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DEPARTMENT OF HEALTH

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TRANSMITTAL: 01 OMM/ADM-6

TO: **Commissioners of Social Services**

DIVISION: Office of Medicaid Management

Office of Managed Care

Division of Planning, Policy and Resource Development

DATE: November 2, 2001

SUBJECT: Eligibility Requirements for the Family Health Plus Program; Facilitated Enrollment of Adults into Medicaid and Family Health Plus

SUGGESTED DISTRIBUTION:

Commissioners
Medicaid Directors
Medicaid Staff
Temporary Assistance Directors
Temporary Assistance Staff
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Staff Development Coordinators

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ATTACHMENTS:

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FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
00 INF-2 00 OMM/ADM-2 99 ADM-5 93 ADM-29 00 OMM/LCM-3 01 ADM-10		360.2.1. 360-2.2(f) 360-2.4	364-j(4)(e) (iv) 366-e 369-ee SSA Section 1903(m)(5) 366(4)(1)		GIS 01MA008 GIS 01MA013 GIS 01MA014 GIS 01MA015 GIS 01MA020 GIS 01MA023 GIS 01MA024 GIS 01MA025 GIS 01MA030 GIS 01MA033 DCL 2/9/01 DCL 3/7/01 DCL 3/12/01 DCL 3/14/01 DCL 5/8/01 DCL 6/8/01 DCL 7/6/01 DCL 8/31/01 DCL 10/2/01 DCL 10/9/01 DCL 10/17/01 MBL Trans-mittal 01-2 MBL Trans-mittal 01-3 WMS/CNS Coordinator Letter 08/21/01 Family Health Plus Model Contract

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I. PURPOSE

The purpose of this joint Office of Medicaid Management/Office of Managed Care/Division of Planning, Policy and Resource Development, Administrative Directive is to:

- advise local social services districts (LDSS) of the program and eligibility requirements relating to Family Health Plus (FHPlus);
- advise LDSSs of systems enhancements relating to FHPlus;
- advise LDSSs of the requirements related to the coordination of the FHPlus application and managed care enrollment processes with approved managed care organizations (MCOs)[1] and lead agencies contracting with the State Department of Health (SDOH) to provide "facilitated enrollment" assistance to individuals and families who apply for Medicaid, Child Health Plus (CHPlus) A and B, FHPlus, the Prenatal Care Assistance Program (PCAP) and the Special Supplemental Food Program for Women, Infants, and Children (WIC);
- introduce a new joint Medicaid, FHPlus, CHPlus, PCAP, and WIC application, "Access NY Health Care", which includes a Documentation Checklist and a Health Care and Nutrition Fact Sheet (Attachment I, DOH-4220); and
- introduce a revised statewide Medicaid Managed Care and Family Health Plus Enrollment Form (Attachment II, DOH-4097).

II. BACKGROUND

The Health Care Reform Act of 2000 (HCRA) established two programs to address the needs of the uninsured poor: FHPlus and Healthy New York. The FHPlus portion of the legislation, which added a new Section 369-ee of the Social Services Law (SSL) (Attachment III) provides Medicaid coverage to a new population of currently uninsured adults who have income and/or resources above the current Medicaid levels. Eligible individuals will receive a comprehensive benefit package similar in scope to the state's CHPlus B program, provided through managed care plans.

The FHPlus legislation made implementation of FHPlus contingent upon federal approval of certain waivers to assure the receipt of federal financial participation. On June 30, 2000, New York State submitted a request to amend the current Section 1115 Demonstration Project (The Partnership Plan), to the Federal Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration), to allow implementation of FHPlus. FHPlus will strengthen and expand the Partnership Plan 1115 Waiver through:

- providing access to health care coverage for additional low-income New Yorkers, who have no other health coverage;

[1] MCO includes all FHPlus health plans participating in the FHPlus program.

- o continuing to reorient the service delivery system of the State to cost-effective, high quality managed care;

- o avoiding costly inpatient interventions through the expanded use of primary and preventive care; and

- o seeking to improve the health outcomes of additional New Yorkers who have slightly higher incomes.

New York is building on the CHPlus model so that lower income parents can have the same type of insurance as their children. FHPlus also covers adults without children who lack insurance.

In order to provide services to this population, the FHPlus legislation required the SDOH to establish a managed care service delivery system and to develop and implement outreach and facilitated enrollment strategies targeted to individuals who may be eligible for FHPlus and Medicaid. In response, SDOH released a recruitment notice for the FHPlus program in February 2001, to solicit proposals from existing Medicaid managed care and CHPlus insurers to become participating FHPlus MCOs, and optionally to also provide facilitated enrollment assistance for adult applicants. Additionally, in April 2001, the SDOH released a single source procurement to current CHPlus lead agencies to expand facilitated enrollment services to adult Medicaid and FHPlus populations. To date twenty-six (26) plans and an indemnity plan, GHI, have been approved to participate in the FHPlus program. Twenty-one (21) plans and thirty-one (31) lead agencies have been selected to coordinate facilitated enrollment in community-based settings. As with CHPlus, many of the lead agencies have subcontracted with other community-based organizations (CBOs) to which they will provide oversight. In counties where no MCOs applied and/or were approved to provide FHPlus coverage, SDOH will contract with a commercial insurer to underwrite a prepaid benefit package covering the services available under FHPlus. (See Attachments IV and V for Statewide Listings of Medicaid/CHPlus and approved FHPlus MCOs and enrollment facilitators that are expected to participate in the FHPlus program.)

SDOH has consulted with consumer advocacy groups, plan insurers, facilitated enrollment organizations and local district representatives, to obtain input on key design issues. Based on the input received, a number of steps have been taken to simplify and ease the definitions, rules and requirements for Medicaid and FHPlus. As required by legislation, a new single health insurance application for children and adults, DOH-4220, has been developed and field-tested. This new integrated application with standardized definitions and a simplified format will assist applicants applying for the CHPlus A and B, FHPlus/Medicaid, PCAP and WIC programs. The current "Growing Up Healthy" application is also being modified but will continue to be used in cases where only children or pregnant women are applying. It is expected that the DOH-4220 will eventually be used for all children and adults applying for State health insurance programs.

A new Medicaid/FHPlus plan enrollment form has been designed to accommodate the enrollment of applicants into managed care.

On May 30, 2001, New York State received the required federal approval of Medicaid waivers necessary to implement FHPlus. On August 31, 2001, SDOH received federal approval to begin accepting applications for FHPlus at local districts, with enrollments to be effective upon the final State approval of managed care contracts and approval by CMS Region II staff. For counties where no MCO has been approved to provide FHPlus coverage, approval from CMS is contingent upon a signed contract with SDOH and the indemnity plan. SDOH is in the process of developing a comprehensive plan for FHPlus outreach that will complement and build upon the efforts currently in place for the CHPlus program. Many of the same strategies used to promote the CHPlus program will be used to support and promote FHPlus. FHPlus/Medicaid outreach will also include local publicity by approved FHPlus/Medicaid facilitators regarding the locations and hours of facilitated enrollment sites.

III. PROGRAM IMPLICATIONS

Under FHPlus, New York will offer comprehensive health insurance to low-income adults who have income or assets above the current Medicaid levels, and who do not have other health insurance coverage. FHPlus will build on the CHPlus/Medicaid facilitated enrollment model so that individual and family applicants for health insurance can easily enroll in Medicaid, FHPlus, and CHPlus A and B in a timely, coordinated and user friendly fashion.

To be eligible for FHPlus, an adult must be uninsured, age 19 through 64, a New York State resident, meet citizenship/alien status requirements, ineligible for Medicaid based on income and/or resources, and must meet certain income requirements. While the majority of Medicaid eligibility standards and rules will apply for FHPlus applicants, there are several differences such as higher income levels, no resource test, and no co-payments, premiums or other types of cost-sharing. Requirements regarding finger imaging, photo ID, alcohol and substance abuse screening, referral, and treatment, do not apply to FHPlus. The FHPlus annual recertification (reauthorization) will be a mail-in process to take place no more than on an annual basis; however, the recipient has a responsibility to notify the LDSS immediately of all changes in circumstances that could affect eligibility.

FHPlus provides a comprehensive set of benefits to individuals who otherwise would have no access to health insurance coverage. The benefit package is modeled on the CHPlus program and includes primary, preventive, specialty and inpatient care (see Attachment VI - FHPlus Benefit Comparison Chart). Similar to CHPlus B, long-term care services for the chronically ill, including nursing home, home attendant, hospice, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) and private duty nursing, are not covered. Other excluded services under FHPlus are non-emergency transportation, medical supplies, and non-prescription medications other than diabetic supplies and equipment and smoking cessation products. All health care services are provided through the FHPlus managed care plan. This includes pharmacy and family planning services. FHPlus enrollees will have direct access (no referral needed) to family planning service providers participating in their plan's network. In the case of MCOs that don't

directly provide these services, an alternate network of providers (through the designated third party contractor) are available to enrollees without a referral from their primary care physician or MCO.

Facilitators will be an important source of information for individuals and families seeking health insurance coverage. They will assist individuals and families to complete the DOH-4220. This assistance will include:

- conducting the required face-to-face interview for Medicaid, FHPlus and CHPlus A, if this responsibility has been delegated to the facilitator;
- screening the family for the appropriate program;
- assisting in the completion of the application;
- assisting in the collection of various documentation items;
- submitting the completed application, documentation and enrollment form to the appropriate program;
- counseling on plan selection, where appropriate; and
- following-up with the individual or family to ensure that they complete the application process.

The LDSS will make the final determinations of Medicaid eligibility, including FHPlus and CHPlus A eligibility, and are responsible for the enrollment of applicants into participating plans.

As with CHPlus/Medicaid, LDSSs may delegate to the facilitator the authority to conduct the FHPlus/Medicaid face-to-face interview with the applying individuals/families, or they may require the facilitator to act as the family's authorized representative during the face-to-face interview at the LDSS. The LDSS cannot require the individual/family to come into the LDSS for the face-to-face interview.

To assure that children and adults can apply for health insurance coverage at the same sites, FHPlus/Medicaid facilitators will be placed in many of the same locations in the community as CHPlus/Medicaid facilitators, such as hospitals, clinics, shopping centers, community action agencies and other community locations. To accommodate working individuals and families, facilitators will be available during convenient hours such as evenings and weekends.

All data confidentiality requirements that apply to Medicaid also apply to FHPlus.

IV. REQUIRED ACTION

A. Local District Responsibilities

1. Application Process

Individuals applying at CBOs and MCOs through the facilitated enrollment process will be completing the DOH-4220. LDSSs must be prepared to accept and process the applications received from these entities.

Districts are encouraged to use the DOH-4220 for individuals under age 65 living in the community and applying for health insurance at the district. To assist in the transition to the new program, local districts may alternatively use the LDSS-2921, "Application for Public Assistance/Medical Assistance/Food Stamps/Services." If the LDSS-2921 is used, districts must allow the applicant to attest to the value of his/her resources and respond to questions about prior health insurance coverage ("crowd out"), by substituting Attachment VII for the resources section of the LDSS-2921. In addition, during the application process, districts must include information about managed care options and must assist applicants in choosing a plan for both FHPlus and Medicaid managed care so that the applicant is enrolled in a plan of his/her choice, regardless of which program he/she ultimately enters. Further details about these requirements are contained in Section IV.C.1 of this Directive.

LDSSs should conduct preliminary screenings based on information provided on the application and at the face-to-face interview. At that time the applicant should be told which program he/she appears to be eligible for, and the eligibility and documentation requirements of that program.

For applicants who indicate a desire to apply for WIC, the district must provide the applicant with a copy of Sections A, B and E of the DOH-4220, and the signature page to present at a WIC office. Applicants must also be provided with the locations of WIC offices in the district.

LDSSs will be provided with an initial supply of form DOH-4220. Additional supplies may be ordered from the SDOH warehouse by contacting:

New York State Department of Health
11 Fourth Avenue
Rensselaer, NY 12144
Distribution Center

Fax - 518-465-0432
E-Mail - b0019w@albnydh2.health.state.ny.us

Individuals applying at the LDSS using the DOH-4220 must also be provided with the separate State Board of Elections NYS Agency-Based Voter Registration Form.

2. Adult Eligibility Criteria

Beginning September 4, 2001, all adults age 19-64, who apply for Medicaid and appear to be ineligible for reasons of excess income and/or resources will be evaluated for their potential eligibility for FHPlus. To be eligible for FHPlus, individuals must be income and/or resource ineligible for Medicaid and have income at or below the applicable FHPlus standard. There is no resource test for FHPlus.

The FHPlus eligibility criteria are as follows:

a) Residency: Individuals must be New York State residents.

b) Age: Individuals may be eligible from age 19 through 64.

c) Citizenship: Citizenship and alien status requirements for FHPlus are now the same as those under the Medicaid program. Immigrants in many categories, including lawfully admitted permanent residents (green card holders) and persons permanently residing in the United States under color of law (PRUCOL), are eligible for FHPlus. Legal aliens who are PRUCOL or who are lawfully admitted permanent residents (green card holders), are eligible to join FHPlus if they meet other FHPlus requirements. In addition, those otherwise eligible qualified aliens who entered the US on or after August 22, 1996 may also qualify for FHPlus benefits.

d) Income: For parents residing with their children who are under age 21, and for 19 and 20-year-olds living with their parents, gross countable income (no deductions) must be no more than 133% of the Federal Poverty Level (FPL) for the family size. This amount will increase to 150% of the FPL effective October 1, 2002.

For single individuals and childless couples, both disabled and non-disabled, and for 19 and 20 year-olds not residing with their parents, gross countable income must be no more than 100% of the FPL for the household size.

Refer to Attachment VIII for FHPlus/Medicaid Income Levels.

Note: When determining gross countable income, exclude those ADC-related and S/CC-related categorical income disregards that are not considered in determining gross, monthly income for Medicaid eligibility. (See pages 150-157 and 210-217 of the Medicaid Reference Guide).

e) Resources/Assets: There is no resource test for FHPlus eligibility.

f) Third Party Health Insurance: Unlike Medicaid, applicants with health insurance are not eligible for FHPlus except in limited instances. Attachment IX contains a listing of exceptions to this policy.

g) MCO Selection: Because FHPlus is a managed care only product, new applicants MUST select a plan AND complete a managed care enrollment form as a condition of eligibility. An application cannot be considered complete unless a plan has been selected. Even in local districts where there is only one plan available, the applicant must complete the MCO enrollment form before the application can be accepted. Where applicants have completed the DOH-4220, local districts may allow plan selection to be made on the application. (NOTE: A plan selection process has been developed for recipients transitioning from Medicaid to FHPlus, i.e., persons whose Temporary Assistance or Medicaid benefits are being discontinued for excess income and/or resources, individuals turning 19, and pregnant women at the end of their authorization period. This process is described in Section IV.A.10.a of this Directive.)

NOTE: Prior to making a plan selection, applicants must be informed about managed care and managed care options available to them. LDSSs are responsible for ensuring that pre-enrollment information provided to individuals applying for FHPlus is consistent with SSL Section 366-e. Since some applicants may be eligible for Medicaid managed care, best practices would include the provision of the pre-enrollment information prescribed in Section 364(j)(4)(e) of the SSL.

h) Other Eligibility Criteria: In addition to the manner in which resources are treated, there are three (3) other requirements of the Medicaid program that are not required for receipt of FHPlus. They are:

(1) the requirement for photo identification;

(2) the requirement for finger imaging; and

(3) the requirement for certain individuals to undergo drug and alcohol screening, referral and treatment.

All other eligibility requirements of the Medicaid program except those defined in this Section apply to FHPlus. (NOTE: Persons financially eligible for Medicaid may not refuse to comply with these requirements and receive FHPlus. Receipt of FHPlus is contingent upon financial ineligibility for Medicaid.)

i) Reauthorization: The annual FHPlus reauthorization will be a mail-in process. Further instructions will be forthcoming.

j) Spenddown: There is no spenddown provision in FHPlus, i.e., applicants with income in excess of the applicable FHPlus standard cannot spenddown to attain FHPlus eligibility. Applicants in federally-participating categories who have medical expenses which would allow them to spend down to full coverage under Medicaid, and who are eligible for FHPlus, should complete an application and enrollment form, and be given the choice of participating in

either the Medicaid Spenddown Program, or FHPlus. Persons eligible for both Medicaid spenddown and FHPlus should be informed of the differences in services and all Medicaid requirements, e.g., photo ID, finger imaging and face-to-face reauthorization, etc., to assist them in making their decision.

Current spenddown individuals must be evaluated for FHPlus at their next scheduled annual reauthorization, when there are reported changes in family size or income, or at any time when a determination of FHPlus eligibility is requested by the recipient.

3. Documentation Requirements

a) Resource Documentation: The LDSS examiner should first determine if the applicant's net income is at or below the Medicaid standard or gross income is at or below the FHPlus standard.

(1) Persons income eligible for Medicaid: Applicants whose income is at or below the applicable Medicaid/Temporary Assistance income standard and who have attested that their resources are below the applicable resource standard, will be required to provide documentation of their resources.

(2) Persons eligible for Medicaid with an income spenddown: If the applicant is income eligible for FHPlus and eligible for Medicaid with an income spenddown, the examiner must advise the applicant of the spenddown option and discuss whether he/she has medical needs that may not be covered by FHPlus, e.g., personal care services. A chart comparing the benefit packages of Medicaid and CHPlus A, FHPlus and CHPlus B is attached to this Directive (Attachment VI). If the applicant opts for Medicaid with a spenddown rather than FHPlus, resource documentation must be obtained.

