NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 16 OHIP/ADM-01

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: January 20, 2016

SUBJECT: Transitioning Essential Plan Consumers from WMS to NY State of Health

SUGGESTED DISTRIBUTION:
Medicaid Staff
Temporary Assistance Staff
Staff Development Coordinators
Fair Hearing Staff

CONTACT PERSON:
Local District Liaison:
Upstate (518) 474-8887
New York City (212) 417-4500

ATTACHMENTS:

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
14 OHIP/LCM-2 13 OHIP/ADM-4			SSL 122, 366(1)(g) & 369-gg Chapter 60 of Laws of 2014		GIS 13 MA/011

I. PURPOSE

This Office of Health Insurance Programs Administrative Directive (OHIP ADM) advises local departments of social services (LDSS) of the provisions of Chapter 60 of the Laws of 2014, which establish a Basic Health Program, and its impact on certain consumers receiving Medicaid benefits through the Welfare Management System.

II. BACKGROUND

The Patient Protection and Affordable Care Act (ACA) of 2010 provides states with the option to establish a Basic Health Program (BHP). Under section 1331 of the ACA, the BHP offers health coverage for individuals with family incomes above 138% and up to 200% of the federal poverty level (FPL) and for individuals with family incomes from 0 to 200% of the FPL who are lawfully present in the United States but do not qualify for Medicaid due to their immigration status. The BHP is intended to offer a more affordable health insurance option than the Qualified Health Plans (QHP) available through existing state and federal marketplaces.

In accordance with federal requirements, all BHP plans must include ten essential health benefits. The amount of the monthly premium and cost sharing charged to eligible individuals may not exceed the amount the eligible individual would have paid if she/he were to receive coverage from a QHP. To help pay for this program, states that operate a BHP receive federal funding equal to 95% of the amount of premium tax credits and cost of sharing reductions that would have otherwise been provided to eligible individuals enrolled in QHPs.

Chapter 60 of the Laws of 2014 added Social Services Law § 369-gg to authorize a Basic Health Program in New York State. In New York, the program has been named Essential Plan. The Essential Plan was available through NY State of Health beginning November 1, 2015 for enrollment starting January 1, 2016.

III. PROGRAM IMPLICATIONS

The Essential Plan is being implemented in two phases. The first phase began on April 1, 2015 with respect to lawfully present immigrants with incomes at or below 138% of the FPL, who are eligible for Medicaid under a Modified Adjusted Gross Income (MAGI) category but are not eligible for federal financial participation because of their immigration status. These immigrants, known as Aliessa immigrants, who are between the ages of 21-64 and are not pregnant, are identified through eMedNY as being eligible for Essential Plan. Until the Department transitions these individuals to an Essential Plan insurer through NY State of Health, the eligible individuals may receive coverage through Medicaid managed care and the State can receive federal funding through the Essential Plan Trust Fund. By providing these immigrants with health insurance coverage through Essential Plan, New York will experience significant savings because of the federal subsidies. These individuals will be transitioned to an Essential Plan insurer beginning in January 2016.

The second phase of Essential Plan implementation started with the 2016 NY State of Health open enrollment period which began on November 1, 2015. Consumers under age 65, not eligible for Medicaid or the Children's Health Insurance Program (CHIP), who have income at

or below 200% of the FPL, and who meet other eligibility criteria, have the ability to enroll in Essential Plan for coverage starting January 1, 2016.

With the implementation of Essential Plan, the Advanced Premium Tax Credit Premium Payment (APTC-PP) program will end on December 31, 2015. This program, which covered consumers who would have been eligible for Family Health Plus had it not ended, paid the consumer's premiums for a Qualified Health Plan after application of the tax credit. Consumers in the APTC-PP program can transition to Essential Plan during the 2016 open enrollment period.

Eligibility rules for Essential Plan closely follow Marketplace rules for Advanced Premium Tax Credits, with the exception that applicants may enroll at any time throughout the year instead of only during the NY State of Health open enrollment period. In addition, Essential plan is available to tax filers and non-tax filers. Eligibility for tax filers is determined using the MAGI rules for APTC eligibility, while Medicaid non-filer rules are used for individuals who do not plan to file taxes (Note: For Essential Plan, if a pregnant woman is in the household, the unborn does not count for other family members.

