

NEW YORK
state department of
HEALTH

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 13 OHIP/ADM-03

TO: Commissioners of
Social Services

DIVISION: Office of Health
Insurance Programs

DATE: 9/25/13

SUBJECT: Medicaid Eligibility Changes under the Affordable Care Act (ACA)
of 2010

**SUGGESTED
DISTRIBUTION:**

Medicaid Staff
Staff Development Coordinators

**CONTACT
PERSON:**

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

ATTACHMENTS:

- Attachment I - MAGI Eligibility Groups and Income Levels
- Attachment II - MAGI and Non-MAGI Eligibility Groups
- Attachment III - OHIP-0069 Referrals from NYSOH Cover Letter
- Attachment IV - OHIP-0072 Important Notice Concerning Medicaid Eligibility for and Adult Who was in Foster Care
- Attachment V - OHIP-0073 Notice of Action on Medicaid Application for an Adult Who was in Foster Care

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other	Manual Ref.	Misc. Ref.
			SSL 366 & 367-a Chapter 56 of the Laws of 2013 SSA 1902 & 1931		

I. PURPOSE

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act of 2010 (ACA), requires states to make significant changes to their Medicaid programs. This Administrative Directive advises local departments of social services of changes to Medicaid eligibility under the Affordable Care Act (ACA) of 2010. Specifically, this directive advises districts of expanded Medicaid coverage under the ACA, a new method for counting household income based on modified adjusted gross income (MAGI), Medicaid benefits under the ACA and Medicaid enrollment in New York's Health Benefit Exchange.

II. BACKGROUND

Effective January 1, 2014, the ACA establishes a new Medicaid eligibility category called the adult group that provides coverage to individuals with modified adjusted gross income up to 133 percent (%) of the federal poverty level (FPL) who are:

1. age 19 or older and under age 65;
2. not pregnant;
3. not entitled to or enrolled in Medicare Part A or Medicare Part B; and
4. are not otherwise eligible for and enrolled in mandatory coverage under the State's Medicaid State Plan, such as certain parents, children, or disabled persons receiving Supplemental Security Income (SSI) benefits.

Prior to the ACA, in addition to meeting financial eligibility criteria, individuals also had to belong to a specific categorical group including children, pregnant women, parents and caretaker relatives, certified disabled or blind individuals and the elderly. Non-disabled individuals under age 65 without dependent children were generally excluded from Medicaid unless the state obtained a waiver to cover them. The provision of the ACA to expand Medicaid coverage to childless adults ages 19-64 up to 133% of the FPL fills in a gap in Medicaid coverage.

NOTE: Due to a Supreme Court decision (National Federation of Independent Business v. Sebelius), states are not required to expand Medicaid to childless adults up to 133% of the FPL. However, states that do not expand their Medicaid programs to cover the new adult group are not eligible to receive any enhanced federal funding for any expansion previously made to cover these individuals.

New York expanded Medicaid eligibility prior to the ACA to cover childless adults with incomes up to 100% of FPL under the Family Health Plus program. This coverage is authorized under the 1115 Medicaid demonstration waiver. These individuals will transition to the new adult group.

Under the authority of the ACA, the State will also cover parents and other caretaker relatives up to 133% of the FPL provided their children under age 21 are enrolled in Medicaid or have other minimum essential coverage.

In addition, effective January 1, 2014, the ACA requires states to adopt a consistent method for counting income based on an applicant's modified adjusted gross income (MAGI). This replaces methodologies based on former programs such as the Aid to Families with Dependent Children program. To further simplify categorical populations and streamline the eligibility determination process, the ACA consolidated existing mandatory and optional eligibility groups into three categories to go with the new adult group: 1) parents and caretaker relatives; 2) pregnant women; and 3) children. For all four categorical groups financial eligibility must be determined based on MAGI, as defined by the Internal Revenue Code (Section 36B (d)(2)(B)), barring certain exceptions. These rules also determine the income of other persons whose income is required to be included in the applicant's "MAGI household income."

The ACA also specifies that an income disregard in the amount of five percent of the highest applicable FPL be used to determine Medicaid eligibility based on MAGI; thus, for example, for the new adult group, 133% of the FPL is increased to 138% of FPL. For the other three existing categorical groups (pregnant women, children, and parents and caretaker relatives), states are required to establish a MAGI equivalent income standard that takes into account the average amount of income disregards that will no longer be applied for an individual categorical group under the MAGI methodology. Since actual disregard data was not available on an individual basis, New York elected to have the Centers for Medicare and Medicaid Services (CMS) calculate the necessary MAGI equivalent thresholds utilizing census data from the Survey of Income and Program Participation (SIPP) and information on New York's income disregards. Categorical groups that are exempt from MAGI-based income eligibility standards, such as the aged, blind and disabled (SSI-related), continue to use pre-ACA income counting rules and asset tests, if applicable.

Most individuals covered under the new adult group must be enrolled in a Medicaid benchmark plan. In New York, Social Services Law (SSL) was amended by Chapter 56 of the Laws of 2013 to define "benchmark coverage" to include all of the cost of medically necessary medical, dental, and remedial care, services, and supplies that are covered by standard coverage, with the exception of institutional long term care services; such care, services and supplies are to be provided consistent with the Medicaid managed care program. Categorical groups previously covered under the State's Medicaid State Plan continue to be provided with full Medicaid benefits.

The ACA also provides that states offer a health insurance marketplace or participate in a federal marketplace where individuals and families can apply for Medicaid. If the household income is above the level needed to qualify for Medicaid but at or below 400% of the FPL, the household may purchase health insurance coverage with the help of advance premium tax credits. The health insurance marketplace will offer individuals with income too high for a tax credit a place to buy private health insurance. New York elected to have its own health insurance marketplace, called New York State of Health (NYSOH). This administrative directive will address aspects of the NYSOH as they relate to Medicaid applicants.