NOTE: Non-disabled single adults and childless couples cannot attain Medicaid eligibility through spenddown. Therefore, if such an applicant(s) has income in excess of the applicable Medicaid/Temporary Assistance income standard, the examiner must continue with the eligibility determination for FHPlus.

(3) Persons who are income ineligible for Medicaid, and who opt for FHPlus rather than Medicaid spenddown: For purposes of determining eligibility for FHPlus, individuals will not be required to document resources because there is no resource test. However, any income generated by a resource (e.g., interest) must be documented.

The DOH-4220 includes the language by which an applicant attests that the value of his/her resources is above or below the applicable standard. If the LDSS-2921 is used, districts must also allow the applicant to attest to the value of his/her resources using the Addendum to LDSS-2921 (Attachment VII). This attachment must be substituted for the resource section of the LDSS-2921. This form must be locally reproduced until supplies are available from SDOH.

This form also includes questions regarding previous health insurance which are contained in the DOH-4220. Instructions will be forthcoming regarding the collection of this information.

(4) Resource look-back: Enrollment facilitators will not be required to gather the resource documentation necessary for the thirty-six (36) month look-back period necessary to receive nursing facility services or waivered services. Additionally, persons wishing to apply for such services cannot use the DOH-4220. Therefore, the provisions of 95 ADM-17, "Community Coverage Option" which offer applicants (other than single individuals and childless couples) the opportunity to complete the LDSS-4481, "Request for Simplified Asset Review for Medicaid Eligibility", do not apply when using the DOH-4220. Effective with this Directive, districts have the option to authorize full Medicaid coverage in such family situations. Districts that opt to provide community coverage to Medicaid eligible families instead of full coverage must notify families of their eligibility for all services except nursing facility services and waivered services. In addition, S/CC rules regarding transfer of assets are not applicable to the FHPlus program.

b) Other Documentation

All other documentation requirements for the FHPlus program are consistent with those of the Medicaid program. These requirements are outlined in 93 ADM-29, "Documentation and Verification Requirements of the Medical Assistance Program." This Directive was re-issued with clarifications in a letter to all Commissioners dated February 9, 2001. Additional documentation clarifications are contained in GIS Message 01 MA/024, dated July 9, 2001.

Previously documented information on the Welfare Management System (WMS) and/or Medicaid Management Information System (MMIS), must not be redocumented. Further, many adult applicants for FHPlus will have children currently in receipt of CHPlus A. Districts must use documents that were obtained to establish the children's eligibility (e.g., proof of residency), and must not require the parent to resubmit documentation of items not subject to change. Proof of income is not required to be resubmitted if the children's eligibility was established within three (3) months of the parents' application date.

4. Coordination with Facilitated Enrollment Agencies

The LDSS must coordinate the application process with the approved facilitated enrollment organizations working in their communities. Attachment V provides a Statewide listing of approved lead agencies. Certain FHPlus plans have also been approved to facilitate enrollment of adults into Medicaid and FHPlus. These organizations are listed in Attachment IV. The responsibilities of the LDSS in the facilitated enrollment process include the following:

a) Work with the lead organizations and MCOs to develop/amend written protocols for obtaining provider directories from plans and for the receipt and processing of applications and managed care enrollments for adults as well as children. This includes developing processes for notifying the lead organization or MCO and, if appropriate, the applicant when additional documentation is required and of the final eligibility determination. Such protocols must allow for the submission of the DOH-4220 and the managed care enrollment form by the lead organizations and MCOs.

b) When needed, provide information to lead organizations to assist facilitators in determining a health care provider's participation in Medicaid managed care or a FHPlus plan, as described in Section IV.B. of this Directive.

c) Accept completed applications from the lead organizations and MCOs, and process applications in a timely manner, but in no event later than thirty (30) days from the date of application, for applications that include pregnant women or children, or forty-five (45) days from the date of application, for adults. Districts must also provide notice of the results of the eligibility determination to the applicant, and to the lead organization and/or MCO.

The date that the application is completed and signed with the facilitator is considered the date of application for Medicaid, CHPlus A, and FHPlus. Applications may be signed by the applicant, or anyone the applicant designates to represent him/her in the application process.

NOTE: If there is a delay in the receipt of a completed application from a lead organization resulting in the thirty/forty-five (30/45) day timeframe for the Medicaid determination being exceeded, local districts are advised to document this circumstance in the case record. This will serve to hold the district harmless in the event of an audit or other administrative review.

d) Accept Medicaid managed care enrollment forms from the facilitators and pend the enrollment until eligibility has been established and managed care enrollment can be completed in the Prepaid Capitation Payment (PCP) subsystem.

e) Provide prompt feedback to the lead organization or MCO on incomplete or incorrect applications so that problems can be addressed in a timely fashion.

f) Delegate the Medicaid face-to-face interview to the facilitators, (or establish procedures that allow the facilitator to act as the authorized representative for the applicant), for purposes of the face-to-face interview with local district staff. In either situation, the facilitator is responsible for informing the applicant of his/her rights and responsibilities, as required by 18 NYCRR Section 360-2.2(f). Where the local district retains responsibility for the face-to-face interview, interviews with staff from the lead organizations or MCOs should be scheduled in a manner that allows several interviews to be conducted during one appointment.

The protocols must describe the above procedures, and such procedures will be made a part of the facilitated enrollment entity's contract with the SDOH. These procedures may include any standards of performance and/or quality control measures agreed to by both parties, and actions to be taken by the local district to correct performance that does not meet the agreed upon standards.

5. Eligibility and Enrollment Procedures for Pregnant Women/Newborns

a) Counseling of Pregnant women - A pregnant woman applying for health insurance is not eligible for FHPlus and must receive coverage through Medicaid. A woman who becomes pregnant after enrollment in FHPlus must be counseled on her options of either remaining in FHPlus until the end of her year of eligibility or switching to full Medicaid coverage. The counseling should include the provision of information on the services available under Medicaid compared to FHPlus, and assisting the woman in determining if her current providers also participate in Medicaid fee-for-service or managed care. There are no limitations in the benefit package for pregnant women enrolled in Medicaid managed care.

There are two ways that this counseling can be completed:

(1) The managed care plan in which the pregnant woman is enrolled may provide the necessary counseling as to the coverage options available to her, using SDOH guidelines. If the plan completes the counseling, it must notify the local district that it was completed, and of the decision of the pregnant enrollee. In these instances, no further counseling is required by the local district. If this counseling is not completed by the plan, it must be undertaken by the local district. Plans are not mandated to provide counseling to pregnant women but may do so at their option. If a plan elects to provide counseling, it is required to use written materials provided by SDOH to assure full disclosure of the benefits of changing coverage and the services available under the two options.

(2) If the plan has not completed this counseling, the LDSS must provide counseling for the enrollee in making a decision as to which program is best for her.

Local districts and MCOs must establish written procedures outlining how the counseling of pregnant women will be handled. However, whether the MCO or the local district completes the counseling, the local district is required to send a notice to the enrollee confirming her decision regarding coverage options.

b) Local District Actions Regarding Pregnancy of a FHPlus enrollee - Whether or not it completes the counseling, the plan is required to notify the local district that a FHPlus enrollee is pregnant in order to set up the requisite newborn record and amend the FHPlus coverage category for the enrollee.

Upon learning of the woman's pregnancy, the district worker must change the woman's coverage from the FHPlus Case Type 24 to a Case Type 20. If the woman has elected to remain in FHPlus, she is assigned Individual Categorical Code of 58 or 59, depending on the level of income (see Section V.A. of this Directive). These codes are used to ensure the appropriate local share of the pregnant woman's expenses. Women who elect to change from FHPlus to Medicaid are authorized in Case Type 20 in the normal manner. If the woman chooses to change to Medicaid, a face-to-face reauthorization is required at the end of the sixty (60) day postpartum period. Districts must insure that the unborn is authorized with the pregnant woman, in Case Type 20, following existing procedures in either situation.

c) PCAP Implications - In order to expedite medical care for pregnant women, all pregnant women applicants who are not currently receiving prenatal care, should be referred to a PCAP provider for a presumptive eligibility determination. When a family that includes a pregnant woman applies for health insurance at a facilitated enrollment site, the facilitator will give the pregnant woman a copy of the DOH-4220 and advise her to bring it to a PCAP provider. The PCAP provider will use the information contained in the DOH-4220 to complete the Medicaid Presumptive Eligibility For Pregnant Women Screening Checklist (LDSS-4150), and forward the screening checklist to the LDSS.

The completed original DOH-4220 with all required documentation will be forwarded by the facilitator to the LDSS for processing of the entire family's eligibility for FHPlus/Medicaid and CHPlus A. If any of the children are screened eligible for CHPlus B by the facilitator, an additional copy of the application will be sent to the health plan.

