in an MA extension case or would have been opened in an MA extension case solely due to PCP Guarantee will now be opened in an MA extension case to ensure Continuous Coverage (see exceptions below). For these individuals, WMS will generate Individual Categorical Code 53 and set the MA Coverage To-date equal to their Continuous Save Date.

The MA Insert Reason Codes will be set to:

858 -(Paragraph I0058) Continuous Eligibility for Children; or,
859 -(Paragraph I0059) Continuous Eligibility for Children - Moved out of District (when PA Closing Reason Code M62 is entered).

Exceptions: The following PA Closing Reason Codes will not cause a Continuous Coverage Extension Case to be generated.

PA Case Closing Reason Codes:
E60 Unable to locate
E66 Not a Resident of State
M63 Will move out of State
M90 Client's request written PA & MA
M91 Client's request verbal PA & MA

PA Individual Closing Reason Codes:
E95 Died
F63 In Prison
M98 Receipt of concurrent assistance non AFIS match
M99 Receipt of concurrent assistance AFIS match

New MA Only Opening Code 715 - Continuous Eligibility or Continuous/PCP Guarantee will be generated when either of the

following conditions occurred for all individuals in the MA extension case:

1) every individual(s) received a Continuous Coverage Extension; or,

2) an individual(s) received a PCP Guarantee Extension and at least one individual received a Continuous Coverage Extension.

MA Extension cases opened with a MA Opening Reason Code 715 will have the Auth To-Date set equal to the CSD. If more than one CSD is present the Auth To-Date will be set to the shortest CSD. Reminder: If the Auth To-Date on the MA case is in the near future, the case may not be included on the WINR4133 Recertification Notice report. However, these cases should be included in the LDSS recertification process as appropriate.

3. CNS - The Client Notice System has been enhanced to accommodate the Title XXI provisions. The new language paragraphs are:

- S19 X0162 GEI, Child turning 19, Excess Income/Resources Both resources and 6 month spenddown met
- S19 X0163 GEC, Child turning 19, Excess Income - 6 month spenddown met
- S19 X0164 GEF, Child turning 19, Excess Income/Resources - both met
- S19 X0165 GED, Child turning 19, Excess Resources - spenddown met
- S19 X0166 GEA, Child turning 19, Excess Income - spenddown met
- S19 X0167 GEH, Child turning 19, Excess Income and Resources - resources spenddown met
- S19 X0168 GEB, Child turning 19, Excess Income - spenddown not met
- U33 X0170, Child turning 19, Excess Income - Discontinue
- U41 X0171, Child turning 19, Excess Resources - Discontinue
- U60 X0172, Child turning 19, Excess Income/Resources - Discontinue
- C17 U0035, Continuous Eligibility for children
- E64 U0036, Continuous Eligibility for children - moved out of district
- E65 C0155, Discontinue, Eligible for continuous coverage, Moved out of District, Accepted in New District.

Existing CNS language paragraphs which previously referred to children born after 09/30/83 who were at least six years of age have been revised to reflect the change to age 19.

B. New York City:

New York City systems instructions will be forwarded under separate cover.

VI. Fiscal Implications:

As stated earlier, significant outreach efforts for both CHPlus and Medicaid will be implemented. The local districts will report those expanded outreach efforts associated with CHPlus and Medicaid as F17 function code expenditures and claim them for reimbursement on the Schedule D-17 "Distribution of Allocated Costs to Other Reimbursable Programs" (LDSS-3274). The costs from the Schedule D-17 are to be brought forward to a LDSS-3922 form entitled "Financial Summary For Special Projects", labeled "CHPlus", and reported on the appropriate lines. The costs will be reported in the Total Column and claimed at 65% Federal Share and 35% State Share.

Please note that there is no state reimbursement for A-87 costs which should be claimed at 65% Federal Share and 35% Local Share.

There may be an allocation of funds set by the Department of Health for these expenditures. If there is an allocation, reimbursement will be available up to the limit set by that allocation. All state share expenditures are outside of the local district administrative cap.

Districts that have already submitted claims for these activities should reverse the amount claimed on the Schedule D, D-4 etc., and submit that adjustment on the ACS as well as the required DSS-3922.

VII. Effective Date:

These provisions are effective August 30, 1999, retroactive to January 1, 1999. WMS system support for these changes became available on February 16, 1999. The instruction in Section IV.B, page 5 regarding the coding of children under FPLs, is effective August 30, 1999.

Donna Farlow, Deputy Director
Office of Medicaid Management

Attachment I

Continuous Coverage Examples:

1. Mr. and Mrs. Bates applied for Medicaid for their two children in September, 1998. They were determined eligible under 100% FPL from 09/01/98 - 02/28/99. During their recertification in January, 1999, the agency determines that the family's income is now in excess of 100% of the FPL. The children are not entitled to six additional months under the continuous coverage provision, because they have not been found eligible for Medicaid on or after 01/01/99. Instead, their parents should be advised of the amount of their spenddown.

2. Mr. and Mrs. Farmer apply for Medicaid for their 9 year old twins in January. Their net income is under 100% FPL. The twins are found eligible from 01/01/99 - 12/31/99. In May, the Farmers report an increase in earnings which, when the LDSS rebudgets, puts the family's income over 100% FPL. The parents are notified that, due to continuous coverage, the twins will remain eligible until 12/31/99. Prior to that date, the family will be sent a recertification. If they are found eligible under LIF or the FPL at that time, a new Continuous Save Date will be established.

3. Mary Brown and her three children are found eligible for Medicaid under LIF effective 02/01/99. In April, 1999, she reports an earnings increase that makes her family ineligible for Medicaid under LIF, but she receives Transitional Medicaid (TMA) from 05/01/99 through 11/30/99. She fails to return her mailer prior to November, 1999. Therefore,she is removed from the case, but her children will continue to receive Medicaid until 01/31/00.

4. Renee Bell is five years old. Her case is recertified effective 01/01/99. She is found to be eligible at 133% FPL. At that time, her parents are sent a notice advising them that her eligibility continues unchanged. Renee will be turning age six in April, and the family income is over 100 % FPL. In April, when her eligibility is redetermined at 100 % FPL, an undercare notice is sent informing her parents that continuous coverage for children under age 19 will extend her coverage through 12/31/99.

5. Bob and Brenda Smith apply for their four children to receive Medicaid in Albany County in February, 1999. The family is income-eligible under LIF. The certification period runs from 02/01/99 to 01/31/00. In May, the family moves to Monroe County. They are advised in their notice that Bob and Brenda will be continued through the end of June (the month following the month of the move), and that they should reapply in their new county of residence. They can either:

   a. Reapply in Monroe County. Monroe County determines eligibility for the family using all appropriate budgeting methodologies. If the children are determined ineligible, coverage for the children will continue to be provided by Albany County until 01/31/00.

b. Reapply in Monroe County. If the children are found eligible, Monroe County will open a Medicaid case effective 07/01/99. If the children are eligible under LIF or expanded eligibility, the system will generate a new continuous save date of 06/30/00. Albany County is advised to close the children, effective 06/30/99.

c. Choose not to apply in Monroe County: The coverage for the children will continue to be provided by Albany County until 01/31/00.