To support states in developing a coordinated eligibility and enrollment system, CMS developed an application to be used for individuals applying for financial assistance for health insurance. (A separate application was developed for individuals who are not seeking financial assistance for health insurance). The application is to be available through a

variety of formats, including on-line and by telephone. As permitted under the ACA, the Department made certain modifications to the application and received CMS approval of its use.

Lastly, in accordance with the ACA, changes are being made to verification of income requirements and other eligibility criteria. For purposes of determining eligibility for financial assistance through NYSOH, self attestation of all eligibility criteria will be accepted, with the exception of citizenship and immigration status. To ensure program integrity, electronic data matches with third party data sources will be used to verify information. Paper documentation may be requested when information cannot be validated through an electronic data source or when information from a data source is not reasonably compatible with information provided by the individual.

III. PROGRAM IMPLICATIONS

A. Definitions

For purposes of Medicaid eligibility under the new rules, the following definitions apply.

1. "Benchmark Coverage" means payment of part or all of the cost of medically necessary medical, dental, and remedial care, services, and supplies that are covered by Standard Coverage, with the exception of institutional long term care services; such care, services and supplies shall be provided consistent with the Medicaid managed care program;
2. "Caretaker Relative" means a relative of a dependent child by blood, adoption or marriage with whom the child is living, who assumes primary responsibility for the child's care and who is one of the following:
 - The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece; or
 - The spouse of such parent or relative even after the marriage is terminated by death or divorce;
3. "Family Size" means the number of persons counted as members of an individual's household; with respect to individuals whose Medicaid eligibility is based on Modified Adjusted Gross Income, in determining the family size of a pregnant woman, or of other individuals who have a pregnant woman in their household, the pregnant woman is counted as herself plus the number of children she is expected to deliver;
4. "Federal Poverty Line" or Federal Poverty Level means the poverty line defined and annually revised by the United States Department of Health and Human Services;
5. "MAGI" means modified adjusted gross income;
6. "MAGI-Based Income" means income calculated using the same methodologies used to determine MAGI as under the Internal Revenue

Code (Section 36B(d)(2)(B)), with the exception of lump sum payments, certain educational scholarships, and certain American Indian and Alaska Native income, as specified by the Commissioner of Health consistent with federal regulation at 42 CFR 435.603 or any successor regulation;

7. "MAGI Household Income" means, with respect to an individual whose Medicaid eligibility is based on Modified Adjusted Gross Income, the sum of the MAGI-based income of every person included in the individual's MAGI household, except that it shall not include the MAGI-based income of the following persons if such persons are not expected to be required to file a tax return in the taxable year in which eligibility for Medicaid is being determined:
 - A biological, adopted, or step child who is included in the individual's MAGI household; or
 - A person other than a spouse or a biological, adopted, or step child, who is expected to be claimed as a tax dependent by the individual;
8. "Medically Frail" or an individual with special medical needs means an individual with a disabling mental disorder, chronic substance abuse disorder, individual with serious and complex medical conditions, or individual with a physical, intellectual or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living.
9. "Standard Coverage" means payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished in accordance with the laws of New York State.

B. Medicaid Categories

Chapter 56 of the Laws of 2013 amended Section 366 (1) of the Social Services Law to conform to the ACA by regrouping Medicaid eligibility categories into those that have eligibility determined by MAGI eligibility rules and those that do not (non-MAGI). All eligibility categories, except the new adult group, were in existing law. The MAGI budgeting methodology is discussed in more detail in the Income Section of this ADM.

1. MAGI Eligibility Groups

- a. Eligibility for the new adult group is 138% of the FPL, representing an expansion for childless adults from 100% to 138% of the FPL. The State will receive 100% federal reimbursement for these newly eligible individuals. The Urban Institute estimates that there are 77,000 individuals who would be eligible for Medicaid at this income level. The ACA also provides that since the State covered childless adults at 100% of the FPL prior to the ACA, it will receive enhanced federal

participation (75% instead of the 50% currently received under the 1115 Waiver) for childless adults up to 100% FPL including 19 and 20 year olds living alone and up to 138% FPL for 19 and 20 year olds living with their parents.

Other MAGI eligibility groups are as follows. The applicable income levels are MAGI equivalents based on 2013 income levels and the value of average disregards for each of the eligibility groups plus the 5% disregard provided for under the ACA, except where noted.

- b. Pregnant women and infants under one year of age are eligible for Medicaid with MAGI household income up to 223% of the FPL for the applicable family size, and pregnant women and infants who meet the presumptive eligibility requirements.
- c. Children at least one year of age but younger than nineteen years of age are Medicaid eligible with MAGI household income up to 154% of the FPL for the applicable family size; and children at least one year but younger than nineteen years of age who meet the presumptive eligibility requirements for Medicaid. Uninsured children ages 6-18 with MAGI household income above 110% of the FPL but equal to or below 154% of the FPL will receive enhanced S/CHIP reimbursement (65% federal reimbursement).
- d. An individual who is a pregnant woman or a member of a family that contains a dependent child living with a parent or other caretaker relative is eligible for Medicaid under the Low Income Families (LIF) category of assistance if MAGI household income does not exceed the MAGI-equivalent LIF level (see Attachment I). Although this group is also eligible for Medicaid at the higher 138% FPL, individuals who qualify under the LIF level will be identified in order to provide Transitional Medical Assistance or the four-month support extension, when applicable, as required by Section 1931 of the Social Security Act.

NOTE: The term "dependent child" means a person who is under 18 years of age, or is 18 years of age and a full-time student.

- e. A child who is under 21 years of age and who was in foster care under the responsibility of the State on his or her 18th birthday is eligible for Medicaid with no income test.
- f. An individual who is otherwise ineligible for Medicaid is eligible for coverage of family planning services if MAGI household income does not exceed 223% of the FPL for the applicable family size. Individuals must continue to elect this coverage when applying for Medicaid.
- g. A child who is 19 or 20 years of age living with his or her parent is eligible for Medicaid with MAGI household income up to 155% of the FPL. The State currently covers this group under the Family Health Plus program. Under maintenance of effort requirements, the State must continue to cover this group up to 150% of the FPL through September 2019. The ACA 5% disregard brings this level to 155% FPL. Standard Medicaid

benefits will be provided to this group starting in January 2014.

- h. A parent or caretaker relative who filed taxes or plans to file federal taxes in the tax year for which eligibility is being determined, whose income is above 138% of the FPL but at or below 150% of the FPL, is eligible for Medicaid payment of health insurance premiums for a silver-rated qualified health plan, after applying advance premium tax credits to the cost of the premiums. The State will receive federal reimbursement for the cost of the premiums not covered by tax credits. This new provision provided for under Section 367-a(3)(e) of the SSL will help provide continued health insurance coverage for individuals currently covered under the Family Health Plus program.

2. Non-MAGI Eligibility Groups

Eligibility determinations for individuals in a non-MAGI eligibility group must be made following pre-ACA budgeting methodologies. There are no changes to the income levels used to determine eligibility for these groups.

The Non-MAGI eligibility groups are as follows.

- a. An individual receiving federal Supplemental Security Income (SSI) payments and/or State Supplement payments.
- b. Medically needy (Surplus) individuals which include:
 - i. SSI-related individuals (individuals age 65 and older, certified blind or certified disabled);
 - ii. Individuals under 21 years of age; and
 - iii. For reasons other than income, individuals who would meet the eligibility requirements of the Aid to Families with Dependent Children program as it existed on the sixteenth day of July, 1996 (pregnant women, parents and caretaker relatives).
- c. A child in foster care (IV-E or Non-IV-E), a handicapped or special needs child who is placed for adoption or who has been adopted and who is in receipt of a medical subsidy, or a child for whom kinship guardianship assistance payments are made. There is no income test for these groups.
- d. Individuals eligible for Medicaid coverage under the Medicaid Buy-In program for Working People with Disabilities Basic Group (Basic Group).
- e. Individuals eligible for Medicaid coverage under the Medicaid Buy-In program for Working People with Disabilities Medical Improvement Group (Medical Improvement).
- f. Individuals eligible for Medicaid coverage under the Medicaid Cancer Treatment Program (MCTP) for Breast and Cervical Cancer.

- g. Individuals eligible for Medicaid under the Medicaid Cancer Treatment Program (MCTP) for Colorectal and Prostate Cancer.
- h. An individual who is otherwise ineligible for Medicaid and who is under 26 years of age; was in foster care under the responsibility of the State on his or her 18th birthday; and was in receipt of Medicaid at that time. This group has no income test.
- i. A resident of a home for adults operated by a social services district, or residential care center for adults or community residence operated or certified by the Office of Mental Health, who does not have sufficient income, or in the case of a person 65 years of age or older, certified blind, or certified disabled, sufficient income and resources, including available support from responsible relatives, to meet all the costs of required medical care and services available under this title.
- j. Individuals applying for the Medicare Savings Program (Qualified Medicare Beneficiaries - QMB, Specified Low Income Beneficiaries - SLIMB, Qualified Individuals - QI and Qualified Working Disabled Individuals - QWDI).
- k. Individuals applying for COBRA continuation of premium payments.
- l. Medicaid continuations for individuals eligible under Section 249e of P.L. 92-603, Section 503 of P.L. 94-566 (Pickle Eligible), Widows/Widowers as described under Section 366 of the SSL and Disabled Adult Children under Section 6 of P.L. 99-643.

See Attachment II of this ADM for a chart of MAGI and Non-MAGI eligibility groups.

C. MAGI Family Size/Household Composition

Family size is one of the factors used in determining Medicaid income eligibility for MAGI eligibility groups. The MAGI-based income of an individual's household is compared to the appropriate income level for the applicable family size. It is important to note that Medicaid eligibility determinations are evaluated from the perspective of each member of the household. Each household member could have different household income or family size as determined by taxpayer status and other factors, rather than the household's legally responsible relationships. Once the composition for each individual's household is determined, the family size for that person is the number of people in that individual's household. To determine the family size of a household that includes a pregnant woman, the pregnant woman is counted as herself and the number of children she is expected to deliver.

To determine the household for each individual, it is necessary to identify the individual as one of the following:

1. Taxpayers not claimed as a tax dependent are individuals who expect to file a federal tax return for the taxable year for which Medicaid eligibility is determined and who do not expect to be claimed as a dependent by another taxpayer. This

individual's household includes the people s/he expects to claim as dependents, plus the taxpayer himself.

For example, Joe, the taxpayer and Mary, his wife, live with their two children (both younger than 19 years old), Aaron and Andrew, as well as Joe's Uncle Matt (who does not file taxes). Joe claims all of them as dependents; Joe's household size is five. His household includes Joe plus his four dependents. This is an example of Joe's household since he is the taxpayer who is not claimed as a tax dependent.

2. Individuals claimed as a tax dependent

- a. Individuals who are expected to be claimed as a tax dependent by a taxpayer for the taxable year for which Medicaid eligibility is determined, use the same household as the taxpayer who is claiming the individual.

Using the example above, as long as Joe and Mary are filing jointly, Mary, Aaron and Andrew have the same household as Joe (the taxpayer), who is claiming all of them as tax dependents.

- b. Individuals who are expected to be claimed as a tax dependent by a taxpayer for the taxable year for which Medicaid eligibility is determined and who fall under one of the exceptions listed below, follow the household rules under Section C. 3.

- i. Individuals claimed as a tax dependent, who are not the spouse or a child of the taxpayer.

In the example above, this individual would be Uncle Matt. Following the rules under Section C. 3, Uncle Matt has no parents, spouse or siblings living in the same household; therefore, his household includes just himself.

- ii. Individuals claimed as a tax dependent, who are less than 19 years old or if a full-time student, less than 21 years old, who expect to be claimed by one parent as a tax dependent even though s/he lives with both parents, who do not expect to file a joint tax return.

In the example above, Aaron and Andrew live with both parents. If Mary and Joe are not filing a joint tax return and Joe claims Aaron and Andrew as tax dependents, following the rules under Section C. 3, the household for Aaron and Andrew includes the child himself, his sibling and both parents.

- iii. Individuals who are less than 19 years old or if a full-time student, less than 21 years old, who expect to be claimed as a tax dependent by the non-custodial parent, as described in a court order or a binding separation, divorce or custody agreement that details physical custody. If there is no such order or agreement or there is a shared custody agreement, the

custodial parent is defined as the parent with whom the child spends the most nights.

Using an example in which Mary and Joe are legally separated and Mary has physical custody of Aaron and Andrew, and Joe (the non-custodial parent) is claiming the boys as tax dependents, Aaron and Andrew's household would each consist of the child himself, the sibling and the parent living with them.

3. For individuals described in Section C.2.b above and individuals who do not expect to file a tax return or who are not expected to be claimed as a tax dependent for the taxable year for which Medicaid eligibility is determined, the household consists of the individual, and, if living with the individual, the following:
 - a. the individual's spouse;
 - b. the individual's child(ren) less than 19 years old or if a full-time student, less than 21 years old; and
 - c. in the case of an individual less than 19 years old or if a full-time student, less than 21 years old, the individual's parents and siblings who are also less than 19 years old or less than 21 years old and a full-time student.

Using the example of Joe, Mary, Aaron, Andrew and Uncle Matt, when no tax return is expected to be filed, each of their households includes Joe, Mary, Aaron and Andrew, except for Uncle Matt who is in his own household.

4. Spouses who are living together are counted in each other's household, regardless of whether they expect to file jointly or if one spouse claims the other as a dependent.

D. MAGI-Based Income

Under the provisions of the ACA, all Insurance Affordability Programs, including the Medicaid program, are to use a budgeting methodology that calculates an individual's modified adjusted gross income (MAGI) as it is defined by the Internal Revenue Code of 1986. This methodology will be used by NYSOH for new applicants.

The MAGI budgeting methodology is used by the Internal Revenue Service when determining the amount of Federal tax that an individual must pay. Some general exclusions that apply under the MAGI budgeting methodology include: pre-tax contributions for dependent care, transportation and health expenses; business expenses; Veteran's disability benefits; child support; Worker's Compensation; and gifts and inheritances. In determining Medicaid eligibility, the following additional income sources are not counted: income from lump sum payments, income from certain educational scholarships and certain American Indian/Alaskan Native income.

For Medicaid purposes, the MAGI household income is the sum of the MAGI-based income of every person included in the individual's MAGI household, except for the MAGI-based income of the following individuals if they are not expected to be required to file a tax

return in the taxable year for which Medicaid eligibility is determined (whether or not they actually file).

1. A biological, adopted or step child who is included in the individual's MAGI household; and
2. A person, other than a spouse or a biological, adopted, or step child, who is expected to be claimed as a tax dependent by the taxpayer.

It is important to remember who constitutes part of the MAGI household in order to determine the MAGI household income. In order to better understand how MAGI household income is determined, use the previous example of Joe and his wife Mary, their children, Aaron and Andrew (both younger than 19 years old) and Uncle Matt, who lives with them. Joe and Mary both work and file a joint tax return. Aaron works part-time and files a tax return, even though it is not required. Uncle Matt is required to file an income tax return, even though he is listed as a tax dependent of Joe. The MAGI household income for Joe and his dependents, Mary, Aaron and Andrew, is the sum of Joe's, Mary's and Uncle Matt's income. Aaron, as a child who is not required to file an income tax return, will not have his income included in the household income. The MAGI household income for Uncle Matt is just his own income as he is the only person in his household (as described under Section C, 2.b.i.).

NOTE: If Uncle Matt is not required to file a tax return, his income would not be included in the MAGI household income of Joe, Mary, Aaron or Andrew.

In the example, if Mary and Joe filed taxes separately, and Joe claimed the boys and Uncle Matt as his dependents, Mary and Joe's MAGI household income includes Mary's, Joe's and Uncle Matt's income. Aaron and Andrew would have MAGI household income that includes just their parents' income (see Section C, 2.b.ii.). Uncle Matt would count just his own income.

E. MAGI Verification

Federal regulations limit the request for documents to verify eligibility to instances when the information provided by the applicant/recipient is not reasonably compatible with information from other sources.

1. MAGI Income Rules

Individuals applying for financial assistance through NYSOH will attest to their MAGI household income for the upcoming year. If income varies from month to month (or any other period of time) the application will assist the individual in constructing MAGI household income. The attested income will be matched to federal and State data sources (federal tax information, Social Security benefits, wage reporting, new hire reporting and Unemployment Insurance Benefit information). If the attested income is reasonably compatible with the income from federal and State sources, eligibility is established. If attested income is not reasonably compatible with income from data sources, and the individual does not provide a reasonable explanation for the discrepancy, income documentation will be required to resolve the

discrepancy. The Medicaid application will be pended while the individual is provided 15 days to submit documentation to verify income.

2. Social Security Number

NYSOH will validate Social Security numbers through the federal data hub. If a Social Security number does not validate, Medicaid eligibility cannot be established. Applicants will have 15 days to resolve a Social Security number that does not validate.

3. Citizenship/Immigration Status

NYSOH will utilize the Social Security Citizenship match that is currently used in Medicaid through the federal data hub. If citizenship status cannot be matched through this process, and the individual is determined to be otherwise eligible for Medicaid, temporary coverage will be provided for 90 days while the individual provides documentation of citizenship. Failure to provide documentation by the 90-day time limit will result in the discontinuance of coverage.

NOTE: The ACA eliminates the requirement to verify pregnancy; therefore, documentation to verify pregnancy will not be required.

F. Coverage/Benefits

Childless adults ages 19-64 who are eligible for Medicaid in the new adult group and parents and caretaker relatives with household income that is above the LIF level for the applicable family size but at or below 133% of the FPL (plus 5% disregard), are eligible for benchmark coverage. This coverage includes all Medicaid covered care and services except for long term nursing home care. It should be noted that "medically frail" individuals who are otherwise entitled to benchmark coverage and who need long term nursing home services can remain in their MAGI eligibility group and receive nursing home care. These individuals are not required to have a disability review, have no resource test and are not subject to a transfer of asset look-back period. Post-eligibility income rules apply to these individuals.

All MAGI eligible individuals will receive fee-for-service coverage retroactive to the first day of month for which the individual is determined Medicaid eligible. For applicants, coverage will be retroactive to the first day of the month of application. Individuals may also qualify for Medicaid coverage of and/or reimbursement of medical bills incurred in the three-month period prior to the month of application. The MAGI eligibility rules cannot be used for eligibility periods prior to January 1, 2014.

Eligible individuals will be enrolled in a Medicaid managed care plan unless otherwise exempt or excluded. The NYSOH Customer Service Center and NY Medicaid Choice will be available for plan counseling. Individuals will select a plan on-line or over the telephone with NYSOH. Auto assignment will occur if no plan is selected within 10 days of an eligibility determination. Plan selections that occur by the 15th of a given month will be effective the first day of the following month. If a plan is not selected until after the 15th of the month, plan enrollment will be effective the first day of the second

month following plan selection. NY Medicaid Choice will process any exemptions from enrollment in managed care.

For recipient restrictions, the Office of Medicaid Inspector General (OMIG) will send recommendations for restricting a NYSOH recipient to a provider (fee-for-service consumers and managed care enrollees) to Department of Health (Department) staff. Department staff will enter the restriction on a new Client screen in eMedNY. Changes to restrictions for NYSOH recipients will be the responsibility of Department staff.

G. Special Eligibility Provisions

1. Transitional Medicaid on NYSOH

The 12-month Transitional Medicaid extension will be administered by NYSOH for individuals whose income was at or below the LIF income level in one of the past six months immediately prior to the loss of Medicaid eligibility and the loss of Medicaid eligibility was due to new or increased earnings. The LIF category includes: parents and caretaker relatives living with a dependent child; children who are not living with a parent or caretaker relative; and pregnant women. A dependent child is defined as a child under age 18 or 18 years of age and a full-time student.

2. Pregnant Women and Children

Pregnant women and children have special provisions that, under certain circumstances, extend eligibility or in the case of a newborn, allow for immediate eligibility. Even though MAGI-based budgeting will be used to determine eligibility for these populations, the special rules for continuing coverage (e.g., 60-day post partum period) remain the same (Section 366 (4)(b) of the SSL).

The newborn data match from hospital files that currently occurs with cases on the Welfare Management System (WMS) will continue to occur, and the files will also be matched to cases on NYSOH.

3. Continuous Coverage for Adults

Individuals who had a Medicaid eligibility determination that was based on MAGI budgeting and who subsequently lose Medicaid eligibility, are eligible to have Medicaid coverage continue until the end of the 12-month authorization period.

NOTE: Individuals who have coverage temporarily pending the submission of documentation of citizenship, other health insurance, SSN, if applied for one, incarceration or American Indian/Alaskan Native status are ineligible for continuous coverage if the case is closed for non-compliance.

4. Medicaid Cancer Treatment Program (MCTP)

The Medicaid Cancer Treatment Program for Breast, Cervical, Colorectal and Prostate Cancers will continue to be centrally administered by the Office of Health Insurance Programs in collaboration with the DOH Cancer Services Program (CSP). Income eligibility for this program continues to be performed by the CSP;

however, an individual may not be eligible if his/her income is under the MAGI level. If the individual is income eligible under a MAGI eligibility group, s/he must apply at NYSOH for Medicaid coverage.

5. Child Health Plus

Under the ACA, Child Health Plus (CHPlus) remains a viable alternative to the Medicaid program for those children whose household income is more than the allowable Medicaid level.

The establishment of NYSOH under the ACA brings about changes to the administration of the CHPlus program. Currently, CHPlus eligibility determinations are performed by the health plans that administer the program. Starting November 21, 2013, CHPlus applications will no longer be processed by the health plans, but will instead be processed by NYSOH. NYSOH will forward files of eligible individuals to the appropriate health plans for CHPlus coverage.

CHPlus renewals will continue to be processed by the health plans to determine continued CHPlus eligibility. This process remains until NYSOH can support the administration of these renewals. Further information will be provided in a future directive.

Express Lane Eligibility will continue to streamline the application and eligibility determination processes for CHPlus children who screen Medicaid eligible at renewal. These cases will continue to transition to the local social services districts until CHPlus renewals are processed by NYSOH. Likewise, when a child renews for Medicaid and is determined ineligible due to excess income, an electronic file will continue to be sent to CHPlus when the Medicaid case closes. CHPlus will enroll the child based on the information obtained from the Medicaid renewal. This statewide process will remain unchanged.

6. Suspensions: Incarcerated Individuals and Certain Individuals in a Psychiatric Center

Medicaid suspensions for individuals who are incarcerated or who are 21-64 years of age and have been placed in a psychiatric center will be processed on the system that maintains the individual's coverage. If the individual has coverage through NYSOH, the coverage will be suspended on NYSOH. If coverage is on WMS, the coverage will be suspended on WMS. Reinstatement of coverage upon release/discharge will occur in the same manner. If NYSOH has responsibility for a suspended individual, NYSOH will reinstate coverage upon release/discharge.

H. Family Planning Benefit Program (FPBP)

Applications submitted to NYSOH that are determined to be FPBP eligible will have FPBP coverage established and administered on NYSOH (if the applicant elected this coverage on the application). Effective January 1, 2014, applications for FPBP-only received by the district will be forwarded to NY Health Options for processing (on the Welfare Management System).

Family Planning providers continue to send FPBP applications or Presumptive Eligibility packages to NY Health Options for central eligibility processing (if a new Memorandum of Understanding has been signed with the Department of Health). Local districts remain responsible for undercare changes for cases processed through NY Health Options. Renewals will continue to be processed through the local district or the Enrollment Center.

I. Third Party Health Insurance Cost Benefit Analysis

Individuals determined to be Medicaid eligible by NYSOH who also have third party health insurance will have a cost benefit analysis completed by the Department of Health's Third Party Resource Unit to determine if Medicaid payment can be made for cost-effective premiums. This includes parents or caretaker relatives who may be in receipt of Medicare benefits.

J. Appeals

An applicant/recipient (A/R) has the right to contest an eligibility determination by requesting an appeal to have the decision reviewed. Appeals for determinations rendered by NYSOH will be handled by NYSOH in accordance with existing requirements. The appeals process for determinations rendered by the local district has not changed. The "Notice of Decision" contains directions on how to request an appeal specific to the source of the determination.

K. Navigators/Certified Application Counselors

The ACA has changed the way insurance is administered in both the public and private sector. With all the changes that have been effectuated, navigating through the new processes and understanding all the options that are available may be overwhelming for individuals in need of health insurance. To assist individuals in applying for health insurance coverage, the ACA provided for Navigators and Certified Application Counselors. Navigators are grant-funded contractors and Certified Applications Counselors are entities that may already be acting as counselors in a variety of capacities and settings such as hospitals or clinics. Navigators and Certified Application Counselors must go through a training course and be certified by NYSOH before they can assist applicants in applying for insurance on-line through NYSOH. Further information will be provided regarding training.

L. Common Benefit Identification Card (CBIC) Replacement

Recipients who have Medicaid through NYSOH who are in need of a replacement Medicaid card (CBIC) can request a new card by calling the Medicaid Help Line at 1-800-541-2831. If a recipient with coverage through NYSOH presents at a local district and requests a replacement CBIC, the local district can generate a replacement through WMS MAIN MENU Selection 27 (CBIC MENU). It will be necessary to verify the individual's identity and review eMedNY to verify active coverage using Name, Gender, Date of Birth and CIN. The local district should verify the mailing address of the recipient; and if necessary, correct the address information stored in CBIC, so that the new permanent card is sent to the correct address. Correcting the address stored in CBIC will not update the address with the NY-HBE. Local district workers

should encourage recipients to contact the NY-HBE to update his/her address.

IV. REQUIRED ACTION

Medicaid Applications

Local social services districts will continue to accept and process Access NY applications (DOH-4220), using current eligibility rules, through December 31, 2013. Any application received on or before December 31, 2013, processed with Family Health Plus (FHP) coverage may only be authorized up to December 31, 2014. Special instructions will be forthcoming for Single Individuals and Childless Couples (S/CCs) who qualify for FHP after December 15, 2013. Effective January 1, 2014, S/CCs will be enrolled in Medicaid managed care under the new adult group.

Through December 31, 2013, Facilitated Enrollers who are transitioning to Navigator roles will continue to send Access NY applications to the local social services district if the individual appears to be eligible for Medicaid. Hospital applications for Medicaid with a date of service prior to January 1, 2014, will also continue to be sent to the local district for processing. Provider applications for presumptive eligibility for pregnant women and children will be sent to the local social services district both prior to and after December 31, 2013.

Beginning January 1, 2014, Access NY applications received by the district will require review. Eligibility determinations will be processed based on the category of the individual (MAGI or Non-MAGI). Instructions regarding the referral of MAGI group individuals to NYSOH will be provided in a separate directive. Applications for FPBP-only individuals will be forwarded to NY Health Options for processing on WMS. As mentioned above, districts will continue to process presumptive eligibility screenings for pregnant women and children and applications for those presumptive cases. The screening tool is being updated to reflect the new income levels effective January 1, 2014.

1. NYSOH

Beginning October 1, 2013, individuals requiring financial assistance for health insurance may apply on-line at NYSOH, by telephone or in person through a Navigator or Certified Application Counselor. Paper applications will be made available when one is required, by the NYSOH Customer Service Center. Local social services districts that opt to provide in-person application counseling will begin to assist with on-line applications to NYSOH beginning January 2, 2014.

New applicants who are determined eligible by NYSOH between October 1, 2013, and December 31, 2013, will receive Medicaid coverage beginning on January 1, 2014. Applicants with a medical need who require coverage prior to January 1, 2014, will be directed to apply at the local social services district. Districts should follow regular processing rules for these applications.

2. Referrals from NYSOH to the LDSS

There will be certain circumstances when NYSOH must refer an individual to the local social services district for a Medicaid

eligibility determination under Non-MAGI rules. NYSOH will identify the various conditions that require a referral. A daily referral file will be sent to the district's secure, electronic post office location ("MOVE IT" mail box) based on the individual's zip code. New York City will receive the referral file through EDITS. Included on the file will be the individual's demographic information, primary residential address, mailing address, if different, preferred telephone contact information, language read, application date and the reason for the referral. Individuals in the same household will be identified under the account holder's name. The individual will be notified by NYSOH that his or her information has been forwarded to the local district for an eligibility determination based on Non-MAGI rules.

a. Referral Categories

1) Referral Type Code HX NH1 (in need of nursing home care) - If an applicant in a single person household indicates on the application that he or she is applying for or in a residential treatment facility or receiving nursing home care in a hospital, nursing home or other medical institution, the applicant will be stopped and instructed to apply for Medicaid at the local social services district. If there is more than one individual applying on the application, the application will be processed for the other family members and the individual in need of the above reference facility services will be notified of a referral to the local district.