When a family, which includes a pregnant woman, applies for health insurance through the facilitated enrollment process, the facilitator becomes the central point of contact and maintains responsibility for the collection of required documentation for all members of the family.

d) Newborn enrollment - The SDOH and LDSSs are responsible for ensuring that timely Medicaid eligibility determinations and enrollments of newborns are effected consistent with State laws, regulations and the newborn enrollment guidelines in 00 OMM/LCM-3 and Appendix H of the FHPlus Model Contract. MCOs are required to notify the LDSS of confirmed enrollee pregnancies, and report newborn demographic information within five (5) days after knowledge of the birth. LDSSs may develop a transmittal form to be used for unborn/newborn notification between the MCO and the LDSS.

LDSSs must authorize Medicaid eligibility for newborns for one (1) year, regardless of changes in income or family size, when born to a woman eligible for and receiving FHPlus on the date of birth. (SSL Section 366[4][1]). LDSSs must insure that Medicaid coverage is authorized for the unborn child as soon as a pregnancy is medically verified.

If the mother remained in FHPlus during her pregnancy, and her FHPlus plan also participates in Medicaid, newborn children not in a Medicaid managed care excluded category will be enrolled in the same plan, effective from the first day of the child's month of birth. If the FHPlus plan does not participate in Medicaid managed care, the pregnant woman must be asked to select a Medicaid managed care plan for the unborn child if she resides in a mandatory county. If she resides in a voluntary county and her plan does not participate in both programs, she may choose a Medicaid plan or choose fee-for-service for the newborn.

If the FHPlus plan is not also a Medicaid managed care plan and a Medicaid managed care plan is not chosen by the mother before birth, or if no Medicaid managed care plan is available in the district, the newborn will be eligible for Medicaid fee-for-service coverage, and such information will be entered on WMS. Under no circumstance will the newborn be without Medicaid coverage authorization.

The LDSS must update WMS with the demographic data for the newborn upon notification of the birth by the MCO, enrollee or hospital. Hospital reporting of births to women in receipt of FHPlus will occur in the same manner as it does for Medicaid. The LDSSs must enroll the newborn retroactively to the first (1st) day of the month of birth. Where newborns will be enrolled in a Medicaid managed care plan, LDSSs must ensure that the mother is informed that the effective date of enrollment will be the first (1st) day of the month of birth.

6. Pursuit of Medical Support

Persons with an absent spouse, 19 and 20 year-olds not residing with parents, and custodial parents of children under age 21 who are in receipt of Medicaid or CHPlus A, must be willing to cooperate with pursuing medical support from the non-custodial parent or spouse. "Cooperation" means non-exempt individuals must cooperate in establishing paternity if necessary, obtaining medical support and payments, and in identifying and providing information to assist in pursuing third parties who may be liable for payment. The DOH-4220 requests information about the applicant's willingness to cooperate with this requirement. Individuals applying at facilitated enrollment sites, who indicate their willingness to cooperate, will be asked by the facilitator to complete Attachment X. This form will be submitted along with the application. LDSSs will use the information provided to complete the DSS-2860 and/or follow LDSS procedures for pursuing medical support from spouses/non-custodial parents. Eligibility determinations must not be delayed for an individual who has indicated his/her willingness to comply with pursuit of medical support.

If an individual claims good cause for not cooperating in the pursuit of medical support by checking "yes" on the DOH-4220 (Section J), the facilitator will take no further action regarding medical support. The determination of whether or not to allow good cause is made by the local district, following existing procedures. Persons who claim good cause are exempt from pursuing medical support until a final determination is made, and must be authorized to receive Medicaid or FHPlus, if they are otherwise eligible.

The failure of an individual, age 19 or over, to cooperate with the pursuit of medical support without good cause, renders the individual ineligible for Medicaid and FHPlus (providing she is not pregnant). Children under 21 must not be denied eligibility due to a parent's refusal to cooperate.

Detailed procedures for pursuit of medical support from non-custodial parents can be found in 99 ADM-5, "Cooperation with Child Support Enforcement for Temporary Assistance, Medicaid, Foster Care and Child Care Services Applicants and Recipients," and in 00 INF-2, "Child Support Cooperation: Questions and Answers." It should be noted that for Medicaid and FHPlus eligibility, parents may choose but are not required to receive other child support services to establish, modify and enforce child support obligations.

7. Potential Disability

Section G of DOH-4220 elicits information about an applicant's health status, so that the LDSS can decide whether a disability determination should be undertaken. Facilitators are not trained to do SSI-related budgeting; therefore, they will screen applicants who indicate they have a potentially disabling condition according to the same criteria as they screen other applicants.

If an applicant answers the question in Section G in the affirmative, and is otherwise eligible for Medicaid or FHPlus, coverage must not be delayed. Districts must follow existing procedures for pursuing a disability determination, when appropriate. If the individual is subsequently determined to be disabled, a SSI-related budget must be done and categorical codes changed as necessary in WMS. The impact on the recipient may be to move him/her from FHPlus eligibility to full Medicaid eligibility, or from Medicaid with a spenddown to full Medicaid eligibility.

8. Potential Income

Under SDOH Regulations, adult applicants must pursue any potential benefits that may be available to them. Such benefits include but are not limited to: unemployment insurance benefits, worker's compensation, New York State disability payments, Veteran's benefits, union benefits, and pensions or retirement benefits. Local district staff, and enrollment facilitators must advise applicants of the requirement to apply for all benefits for which they may qualify. (NOTE: pursuant to OMM/ADM 97-2 "Medicaid Implications of Welfare Reform", employment requirements, including job search are not conditions of eligibility for Medicaid and likewise are not requirements for FHPlus.)

Eligibility must not be delayed when the adult has demonstrated that he/she has begun the process of applying for the benefit. This may be demonstrated by written proof (e.g., letter from the appropriate entity confirming a future appointment) or proof of verbal contacts (e.g., telephone contact to initiate the process). For telephone contact, the applicant may write a note indicating the person spoken to, and the date and time of the contact to be placed in the case record.

9. Alcohol and Drug Abuse Screening, Referral and Treatment

Alcohol and drug abuse screening, referral and treatment is a Medicaid eligibility requirement only for single individuals and childless couples who are age 21 and over, not pregnant or certified blind/disabled. It is NOT a requirement for FHPlus. Therefore, when an applicant screens Medicaid eligible, facilitators will ask such applicants to complete the LDSS-4571, the Alcohol and Drug Abuse Screening and Referral Form (01 ADM 10). If a LDSS receives the form with at least two (2) affirmative replies to Section A, a referral for assessment by a Credentialed Alcohol and Substance Abuse Counselor (CASAC) should be made in accordance with existing agency procedures.

Local districts should provide a supply of LDSS-4571's to those plans and agencies approved to serve as FHPlus/CHPlus/Medicaid enrollment facilitators. If the local district's supply is not sufficient, additional forms can be ordered by following the instructions contained in 01 ADM 10.

10. Transition Between FHPlus and Medicaid/Temporary Assistance

a) Medicaid/Temporary Assistance to FHPlus

Adults who become ineligible for Medicaid or Temporary Assistance due to excess income or resources must be evaluated for eligibility under FHPlus.

Currently, individuals losing Temporary Assistance eligibility, who are pregnant, under 21 years of age, parents residing with children under age 21, certified blind/disabled, or age 65 and over, are provided with an extension of Medicaid coverage in order to perform a separate determination of Medicaid eligibility. This process is being extended to single adults/childless couples when they are determined ineligible for Safety Net Assistance based on income or resources, and the individual's ABEL budget shows income at or below 100% of the FPL. The individual's Temporary Assistance closing notice will advise him/her that Medicaid coverage will continue pending a separate Medicaid determination.

Medicaid only adults must also be screened for FHPlus eligibility upon losing financial eligibility for Medicaid. When determined eligible for FHPlus, and the person is currently enrolled in a Medicaid managed care plan and the plan is also a FHPlus plan, the individual remains enrolled in the same plan and coverage is changed to FHPlus coverage. In this instance, the person will be sent a notice advising him/her of enrollment in the same plan, with FHPlus coverage, and that he/she can contact the local district for more information. (LDSS must be aware that lock-in rules may apply in mandatory counties and in some voluntary counties. See Section IV.C. of this Directive.) FHPlus eligible persons who are not currently enrolled in a FHPlus participating plan must be provided an additional sixty (60) days of Medicaid coverage beyond the determination of Medicaid ineligibility to allow an administrative period in which to enroll the person in a FHPlus plan, if the person is not already enrolled in a plan participating in the FHPlus program. This will ensure that no lapse in coverage occurs. At the time of the determination, an undercare notice will be generated by the Client Notices Subsystem (CNS), based on the appropriate reason code (see Section V.D. of this Directive) explaining why the person is ineligible for full Medicaid, and offering new FHPlus eligibility. The notice will instruct the person that he/she must pick a FHPlus plan within thirty (30) days (transaction date plus thirty (30) days). This notice will also include information regarding the differences in the benefit package provided by FHPlus, information about the Medicaid spenddown program, when appropriate, and instructions to contact the LDSS if spenddown is preferred. The notice will also indicate that failure to select a plan by the date specified (day 30) could result in a lapse of coverage or in case closing. The transaction necessary to initiate this CNS notice must include the shortening or lengthening of the Medicaid coverage period to ensure coverage through the end of the month in which the sixtieth (60th) day following the transaction date occurs.

Local districts must have a process in place to ensure the person receives a managed care information package and plan enrollment form for FHPlus. These materials can either be handed to the person if he/she is in the agency at the time of the determination (e.g., reauthorization) or mailed under separate cover within five (5) business days of the CNS notice, by either the Medicaid or Managed Care staff, whichever process the local district prefers. Cases need to be tracked to insure plan selection by the thirtieth (30th) day.

If the person picks a plan within the thirty (30) day period and there are no individuals who will remain on Case Type 20, then the worker will change the Case Type from 20 to 24 and the Coverage Code to 34. The worker will send a notice (see Section IV.D. of this Directive) indicating the name of the plan chosen, and informing the person that he/she may begin using services when notified by the plan. The managed care enrollment form is processed according to local district procedures. FHPlus coverage is for twelve (12) months from the date of enrollment provided the enrollee remains otherwise eligible.

If the person has not responded to the undercare notice and has not selected a FHPlus plan by day thirty (30), a timely closing notice must be sent and the case closed. The closing notice will inform the recipient that his/her case is being closed for failure to select a FHPlus plan, and it will include fair hearing rights. If the recipient responds within the timely notice period, he/she may still be enrolled in a plan, but there may be a lapse in coverage if the plan pull down dates are not met.

There will be situations when an adult becomes FHPlus eligible, and is a member of an active Medicaid case with children or other recipients who remain Medicaid eligible. The FHPlus eligible individual should be deleted from the Case Type 20, with Transaction Type 06 (which deletes effective the end of the current authorization period) or an 05 Transaction Type and double pass the MA coverage To Date so that the coverage goes to the end of the month. The transaction type should be based on when the individual can be enrolled in the plan. A new Case Type 24 must be opened for him/her. The Case Type 20, with the remaining family members must be given an authorization To Date equal to twelve (12) months from the FHPlus opening date to ensure coordination of the reauthorization periods. (See Section V.B. of this Directive.)

b) FHPlus to Medicaid

FHPlus enrollees who may be eligible for Medicaid because of a reduction in income or resources, must be evaluated for eligibility under Medicaid. In the event that a FHPlus participant gains eligibility for full Medicaid, and the FHPlus plan in which the person is enrolled also provides Medicaid managed care, the individual will remain enrolled in the same

plan. The person will be sent a notice advising him/her that he/she has been enrolled in the same plan and is eligible for all services available under the Medicaid program.

When the participant's FHPlus plan is not a Medicaid plan, and the individual has not yet been enrolled in a Medicaid plan, the individual's coverage will be authorized under fee-for-service Medicaid. The LDSS is responsible for ensuring that the beneficiary is informed of his/her Medicaid managed care options.

B. Facilitated Enrollment

The FHPlus/Medicaid facilitator is responsible for assisting all adult applicants in completing the application and assisting in plan selection. All FHPlus/Medicaid applications will be forwarded to the LDSS for determinations of eligibility, plan assignment and issuance of client notices.

1. Facilitator Responsibilities

Facilitators are responsible for the following:

- Conduct the face-to-face interview in accordance with Medicaid requirements, policies and procedures. In those LDSSs in which the personal interview is not delegated to the facilitator, the facilitator shall act as the enrollee's authorized representative at the personal interview between a LDSS representative and the facilitator.

- Assist applicants in completing the DOH-4220, and screen adults and family applicants to assess their potential eligibility for various programs using a documentation checklist and screening tool. The CHPlus/Medicaid Documentation Checklist and Health Insurance Eligibility Screening Worksheet have been revised to accommodate the new adult population (Attachments I and XI).

- Explain the application and documentation requirements and help applicants obtain required documentation. Required documentation may include but is not limited to residency and income information, social security number and citizenship/alien status. Facilitators must also follow-up with applicants to ensure that the application process, including plan enrollment, is completed.

- Educate all eligible applicants, including adults and families, about their rights and responsibilities in the application process, and about managed care and how to access benefits in a managed care environment. This includes the dissemination of SDOH approved materials developed for this purpose.

- Distribute SDOH approved informational materials in English and other appropriate languages regarding New York State's health insurance coverage options. These include brochures and information developed by SDOH to explain health insurance coverage options available through the FHPlus, CHPlus and Medicaid programs and various other public programs designed to support self sufficiency.

- Counsel all eligible applicants regarding the selection of a participating MCO, describe the important role of a primary care provider, and describe the benefits of preventive health care. All facilitators must agree to operate as a neutral party in the MCO selection process to assure that applicants are allowed to make an informed choice of plans.

- Submit the completed application with required documentation directly to the appropriate LDSS responsible for the processing of applications and eligibility determinations. All approved lead agencies are required to establish acceptable protocols, or amend existing SDOH approved protocols with LDSSs. These protocols should address procedures for the delivery and processing of completed applications in accordance with State administrative directives. Such protocols must be approved by the LDSS and the SDOH prior to the lead agency's commencement of facilitated enrollment activities.

- Comply with LDSS established procedures for transmitting the Medicaid or FHPlus applicant's managed care plan choice directly to the appropriate LDSS or enrollment broker.

- Follow-up if necessary on each application with the appropriate LDSS to ensure that applications are being processed, and that applicants are able to enroll and receive services in a timely manner.

- Develop a mechanism for tracking the individuals and families they have enrolled in health insurance, and assist enrollees in reauthorizing their coverage prior to the expiration of their twelve (12) month enrollment period, if the enrollee approaches the facilitator regarding reauthorization. Because FHPlus/CHPlus B families will be able to submit their reauthorizations by mail, the role of the facilitator in this process is expected to be minimal. However, tasks associated with reauthorization may include assisting in the completion of the reauthorization form and collection of required documentation to ensure that the process is completed within the required timeframes.

- Provide all applicants with information about their rights regarding complaints to LDSSs about eligibility determinations, and also complaints to plans regarding service decisions.

o Make available SDOH and State materials regarding other State programs for which applicants may be eligible.

NOTE: Because facilitators cannot make the eligibility determination for either the FHPlus or Medicaid program, it is possible that their screening outcomes could be reversed when eligibility is subsequently performed by the LDSS worker. Therefore, it is important that facilitators emphasize to applicants who screen eligible for FHPlus that if they are subsequently determined eligible for Medicaid by the LDSS they may be required to comply with certain Medicaid requirements, e.g., documentation of resources, photo ID, finger imaging, and if applicable, alcohol and drug abuse screening, referral and treatment.

2. Plan Enrollment in Counties with Enrollment Brokers

SDOH has contracted with an enrollment broker, currently Maximus, Inc., in certain boroughs/counties of the State to conduct certain enrollment, outreach and informational activities for Medicaid. The enrollment broker may assist in some portions of the enrollment process for FHPlus, such as the receipt and entry of plan selection information from the facilitator and notification of plans as to the new enrollee. In local districts served by the enrollment broker, the broker will be responsible for processing the managed care enrollment after eligibility has been established by the LDSS. However, the LDSS remains responsible for compliance with all program requirements.

a) Facilitated enrollment lead agencies and MCO facilitators must submit the managed care enrollment forms to the enrollment broker (not the LDSS), with a cover sheet on all batches that clearly identifies the name and ID# (assigned by the enrollment broker) of the enrolling entity. All enrollment forms must also have the entity name and ID# included on the top of each form. Health plan enrollment facilitators may choose to submit the managed care enrollment to the enrollment broker electronically rather than submitting the hard copy form.

b) The enrollment broker will pend these enrollments until eligibility has been established, and the LDSS updates the eligibility database with the new eligible information. The broker will match with the eligibility update using the social security number. Therefore, it is essential for the facilitators to accurately enter the social security number of the potential enrollee on the managed care enrollment form. It is also critical that the LDSS staff accurately enter the social security number of the newly eligible individual so that the broker may match the eligibility with the pended managed care enrollment.

In cases where the individual does not have a social security number, or it is not known, the enrollment broker cannot process the managed care enrollment. The LDSS must enter the managed care enrollment for these applicants.

C. Managed Care Enrollment

Overall, the LDSS's role in the FHPlus program is the same as for the Medicaid managed care program. All LDSS requirements under the Medicaid Managed Care Section 1115 Waiver Demonstration Program, (the Partnership Plan), apply to FHPlus activities except for specific provisions related to: contracting with MCOs; mandatory enrollment; exempt or excluded populations; auto-assignment; disenrollment to fee-for-service; and wrap-around services. Implementation of FHPlus will require increased coordination between eligibility, education and enrollment processes within the local district and with facilitated enrollment contractors in the county.

LDSSs should refer to the Partnership Plan Special Terms and Conditions as amended on June 1, 2001; the Partnership Plan Operational Protocol as amended for FHPlus; and the FHPlus Model Contracts for a full program description, including roles and responsibilities of SDOH, MCOs, FEs and LDSSs.

LDSS functions include determining eligibility, providing the applicant with information about managed care options, coordinating with approved facilitated enrollment entities, processing enrollments and disenrollments, MCO marketing oversight, provision of enrollee notices, complaint resolution, and reporting as required by SDOH.

1. Informing Applicants about Managed Care and Plan Options

The application process must include an eligibility determination and provision of information about managed care options. LDSSs are responsible for ensuring that pre-enrollment information provided to individuals applying for FHPlus is consistent with SSL Section 369-ee.

A variety of methods and programs for informing FHPlus applicants may be employed including, but not limited to enrollment assisted by SDOH approved enrollment facilitators, enrollment broker, LDSS, or a combination of such. These entities are the LDSS designees for providing pre-enrollment information. Local districts must ensure all pre-enrollment activities in their county are comprehensive and consistent with local requirements. This may necessitate modifications to current policies and protocols. The LDSS may provide training in these protocols and best practices to all persons assisting applicants for FHPlus.

The LDSS may elect to combine information provision, eligibility, and enrollment processes into a one-stop shopping model. The preferred approach to providing pre-enrollment information to applicants is to ensure that both the Medicaid managed care and FHPlus programs are fully discussed at the time of application. In this way, a participant can obtain coverage under whichever program he/she is eligible for without returning to the local district or the enrollment facilitator. The DOH-4220 and enrollment form is designed to assist applicants in choosing a plan for both FHPlus and Medicaid managed care at the time of application so that, regardless of which program they ultimately

enter, they are enrolled in a plan of their choice. Applicants for FHPlus are required to complete the health plan selection areas of the DOH-4220 and/or enrollment form even in local districts where there is only one FHPlus health plan.

2. Other Requirements

Pre-enrollment information must advise potential enrollees of the availability of FHPlus MCOs and the scope of services covered by each plan. LDSSs or their designees must also inform potential enrollees of the right to discuss their enrollment options in a confidential, individualized setting, and must make confidential, individualized sessions available upon request.

In written materials relating to enrollment, the LDSSs or their designees must advise potential enrollees to verify that the medical service providers they prefer to maintain or develop a relationship with, actually participate in the selected plan's network and can serve the applicant. For enrollments made during a confidential, individualized session, if the potential enrollee has a preference for a particular medical service provider, persons assisting applicants must verify with the medical service provider that he/she participates in the selected plan's network and is available to serve the applicant.

3. Medicaid Managed Care/FHPlus Enrollment

LDSS's are responsible for processing enrollments and determining the status of applications as enrolled, pending or denied. See the PCP Subsystem (Section V. of this Directive) for information on how enrollments are processed.

Consistent with the FHPlus Model Contract, an enrollee's effective date of enrollment will be the first (1st) day of the month on which the enrollee's name appears on the PCP roster for that month. From the effective date of enrollment, until the effective date of disenrollment, the MCO is responsible for the provision and cost of all care and services covered in the benefit package and provided to enrollees whose names appear on the PCP roster.

4. Plan Enrollment Conditions

Participation in FHPlus is voluntary and an enrollee may disenroll from the program at any time. Disenrollment from the FHPlus program means the individual will no longer receive health care coverage unless the individual becomes eligible for full Medicaid eligibility or eligible for Medicaid with a spenddown.

In FHPlus, there is no requirement that individual members of the same family be enrolled in the same MCO.

FHPlus participants are enrolled in a MCO for an initial enrollment period of twelve (12) months from the effective date of enrollment, with a ninety (90) day grace period to disenroll from the FHPlus plan and enroll in another FHPlus MCO without cause (transfer). After the ninety (90) day grace period, and during the remaining nine (9) months of the initial enrollment period, an enrollee may only change FHPlus plans with good cause, as defined in Section IV.C.5. of this Directive. Once the FHPlus initial enrollment period has expired, an enrollee may disenroll from the FHPlus plan and enroll in another FHPlus plan, if available, at any time and for any reason. A LDSS or MCO will provide enrollees who transfer voluntarily with an opportunity to identify, in writing, their reason(s) for switching plans.

LDSSs are responsible for making determinations on requests for transfers and notifying enrollees of the outcomes of such requests. LDSSs are also responsible for making determinations when an individual's eligibility status changes:

- An enrollee may disenroll from his/her MCO and enroll in another FHPlus plan, if available, during the initial enrollment period for "good cause" as defined by SDOH. (See Section IV.C.5. of this Directive.)

- A new enrollee who loses eligibility for FHPlus during the first six (6) months of his/her enrollment is entitled to receive FHPlus benefits from the MCO for a guaranteed eligibility period of six (6) months from his or her effective date of enrollment. During this time the FHPlus ineligible enrollee may not change MCOs.

- Guaranteed eligibility is not available to enrollees who lose FHPlus eligibility due to death, moving out of State, or incarceration. An enrollee-initiated disenrollment from the MCO also terminates the Guaranteed Eligibility period.

- Persons who are disenrolled from a MCO due to loss of FHPlus eligibility and who regain eligibility within ninety (90) days will automatically be prospectively re-enrolled in the same plan, subject to available enrollment capacity in that plan, and will not be entitled to a new period of six (6) months guaranteed eligibility.

- If a FHPlus enrollee gains eligibility for full Medicaid, and his/her FHPlus MCO is also a Medicaid plan, the participant will be enrolled in the same plan, subject to available enrollment capacity in that plan, unless the participant indicates otherwise in writing. This enrollment change must be manually processed until automated systems are developed to support this transition. If the FHPlus plan is not a Medicaid plan, the individual is covered through fee-for-service until a new plan, if available, is selected.

- If a FHPlus enrollee gains eligibility for full Medicaid, then loses that eligibility and returns to the FHPlus program within ninety (90) days, the participant will be re-enrolled in the same plan, subject to available capacity in that plan. This enrollment change must be processed manually. In this situation the twelve (12) month initial enrollment period and six (6) month guarantee period do not begin again.

- For any individual who loses FHPlus eligibility due to eligibility for Medicaid, if the individual remains in the same MCO as a Medicaid enrollee, any remaining guarantee period that began when the person enrolled in FHPlus continues to run under Medicaid managed care. Likewise, any period of lock-in would continue to run under Medicaid managed care. Individuals whose FHPlus plan does not provide Medicaid managed care are provided coverage under fee-for-service Medicaid beginning on the first (1st) day of the month following the month of the determination unless the individual has enrolled in another Medicaid plan. If this decision is made after the monthly roster pulldown date, the LDSS is responsible for notifying the MCO in writing or electronically that the enrollee is no longer in the plan and the effective date of that disenrollment.

5. Disenrollment Process

Disenrollment of an enrollee from a MCO may be initiated by the enrollee, a LDSS, or the MCO under certain conditions. LDSSs are responsible for making the final determination concerning disenrollment, except in circumstances in which MCO-initiated disenrollments and expedited disenrollments may be subject to SDOH approval. All disenrollment policies and procedures outlined in the New York State Operational Protocol and the FHPlus Model Contract must be followed.

LDSSs must utilize the SDOH Disenrollment Form (DOH-4111) to process disenrollments, and use the revised enrollment form DOH-4097 to re-enroll the individual in another MCO. LDSSs must process routine disenrollment requests to take effect on the first (1st) day of the following month if the request is made before the fifteenth (15th) day of the month. In no event shall the effective date of disenrollment be later than the first (1st) day of the second (2nd) month after the month in which an enrollee requests a disenrollment.

During the initial enrollment period, an enrollee may request a disenrollment for "good cause" and re-enrollment in another FHPlus plan, if available, by filing a written request with the LDSS or the MCO. The MCO must notify the LDSS of the request. The LDSS must accept requests for disenrollment directly from enrollees and may not require enrollees to approach the MCO for a disenrollment form. The LDSS must respond with a determination within thirty (30) days after receipt of the request.

LDSSs will disenroll enrollees upon determination that they meet the "good cause" criteria, as defined by SDOH. Examples of "good cause" include but are not limited to:

- o failure of the MCO to furnish accessible and appropriate medical care to which the enrollee is entitled;
- o nonconsensual enrollment; and
- o the enrollee, MCO, and LDSS agree that a change of MCO is in the best interest of the enrollee.

In the event that the LDSS denies an enrollee's request to disenroll for "good cause", the LDSS must inform the enrollee of the denial with a written notice which explains the reason for the denial, states the facts upon which the denial is based, cites the statutory and regulatory authority for the denial, and advises the enrollee of his/her right to a fair hearing pursuant to 18 NYCRR Part 358. If the enrollee's request to transfer is approved, the notice must state the effective date of disenrollment from the original plan. LDSSs will update the PCP subsystem file with the end date. The Electronic Eligibility and Verification System (EMEVS) and the Fiscal Agent are then updated and the enrollee is removed from the original MCO's roster.

Enrollees may request an expedited disenrollment from the LDSS or the SDOH. LDSSs will expedite the disenrollment process in those cases where an enrollee's request for disenrollment involves an urgent medical need, or a complaint of non-consensual enrollment. If approved, the LDSS will manually process the disenrollment and re-enrollment in another FHPlus MCO through the PCP Subsystem.

6. Retroactive Disenrollment

LDSSs can only retroactively disenroll a participant when necessary to avoid inappropriate payments for services. Circumstances warranting a retroactive disenrollment are rare and include when an enrollee is later determined: to have entered and stayed in a residential institution and gained full Medicaid eligibility; to have been incarcerated; to have moved out of the county of fiscal responsibility, subject to any time remaining in the enrollee's guaranteed eligibility period; or to have died - as long as the MCO was not at risk for provision of benefit package services for any portion of the retroactive period. LDSSs must notify the MCO of a retroactive disenrollment prior to the action. LDSSs must find out if the MCO has made payments to providers on behalf of the enrollee prior to disenrollment. After this information is obtained, LDSSs and the MCO must agree on a retroactive disenrollment or prospective disenrollment date.

The effective dates of retroactive disenrollment for specific circumstances are described in the Operational Protocol and FHPlus Model Contract and must be adhered to.

7. Roster Reconciliation and Capitation Payments

All enrollments are effective the first (1st) of the month.

SDOH shall send each MCO and LDSS monthly (according to a schedule established by SDOH), a complete list of all enrollees for which the MCO is expected to assume medical risk beginning on the first (1st) of the following month (first monthly roster). Notification to MCOs and LDSSs can be accomplished via paper transmission, magnetic media, or via an electronic bulletin board. The SDOH will also forward an error report as necessary to each MCO and LDSS.

On the first (1st) weekend after the first (1st) day of the month following the generation of the first (1st) roster, SDOH shall send MCOs and LDSSs a second (2nd) roster which contains any additional enrollees that a LDSS has added for enrollment for the current month. The SDOH will also include any additions to the error report that have occurred since the initial error report was generated.

The combination of the first (1st) and second (2nd) monthly rosters generated by SDOH will be the official MCO enrollment list for purposes of MMIS premium billing and payment, subject to ongoing eligibility of the enrollees as of the first (1st) day of the enrollment month. Modifications to the roster may be made electronically or in writing by the LDSS or the enrollment broker prior to the end of the month the roster is generated.

LDSSs must make data on eligibility determinations available to the MCO and SDOH to resolve discrepancies that may arise between the roster and the MCO's enrollment files.

LDSSs must notify the MCO electronically or in writing of changes in the roster and error report no later than the end of the month. (Note: To the extent practicable the date specified must allow for timely notice to enrollees regarding their enrollment status. MCOs and LDSSs may develop protocols for the purpose of resolving roster discrepancies that remain unresolved beyond the end of the month.)

Enrollment and eligibility issues are reconciled by the LDSS to the extent possible, adjusting the PCP subsystem enrollment and WMS eligibility files, if appropriate.

If the MCO does not receive the roster before the last business day of the month prior to the roster effective date, the MCO will receive the applicable monthly capitation rate for any individual who is no longer on the roster, was eligible the prior month, and is inadvertently served by the MCO before receipt of the roster.

In instances in which the enrollee is enrolled in the MCO on the date of the delivery of a child, the MCO shall be entitled to receive a Supplemental Maternity Capitation Payment. The Supplemental Maternity Capitation Payment reimburses the MCO for the inpatient and outpatient costs of services normally provided as part of maternity care including

antepartum care, delivery and post-partum care. The Supplemental Maternity Capitation Payment is in addition to the monthly capitation rate paid by the SDOH to the MCO for the enrollee.

If CMS denies payment for new enrollees, as authorized by Social Security Act (SSA) Section 1903(m)(5) and 42 CFR Section 434.67, or such other applicable federal statutes or regulations, based upon a determination that the MCO failed substantially to provide medically necessary items and services, imposed premium amounts or charges in excess of permitted payments, engaged in discriminatory practices as described in SSA Section 1932(e)(1)(A)(iii), misrepresented or falsified information submitted to CMS, SDOH, LDSS, the enrollment broker, or an enrollee, potential enrollee, or health care provider, or failed to comply with federal requirements (e.g., 42 CFR Section 417.479 and 42 CFR Section 434.70) relating to physician incentive plans, SDOH will deny capitation payments to the MCO for the same enrollees for the period of time for which CMS denies such payment.

8. Marketing

After the start of the program, SDOH will delegate to the LDSS the responsibility for monitoring MCO compliance with SDOH Marketing Guidelines for FHPlus (Appendix D of the FHPlus Model Contract), in the categories described below.

- MCO marketing plans, describing the marketing activities the MCO will undertake within designated geographic areas while under contract with SDOH;

- County specific marketing materials to be used in the local district, including: scripts or outlines of presentations, pre-enrollment written materials, MCO informational brochures to be included in LDSS enrollment packets, and all MCO direct mailings targeted to the FHPlus market; and

- Plan marketing at community events and locations where potential enrollees are likely to gather.

Note: SDOH is developing an informational brochure for FHPlus.

The LDSS will retain county-specific marketing plans on file. If the MCO requests modifications to the marketing plan, the LDSS (or SDOH) must take action on the request within sixty (60) calendar days of submission or the MCO may consider the changes approved.

The LDSS is responsible for monitoring plan marketers and ensuring that marketing activities by the MCO conform to approved marketing plans, utilizing approved materials. Action against MCOs failing to comply with the Marketing Guidelines will be taken by SDOH in collaboration with LDSSs to protect the interests of the program and its clients.

9. Complaints

Complaint and appeal processes, including the right to a fair hearing and aid continuing must be accessible to all FHPlus applicants and enrollees. FHPlus plans are required to establish procedures to handle enrollee inquiries, complaints, grievances, and appeals. Generally, enrollees should be instructed to contact the plans first if they have problems related to the medical care provided. Enrollees may request a fair hearing regarding adverse LDSS determinations concerning enrollment, disenrollment and eligibility, and regarding the denial, termination, suspension or reduction of a clinical treatment or other benefit package service by the MCO.

LDSSs must log complaints about the FHPlus program, including the nature of the complaint and its resolution. Where applicable, the LDSS should forward complaints to SDOH or the MCO for resolution. Applicants must be informed that they may file a complaint directly with the SDOH at any time. Complaint information must be reported to SDOH as described in the Operational Protocol.

10. Surveillance

All LDSSs are subject to periodic surveys by SDOH for compliance with FHPlus program requirements.

D. Family Health Plus Notices

Districts are responsible for sending SDOH prescribed notices to enrollees regarding their enrollment status. Notices may include and are not limited to:

1. Eligibility Notices

- FHPlus Notice of Acceptance: this notice informs the new applicant of approval of eligibility for FHPlus and the name of the MCO selected by the applicant. It contains language to notify enrollees of their right to transfer to another MCO within ninety (90) days after the effective date of enrollment. This notice must be sent manually. The wording is provided in Attachment XII, and is required to be attached to the LDSS-3622, "Notice of Decision on Your Medical Assistance Application." The reason for ineligibility for Medicaid must be provided on the LDSS-3622, which contains the appropriate fair hearing language. This Attachment must be locally reproduced until supplies are available from SDOH.

- Notices of Denial of Eligibility: these notices are used when an individual has been determined by LDSS to be ineligible for FHPlus, and they contain the appropriate fair hearing language. In New York City, denial notices are sent manually. In all other counties, these notices are automated based on the use of appropriate reason codes in CNS and/or WMS.

- Notices of Ineligibility for FHPlus Coverage: These notices will advise the enrollee that his or her eligibility for FHPlus coverage is ending, and contain appropriate fair hearing language. These notices are automated based on the use of appropriate reason codes in CNS and/or WMS.

2. Undercare Notices

New notices have been developed for individuals transitioning between Medicaid and FHPlus. In New York City, these notices must be sent manually. In all other counties, these notices are automated based on the use of appropriate reason codes in WMS.

An explanation of the new codes and changes to existing codes is provided in a CNS/WMS Coordinator Letter, dated August 21, 2001 for the changes being made in the September 4, 2001, migration. As more new codes and changes to existing codes are available, LDSSs will be notified via CNS/WMS coordinator letters.

3. Managed Care Notices

- Notice of Decision on Your Request to Disenroll From Your Health Plan for Good Cause: This notice will advise an enrollee of the status of his/her request to disenroll during a grace period, or for good cause. Fair hearing language is included. Wording for this notice is provided in Attachment XIII. The notice must be reproduced by the LDSS.

- Notice of Action Taken After Your Plan Asked to Drop You as a Member: This notice will advise the enrollee of the status of the MCO's request to disenroll him/her. Fair hearing language is included. Wording for this notice is provided in Attachment XIV. The notice must be reproduced by the LDSS.

- Denial of Your Request to Join a Health Plan: This notice is sent to an applicant who has chosen a health plan that does not participate in the FHPlus program. LDSS must include with this letter a new enrollment form and information on FHPlus plans available in the district. Wording for this notice is provided in Attachment XV. The notice must be reproduced by the LDSS.

- End of Initial Enrollment Period: This notice is sent by the LDSS or the enrollment broker to notify enrollees at least sixty (60) days before the end of their initial enrollment period of their right to change MCOs. Wording for this notice is provided in Attachment XVI. The notice must be reproduced by the LDSS. Local districts receive monthly lists and mailing labels of persons who must be sent this notice from the SDOH.

E. Temporary Assistance Implications

Previously, a separate determination of eligibility for Medicaid was provided under certain circumstances for Temporary Assistance cases that were closed or denied, pursuant to the Rosenberg decision. Generally, single individuals or childless couples in Safety Net Assistance cases that were closed or denied due to financial ineligibility were not provided a separate determination, since they would also be financially ineligible for Medicaid.

With the implementation of FHPlus, whenever a Safety Net Assistance case is closed or denied for the reasons of excess income or excess resources, it will be subject to a separate determination of potential FHPlus eligibility.

When a cash Safety Net Assistance case is closed for excess income with no TMA extension (Reason Code E30), or excess resources (Reason Code U40), the system will review the ABEL budget to determine if the total household income is less than or equal to 100% FPL. If it is, the Medicaid Extension Reason Code will be set to 758 (Medicaid continuing until a separate determination regarding Medicaid has been made). Individual(s) on the case will receive an extension under existing processes. Local district staff must review these individuals for potential Medicaid or FHPlus eligibility.

V. SYSTEM IMPLICATIONS

UPSTATE

Systems codes and edits have been modified to support the FHPlus program. A detailed description of the items below can be found in the WMS/CNS Coordinator Letter dated August 21, 2001. The following is a summary of the changes:

A. WMS Instructions

1. WMS has been revised to support a new Case Type (24 - Family Health Plus) for the FHPlus program. Changes to Case Type 20 (Medicaid-Only) have also been implemented to support Pregnant Women who elect to remain in FHPlus.

2. Four (4) new Individual Categorical Codes have been added for Federal/State/Local claiming purposes:

   56 FHP Singles & Childless Couples/19-20 Not Living with Parents
   57 FHP Parents/19-20 Living with Parents
   58 FHP Pregnant Woman 100% FPL
   59 FHP Pregnant Woman 100-200% FPL

   Codes 56 and 57 are allowed in Case Type 24 only.

Codes 58 and 59 are allowed in Case Type 20 only. They are used to designate pregnant women who have elected to remain in FHPlus, and will drive appropriate claiming, depending upon the woman's income level.

3. Two (2) new Recipient Medicaid Coverage Codes have been added for reporting purposes to differentiate the standard FHPlus from FHPlus Guarantee:

   34 FHP
   36 FHP Guarantee

4. Since FHPlus is managed care only, and all services will be provided through the managed care premium payment, a Medicaid ID Card will not be issued to FHPlus enrollees. The Card Code must be "X". If the recipient has an active card from another program (such as Food Stamps) the "X" will not adversely affect the card.

5. Since FHPlus is a program for adults only, unborns are not allowed on Case Type 24. All pregnant women will be authorized in Case Type 20 (Medicaid-Only), including those women electing to remain in FHPlus. Unborns must be authorized in Case Type 20 with the FHPlus eligible mother, following existing procedures.

6. Case Type 24 can be changed (05 - Undercare Maintenance or 06 - Reauthorization) to Case Types 20 or 22. A Case Type 20, or 22 can also be changed to a Case Type 24 using Transaction Code 05 or 06.

7. WMS Force Close procedures apply to this Case Type the same way they apply to a Case Type 20. When the Case Type hierarchy would close a Case Type 20, it will also close a Case Type 24.

8. For Case Type 24, State/Federal Charge Codes are not allowed. There are also no Utilization Threshold, Co-pay, or AFIS requirements, but the usual RFI procedures apply.

B. Linking Family Health Plus and Medicaid Eligible Family Members

Because FHPlus eligible individuals will have a discrete Case Type, there will be situations in which the children in a family will have coverage under CHPlus A, (Case Type 20), and the parents of these children will have coverage under FHPlus (Case Type 24). For the convenience of both the local district and the family, the case records, case numbers and authorization periods of the family should be linked.

This may be accomplished by including a suffix or prefix in the same case number used in WMS, as is currently the practice in many local districts to link Medicaid and cash assistance or Food Stamp cases (e.g., 0123456MA for the children, and 0123456FHP for the adults). Local districts must maintain one case record for the family to ensure family members are not asked to duplicate documentation already in the possession of the district. Cases may also be linked using the Cooperative Case Number field.

In the instance where the parents of children already in receipt of CHPlus A apply for health insurance and are found eligible for FHPlus, the eligibility determination of the parents will constitute a redetermination of eligibility for any children, as items subject to change will have been verified to determine the parents' eligibility. At the time the parents are authorized, a Reauthorization Transaction (06) is completed for the children, and their authorization dates are aligned with their parents, so that all family members will be due for reauthorization at the same time. For example, the children are authorized from February 1, 2001 to January 31, 2002. Their parents apply in September and are found to be eligible for FHPlus. The parents' authorization for FHPlus will be from October 1, 2001 to September 30, 2002. The children's authorization period will also be changed to run from October 1, 2001 to September 30, 2002.

As noted in Section IV.A.3. of this Directive, districts must not require parents to resubmit documentation of items not subject to change that were obtained to establish their children's eligibility. In addition, proof of income is not required to be resubmitted if the children's eligibility was established within three months of the parent's application date.

C. MBL Instructions

The Medicaid Budget Logic (MBL) has been enhanced to include the FHPlus eligibility calculation for families up to 133% of the FPL and 100% of the FPL for singles and childless couples. In order to support this, a new heading for FHPlus will appear on the Expanded Eligibility Screen. The previous single Expanded Screen will now be two (2) screens, to accommodate FHPlus and future Medicaid expansion. Please refer to MBL Transmittal 01-2 and 01-3 for the details.

D. CNS

Numerous changes and additions to the CNS Denial, Closing, and Undercare codes will be implemented to accommodate the FHPlus program. Many of the notices will be available for September 4, 2001 implementation and others will follow during the Fall of 2001. The WMS and CNS Code Cards will also be updated to reflect any new codes. Initial details regarding CNS are contained in the WMS/CNS Coordinator Letter dated August 21, 2001.

E. PCP Subsystem

A participant's enrollment in a FHPlus Plan will be entered in the PCP subsystem either by manual on-line entry or EMEVS PC software by the local district. For NYC, Nassau and Suffolk counties, the enrollment broker will send on-line enrollments for FHPlus enrollees. These are the same system processing methods currently used for entering enrollments in Medicaid managed care.

If a FHPlus plan is also a Medicaid managed care plan, it will have the same provider identification number, as well as the same EMEVS plan code. If the plan is only a FHPlus plan, it will be assigned a new provider ID number, and EMEVS plan code. All FHPlus plans will have the unique benefit package code of "70". This code should be entered in the PCP subsystem field "BP" for all FHP enrollments. This is the only difference in the enrollment entry from a Medicaid managed care enrollment entry.

NOTE: Additional information regarding WMS and CNS changes for FHPlus, necessitated by Aliessa, et al. v. Novello, will be forthcoming.

DOWNSTATE

WMS, MBL and CNS instructions for New York City will be issued under separate cover.

VI. EFFECTIVE DATE

The SDOH will soon begin a broad based outreach program, and will be working with LDSSs, FHPlus MCOs, and facilitated enrollment organizations to encourage awareness and interest in the program.

LDSSs shall begin using the new application and plan enrollment forms (DOH-4220 and DOH-4097) on September 4, 2001.

Although individuals may apply for enrollment in FHPlus plans through local districts starting September 4, 2001, actual enrollments are not to be processed by local districts until the district is notified by SDOH that the plans in that county have been approved to begin services, consistent with the "Dear Commissioner" Letter distributed August 31, 2001.

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