

NEW YORK
state department of
HEALTH

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Commissioner

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Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 13 OHIP/ADM-01

TO: Commissioners of
Social Services

DIVISION: Office of Health
Insurance Programs

DATE: 6/4/13

SUBJECT: Changes to Family Planning Benefit Program and Family Planning
Extension Program

**SUGGESTED
DISTRIBUTION:**

Medicaid Staff
Temporary Assistance Directors
Staff Development Coordinators
Fair Hearing Staff

**CONTACT
PERSON:**

Local District Liaison
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New York City - (212)417-4500

ATTACHMENTS:

See Appendix I for Listing of Attachments

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other	Manual Ref.	Misc. Ref.
02 ADM-07		360-3.7	SSL 366(1) (b) (6) Chapter 57 of the Laws of 2000		GIS 02 MA 026 GIS 03 MA 024 GIS 04 MA 011 GIS 04 MA 019 GIS 04 MA 021 GIS 06 MA 017 GIS 06 MA 028 GIS 12 MA 030 Oct 2012 WMS/CNS Coordinator Letter 8.25.1998 Dear Commissioner Letter

I. PURPOSE

This Office of Health Insurance Programs Administrative Directive (OHIP/ADM) advises local departments of social services (LDSS) of changes to the Family Planning Benefit Program (FPBP) and the Family Planning Extension Program (FPEP). The changes include moving the authority for the FPBP from the 1115 Partnership Plan Waiver to the Medicaid State Plan, implementation of Presumptive Eligibility (PE) for FPBP, and inclusion of FPEP into the Welfare Management System (WMS) and eMedNY. In addition, this ADM will cover the State assumption of certain responsibilities related to the FPBP.

II. BACKGROUND

Family planning services and supplies have been provided under the State's Family Planning Benefit Program (FPBP) since October, 2002. The Centers for Medicare and Medicaid Services (CMS) approved this program under the State's 1115 Partnership Plan Waiver. Medicaid coverage of family planning services provided under the FPBP has been found to be cost effective for the Medicaid program.

The FPBP provides confidential family planning treatment, services and supplies on a fee-for-service basis to individuals who reside in New York State with incomes at or below 200% of the Federal Poverty Level (FPL), who are also U.S. Citizens or who have satisfactory immigration status. FPBP services are available to persons who are not otherwise eligible for Medicaid or Family Health Plus (FHPlus), or who have indicated that they only want to apply for the FPBP. Child Health Plus enrollees may enroll in the FPBP, for confidentiality purposes, if they are otherwise eligible. FPBP enrollees are excluded from enrollment into Medicaid managed care health plans, and have no co-pay responsibilities for covered services.

The Affordable Care Act (ACA) allows states the option of providing Medicaid coverage for family planning services under their Medicaid State Plan instead of a demonstration under an 1115 waiver. In addition, states that elect this option can also provide presumptive eligibility for family planning services. New York State elected these options, effective November 1, 2012.

The Family Planning Extension Program (FPEP) was established in September 1998, under the 1115 Partnership Plan Waiver, to provide 24 months of family planning services to women who lose their eligibility for Medicaid after their 60-day post partum period. A manual process has been used to access services through the FPEP. The Upstate closing notice sent to a woman after her 60-day post partum period indicated she was eligible for 24 months of family planning services, supplies and treatment from a participating Family Planning provider. The woman was directed to bring the notice to the Family Planning provider to identify herself as eligible for the FPEP. A Common Benefit Identification Card (CBIC) was not used to obtain covered services. Administration of the FPEP, including reimbursement, was a manual process performed by the New York State Department of Health (the Department). These cases have been managed off-line and have not been opened or maintained in WMS or in eMedNY. Districts have had no responsibility for FPEP cases. Administration of the FPEP transitioned to WMS/eMedNY effective November

1, 2012 for upstate districts. New York City FPEP cases will be supported by WMS/eMedNY at a future WMS migration.

III. PROGRAM IMPLICATIONS

The changes to the FPBP are designed to provide increased access for family planning services. There are potential savings to the Medicaid program in the form of healthier birth outcomes due to planned and well-spaced pregnancies, as well as savings resulting from fewer unintended births of children that potentially would have been covered by Medicaid.

A. Transitioning the Authority for the Family Planning Benefit Program from the 1115 Partnership Plan Waiver to the Medicaid State Plan

There are three changes associated with the FPBP becoming a Medicaid State Plan service.

1. The FPBP has been limited to individuals who are age 10 through 64. Effective November 1, 2012, the age limits in WMS will be eliminated.

2. Transportation services have been added to the benefit package for FPBP. Transportation must be covered to the same extent that it is covered for fully eligible Medicaid individuals. This includes using the same request and prior approval process.

As a reminder, the FPBP covers:

- Most FDA approved birth control methods, devices, and supplies (e.g., birth control pills, injectables, or patches, condoms, diaphragms, IUDs);
- Emergency contraception services and follow-up care;
- Male and female sterilization;
- Preconception counseling and preventive screening and family planning options **before** pregnancy; and
- Transportation effective November 1, 2012.

The following additional services are considered family planning only when provided within the context of a family planning visit and when the service provided is directly related to family planning:

- Pregnancy testing and counseling;
- Comprehensive health history and physical examination, including breast exam and referrals to primary care providers as indicated (mammograms are not covered);
- Screening and treatment for sexually transmitted infections (STIs);
- Screening for cervical cancer and urinary tract or female-related infections;
- Screening and related diagnostic laboratory testing for medical conditions that affect the choice of birth control, e.g., a history of diabetes, high blood pressure, smoking and blood clots;
- HIV counseling and testing;

- Counseling services related to pregnancy, informed consent, and STD/HIV risk counseling;
- Bone density scan (only for women who plan to use or are currently using Depo-Provera); and
- Ultrasound (to assess placement of an intrauterine device).

Abortions, treatment for infertility, and follow-up care that is not related to family planning, are not covered by the FPBP.

3. Retroactive FPBP coverage for up to 3 months prior to the month of application will be available as of November 1, 2012, if the individual is eligible for the retroactive period.

FPBP funding remains unchanged. Shares continue to be 90 percent Federal, 10 percent State and 0 percent Local.

B. Presumptive Eligibility for the Family Planning Benefit Program

Effective November 1, 2012, Presumptive Eligibility (PE) for the FPBP was included in the Medicaid State Plan. Under PE, individuals have the opportunity to be screened presumptively eligible for FPBP at a Medicaid enrolled and trained Family Planning provider who has signed a Memorandum of Understanding (MOU) with the Department. Presumptive eligibility provides an individual immediate access to FPBP covered services and assures that the FPBP provider will receive Medicaid reimbursement for covered family planning services, supplies and treatment provided during the presumptive period.

In order to centralize the processing of PE screenings and FPBP-only applications (DOH-4282), Family Planning providers, who have a signed MOU with the Department, will forward all PE screening forms (Attachment I), FPBP applications and required documentation to the Department's designated agent, New York Health Options. New York Health Options is responsible for processing all screening and FPBP applications received from Family Planning providers and final signoff on eligibility decisions is the responsibility of the Department.

Note: Attachment II to this directive is the OHIP-0062, "Instructions for Completing the PE for FPBP Screening Form." Family Planning providers began submitting FPBP PE screening forms and FPBP applications to New York Health Options in December 2012 for Upstate districts. Family Planning providers in New York City (NYC) began PE for FPBP in March, 2013. Family Planning providers are required to have a signed MOU with the Department in order to begin submissions. See Section III.C of this directive for further information regarding the MOU.

1. Family Planning Provider Responsibilities

When an applicant screens presumptively eligible for the FPBP, the Family Planning provider will give the individual a determination letter (Attachment III) explaining the PE period, the application process for the FPBP, and a documentation checklist (Attachment IV) requesting any documentation that may be required to accompany a FPBP application. The applicant has until the end of the month following the month of the screening to complete the application process. The Family Planning provider will submit the FPBP

Provider Request for Enrollment Activity (Attachment V), screening form, determination letter and documentation checklist to New York Health Options for processing. The Family Planning provider is also responsible for sending the completed FPBP application and any required documentation to New York Health Options.

If an applicant screens ineligible for PE for FPBP, the Family Planning provider will give the applicant a copy of the PE screening and a determination letter explaining why the individual was not eligible. The Family Planning provider will not send ineligible screenings to New York Health Options.

2. Presumptive Eligibility Coverage Period

When New York Health Options receives a PE package from a Family Planning provider, a PE case will be opened using a Case Type 21 (Medicaid Presumptive Eligibility) and Medicaid Coverage Code 18 (Family Planning Services Only). All PE eligible individuals who have never been issued a Common Benefit Identification Card (CBIC) and those who request a new card will receive one when their case is opened. If a FPBP application is not received by New York Health Options, the PE coverage period is from the date of the screening until the last day of the month following the month of screening.

If a FPBP application is submitted during the PE period:

- and the recipient is determined ineligible for ongoing FPBP coverage, PE will be discontinued effective the date of the determination.
- and the recipient is determined to be eligible for on-going FPBP services, the Case Type will be changed from a 21 to a Case Type 20 (Medical Assistance), and FPBP coverage will be authorized for 12 months (Coverage Code 18), beginning the first day of the month of the screening. New York Health Options will also determine eligibility for retroactive coverage, if it is requested and the necessary documentation is received. The FPBP application does not include a question regarding retroactive coverage. However, providers have been instructed to make a note on the application, including the dates for which retroactive coverage has been requested.

It should be noted that there is no limit to the number of times an individual can apply for PE for FPBP.

3. Good Cause

When screening for PE, the Family Planning provider will ask the applicant if he or she has third party health insurance (TPHI). Applicants who have TPHI are asked if billing the insurance is a concern. If the applicant states that billing the insurance could jeopardize their emotional or physical health, safety and/or confidentiality and privacy, the Family Planning provider is required to call the New York Health Options Statewide Call Center (1-800-541-2831) to request a "good cause waiver authorization." This good cause waiver can be authorized for a period of up to one

year. During that time, the TPHI will not be billed. The New York Health Options Statewide Call Center will enter the necessary information into eMedNY. For FPBP applications, when an applicant is under age 21, the TPHI information is not required to be documented. For applicants age 21 and over, TPHI documentation is requested to be submitted within 30 days of filing a FPBP application. If TPHI documentation is not submitted, however, the case will not be denied, if otherwise eligible. In such cases, FPBP coverage will be authorized, as soon as an eligibility determination is made. The LDSS will follow up with TPHI verification. If the documentation is not received by the LDSS within 30 days, the case should be closed for failure to verify factors which affect eligibility. In New York City, such cases will be reviewed at renewal.

C. Memorandum of Understanding (MOU) Between the Department and a Family Planning Provider

To implement PE for FPBP, a new MOU between the Department and the Family Planning provider is required. The MOU has been sent to Family Planning providers who currently have an MOU with a LDSS for purposes of processing FPBP applications. Once signed, the new MOU will supersede an existing FPBP MOU. As new MOUs are signed, a listing of participating providers will be sent to district Medicaid Directors and New York Health Options via email. The list will be updated on a regular basis. LDSS will continue to process FPBP applications submitted by Family Planning providers with whom they have a current MOU until a new MOU is signed with the Department.

D. Fair Hearings

New York Health Options is responsible for agency conferences and fair hearings that result from decisions on FPBP applications processed by New York Health Options. Notices issued for cases processed by New York Health Options include their contact information.

E. Changes to the Family Planning Extension Program

The current policy that guarantees 24 months of family planning services for women who were in receipt of Medicaid during their pregnancy, and who lose eligibility for Medicaid, FHPlus or FPBP after the 60-day post partum period, is not changing. However, effective November 1, 2012, Upstate, this coverage will be supported on WMS/eMedNY. This change will make FPEP more accessible to participants and will allow payments to be made to providers electronically through eMedNY.

This change will allow women to use their CBIC to obtain family planning services from any Medicaid enrolled provider who provides family planning services. Coverage under the FPEP will be automatically generated on WMS based on the ineligibility of the individual at the end of the 60-day post partum period. A new Coverage Code 27 (Family Planning Extension Program) was created for FPEP which includes the same family planning services as the FPBP Coverage Code 18, except for transportation. Transportation is not included as a covered benefit for individuals in the FPEP.

Note: Women in NYC who were on Medicaid while pregnant will continue to obtain family planning services under the existing manual process until further instructions are provided.

IV. REQUIRED ACTION

Local Departments of Social Services will not be processing FPBP PE screening forms or FPBP applications submitted by Family Planning providers who have MOUs with the Department. However, districts will continue to process FPBP applications submitted by individual applicants and will remain responsible for the maintenance of FPBP cases, including renewals if the district is not using the Enrollment Center to process renewals. FPBP renewals will continue to be processed by New York Health Options for counties who are using the Enrollment Center to process renewals.

A. Family Planning Benefit Program as a Medicaid State Plan Service

Effective with FPBP applications filed on or after November 1, 2012, individuals may request up to three months of retroactive coverage. If retroactive coverage is requested, the LDSS must require documents necessary to determine FPBP eligibility for the applicable retroactive month(s). The FPBP application will be revised to obtain information regarding medical bills in the three-month period prior to the month of application. In the interim, districts should ask the FPBP applicant if he or she has any medical bills in the three-month retroactive period.

If an Access NY Health Care Application (DOH-4220) is filed, FPBP eligibility will only be determined if the applicant answers "YES" to the question regarding interest in receiving only family planning services if found ineligible for Medicaid or FHPlus. Eligibility for the FPBP is not determined if this question is not answered.

B. Presumptive Eligibility for the Family Planning Benefit Program

For Upstate cases, the FPBP PE case will be assigned a Case Number by New York Health Options. The case numbers will either consist of an E followed by a 6-digit number (the number of digits may increase at a later date) or consist of the 2-digit county number followed by a "P" and a series of numbers. The case number must not be changed or altered once it is assigned. At no time should the case be closed and reopened with another number. Cases should not be closed if the coverage ends; the Case Type 21 will remain open to support additional PE periods. The office, unit and worker identifiers should not be changed on PE cases.

New York City case numbers will continue to be issued as they have in the past. PE for FPBP and FPBP cases opened by New York Health Options can be distinguished by a Center Code of "5A6" or "506".

New York Health Options will only be including one person on a FPBP case, even in the event that two people apply for FPBP together on the same application. In order to prevent a breach of confidentiality, districts should not combine separate FPBP cases of family members.

As stated above, districts will not be processing FPBP PE screening forms since the Department is centralizing this process. However, there may be times when district action is needed.

1. If a district receives a PE Screening Form (DOH-5057), or FPBP application (DOH-4282) from a Family Planning provider who has signed a new MOU with the Department, the screening form/application should be forwarded to New York Health Options at the following address:

New York Health Options
FPBP Processing Unit
P.O. Box 11640
Albany, NY 12211
or
Toll Free FAX#: 855-268-8240

When sending documents to New York Health Options, the LDSS must use the attached district coversheet (Attachment VI - LDSS/HRA Request for Enrollment Activity). This coversheet has been updated so that it may be used for both renewals and FPBP applications. All documents mailed or faxed to New York Health Options must be accompanied by this coversheet in order for the FPBP Processing Unit to recognize, scan and store documents received into the appropriate category for processing. A separate cover sheet must be used for each individual's set of documents. If documents are sent to New York Health Options without this cover sheet, they will be rejected and returned to the sender for re-submission.

2. The LDSS may receive a returned CBIC card or a report of a returned card for a PE case that New York Health Options processed. If this occurs, the card is to be mailed to New York Health Options using the instructions outlined above. The district should not take any action on PE for FPBP cases (Case Type 21).
3. The LDSS remains responsible for all regular undercare maintenance actions taken on fully opened FPBP cases (Case Type 20). This includes renewals for districts that do not have renewals processed through the Enrollment Center.
4. Individuals may need family planning services even if they already have an active Medicaid case (for example, someone who hasn't met a spenddown or a case with Medicare Savings Program (MSP) coverage). Providers have been instructed to advise the individual to contact his or her district's Medicaid unit to obtain coverage for FPBP services through their active case.

An individual who has a spenddown for Medicaid but is fully eligible for FPBP can flip between FPBP and Medicaid, getting outpatient or inpatient coverage when their spenddown is met. However, this is a manual process and the LDSS worker must manually change the Coverage Code and coverage dates for each coverage change. The individual who opts for this type of coverage

will have a category code of 68 (Family Planning Only - FP) which should be used for FPBP coverage requirements.

An individual can have concurrent MSP and FPBP benefits using WMS Coverage Code 18. However, the individual's Medicare Part D benefits may be disrupted. Until eMedNY can be modified, Coverage Code 18 can prevent an individual from being deemed eligible for the Medicare Part D Low Income Subsidy (LIS). If a district encounters a case such as this, the district should contact the DOH TPHI unit and a work around procedure to re-establish LIS eligibility will be provided. The applicant should be informed of this possibility prior to authorizing FPBP coverage. In instances where an individual was in receipt of FPBP and MSP and coverage is being discontinued, the CNS closing reason codes used for FPBP do not automatically close the MSP (Buy-in) span in eMedNY. The LDSS worker will have to manually close the Buy-in span when MSP eligibility is lost.

5. If an application that has been processed for FPBP by New York Health Options appears on a district's WMS error report, the district should contact their local district liaison.
6. Although individuals are instructed to return documents to the Family Planning provider, an individual may mistakenly send documents to the LDSS. An individual may also provide a change of address to the LDSS. If the LDSS receives documentation or a change of address for a person with no pending application or active case in the district, New York Health Options may have an application pending for the individual. This can be confirmed by looking into WMS using the individual's demographic information. If there is an open Case Type 21 (PE for FPBP) with Coverage Code 18 or a pending application for a Case Type 20 with New York Health Options designated as the current office/worker (identified by FPM in the Responsible Office field on Screen 1), then the LDSS must send the documents to New York Health Options using the LDSS/HRA Request for Enrollment Activity coversheet.
7. If the LDSS receives an application for Medicaid or FHPlus that includes someone with an open PE case (Case Type 21), it is imperative that confidentiality be maintained. A Case Type 20 opening will force close a PE Case Type 21 within that district. If the PE case is not within the district, the district should contact their local district liaison.
8. Districts are not responsible for applications that do not meet timeliness standards if processing is done by New York Health Options. However, it should be noted that those cases will be included in the districts' monthly processing times report (WINR-1240).
9. Individuals who have questions about pending PE or FPBP applications submitted by a Family Planning provider should be referred back to the provider who assisted with the PE or FPBP application using the Medicaid help line (operated by New York Health Options) at 1-800-541-2831.

C. Eligible for 24 Months of Family Planning Benefits as of November 1, 2012

The following instructions are for Upstate districts, effective November 1, 2012. Instructions for NYC will be forthcoming once system support is available.

Districts and New York Health Options (for Enrollment Center counties) will continue to send Medicaid renewal packages to women prior to the end of the 60-day post partum period.

1. For individuals found to be Medicaid or FHPlus eligible, the LDSS or New York Health Options, if an Enrollment Center county, will process the on-going coverage.
2. If, based on the Medicaid renewal, a woman is determined eligible for the FPBP and has indicated on the renewal that she does want to be enrolled in the FPBP; the individual will be enrolled in the FPBP for 12 months, as is done currently. The reason codes for this transaction include D70 (S/CC - category code 69), D75 (FNP - category code 69) or D76 (FP - category code 68). An AFA code of 915 with the same date as the coverage "To" date should be entered. This AFA code indicates the end of the first 12-month block of the 24 months of post partum family planning services. Before the end of this 12-month coverage period, another renewal package will be sent. Individuals who continue to be FPBP eligible must be issued another 12 months of FPBP coverage using reason code C15 (Continue FPBP Unchanged) to complete the continuous 24 months of family planning services. No AFA code is needed.

If, after the first 12 months of FPBP coverage, the woman is no longer eligible for FPBP, or fails to complete the FPBP renewal process, the LDSS or New York Health Options, must issue 12 months of family planning services through the FPEP (Coverage Code 27), using reason code D66 (Income >200% FPL), D67 (Fail to Document) or D68 (Fail to Renew). Using one of these reason codes will generate a CNS notice informing the recipient of the change in coverage and that transportation will no longer be a covered service. No renewal packet will be sent to the woman at the end of this coverage period.

3. Individuals who are determined ineligible for Medicaid or FHPlus, based on their renewal, will be discontinued at the end of the 60-day post partum period using the appropriate notice, if they did not elect FPBP on the renewal.
4. If, after the 60-day post partum period, a woman is ineligible for FPBP, including ineligibility due to an unsatisfactory immigration status or failure to complete the renewal process, the LDSS or New York Health Options must issue 24 months of family planning services through the FPEP (Coverage Code 27). This coverage includes all of the family planning services available through the FPBP except transportation. No renewal packet is to be sent to the woman at the end of her coverage through the FPEP. One of the following closing reason codes must be used for this transaction:

- D61 Unsatisfactory Immigration Status

- D64 Failure to Document
- D65 Failure to Renew
- D72 Income >200%;S/CC
- D73 Income >200%;FNP
- D74 Income >200%;FP

When a case is closing after the 60-day post partum period, for one of the reasons listed above, and there is an unborn on the case, a two-step process must be used. The first step is to remove the unborn from the case using Y70. The second step involves using a Transaction Type 07 or 08 to close the case using one of the above listed reason codes at the case level. The System will generate a Coverage Code of 27 and coverage dates that accommodate 24 months of FPEP coverage. This will also generate proper notification to the individual.

If the FPEP eligible woman is on a case that will remain open for other individuals when her 60-day post partum period ends, a Transaction Type of 05 or 06 must be used to authorize the FPEP coverage. The woman's Individual Status code must be changed to 15 (Deleted) and her Coverage Code changed to 27 (FPEP). The individual's coverage dates must be entered manually for this transaction.

Whether the individual is discontinued or deleted, FPEP coverage must be retained for 24 months. Since the individual is not in active status, the individual may not be visible on the WMS Case Comprehensive screen or on an Authorization Change Form (LDSS-3209). Coverage can be viewed on the WMS History screen and in eMedNY. Detailed instructions for FPEP coding can be found in the October 2012 WMS/CNS Coordinator Letter.

In the event that an individual receiving 24 months of family planning services no longer resides in the State, the LDSS must end family planning services. To end coverage on a closed case, a new Registry needs to be done, creating an application from the existing case. The new application can have coverage that ends earlier than the coverage that was previously established. This new coverage will "stack" above the previous coverage, shortening the coverage period.

Note: Recipients who were receiving the 24 months of family planning coverage prior to October 31, 2012, will continue to receive services using pre-November 1, 2012 instructions contained in the Dear Commissioner Letter dated August 25, 1998.

V. SYSTEM IMPLICATIONS

A. Transitioning the Authority for the Family Planning Benefit Program from the 1115 Partnership Plan Waiver to the Medicaid State Plan

1. WMS (Upstate and NYC)

The following changes have been made to the Family Planning Benefit Program:

- Transportation is now included under Coverage Code 18 (FPBP Coverage);
- Family Planning (Coverage Code 18) is allowed for up to a 3-month retroactive period; and
- Age edits have been removed.

2. CNS

The following reason codes have been edited to support the changes referenced in this ADM. These codes are detailed in Attachment III of the October 2012 WMS/CNS Coordinator Letter.

C12/U0156, C20/U0157, C43/Y0026, C49/U0188, C68/U0184, C92/U0207, F82/U0138, S61/Y0040, S66/Y0041, S67/Y0050, S88/D0158, U91/C0226, V31/D0013, V76/U0139, V77/U0140, V79/U0137, V84/C0190, V85/D0138, V93/U0164, V95/U0165, E0009, R8307

Retroactive coverage determinations will require manual notices. To accomplish this, two notices were developed; OHIP-0066, Notice of Decision to Approve Retroactive Family Planning Benefit Program Coverage (Attachments VII and VIII) and OHIP-0067, Notice of Decision to Approve Ongoing Family Planning Benefit Program Coverage, Deny Retroactive Family Planning Benefit Program Coverage (Attachments IX and X)

See the October 2012 WMS/CNS Coordinator Letter for more detailed systems information.

B. Presumptive Eligibility for Family Planning Benefit Program

1. Upstate WMS

All PE for FPBP screenings will be processed by New York Health Options. However, districts should note certain system modifications.

Presumptive eligibility for FPBP cases will be authorized using a Case Type 21, with Coverage Code 18. Individuals on a PE case will be assigned Individual Categorical Code 68 (Family Planning Only - FP individuals <21) or 69 (Family Planning Only - FNP individuals 21 and over).

A PE Case Type 21 will be authorized by New York Health Options for 12 months beginning on the day of screening and continuing to the end of the 12th month. The initial "Coverage From" date is the date of screening and the "To" date is the last day of the month following the month of screening. Although PE coverage ends the last day of the month following the month of screening, the Case Type 21 remains open until the case "Authorization To" date. By keeping the case authorized for 12 months, subsequent periods of PE coverage can be established by New York Health Options using an undercare transaction. There is no limit to the number of times an individual can be screened PE for FPBP. These cases should not be closed by LDSS even though coverage has expired.

Example:

Individual Screens eligible for PE on 1/15/13
New York Health Options opens Case Type 21

- Screen One from 3209: Case authorization 1/15/13 - 12/31/13
- Screen Five from 3209: Medicaid Coverage Code 18 for 1/15/13 - 2/28/13

When a PE for FPBP case (Case Type 21) is transitioned to a FPBP case (Case Type 20), a LDSS-3209 will print in the district. The LDSS is responsible for entering the appropriate office and worker numbers responsible for the ongoing FPBP case. The case should remain authorized under the original case number.

If the LDSS determines an applicant eligible for Medicaid/Family Health Plus and there is a current Case Type 20 FPBP only case processed by New York Health Options with a unique case number, the LDSS must close the FPBP only case and open a new case for Medicaid/Family Health Plus coverage using their usual process and case number assignment. The WMS transaction to close the FPBP case should be an 07 with closing reason code Y99 and with no notice (N in the CNS field).

2. Upstate CNS

A CNS notice is not sent to an individual when a PE case is opened. The Screening Determination Letter (Attachment III) an individual receives from the provider is notification that the individual is presumptively eligible for the FPBP, the time period of PE, and what action the individual needs to take to gain ongoing coverage for FPBP services.

Three reason codes, D12, D14, and D15, have been developed for use by New York Health Options when a FPBP application is received for an individual with PE. The LDSS will not utilize these codes.

See the October 2012 WMS/CNS Coordinator Letter for more detailed systems information.

3. NYC WMS

Similar to Upstate districts, all PE for FPBP screenings in NYC will be processed by New York Health Options.

The coding method used for NYC cases allows an authorization period of 12 months beginning on the day of screening and continuing to the end of the 12th month. The initial "Coverage From" date is the date of screening and the "To" date is the last day of the month following the month of screening.

Although there is no limit to the number of times an individual can receive PE for the FPBP, additional periods of coverage will necessitate a new case opening.

4. NYC CNS

A CNS notice is not sent to an individual when a PE case is opened. The Screening Determination Letter (Attachment III) an individual receives from the provider is notification that the individual is presumptively eligible for the FPBP, the time period of PE, and what action the individual needs to take to gain ongoing coverage for FPBP services.

Reason code H28 has been developed for use by New York Health Options when a FPBP application is received for an individual with PE who is determine eligible for ongoing FPBP. Existing denial codes will be used for an individual who is denied FPBP. The LDSS will not utilize these codes.

C. Family Planning Extension Program

The following systems modifications have been made to support the FPEP.

1. Upstate WMS

Coverage Code 27 (FPEP) will include all of the family planning services provided under Coverage Code 18 (FPBP), with the exception of transportation. Existing Individual Categorical Codes 68 (Family Planning Only - FP) and 69 (Family Planning Only - FNP) will be used for these individuals.

2. Upstate CNS

A number of CNS notices have been revised and created to support the FPEP. The following three notices are specifically for use when issuing 12 months of FPBP coverage after the 60 day post partum period.

- D70- 60 days PP, MA to FPBP (24 month ext.), MA ineligible Exc. Inc., FHP ineligible Exc. Inc., Equivalent Ins or Federal Employee, SCC
- D75- 60 days PP, MA to FPBP (24 month ext.), MA ineligible Exc. Inc., FHP ineligible Exc. Inc., Equivalent Ins or Federal Employee, FNP
- D76- 60 days PP, MA to FPBP (24 month ext.), MA ineligible Exc. Inc., FHP ineligible Exc. Inc., Equivalent Ins or Federal Employee, FP

The following notices are to be used when issuing 24 months of FPEP coverage to an individual after the 60-day post partum period.

- D61- Medicaid to FPEP, Non Immigrant/Undocumented Immigrant 60 day PP
- D64- Woman at 60 days PP to FPEP due to Failure to Provide Documentation
- D65- Woman at 60 days PP to FPEP due to failure to Return Renewal

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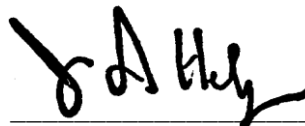
- D72- Woman at 60 days PP to FPEP (24 month ext) Ineligible for MA/FHPlus/FPBP Due to Income Exceeding 200% FPL (SCC)
- D73- Woman at 60 days PP to FPEP (24 month ext) Ineligible for MA/FHPlus/FPBP Due to Income Exceeding 200% FPL (FNP)
- D74- Woman at 60 days PP to FPEP (24 month ext) Ineligible for MA/FHPlus/FPBP Due to Income Exceeding 200% FPL (FP)

3. NYC WMS

Instructions will be provided prior to the anticipated implementation date of July 2013.

VI. EFFECTIVE DATE

The provisions of this Administrative Directive are effective November 1, 2012.



Jason A. Helgerson
Medicaid Director
Deputy Commissioner
Office of Health Insurance Programs