A. Essential Plan Eligibility Requirements

To be eligible for Essential Plan, an individual must be:

- A lawfully present individual (United States citizen or non-citizen) with income greater than 138% of the FPL and less than or equal to 200% of the FPL, or a lawfully present immigrant, not eligible for federal financial participation for Medicaid due to his or her immigration status, with income at or below 138% of the FPL;
- A New York State resident;
- Under age 65;
- Not eligible for Medicaid or Child Health Plus;
- Not receiving long term care services; and
- Not eligible for comprehensive third party health insurance including Medicare.

Lawfully present immigrants who are eligible for Essential Plan include qualified aliens in the five-year ban, persons Permanently Residing Under Color of Law (PRUCOL) and temporary non-immigrants meeting residency requirements. Immigrants who are pregnant or are under 21 years of age, and are in the first five years of their qualified status or are PRUCOL, are eligible for federal financial participation and, therefore, are not eligible for Essential Plan and will remain in Medicaid.

B. Benefits

The Essential Plan offers a comprehensive package of services known as Essential Health Benefits (EHB). Essential Health Benefits include:

1. Ambulatory patient services (out-patient care);

2. Emergency Services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services (those that help patients acquire, maintain, or improve skills necessary for daily functioning) and devices;
8. Laboratory services;
9. Preventative and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

In order to comply with the *Aliessa vs. Novello* court decision, Aliessa immigrants enrolled in Essential Plan with incomes from 0- 138% of the FPL, will receive benefits that mirror Medicaid. These benefits include adult vision and adult dental benefits at no additional cost. Most services will be provided through the Essential Plan benefit package, except Aliessa immigrant consumers will be able to access non-emergent transportation and out-of-network family planning providers who accept Medicaid, using a Common Benefit Identification Card (CBIC). Consumers needing long-term care services will remain eligible for Medicaid with no federal financial participation.

Cost sharing will vary by income level. Aliessa immigrants with incomes less than 100% of the FPL have no premiums and no co-payments. Aliessa immigrants with incomes equal to or greater than 100% but less than or equal to 138% of the FPL also have no premiums but do have co-payments.

All health plans in Essential Plan have no annual deductible. Enrollees with incomes greater than 138% of the FPL will have the option of purchasing adult vision and adult dental benefits at an additional cost. Consumers whose income is greater than 138% and less than or equal to 150% of the FPL will not have to pay a premium, unless they select a plan with adult dental and vision, but will have co-payments. Individuals whose income is greater than 150% but less than or equal to 200% of the FPL have a $20 premium per individual per month (or higher if adult dental or adult vision is included) and co-payments.

C. WMS to NY State of Heath Transition

Aliessa immigrants receiving coverage through WMS, who are identified as being eligible for Essential Plan in phase one of Essential Plan implementation, and their MAGI family members, will be transitioned to NY State of Health at their regularly scheduled renewal. Cases will be selected approximately 90 days prior to the eligibility

end date. This transition will begin in January 2016 in New York City (NYC), starting with single individuals. In February 2016 in NYC and March 2016 Upstate, the Department will apply the selection criteria to all Aliessa immigrants who meet the eligibility criteria for Essential Plan and their MAGI family members (even if the family members are not Aliessa Immigrants).

The Department will create an electronic file of demographic information and satisfied verifications from WMS, such as immigration status, SSN and U.S. Citizenship. These will not have to be verified again when individuals transition to NY State of Health. NY State of Health will receive this file and create shell accounts with the information from WMS to assist individuals in the transition to NY State of Health.

Upstate WMS and the Human Resources Administration (HRA) in NYC will generate a notice informing individuals that they are due for their annual renewal and the date on which their coverage on WMS will end. The notice will explain that they need to renew on NY State of Health to continue their coverage. Additionally, a letter will be sent by NY State of Health informing individuals how to access their NY State of Health account. The notice will include an invitation code that can be used to access their newly created NY State of Health account, along with the time period during which the renewal needs to be completed. It is the consumer's responsibility to complete their renewal and this can be done online using their invitation code or by contacting the NY State of Health call center. Although demographic information will be brought over from WMS, previous enrollment in a Medicaid Managed Care plan will not transition to NY State of Health. To prevent gaps in coverage, consumers determined eligible must select a health plan.

Aliessa immigrants and their MAGI family members will be given the phone number of the call center for renewal/application assistance information on their notice, and the web address for Navigators and Certified Application Counselors (CAC). In NYC, renewals will also include a separate list of HRA sites where CACs are available to assist recipients with the renewal process in NY State of Health. To further assist individuals in this transition, the Department will provide a list of individuals who are required to renew in NY State of Health to their current managed care plan in order for the plan to provide assistance.

Some recipients in this population will receive a letter from NY State of Health that does not include an invitation code. This will occur when all or some members of the household are already known to NY State of Health. This could happen if an account already exists and the application was never completed, or if some members of the family previously applied on NY State of Health. The letter sent to these recipients will inform the recipient of the account number associated with the household. In these cases, the recipient should access the account they are already associated with and update all information to complete their renewal. This will include adding any household members that are not already listed on the account, and ensuring that all household members that need continued health coverage indicate they are seeking coverage. In some instances, consumers will be told to contact customer service about their accounts because they appear to have an account on NY State of Health, but it is not a perfect match.

IV. REQUIRED ACTIONS

A. Medicaid Renewals

Current Aliessa consumers who meet Essential Plan eligibility criteria, and their MAGI family members, will be transitioned to NY State of Health at their renewal. CNS reason codes and notices have been created to inform the identified individuals of the requirement to renew through NY State of Health. For upstate districts, new Reason Code W2H has been created and in NYC, Reason Codes 620 (Case Level) and G82 (Line Level) have been created to inform identified individuals and their MAGI family members that they must renew in NY State of Health. Identified individuals and their family members will not be part of a district's regular renewal process nor will they be on the upstate WINR 4133 report. A new monthly report, WINR 4140, will be generated for upstate districts to identify cases impacted by this process.

Consumers in NYC who fail to complete the renewal process in NY State of Health will be issued a new notice (Reason Code 606) informing the individual that his or her Medicaid coverage is ending. Reason Code 606 will include fair hearing rights/information.

New York City consumers who have been directed to renew their Medicaid coverage through NY State of Health may contact the helpdesk or HRA to self-identify that they may not be appropriate for the transition. New Reason Code 609 can be used when an individual's circumstances have changed and the individual needs to remain in WMS.

B. Temporary Assistance (TA) Discontinuances

The upstate TA discontinuance process will remain unchanged. Reason Codes 758 and 821 will continue to generate an extension of Medicaid coverage pending a separate Medicaid eligibility determination. The Medicaid re-determination process will identify Aliessa immigrants who meet Essential Plan eligibility criteria, and their MAGI family members, and will system generate a transitional notice (Reason code W2H) informing the individual to access the NY State of Health account created for them. This process will ensure that there are three months of Medicaid coverage on WMS in order for the individual to complete the eligibility process on NY State of Health. Similar to the Medicaid renewal process, an account will be established on NY State of Health for individuals transitioning to NY State of Health.

In NYC, the downstate separate determination process will remain unchanged. Individuals will receive a Medicaid extension on WMS as appropriate. The recertification process will evaluate individuals and, if appropriate, direct them to NY State of Health for their recertification.

Note: For Medicaid renewals and TA discontinuances, upstate notice W2H and NYC Reason Code 606 will include fair hearing rights. If an individual requests a fair hearing regarding the transition to NY State of Health, the district should include the following documents in the fair hearing packet: a copy of the notice; an affidavit prepared by the Department of Health describing the transition process (to be provided to districts under separate cover); a screen print from WMS showing the State/Federal Charge Code for the Aliessa individual; and a screen print of Concurrent Eligibility from eMedNY.

C. Temporary Assistance Acceptances

Applicants who are determined eligible for Medicaid based on a combined TA and Medicaid application will not be transitioned to NY State of Health for Essential Plan. These recipients will remain in Medicaid through WMS.

D. Temporary Assistance Denials

Pursuant to current procedures, when an individual applies at the district for both TA and Medicaid on the combined application, a separate Medicaid eligibility determination must be completed if the individual is denied TA. If the applicant is an Aliessa immigrant, aged 21 to 64, not in receipt of comprehensive TPHI/Medicare, and not pregnant, the individual and their MAGI family members must be referred to NY State of Health for an eligibility determination. The Aliessa immigrant will have eligibility determined for Essential Plan and the MAGI family members will have eligibility determined for Medicaid.

When reviewing an application for Medicaid under the separate determination process, upstate districts must forward the application packet and supporting documentation to NY State of Health. Client Notice System (CNS) Reason Code DD2 will provide the applicant with proper notification. For applicants who are within 90 days of their 65th birthday or within 90 days of the end of their 5 year ban, districts must follow existing Medicaid separate determination processing rules. Such Aliessa immigrants and their family members are not to be referred to NY State of Health for Essential Plan.

New York City applicants denied/rejected for TA who meet the Essential Plan eligibility criteria will have their applications and supporting documentation transferred via a secure file transfer to NY State of Health, where the application will be evaluated for Essential Plan coverage, and for Medicaid coverage for any MAGI family members. CEM/WMS Reason Code BH1 will provide proper notification to the applicant.

E. Exceptions

Community based long term care (CBLTC) services are not provided in the Essential Plan scope of benefits. Individuals in receipt of or in need of CBLTC are to be excluded from Essential Plan. A new Recipient/Exception (R/E) code B7 was developed to prevent/exclude individuals in receipt of CBLTC from being enrolled in Essential Plan. The list of CBLTC services include:

- Nursing home care, other than short-term rehabilitation;
- Nursing home care provided in a hospital;
- Hospice in a Nursing home;
- Managed long-term care in a nursing home;
- Adult day care;
- Assisted living program;
- Certified home health care, other than short-term rehabilitation;

- Hospice in the community;
- Managed long-term care in the community;
- Personal care services;
- Personal emergency response services;
- Limited licensed home care;
- Private duty nursing
- Consumer directed personal assistance program; and
- Waiver and other services provided through a home and community based waiver program.

In order to identify consumers who are currently in receipt of CBLTC, the Department will receive a file, based on encounter data, from the Medicaid Data Warehouse (MDW). The Department will load the R/E B7 code on identified consumers. This will be an ongoing monthly process. The R/E B7 code will have an end date eleven months into the future.

In order to prevent inappropriate referrals to Essential Plan, if a district is aware that an individual is in need of and/or authorized for CBLTC, the district will have the ability to data enter the B7 R/E Code into eMedNY. New York City will also be able to data enter the R/E B7 code into WMS via the "one step" process.

Conversely, if a district is aware that an individual is no longer in receipt of CBLTC, the district should end date the R/E B7 code. This will help ensure a more timely transition into Essential Plan for eligible individuals.

D. Referral from NY State of Health to WMS

Similar to MAGI Medicaid recipients, Aliessa immigrants (those with incomes at or below 138% of the FPL) enrolled in Essential Plan on NY State of Heath will be referred to WMS on the daily referral file when the individual no longer meets the category criteria for MAGI or has an increase in income and is no longer eligible for Essential Plan and may be eligible to participate in the spenddown program. These referrals will be undercare referrals with an existing referral Reason Code of HX NMD (individual age 65 and not a parent or caretaker relative), HX WMD (individual in receipt of Medicare and not a parent or caretaker relative) or HX NTX (parent, caretaker relative or child under age 21 no longer financially eligible for Medicaid). When the referral is received, the district should process the referral in accordance with the policies and procedures outlined in 14 OHIP/LCM-2, "Medicaid Recipients Transferred at Renewal from New York State of Health to Local Departments of Social Services."

V. SYSTEM IMPLICATIONS

A. Clearance Report

Aliessa immigrants who are determined to be eligible for Essential Plan will have Client Identification Numbers (CINs). On the Clearance Report, if a match occurs, the individual will appear with a Case Type 26 and a District Code of 78 (HX). Districts will be informed under separate cover when this will be available on the Clearance Report.

B. Aid Categories

New aid categories have been created to identify Essential Plan consumers which will determine proper federal claiming.

- B0 PRUCOL/Qualified Aliens in 5 year ban < 100% FPL
- B1 PRUCOL/Qualified Aliens in 5 year ban>=100 % FPL <=138% FPL
- B2 >138 % FPL <= 150% FPL and AI/AN
- B3 >138% FPL <= 150% FPL
- B4 >150% FPL <=200% FPL and AI/AN
- B5 >150% FPL <=200% FPL

C. Notices

The following is a list of EP notices and titles (paragraph number):

1. NYC Notices
    - BH1 – TA denial, Transition to NY State of Health (NYSOH), Recipient PRUCOL/in 5 yr. ban (I0135)
    - 721 – Transition Medicaid coverage to NYSOH, PRUCOL/in 5 yr. ban (I0134)
    - 620/G82 – Transition MA to NYSOH (C0390)
    - 606 - EP failed to Renew NYSOH (C0398)
    - 608 – HX Transfer of EP individual (Y0137)
    - 609 – EP transfer remain in WMS (Y0138)
2. Upstate Notices
    - W2H – Transition MA to NYSOH-PRUCOL/in 5 yr. ban (C0395)
    - F4N – Cover letter for FPBP renewal-Individual staying with LDSS (R0048)
    - S4N – Renewal Letter, Individual remains with LDSS (R0049)

VI. EFFECTIVE DATE

The provisions of the Administrative Directive are effective January 1, 2016.

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs