STATE OF NEW YORK
DEPARTMENT OF HEALTH

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 05 OMM/ADM-4

TO: Commissioners of Social Services

DIVISION: Office of Medicaid Management

DATE: August 18, 2005

SUBJECT: Family Health Plus Program Changes Required by Chapter 58 of the Laws of 2004, Chapters 58 and 63 of the Laws of 2005

SUGGESTED DISTRIBUTION:

Medicaid Staff
Fair Hearing Staff
Legal Staff
Staff Development Coordinators
Temporary Assistance Staff

CONTACT PERSON:

Bureau of Local District Support
Upstate: (518) 474-8887
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ATTACHMENTS:

Attachment I: New York State Income and Resource Standard and Federal Poverty Lines
Attachment II: Important Changes to Family Health Plus Program
Attachment III: Notice to Family Health Plus Members

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
01 OMM/ADM-6 04 OMM/ADM-6			369-33		

I. PURPOSE

The purpose of this Administrative Directive (ADM) is to provide local social services districts with instructions for implementing changes to the Family Health Plus Program required by Chapter 58 of the Laws of 2004, Chapters 58 and 63 of the Laws of 2005. These statutory amendments require a resource test for Family Health Plus eligibility, co-payments for certain Family Health Plus services, and changes to the Family Health Plus vision benefit. In addition, the statutory amendments provide that individuals eligible for health coverage through certain governmental employers are not eligible to enroll in the Family Health Plus program.

II. BACKGROUND

Family Health Plus is designed to offer comprehensive health care benefits to uninsured, low-income adults who have income or assets above the Medicaid levels and do not otherwise have access to affordable health insurance. The benefits are intended to be comparable to those available under employer-sponsored plans. The changes contained in this directive will bring the program more in line with the legislative intent and will help ensure the program remains affordable for the State. The Department has obtained the required federal approval of these changes through amendments to the Family Health Plus Operational Protocol, approved by the Centers for Medicare and Medicaid Services (CMS) on August 2, 2005.

III. PROGRAM IMPLICATIONS

Currently, eligibility for Family Health Plus is determined without regard to resources. Chapter 58 of the Laws of 2004 provides that, in order to be eligible for Family Health Plus, individuals must have resources at or below 150% of the Medicaid income amount permitted for the individual’s household size. This provision is effective August 1, 2005.

Chapter 58 of the Laws of 2004 requires Family Health Plus enrollees to pay part of the costs of some services, in the form of co-payments, subject to obtaining any necessary waivers or approvals from the Federal Medicaid agency.

Chapter 58 of the Laws of 2005 provides that Family Health Plus is not available to Federal, State, county, municipal or school-district employees. In addition, this chapter eliminates the annual co-payment limitation of $200 for Family Health Plus recipients.

Chapter 63 of the Laws of 2005 changes the Family Health Plus vision benefit, making it comparable to benefits provided to employees of New York State; revises the Family Health Plus co-payment levels for drugs and clinic visits and adds co-payments for dental and physician visits; and clarifies that Family Health Plus is only unavailable for those Federal, State, county, municipal or school-district employees who are eligible for health care coverage through their employer. These provisions are effective September 1, 2005.

IV. REQUIRED ACTION

A. Resource Test

Upon the receipt of a new application on or after August 1, 2005, with signature dates of August 1, 2005 or later, districts must consider countable resources when determining Family Health Plus eligibility. Renewals and undercare transactions must have an authorization "from" date of August 1, 2005 or later in order for local districts to apply the resource test.

Districts may also take action on a case if the district has information from the recipient that he/she has resources in excess of the Family Health Plus limit, or if the information comes to the district's attention in another manner (e.g., a district receives a "Financial Institution Recipient Match" (FIRM) match) consistent with existing Medicaid policy outlined in 04 OMM/ADM – 6, "Resource Documentation Requirements for Medicaid Applicants/Recipients". However, if an individual is still within the six-month guarantee period, districts must not terminate coverage until the end of that period.

Individuals may attest to the amount of their resources for purposes of determining Medicaid eligibility for Family Health Plus. Countable resources are those items required to be considered, after first applying ADC-related resource disregards for parents and 19 and 20 year olds, and the S/CC-related resource disregards for single individuals and childless couples. This includes applying the appropriate categorical treatment of income-producing property (see Medicaid Reference Guide, Resources/Income-Producing Property). At this time, facilitated enrollers will refer Family Health Plus applicants with income-producing property to their local district since facilitated enrollers have not yet been trained on this issue. Attachment I lists the maximum resource level allowed, by family size. Individuals with resources in excess of the maximum level allowed will not be permitted to spenddown their resources in order to become eligible.

Under the Medicaid program, if an ADC-related or SSI-related individual makes a prohibited transfer of assets within the 36-month period proceeding the month of application (60 months for trusts), the individual may be disqualified for nursing facility services. Since Family Health Plus only covers nursing home care on a limited basis, a prohibited transfer of assets will not affect an individual's eligibility for Family Health Plus. However, S/CC-related applicants who have sold or given away any resources for less than the fair market value in the past 12 months are ineligible for all Medicaid covered care and services. Therefore, effective August 1, 2005, an S/CC-related individual who has sold or given away any resources for less than the fair market value in the past 12 months is ineligible for Family Health Plus for the duration of the penalty period (12 months).

Effective with the release of Administrative Directive 04 OMM/ADM-6, "Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources)," all applicants must provide the total value of their countable resources in Section I of the DOH 4220, "Access NY Health Care Application."

The Department of Health will be amending the DOH 4220, to request information about the transfer of assets in the past 12 months, upon the next reprinting.

B. Government and School District Employees

Government employees who have access to employer-sponsored health coverage, and their family members, will no longer be allowed to enroll in Family Health Plus. Districts will be required to deny applications filed on or after September 1, 2005 when the employee or his/her family member has access to employer-sponsored health coverage through a Federal, State, county, municipal or school-district benefit plan. Part-time or temporary employees, who are ineligible for their employer-sponsored coverage, if otherwise eligible for Family Health Plus, will be allowed to enroll. If a Family Health Plus applicant claims he/she does not have access to such coverage, the applicant must provide a statement from the employer documenting that he/she is not eligible for coverage under the employer's plan.

At the next reprinting of the DOH 4220, "Access NY Health Care Application", the Department of Health will add a question regarding employment by Federal, State and county governments, municipalities and school districts. However, before this change, districts should look at Section E "Household Income" under the box labeled "List type of income/employer name" to see if the applicant or family member is a government employee.

Current enrollees who have access to such plans will remain enrolled in Family Health Plus until their next scheduled annual renewal occurring on or after September 1, 2005.

C. Co-Payments

Effective September 1, 2005, Family Health Plus enrollees will be responsible for the following co-payments:

• Brand name prescription drugs	$6 for each prescription and refill
• Generic prescription drugs	$3 for each prescription and refill
• Clinic visits	$5 per visit
• Physician visits	$5 per visit
• Dental service visits	$5 per visit up to a total of $25 per year
• Lab tests	$0.50 per test
• Radiology services (e.g., diagnostic x-rays, ultra-sound, nuclear medicine, and oncology services)	$1 per radiology service
• Inpatient hospital stay	$25 per stay
• Non-urgent emergency room visit	$3 per visit
• Covered over-the-counter drugs (e.g., smoking cessation products; insulin)	$0.50 per medication
• Covered medical supplies (e.g., diabetic supplies such as syringes, lancets, test strips, enteral formula)	$1 per supply

Co-payments will not be applied to the following services:

- Emergency services
- Family planning services and supplies
- Mental health clinics
- Chemical dependence clinics
- Psychotropic drugs
- Tuberculosis drugs
- Prescription drugs for a resident of an Adult Care Facility licensed by the State Department of Health

Similar to the policy for Medicaid, the following people are exempt from making co-pays: pregnant women; individuals under age 21; permanent residents of nursing homes, and residents of community-based residential facilities licensed by the Office of Mental Health or Office of Mental Retardation and Developmental Disabilities. If a Family Health Plus enrollee cannot afford the co-payment at the time of the service, the provider cannot refuse to provide the care or service.

Other than the $25 annual cap for co-payments on dental services, Family Health Plus has no other cap on co-payments. Family Health Plus plans will be responsible for the implementation of applicable co-payments and tracking the annual dental cap.

D. Vision Benefit Change

Currently, the Family Health Plus vision benefit is similar to the Medicaid vision benefit. Effective September 1, 2005, the Family Health Plus vision benefit will cover the following once every 2 years: 1) one eye exam; 2) either one pair of prescription eyeglass lenses and a frame, or prescription contact lenses where medically necessary; and 3) one pair of medically necessary occupational eyeglasses. Lost eyeglasses are no longer a covered benefit.

The Department is implementing this change effective September 1, 2005.

V. NOTICE REQUIREMENTS

Attachment II to this directive provides information for applicants about Family Health Plus program changes. Districts must provide this notice to all applicants as a supplement to the LDSS-4148B, “What You Should Know about Social Services Programs – Book 2” until the next reprinting of the booklet.

The Department of Health is mailing a notice to all current Family Health Plus households notifying them of the new co-payment requirements, the changes to the vision benefit, and the prohibition of government employees from enrollment. A copy of this notice is attached to this directive (Attachment III). This notice will be mailed approximately 30 days prior to the effective date of these changes on September 1, 2005.

Effective with the July 18, 2005 WMS/CNS migration, changes to the Client Notices Subsystem (CNS) have been programmed to add new denial (Upstate only) and closing reason codes for ineligibility for Family

Health Plus based on excess resources or employment with a government agency. Districts must only use excess resource notices for denials (Upstate) and closings on August 1, 2005 or later. Denial notices for individuals who are ineligible due to their own employment or a family member's employment with a government agency must be used only for applications filed on or after the effective date of this policy change September 1, 2005. Further, individuals and their family members who are current recipients of Family Health Plus, who lose eligibility under the provision prohibiting enrollment of government employees, must not be terminated from Family Health Plus until their first annual renewal occurring on or after September 1, 2005.

VI. SYSTEMS IMPLICATIONS

Effective with the WMS migration on August 22, 2005, the Medicaid Budget Logic (MBL) will compare the total countable resources entered in MBL to the appropriate Family Health Plus resource level for the family size, when the budget "From Date" is August 1, 2005 or later. This modifies the previous effective date of July 1, 2005 that took effect with the July 18, 2005 WMS migration.

For applications filed August 1, 2005 or later, when there are parents and children under age 21 applying, with medical expenses in any of the three months prior to August 1, 2005, districts may have to complete two separate budget calculations. First, determine eligibility using a budget "From Date" prior to August 1, 2005 to determine eligibility during the three-month retro-period. If the parents are not Medicaid eligible during this time period, determine eligibility for the parents using a second budget with a "From Date" of August 1, 2005 or later. In this way, the correct Family Health Plus resource determination will be made for the parents.

VII. EFFECTIVE DATE

The effective date of this Directive is August 1, 2005 for the Family Health Plus resource test and September 1, 2005 for co-payments, vision, and governmental employee provisions.

Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid