NEW YORK
state department of
HEALTH

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LOCAL COMMISSIONERS MEMORANDUM

Transmittal No: 14 OHIP/LCM-2

Date: December 1, 2014

Division: Office of Health Insurance Programs

TO: Local District Commissioners

SUBJECT: Medicaid Recipients Transferred at Renewal from New York State of Health to Local Departments of Social Services

ATTACHMENTS: Attachment I - H2W, Renewal Letter, Individual Transferred from NYSOH
Attachment II – Statewide Provider Names and IDs
Attachment III – Recipient Referral Information

I. PURPOSE

The purpose of this Local Commissioners Memorandum (LCM) is to inform local departments of social services (LDSS) that Medicaid renewals will begin at New York State of Health (NYSOH) in October, 2014. At renewal, certain individuals, whose eligibility can no longer be determined under Modified Adjusted Gross Income (MAGI) rules, must be transferred to the LDSS for a re-determination of eligibility under non-MAGI eligibility rules (ADC-related or SSI-related category of assistance). This LCM provides procedures that must be followed to ensure that the transferred individuals have no break in coverage while the re-determination of eligibility is being made by the local district.

II. BACKGROUND

New York State of Health (NYSOH) began enrolling certain Medicaid eligible individuals in October, 2013, with coverage starting January 1, 2014. As outlined in 13 OHIP/ADM-3, the eligibility groups that have Medicaid eligibility determined through NYSOH include: pregnant women; children; parents and caretaker relatives and childless adults age 19 (or over age 20 if living with a parent) and under age 65 if not in receipt of Medicare. These groups are commonly referred to as the MAGI eligibility groups since eligibility is determined using MAGI rules. Once a MAGI individual is determined eligible by NYSOH, Medicaid coverage continues for a 12-month authorization period, with certain exceptions. Prior to the end of the 12-month authorization period, individuals must have their eligibility renewed. In October, 2014, NYSOH began processing renewals

for individuals whose Medicaid authorization period is set to end December 31, 2014. During the NYSOH renewal process, certain individuals will be identified for a referral to the local district for a re-determination of eligibility under non-MAGI eligibility rules. Referrals will include individuals selected for an administrative renewal who meet the criteria listed in the "Referred Individuals" chart under Program Implications below. Individuals who respond to a manual renewal, who are listed in the "Referred Individuals" chart, who elect to have eligibility determined on a non-MAGI basis will be referred. Individuals who are being manually renewed who are no longer MAGI eligible due to the receipt of Medicare, will be automatically referred to the district for a re-determination of eligibility.

It is anticipated that referrals for individuals who fall into the administrative renewal group will be sent to local districts at the end of November, 2014, using the existing daily referral file process. Districts will be notified of the exact start date. Medicaid recipients, who respond to a manual renewal on NYSOH and elect to be referred, will appear on a referral file starting the end of November, 2014 through December 31, 2014. The actual referral date for these individuals is dependent on the date they access their NYSOH account to renew coverage for next year. Such individuals are being notified to renew coverage between November 16, 2014 and December 15, 2014, to ensure enrollment for January 1, 2015.

This referral process will continue each month as NYSOH recipients are due for renewal. Those who are administratively renewed will be included in the file sent on the 16th of the month prior to the month eligibility ends and those who complete a manual renewal will be included in the daily file beginning the 16th of the month prior to the month eligibility ends. Individuals who are referred to the local district for a re-determination of eligibility under non-MAGI rules will be notified of the referral by NYSOH.

When a Medicaid recipient on NYSOH does not complete a manual renewal by the end of his or her eligibility period, Medicaid coverage will be discontinued. If the individual later enters a life status change on his or her NYSOH account, and the individual is not MAGI-eligible, the individual will be referred to the district in accordance with the policy outlined in 13 OHIP/ADM-03, "Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010." Referred individuals will appear as applicants on the daily referral file.

III. PROGRAM IMPLICATIONS

The transfer of MAGI-ineligible individuals from NYSOH to the LDSS will be a manual process upstate requiring local districts to authorize a Medicaid case until a re-determination of eligibility can be made. Local districts will receive referrals daily starting the end of November, 2014. These referrals will be incorporated into the current daily referral file that is sent to each district's "MOVE IT" mailbox.

Listed in the chart below are the groups of individuals who will be transferred at renewal because of categorical or financial ineligibility. Included are new referral codes to indicate the type of referral.

Referral Code	Referred Individuals
HXNMD	• Individuals who are age 65 (by the end of current eligibility period) and who are not a parent/caretaker relative.*
HXWMD	• Individuals who are 19 or 20 years old, in receipt of Medicare, who are living alone and are not pregnant or a parent/caretaker relative. • Individuals who are least 21 years old but less than 65 years old, in receipt of Medicare, who are not pregnant or a parent/caretaker relative.
HXNTX	• A pregnant woman or a parent/caretaker relative who is no longer financially eligible for Medicaid.* • Children 19 or 20 years old who are no longer financially eligible for Medicaid.* • Individuals who are 19 years old or older, who say they are disabled or chronically ill, who are no longer financially eligible for Medicaid.*

*Includes individuals renewed administratively who are not eligible for APTC for non-financial reasons (e.g., non-tax filer).

Unlike referrals currently sent to the district by NYSOH for individuals applying for Medicaid coverage that require the completion of a Medicaid application, these referrals which are triggered at renewal, require the district to open a case on the Welfare Management System (WMS) as soon as possible following the receipt of the referral information but no later than the 15th of the month following the month of referral. The referrals include enough information to allow a case to be opened on WMS with coverage identical to what the recipient had on NYSOH.

For upstate districts, Medicaid coverage is to be authorized for four months (the month of referral plus three months) in order to allow sufficient time to renew the individual’s eligibility under a non-MAGI eligibility group. To obtain the additional information required to make a re-determination of eligibility, a new opening reason code “H2W” has been created (Attachment I). Use of this new opening reason code will trigger a notice to inform the recipient that his/her case is now administered at the local district and includes a Medicaid renewal form for the recipient to complete and return. The renewal form requests resource information, if applicable. Supplement A to the Access New York Health Care application will not be required for these referrals unless the individual requires coverage for long term nursing home care.

A daily referral file will also be sent to New York City. The renewal referrals for New York City recipients will be processed systematically through the Eligibility Data and Image Transfer System (EDITS) to provide recipients with uninterrupted coverage until the case is renewed in WMS. These cases will have coverage extended for five months (the month of referral plus four months) in order for the cases to enter a regular renewal cycle. Renewals will be handled by HRA renewal staff in accordance with standard Medicaid renewal protocols.

IV. INSTRUCTIONS FOR PROCESSING

To process the referrals upstate, district protocols are to be used for Application/Registration (App/Reg) of the referred individual. The case is then opened using Transaction Code "02" with the new Reason Code "H2W" (Renewal Letter, Individual Transferred from NYSOH). The Client Notice System (CNS) notice includes a renewal form to be completed and returned by the recipient. The Anticipated Future Action Codes for generating a renewal notice (Z Codes) do not need to be entered when opening the case. When Reason Code "H2W" is entered, the system also generates a Recertification Source Code "O" (Referred by NYSOH). This code is used to identify the referral when it appears on the case on the Benefits Issuance and Control System (BICS) WINR 4133 "Recertification Notice" report. The letter "O" indicates to the worker that a recertification notice has already been sent. The Language Indicator on the referral file will be "S" (Spanish) for every case, this is to be used when opening the case unless the local district has previous records for the individual that indicate that the Language Indicator should be "E" (English). New York City referrals will be opened through EDITS with an opening code based on the type of referral sent. Opening code "613" will be used for referrals coded "HXNMD," opening code "614" for those coded "HXWMD" and "621" for referrals coded "HXNTX." The Language Indicator will be "S".

Pregnancy/Parenting Codes will need to be entered for individuals under 21 years old. The case should be opened with a Pregnancy/Parenting code "3" (Neither Pregnant nor Parenting). This code is to be changed, if appropriate, when the renewal is completed.

To open the case, a Resource Verification Indicator (RVI) code is required. Since NYSOH does not have resource information or RVI codes to send on the file, two new RVI codes have been created. RVI code "5" (Transfer from NYSOH) is a system-generated code that will be used for New York City referrals processed through EDITS. RVI code "6" (Transfer from NYSOH), is to be manually entered when opening an upstate case and may only be used during Eligibility Error Correction in New York City. When the renewal re-determination is completed and the case is updated in WMS, the RVI "5" or "6" must be changed to the appropriate RVI code. Upstate, when the case is updated and the RVI code is changed, the renewal transaction code "06" (Recertification/Reauthorization) will systematically delete the Recertification Source Code "O".

A Client Identification Number (CIN) will be included on the referral file. If the individual does not have a different active Food Stamp CIN, the CIN on the referral file should be used when opening a Medicaid case for the referred individual. This may require the worker to override error 0869 (Potential CIN /error) if the individual is known to WMS with a different CIN. If an individual has a different active Food Stamps CIN, the Food Stamps CIN should be selected.

The referral file will not include a Veteran's Status code. The case is to be opened with a Veteran's Status code of "9" (Not a Veteran), unless the local district has information indicating the individual is a veteran.

The referral file will include an Alien/Citizenship Indicator (ACI) code. For upstate districts, if the ACI indicator is listed as a blank or an "X"

on the referral file, the district worker needs to contact his/her State Local District Support field representative, who will check for any

citizenship/immigration documentation that may be present on the NYSOH and advise the district regarding the appropriate ACI code. When the ACI field is blank or has an "X" for a New York City individual and the individual was previously known to NYC WMS, the ACI information will be extracted from the WMS database. If the individual was not known to NYC WMS, the case will be processed without an entry in the ACI field. In this case, NYC workers must make sure that the ACI information is provided on the renewal.

Another addition to the referral file is the Individual Categorical Code (ICC). For New York City recipients, two new category codes have been developed. Code "97" will be used for individuals referred under "HXNMD" and "HXWMD" whose income on NYSOH was less than or equal to 100% of the Federal Poverty Level (FPL) and "98" will be used for the same two groups, but for individuals whose income was greater than 100% but less than or equal to 138% of the FPL. When the case is renewed, category codes "97" and "98" must be changed to the appropriate categorical code. Upstate workers must pay close attention to the Individual Categorical Codes (ICC) sent on the referral file. If the referral file has ICC "51," the worker must enter "45" in the ICC field on WMS. When the ICC is "97," the worker must enter ICC "96" if the individual is 19 or 20 years old and ICC "09" if the individual is 21 years old or older. ICC "98" must be converted to ICC "93". See the chart below. If the ICC field is blank or X on the referral file, the district worker needs to contact his/her State Local District Support filed representative, who will provide the ICC to the district. In New York City, if the ICC is blank or X, the record will be an error and WMS Downstate System staff will evaluate for further processing.

Upstate Individual Categorical Code (ICC) Conversion Chart	
ICC on Referral File	**WMS Entry**
ICC 51	ICC 45
ICC 97 (19 or 20 years old)	ICC 96
ICC 97 (21 years old or older)	ICC 09
ICC 98	ICC 93

The coverage period to be entered when opening these cases begins with the first day of the month that the referral is received plus three months for upstate districts and the month of the referral plus four months for New York City recipients. For example, if the referral is received upstate on November 20, 2014, the coverage period is November 1, 2014 through February 28, 2015. In New York City, EDITS will extend coverage through to March 31, 2015. Even though WMS shows active coverage starting the month of referral, eMedNY will continue to hold NYSOH responsible for any Medicaid claims for individuals in Fee for Service (FFS) Medicaid for the month of referral. The following month, eMedNY will shift responsibility to the Fee-for-Service WMS coverage. Using the previous example, the referral is made in November, coverage remains NYSOH's responsibility until the end of November, and coverage under WMS starts December 1st. For referred individuals with Medicaid managed care, eMedNY will continue to hold NYSOH responsible for any Medicaid claims for the month of referral and the following month. The second month following the month of referral, eMedNY will shift responsibility to the Medicaid managed care coverage through WMS. Using our example, the referral is made in

November, coverage remains NYSOH's responsibility until the end of December, and Medicaid managed care coverage under WMS starts January 1st.

Referred individuals who are enrolled in managed care on NYSOH must be enrolled in the same managed care plan on WMS effective the first day of the month of referral. The referral file will include a 2-character Provider ID (PID) that indicates the individual's managed care plan. See Attachment II "Statewide Provider Names and IDs" for all PIDs, corresponding provider identification numbers and provider names. If the referred individual is not enrolled in managed care on NYSOH, the individual should be authorized with full (01) coverage, unless the individual has an ACI code "E" (Alien Only Eligible for Emergency Medicaid) and no State/Federal Charge code. Individuals with an ACI code "E" and no State/Federal Charge code should be authorized with "07" (Emergency Services Only) coverage.

Attachment III contains a full list of the information that will be made available on the referral file in order for districts to immediately open a Medicaid case pending the completion of renewal.

V. THIRD PARTY MEDICARE INSURANCE PREMIUM PAYMENT (MIPP)/HEALTH INSURANCE PREMIUM PAYMENT (HIPP)

Individuals in receipt of premium payment assistance on NYSOH for Medicare (MIPP) or commercial health insurance (HIPP), who are referred to the local district, need to have their premium payments continued until a re-determination of eligibility is completed. The Department's Third Party Health Insurance (TPHI) unit will determine if any of the referred individuals are in receipt of a premium payment by NYSOH. A list of recipients who are identified as having a premium payment will be sent daily by e-mail to the appropriate local district.

Note: NYSOH Medicaid recipients who have Medicare Part B receive a MIPP payment for the amount of the Part B premium.

Once a Medicaid case for the referred individual is opened on WMS, anyone on the TPHI/Medicare list who is in receipt of a HIPP or MIPP payment, needs to have a payment entered by the district in eMedNY's HIPP program (not entered in BICS) starting the second month following the month of referral. As with Medicaid managed care coverage, NYSOH is responsible for the HIPP or MIPP payment for the month of referral and the following month and the local district is responsible for the HIPP or MIPP payment beginning the second month following the month of referral. For example, if the referral month is November, the local district enters HIPP or MIPP payments in eMedNY for January and February, unless eligibility has been re-determined and the individual is no longer eligible for premium payments, including under the Medicare Savings Program (MSP), if applicable. In this example, for a New York City recipient, premium payments would be entered for December through March.

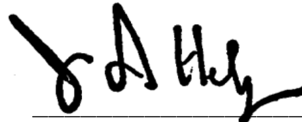
When the renewal is returned, individuals with Medicare are to have eligibility determined under MSP and if eligible, the district must enter the Buy-In span into eMedNY. If not MSP eligible, notification must be provided regarding the discontinuance of the premium payment. For those individuals in receipt of a HIPP payment, the district must follow routine renewal procedures to determine the cost effectiveness of the health insurance plan and processes the renewal and payments accordingly.

Renewals completed and returned for cases with a premium payment should be prioritized to minimize the chance of a gap in premium payment for individuals who remain eligible for these payments.

The information sent daily by the TPHI unit to the local district will also include any Recipient Restriction/Exception (RR/E) information for the individual that needs to be entered in the WMS Restriction/Exception Subsystem after the case is opened. The RR/E code should be entered on WMS beginning the same date as the coverage "From" date. Since the RR/E was entered originally on eMedNY by NYSOH, any subsequent change to that RR/E must be entered on both WMS and eMedNY. When a change to the RR/E is input on WMS for these individuals, an error will appear on the MOBIUS Reject/Warning Report. Until local districts have access to enter RR/E information in eMedNY, it will be necessary for districts to send a copy of the error information to hxfacility@health.state.ny.us (or by fax to (518) 474-9062) to request that the RR/E change be entered on eMedNY. Any new RR/E entries for the individual can be added as per existing district procedures.

If you have questions regarding any of the information provided in this memorandum or its attachments, please contact your Local District Support Unit field representative, Upstate at (518) 474-8887 or in NYC at (212) 417-4500.

Sincerely,



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