STATE OF NEW YORK
DEPARTMENT OF HEALTH

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TRANSMITTAL: 02 OMM/ADM-7

TO: **Commissioners of Social Services**

DIVISION: Office of Medicaid Management

DATE: December 10, 2002

SUBJECT: Family Planning Benefit Program

SUGGESTED DISTRIBUTION:

Medicaid Directors
Staff Development Coordinators
Temporary Assistance Directors
CAP Coordinators
TOP Coordinators

CONTACT PERSON:

Local District Liaison
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ATTACHMENTS:

Attachment I Family Planning Benefit Program Application
Attachment II Declaration of Age
Attachment III Memorandum of Understanding
Attachment IV Notice of Decision on Medical Assistance Application (Family Planning Acceptance)
Attachment V Notice of Decision on Your Family Planning Application (Acceptance)
Attachment VI Notice of Decision on Medical Assistance Application: Medicaid/Family Health Plus Denial/FPBP Declination

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
			Chapter 57 of Laws of 2000 SSA 1903(a)(5) SSL 366 (1)(a)(11)		Dear Commissioner Letter 9/28/98

I. PURPOSE

The purpose of this Office of Medicaid Management Administrative Directive (OMM/ADM) is to inform local social services districts of the Family Planning Benefit Program demonstration program approved as a waiver pursuant to Section 1115 of the Social Security Act by the Centers for Medicaid and Medicare Services (CMS). This directive advises local social services districts (LDSS) of:

- the eligibility requirements;
- the application process; and
- the systems enhancements for the Family Planning Benefit Program (FPBP).

II. BACKGROUND

Governor Pataki and the New York State Legislature enacted the Family Planning Benefit Program as part of Chapter 57 of the Laws of 2000. Chapter 57 added Section 366(1)(a)(11) of the Social Services Law to expand eligibility for family planning services to individuals with incomes at or below 200% of the Federal Poverty Level (FPL), contingent upon approval of a federal waiver. The waiver was approved by CMS on September 27, 2002. It is effective October 1, 2002.

The purpose of the FPBP is to offer Medicaid coverage for family planning services on a fee-for-service basis to men and women with incomes at or below 200% of the FPL. FPBP services will be available only to persons who are not otherwise eligible for Medicaid or Family Health Plus, or who have indicated in writing that they want to apply for the FPBP only.

The FPBP is intended to increase access to family planning services designed to enable individuals, including minors who may be sexually active, to prevent or reduce the incidence of unintended pregnancies. In addition, the program is intended to improve health outcomes and reduce the cost and societal burdens associated with unintended pregnancies.

The expansion will provide only Medicaid reimbursed family planning services, exclusive of abortions, for eligible individuals. Federal financial participation for such services will be available at a rate of 90 percent in accordance with Section 1903(a)(5) of the Social Security Act. There is no local cost for services provided under the FPBP.

The FPBP does not replace the Family Planning Extension Program (FPEP) that is now available to a limited population of women. In September 1998, under the 1115 Partnership Plan waiver, the FPEP was implemented to provide 24 months of family planning services for women who lost Medicaid eligibility but were pregnant while in receipt of Medicaid. Women who qualify may receive a full range of family planning services, exclusive of abortions, from one of the participating providers (Title X Clinics) for 26 months after the end of their pregnancy regardless of changes in income. If a woman does not recertify for Medicaid after the 60 day postpartum extension, she is still eligible for FPEP for 24 months; there is no application for FPEP. In addition, there are no citizenship requirements for FPEP.

III. Program Implications

As a result of legislation and waiver approval by the federal government, the FPBP will be implemented effective October 1, 2002. Family planning benefits will be available to individuals of child bearing age whose income is at or below 200% of the FPL.

A. Scope of Program Benefits

Eligible recipients will have access to family planning services from all Medicaid enrolled family planning providers including hospital based and free standing clinics, county health department clinics, federally qualified health centers or rural health centers, obstetricians and gynecologists, family practice physicians, licensed midwives, nurse practitioners, and family planning related services from pharmacies and laboratories. The scope of the family planning benefits is the same as those currently available to all fully eligible Medicaid recipients. These services include: all FDA approved birth control methods, devices and supplies and related testing and procedures; comprehensive reproductive health history and physical examination, screening for sexually transmitted diseases, and HIV and cervical cancer (when performed within the context of a family planning visit); clinical breast exam; male testicular exam performed during a family planning visit; emergency contraceptive services and follow-up; screening and related diagnostic testing for conditions impacting contraceptive choice, i.e. glycosuria, proteinuria, hypertension, etc.; laboratory tests to determine eligibility for contraceptive choice; male and female sterilization; preconception counseling, pregnancy testing and non-directive counseling; and client education and counseling services required to render the above services effective. Abortion is not covered in the FPBP.

As is described in Section V. Systems Implications, a new Coverage Code (18) supports provision of family planning services only to eligible individuals.

B. Eligibility Requirements

Males and females of child bearing age whose income is at or below 200% of the FPL, may be eligible for the FPBP when they:

- are New York State residents; and
- are citizens or otherwise eligible aliens with satisfactory immigration status; and are either:

- not otherwise eligible for Medicaid or Family Health Plus (FHPlus); or
- have indicated in writing that they want to apply for the FPBP only; or
- are under age 21 and living with their parents and apply for family planning services and do not have parental financial information; eligibility will be determined by comparing their own income to 200% of FPL.

There is no resource test for the FPBP.

When individuals described above are denied or terminated from Medicaid and/or FHPlus, eligibility must be determined for the FPBP. However, the individual may choose not to participate in family planning coverage, either at the interview or by contacting the district to request that FPBP coverage be terminated after receiving the acceptance notice. (See Section IV.A.)

The FPBP does not require previous eligibility for Medicaid during pregnancy.

Persons may choose to apply for the FPBP only, without applying for Medicaid and FHPlus. This includes teens living with their parents, and anyone else who wants family planning services only. They must use the new one-page application, "Application: Family Planning Benefit Program", (Attachment I). Persons using this application must sign the "Declination of Medicaid and Family Health Plus Eligibility Determinations" statement, and thus cannot be found eligible for those programs through the FPBP application. Anyone who signs this declination may apply for Medicaid and FHPlus at any time in the future using a full application such as "Access NY Health Care" (DOH 4220).

The FPBP has fewer eligibility requirements than other programs. The non-financial requirements that apply are verification of age, identity, residency and citizenship/alien status. Finger imaging, the photo identification card requirement, drug/alcohol requirements and child support requirements do not apply to those individuals applying only for the FPBP. As such, any individual who is currently ineligible for cash assistance, Medicaid or FHPlus due to noncompliance with these requirements may be eligible for the FPBP.

The provisions of the Family Planning Extension Program (FPEP) continue. The eligibility requirements for FPBP and FPEP are somewhat different and are described in an August 25, 1998 "Dear Commissioner" letter. A woman who was eligible for Medicaid while she was pregnant is eligible for FPEP services for 26 months following the end of the pregnancy. There is no application for the FPEP. Therefore, if a woman does not recertify for Medicaid after the 60 day postpartum extension, she is still eligible for 24 months, regardless of income, resources or immigration status. A limited number of providers participate; the State Department of Health, Bureau of Women's Health, has a list. Payments to providers under the FPEP are administered by the Department's Bureau of Woman's Health.

C. Documentation Requirements

The documentation checklist that is part of the "Access NY Health Care Application" (DSS-4220) may be used for the FPBP application process. The documentation requirements of financial and non-financial factors generally follow those that apply to Medicaid and FHPlus eligibility. However, certain exceptions apply to minors living with their parents.

For applicants under age 21 living with their non-applying parents, age and citizenship requirements are modified in recognition that these applicants may have limited or no access to the documents that prove these items.

When an under 21 year old is not able to obtain verification of date of birth by providing a copy of his or her birth certificate, passport, official school records, or other documentation alternatives commonly accepted for Medicaid or FHPlus applicants, a statement by the minor attesting to his or her date of birth, and acknowledging that he or she is not able to provide other documentation, is acceptable. A sample "Declaration of Age" statement is attached as Attachment II.

All applicants must complete the citizenship portions of the FPBP application. When citizenship cannot be documented by under 21 year olds living with their parents, the statement in Section D of the FPBP application and the certification of citizenship under "Terms, Rights and Responsibilities" on the back of the application will suffice.

Once an applicant is determined eligible for the FPBP, eligibility will not be redetermined for 24 months, unless eligibility circumstances change, such as income increasing above 200 percent of the poverty level.

IV. Required Action

A. Application Process

Districts must provide for the initial intake and processing of applications for the FPBP. Districts must determine FPBP eligibility for individuals who are ineligible for Medicaid and FHPlus and who apply on the "Access New York Health Care" application (DOH-4220) or on the "Application for Temporary Assistance (TA)- Medical Assistance (MA)- Food Stamp Benefits (FS)- Services (S)- including Foster Care (FC)- Child Care Assistance (CC)" (LDSS-2921).

When a parent and teen(s) apply for Medicaid/FHPlus and are determined ineligible, FPBP eligibility will be determined for all applicants of child bearing age.

FPBP applicants must be informed by the interviewer of the benefits available under Medicaid and FHPlus and of their right to a Medicaid and FHPlus determination. If the reported income is below the Medicaid or FHPlus income standards, the individual/family should be encouraged to apply for Medicaid or FHPlus, and the application requirements must be explained. After this discussion, if applicants choose to apply for the FPBP only, they must complete the "Family Planning Benefit Program" application and sign the "Declination of Medicaid and Family Health Plus Eligibility Determinations" statement on the back of the application. These applicants must be advised that they may apply for Medicaid or FHPlus at any time in the future and that all FPBP participants will need to recertify every 24 months. (See Section IV.B. Recertification/Renewal Process of this ADM.)

Under 21 year olds who want to apply for family planning services, are living with their parents, and do not have parental financial information, and adults who choose not to apply for Medicaid and Family Health Plus must use the "Family Planning Benefit Program" application (Attachment I). Districts must accept FPBP only applications when individuals choose not to apply for Medicaid and Family Health Plus.

Workers should pay particular attention to confidentially concerns, i.e., entering applicant's mailing address in the Associated Name section on WMS. If the applicant is requesting confidentiality, instructions for completion of the application suggest that the applicant write "confidential" in the margin and circling the mailing address, if different from the applicant's address. However, if the application contains a different mailing address and/or the "Yes" box is checked in answer to the question, "Do you need these services kept confidential?", the application should be treated as confidential, regardless of whether the applicant circled the mailing address or wrote "confidential" in the margin.

If minors receiving Child Health Plus have confidentiality concerns about using their Child Health Plus coverage for family planning services, they should be allowed to enroll in FPBP.

Individuals receiving Medicaid, Child Health Plus A and Family Health Plus are not eligible for FPBP.

Individuals who have applied for Medicaid/Family Health Plus and been determined ineligible for Medicaid and Family Health Plus, must have their eligibility determined for FPBP. Individuals who are financially eligible for FPBP, but who choose not to participate in FPBP, must be sent the manual notice, "Notice of Decision on your Medical Assistance Application: Medicaid/Family Health Plus Denial/Family Planning Benefit Program Declination" (Attachment VI).

B. Recertification/Renewal Process

Eligibility for the FPBP must be redetermined every 24 months. As described in Section V. Systems Implications, the district will authorize the initial 12 months of coverage. The second 12 months of coverage will be generated systemically. Required renewal notification procedures will apply at the conclusion of the 24 month eligibility period.

C. Memorandum of Understanding

Family planning providers, local county health departments, and Prenatal Care Assistance Program (PCAP) providers can assist in the application process. Districts are encouraged to work with these entities to facilitate the processing of applications, including the delegation of the face-to-face interview. All applications taken by these family planning providers will be forwarded to the LDSS for final eligibility determinations.

To facilitate the application and interview process, the attached model Memorandum of Understanding (MOU) (Attachment III) has been developed for use by LDSS and family planning providers.

Included as an attachment to the MOU is the Confidentiality Agreement. Designated provider staff assisting the applicant in completing the application and obtaining documentation must sign the agreement and acknowledge that they understand the strict need for confidentiality. Also included as an attachment to the MOU is an Applicant Release Agreement that must be signed by the applicant and submitted with the application packet to the LDSS by the provider.

If an LDSS chooses to modify the MOU regarding procedures that are agreed to by the providers, the revised MOU must be submitted to and approved by State OMM. However, no change or deletion can be made to any paragraph that mentions confidentiality or release forms or signatures required on the confidentiality agreements or release forms.

D. Notices

For individuals determined eligible for the FPBP under either application, a manual acceptance notice must be sent. The "Notice of Decision on Your Medical Assistance Application (Family Planning Acceptance)" will be used when an individual has applied for Medicaid and FHPlus as well as the FPBP but is eligible only for the FPBP (see Attachment IV). The "Notice of Decision on Your Family Planning Application (Acceptance)" will be used when eligibility is determined for the FPBP only (see Attachment V). The "Notice of Decision on your Medical Assistance Application: Medicaid/Family Health Plus Denial/Family Planning Benefit Program Declination" (Attachment VI) will be used for individuals determined ineligible for Medicaid/Family Health Plus and who chose not to participate in FPBP. Local districts should make copies of these notices until a supply is printed and distributed.

Applicants determined ineligible for the FPBP must be notified with the appropriate Client Notice System (CNS) notice as described under Section V. Systems Implications.

V. Systems Implications

Systems support for the FPBP will be available in mid-November 2002. Further systems details may be found in the WMS/CNS Coordinator Letter dated October 31, 2002 and MBL Transmittal 02-3 dated October 24, 2002 associated with the November 18, 2002 (2002.3) systems migration.

Upstate Systems

For Case Type 20, "Medical Assistance (MA)",two new Individual Categorical Codes have been developed to identify individuals eligible for family planning services only. Categorical Code 68 is "Family Planning Only-FP" and Categorical Code 69 is "Family Planning Services Only - FNP" (singles and childless couples over 21). Categorical Code 68 must be used for individuals of child bearing age under age 21 since they always meet federal categorical requirements. Individuals aged 21 through 64 can have either Categorical Code depending on the

individual's circumstances, for example, a mother living with a 6 year old child or a certified disabled individual would be coded with Individual Categorical Code 68. A 34 year old single healthy man would be coded with Individual Categorical Code 69.

Coverage Code 18 will be used for the FPBP to provide only family planning services. Once system support is in place in mid-November, districts will need to authorize cases using Coverage Code 18, retroactive to October 1, 2002, if appropriate.

Certain individuals who are eligible for FPBP may also be eligible for spenddown if they have sufficient medical bills and have resources under the applicable resource level. If such individuals meet their spenddown, districts may upgrade coverage from Coverage Code 18 to MA Coverage Code 02 (Outpatient Only) for the months for which the spenddown has been met. WMS will return Coverage Code 18 for the remaining balance of the authorization period.

MBL Expanded Eligibility Code (EEC) "J" (Medicaid/Family Planning) will be added into EEC Code "B", which is the EEC Code entered when multiple standards may apply in a case. FHPlus Codes "F" (FHPlus for Families/19-20 Year Olds Living with Parents (133%)), "N" (FHPlus for 19-20 Year Olds Not Living with Parents (100%)) and "S" (FHPlus for Singles/Childless Couples (100%)) will also calculate eligibility for FPBP. EEC Code "K" (Family Planning Only) will be added to MBL when application is for Family Planning only, not for Medicaid or FHPlus. Comparison of income will be only to 200% FPL when Code "K" is used.

The "J" and "K" Codes are valid with Budget types 01, 02, 04, 05 and 06. The FPL for the two new codes is 200%. The MBL Expanded Screen will display "Family Planning Eligible" or "Family Planning Ineligible" and the net income figure for individuals eligible under Code "J" or "K".

The Welfare Management System (WMS) is not able to accommodate a 24 month authorization. FPBP cases should be authorized by the district for 12 months. WMS will automatically extend the authorization period for the second 12 months. At the end of the 24 months of family planning eligibility, the case will enter a recertification cycle and must be recertified.

The Client Notice System should be used for denials, discontinuances and undercare notices. CNS language has been revised to note ineligibility for the FPBP for financial reasons. Use appropriate CNS codes pertaining to the particular circumstances, for example, for denial reason code U35, "Excess Income, S/CC or FNP Parent", when income is over 200% FPL, language will also note ineligibility for the FPBP. Few CNS changes are expected as a result of implementation of FPBP. The new and revised CNS notices were released in the October 31, 2002"Dear WMS/CNS Coordinator" letter. Additional CNS notices are under development for the Spring 2003 migration.

New York City Systems

Systems capabilities for the FPBP will be developed in two phases. Phase I became operational November 18, 2002, retroactive to October 1, 2002, and Phase II will become operational early in 2003.

Phase I uses Presumptive Eligibility Case Type 21 for FPEP temporarily for systems reasons only; there is no presumptive eligibility. For Phase 2, Case Type 20 will be able to support FPBP andCase Type 21 will no longer be used for FPBP.

Phase I includes two new Categorical Codes for family planning. Categorical Code 68 is used for individuals eligible for Family Planning Services Only - FP and Categorical Code 69 uses for individuals eligible for Family Planning Services Only - FNP. Medicaid Coverage Code 18 (Family Planning Services Only) will be available and anew opening reason code 076 will be valid.

Detailed instruction will be provided.

VI. Effective Date

The effective date of this Administrative Directive is October 1, 2002.

Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid Management