2) Referral Type Code HX NH1 (waiver services, home care or personal care services) - Applicants who are determined to be ineligible for Medicaid under a MAGI category who indicate on the application that they are in need of waiver services, home care or personal care services, will be referred to the local district for an eligibility determination under the medically needy category of assistance (ADC-related or SSI-related), including participation in the Excess Income or Spenddown program. This referral may include waiver applicants who need "no parental deeming" in order to qualify for Medicaid.

NOTE: Applications for Medicaid coverage for applicants of the Care at Home waiver should continue to be sent directly to the social services district since certification of disability status is a requirement for participation in the waiver.

3) Referral Type Code HX SUR (all spenddown referrals) - Children under age 21, parents and caretaker relatives, individuals age 65 and older and individuals who indicate they have a disabling impairment or are chronically ill (who do not fall under referral group two above), will be referred to the local district if they are determined to be ineligible for Medicaid and they elect to have eligibility determined on a Non-MAGI basis. Individuals who are determined to be in a Non-MAGI category will also be referred to the district if they elect to have eligibility determined on a Non-MAGI basis.

4) Referral Type Code HX DAB (retroactive Medicaid coverage) - Beginning October 1, 2013, for applicants who indicate on the application that they need help paying for medical bills incurred in the three month period prior to application a referral to the local district will be completed. This referral process will

continue until April 1, 2014. After April 1, 2014, referrals to the local district for retroactive Medicaid coverage will be made when an applicant is not found to be Medicaid eligible and indicates that household income was the same in the past three months. The district will determine if the individual is eligible for any assistance under a medically needy category of assistance. If the person states that household income was different in the past three months (Medicaid eligible individuals and ineligible individuals), NYSOH Customer Service Center will follow-up with the individual to verify income for the past three months. Following a review by the Customer Service Center, a referral may then be made to the district if the individual requires eligibility under a medically needy category of assistance.

5) Referral Type Code HX FOS (foster care) - Applicants under age 26 will be asked if they were in foster care and receiving Medicaid at age 18 and whether they were in foster care in New York State or another state. If the individual indicates they were in foster care in the State, a referral will be made to the local district. The individual will be notified that they may be entitled to more benefits due to their foster care and Medicaid status at age 18 (no income test until age 26) and the local district will follow-up. An application is not submitted on the NYSOH. If the individual indicates they were in foster care in another state at age 18, the individual will proceed to submit an application and eligibility will be determined. The eligibility decision notice sent will instruct the individual to contact NYSOH Customer Service Center as he or she may be entitled to special benefits (no income test until age 26). When contacted, NYSOH Customer Service will attempt to verify the individual's former foster care and Medicaid status with the other state. If foster care and Medicaid status is confirmed, the case will be transferred to the local district following manual procedures.

3. LDSS and Referrals from NYSOH

When the district receives a referral from NYSOH, an application must be registered using the application date on the transfer file, residential address, mailing address if different than the residential address and the demographic information. Effective with the October 2013 WMS Migration, a Client Notice System (CNS) notice (notice reason code to be provided) will be available to send the individual a DOH-4220 application, Supplement A and a cover letter explaining that the application must be completed and returned to the agency within 15 days in order for the district to determine eligibility under a Non-MAGI basis. If the district receives a referral prior to the October 2013 Migration, the district must use Attachment III to this directive to notify the individual of the requirement to complete the DOH-4220. The district must mail the cover letter with a DOH-4220 application and Supplement A. New York City will use a cover letter approved by the Department for use through EDITS. Pre-ACA eligibility rules and documentation requirements apply to the processing of these applications and eligibility determinations. If an individual fails to return the DOH-4220, a denial notice must be sent due to the failure to submit required documentation.

For former foster care individuals, the application date will be the date the file is transferred to the district. Prior to sending the DOH-4220 application, the district should review a list that will be

provided separately by the State to verify whether the individual was in foster care and receiving Medicaid at age 18. If an individual is not found on the list, the district must contact their Medicaid Local District Liaison to verify former foster care and Medicaid status. If confirmed, the DOH-4220 should be sent to the individual with instructions to complete Sections A, B, D, G and I of the application, sign and date the application and return it with required documentation to the district within 15 days. Attachment IV to this directive must be used to notify the individual of this requirement. A DOH-4220 application must be mailed with the cover letter. If an individual returns a signed DOH-4220 and required documentation, the individual should be authorized Medicaid coverage. While the Chaffee Indicator should be assigned to these cases, the indicator will not be available until the February WMS Migration. Districts should separately identify these cases until the indicator is available. Policies and procedures for individuals identified with the Chaffee Indicator are detailed in GIS 11 MA/002, "Chafee Auto Renewal Process - Upstate." If the district is not able to confirm former foster care and Medicaid status, Attachment V to this directive must be used to notify the individual that his/her former foster care status could not be confirmed and to resume applying for financial assistance for health insurance through NYSOH. Attachments IV and V will be converted to a CNS notice in the future.

4. Temporary Assistance/Medicaid Separate Determinations

Applications for Temporary Assistance and Medicaid where Temporary Assistance is denied must have a separate determination of Medicaid eligibility made. Local social services districts will continue to make these separate eligibility determinations. Local districts are to use current eligibility rules for applications dated prior to January 1, 2014. Instructions for applications filed on or after January 1, 2014, for individuals in a MAGI category will be included in a forthcoming directive.

Similarly, when a Temporary Assistance/Medicaid recipient is discontinued from receiving Temporary Assistance, a separate determination of Medicaid eligibility must be made. Local social services districts will continue to make these eligibility determinations. Instructions for eligibility determinations made on or after January 1, 2014, for individuals in a MAGI category will be forthcoming in a subsequent directive.

5. Supplemental Security Income (SSI) Recipients

Individuals receiving SSI cash and Medicaid who lose eligibility for SSI, must have eligibility for Medicaid re-determined. The local social services district will continue to determine Medicaid eligibility for these individuals when notified by the State Data Exchange (SDX) of the loss of SSI. Instructions for eligibility determinations made on or after January 1, 2014, for individuals in a MAGI category will be forthcoming in a subsequent directive.

NOTE: Medicaid renewals, changes and updates for cases on WMS will remain the responsibility of the local social services district (and Enrollment Center as applicable) for an interim period. Further instructions regarding the transitioning of cases from FHP and MAGI-like budgeting for individuals in a MAGI category will be provided in a forthcoming directive.

VI. SYSTEMS IMPLICATIONS**A. Clearance Process and Client Identification Number (CIN) Generation**

Medicaid applicants must be uniquely identified to ensure the program integrity of their eligibility, benefits and claims payment history. A CIN is a Client Identification Number assigned by the Office of Temporary and Disability Assistance (OTDA) to individuals receiving public benefits. Currently, each of the two WMS systems (Upstate and NYC) uses a clearance process when an individual is registered for benefits to determine if they are already known to the system. This allows for the re-use of a CIN in cases where the individual has a previous history of applying for benefits and avoids duplicate benefits if the individual has coverage. With the implementation of NYSOH, there will be an additional entry point for new applicants. To maintain the integrity of historical and future data for Medicaid applicants/recipients and to avoid duplication of benefits, this new entry point will also perform a clearance for applicants.

Effective October 1, 2013, applicants on NYSOH will be cleared first against eMedNY to determine if the individual is already in receipt of active Medicaid coverage. If the individual is in receipt of active coverage, the application will be denied due to already being in receipt of benefits. There are exceptions for Provisional Coverage (Coverage Code 06), Outpatient Only Coverage (Coverage Code 02), Family Planning Benefit Program Only Coverage (Coverage Code 18) and Medicare Savings Program Only Coverage (Coverage Code 09). These cases will pass through on NYSOH for a determination of eligibility. Effective December 2, 2013, individuals who are not identified as having active Medicaid coverage and who are determined to be eligible for Medicaid, will be cleared against the WMS system that corresponds to their primary residential address (Upstate addresses will be cleared against Upstate WMS and NYC addresses will be cleared against NYC WMS, using the same data elements that are currently used in the clearance process). Results will be scored based on existing match criteria. If a match is found at the 102 level (SSN and DOB match) or higher, the found CIN will be assigned to the individual. If no match is found at the 102 level or higher, a new CIN will be assigned. Upstate residents will receive an Upstate CIN and NYC residents will receive a NYC CIN.

NOTE: Individuals who apply and are determined eligible for Medicaid prior to December 2, 2013, will have CINs assigned December 2, 2013. For purposes of establishing coverage on NYSOH, individuals with coverage 06, 02, 18 and 09, are not considered to have minimum essential coverage.

Individuals who move from an Upstate district to NYC or from NYC to an Upstate district within NYSOH will be re-cleared against the appropriate WMS system for CIN retrieval or the generation of a new CIN.

For both Upstate districts and NYC, effective October 21, 2013, the clearance process will include a search of NYSOH for possible CIN matches and coverage information. Matches may start appearing on the clearance report once CINs are available on NYSOH (December 2, 2013). Districts must follow existing procedures and rankings when reviewing

clearance reports that contain a person who accessed Medicaid benefits through NYSOH (District Code 78).

B. Inquiry for NYSOH Recipients and Reports

Individuals receiving Medicaid coverage through NYSOH will be identified by a District Code of 78. Coverage history will be viewable on eMedNY. A search can be made by CIN or first name, last name and DOB.

NYSOH will receive a weekly Duplicate CIN report from eMedNY for review and appropriate action.

Reports that include local expenditures for Medicaid benefits provided to eligible individuals will continue to be reported based on the district of fiscal responsibility.

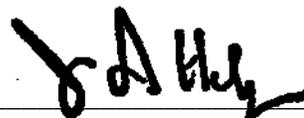
C. NYSOH Closings/Transitions to WMS

Currently, when an individual receives Temporary Assistance (TA) benefits, SSI cash assistance or is placed in foster care, including adoption assistance and kinship guardianship, Medicaid coverage is provided on the basis of the receipt of the cash assistance or foster care status. If there is an existing Medicaid-only case for the person, that case is closed and Medicaid is provided on the cash case or in the case of foster care, a Medicaid case is opened under a foster care case type on WMS. In order to ensure that this process continues, individuals who have Medicaid coverage on NYSOH must be identified so that Medicaid coverage can be transitioned to the case on WMS. To close coverage on the NYSOH and transition Medicaid managed care coverage to the new case opened on WMS, when appropriate, a daily batch file will be sent from WMS to NYSOH identifying individuals with a TA, SSI or foster care case opening. NYSOH will search the system for records in the batch file by CIN and if found, will send an 834 transaction to eMedNY to end date NYSOH coverage at the end of the month following the date the file is processed in NYSOH. If the individual is enrolled in a Medicaid managed care plan, an 834 transaction will also be sent to the health plan notifying the plan of the effective date of the transition to a Roster (managed care enrollment on WMS), if applicable. Staff in the Department will manually transition managed care enrollment to WMS when an individual does not change enrollment area.

NOTE: This transition process will be expanded in the future to address additional transfer situations.

VI. EFFECTIVE DATE

The provisions of this Administrative Directive are effective October 1, 2013, except where otherwise noted.



Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs