NEW YORK
state department of
HEALTH

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Commissioner

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ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 13 OHIP/ADM-04

TO: Commissioners of Social Services

DIVISION: Office of Health Insurance Programs

DATE: 12/3/13

SUBJECT: Medicaid Application and Renewal Processing for Modified Adjusted Gross Income (MAGI) Eligibility Groups

SUGGESTED DISTRIBUTION:	Medicaid Staff Staff Development Coordinators Fair Hearing Staff
CONTACT PERSON:	Local District Liaison: Upstate - (518)474-8887 New York City – (212)417-4500
ATTACHMENTS:	See Appendix for a List of Attachments (I-X)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other	Manual Ref.	Misc. Ref.
			SSL 366 & 367-a		GIS 13 MA/021
13 OHIP/ADM-03			Chapter 56 of the Laws of 2013		
			SSA 1902 & 1931		

I. PURPOSE

This Administrative Directive (OHIP/ADM) advises local Departments of Social Services (LDSS) of the referral process for applicants in a Modified Adjusted Gross Income (MAGI) eligibility group to New York State of Health (NYSOH), New York's Health Insurance Marketplace, and the requirements for determining or renewing Medicaid eligibility for certain individuals using MAGI-like budgeting rules. This directive also informs districts of the actions the State will take to transition Family Health Plus (FHPlus) Single Individuals and Childless Couples to coverage under the Affordable Care Act (ACA) effective January 1, 2014, and advises districts of special instructions for processing Medicaid referrals from NYSOH for coverage/payment of medical bills in the three-month retroactive period.

II. BACKGROUND

Effective January 1, 2014, New York will have made significant changes in implementing the provisions of the Affordable Care Act (ACA) of 2010. Specifically, New York will have expanded Medicaid eligibility for individuals under the age of 65 with income at or below 138 percent (%) of the Federal Poverty Level (FPL), made changes to the methodology used for determining eligibility for pregnant women, children, parents and caretaker relatives and childless adults under age 65 who are not entitled to Medicare (MAGI eligibility groups), adjusted reimbursement shares for newly eligible individuals and certain individuals enrolled in the new adult group who were Medicaid eligible prior to implementation of the ACA, and provided individuals with options to apply for Medicaid online through NYSOH, over the phone, by mail or in person through a Navigator or Certified Application Counselor.

To maintain stability in coverage for over three million currently enrolled Medicaid recipients whose eligibility will be determined under MAGI rules, these enrollments will remain on the Welfare Management System (WMS) until they can be transitioned to NYSOH. This is expected to occur during the latter part of 2014. During the interim period, local districts will continue to be responsible for renewing these cases (or the Enrollment Center if the district's renewals are processed by the Enrollment Center) and for making any updates or changes. To support the application of MAGI rules for individuals in a MAGI eligibility group, WMS will be modified to calculate budgets using MAGI rules to the maximum extent possible (MAGI-like). For most enrollees, the transition to Medicaid using MAGI-like budgeting rules will occur at renewal starting with Authorization "From" dates of April 1, 2014. Family Health Plus Singles and Childless Couples will have their coverage changed to the Alternative Benefit Plan effective January 1, 2014. There will be no new Family Health Plus enrollments after December 31, 2013, with certain exceptions. Once the new eligibility system (NYSOH) is ready to transition MAGI recipients from WMS, such individuals will be transitioned at renewal.

Although special instructions will apply to new applications submitted to local departments of social services through December 31, 2013, most applications submitted on or after January 1, 2014 that contain an individual in a MAGI eligibility group, will have eligibility determined through NYSOH, with certain exceptions. If a district receives an application for an individual in a MAGI eligibility group, the individual's application must be forwarded to the NYSOH. Districts will

continue to make separate Medicaid eligibility determinations for combined Temporary Assistance (TA) and Medicaid applications where TA is denied and for Presumptive Eligibility screenings and associated applications for pregnant women and children.

Beginning in October 2013, districts started to receive referrals from NYSOH for eligibility determinations for the three-month retroactive period prior to application on the Marketplace. These referrals require special instructions once WMS (both Upstate and Downstate) begins to clear against the Marketplace. The start date for this clearance is temporarily on hold. Districts will be separately advised of the begin date for clearances against NYSOH. When the clearance starts, districts will see active NYSOH recipients on the WMS Clearance Report. In order to not truncate Medicaid coverage on the Marketplace for recipients seeking coverage for the three-month retroactive period, special instructions must be followed.

III. PROGRAM IMPLICATIONS

A. Medicaid Applications and Renewals – MAGI-Like Budgeting

Special instructions will apply to applications received by local districts prior to January 1, 2014 that are processed after January 1, 2014. Beginning January 1, 2014, local districts may also continue to receive Access New York (DOH-4220) applications or common applications (LDSS-2921) for Medicaid-only which contain individuals in a MAGI eligibility group. Districts will need to screen these applications and refer individuals in a MAGI eligibility group to NYSOH following the instructions in the Required Action section of this directive.

Due to the need to retain Medicaid renewals on WMS until NYSOH is prepared to transition MAGI recipients, local districts (or NY Health Options for Enrollment Center districts) will remain responsible for processing Medicaid renewals for an interim period. In order to ensure that individuals in a MAGI eligibility group have eligibility determined under MAGI rules, a MAGI-like budget will be available in the Medicaid Budget Logic (MBL) subsystem of WMS. This logic will be available following the WMS/CNS February Migration (February 18, 2014).

MAGI individuals renewing coverage with a "From" date of October through December 2013, will have eligibility determined using existing rules (pre ACA). If determined eligible, individuals will be renewed for 12 months. Individuals' who are determined ineligible at renewal, will be sent a decision notice informing the person of additional health insurance benefits that may be available through NYSOH and information about how to apply to the Marketplace.

As advised in General Information System (GIS) message GIS 13 MA/021, "Renewal Processing for MAGI Eligibility Groups Beginning January 1, 2014," Medicaid recipients who are in one of the MAGI eligibility groups who renew with a "From" date of January, February or March 2014, must have the benefit of pre-ACA rules, and if found income ineligible under pre-ACA rules, must be budgeted under MAGI-like rules. For these renewals, Medicaid eligibility cannot be discontinued based on pre-ACA rules without performing a MAGI-like budget. This requirement also applies to renewals with an

Authorization "From" date of April 2014, if the eligibility is ready to be determined and MAGI-like rules are not available.

For cases renewed with a "From" date of January, February or March 2014, if an individual reports an income change after renewal but before April 1, 2014, the income change is not considered until next renewal. If a change in income is reported on or after April 1, 2014, the income change is considered and eligibility is to be re-determined. For renewals with a "From" date of April 1, 2014 or later, if a change in income is reported prior to renewal, the change in income is not considered until renewal. Special instructions also apply when a person is added to a case or closed from a case based on the date of the reported change and the type of budgeting that was applied (pre-ACA or MAGI-like). (See instructions in the Required Action section of this directive.)

Effective January 1, 2014, districts must apply the MAGI-like rules when making separate Medicaid eligibility determinations for TA/Medicaid applicants where TA has been denied and for applications submitted with or following a presumptive eligibility screening (pregnant women and children). If the district is making an eligibility determination prior to February 18, 2014, the district must use pre-ACA rules. If determined eligible, coverage must be authorized (Family Health Plus cannot extend beyond December 31, 2014). If the individual is determined income ineligible or eligibility changes to FPBP-only coverage, the district must pend the eligibility determination until the MAGI-like rules are available. Once available, the district will re-determine eligibility using MAGI-like rules. These instructions will enable districts to adhere to application processing time frames whenever possible, while assuring applicants receive the benefit of the new MAGI-like budget as required by the ACA.

Districts will continue to use existing applications and renewal forms for MAGI-like eligibility (re)determinations (DOH-4220, LDSS-2921 and Medicaid CNS Renewal). New York City will continue to use its renewal forms MAP 2096F (MA/FHP Renewal) and MAP 909e (DAB-MLTC Renewal). Automated Client Notices (CNS) specific to MAGI-like eligibility determinations have been developed and will be available to districts following the February WMS Migration.

Family size and household composition, as discussed in 13 OHIP/ADM-03, "Medicaid Eligibility Changes for 2014 Under the Affordable Care Act (ACA)" are important concepts for the district worker to understand as it relates to the Medicaid (MAGI) eligibility determination process at NYSOH. For the MAGI-like budget that will be used at the district, the MAGI family size and household composition described in that ADM will not be used; rather, pre-ACA Medicaid household size rules must be used. For the purpose of MAGI-like budgeting, districts will use the information from the current Medicaid application and renewal form and apply pre-ACA household rules.

The countable income for a MAGI-like budget is gross income. In order to calculate gross income according to IRS rules, several types of unearned income will not be included in the MAGI-like budget calculation. In addition, for self-employed individuals, a revised Self-Employment worksheet must be used to obtain countable gross income.

Another requirement of the MAGI-based budgeting methodology that will apply to the MAGI-like budget is the application of MAGI equivalent income levels and the addition of the 5% deduction applied to the highest income level for which an individual may qualify. The MAGI equivalent income levels and 5% deduction replace the individual disregards that were eliminated with the adoption of MAGI-based budgeting.

B. Transition of FHPlus Single Individuals and Childless Couples

Single Individuals and Childless Adults (S/CC), including 19 and 20 year olds not living with parents, who are eligible with incomes greater than the Medicaid income standard but at or below 100% of the FPL (FHPlus eligible), are eligible for enhanced federal reimbursement (75% FP) effective January 1, 2014. In order to qualify for this enhanced reimbursement, FHPlus S/CCs must be receiving coverage under the Alternative Benefit Plan (coverage equivalent to Medicaid Managed Care).

To obtain the appropriate federal participation beginning January 1, 2014, these individuals will have their coverage changed to Medicaid Managed Care, wherever possible. Individuals, who do not have Medicaid Managed Care available through their plan, will receive fee-for-service Medicaid coverage until enrollment in a Managed Care plan can occur. The automated conversion will take place in December 2013.

Enhanced Federal reimbursement of 75% will also be available starting January 1, 2014, for currently eligible Single Individuals and Childless Couples (including 19 and 20 year olds) with incomes at or below the Medicaid income standard. Changes to the Aid Category Matrix have been made to claim the additional reimbursement. Newly eligible Single Individuals and Childless Couples with incomes at or below 138% of the FPL, who are eligible for 100% federal reimbursement, will be identified under the MAGI-like budget at renewal.

C. Referrals from NYSOH for Retroactive Period

As outlined in 13 OHIP/ADM-03, individuals who apply through the Marketplace prior to April 1, 2014, who indicated that they are seeking Medicaid payment/reimbursement for medical bills incurred in the three month period prior to application, are referred to the local district for a determination of eligibility for the three-month retroactive period. If determined eligible, coverage/reimbursement is provided for the retroactive period starting with the month eligibility is established (the earliest month in which a bill is incurred). Effective with referrals received on or after (date to be separately announced), when districts register an individual who has been referred from NYSOH on WMS, the Clearance Report will display whether the individual has active Medicaid coverage on NYSOH. For individuals with active Medicaid coverage on NYSOH, retroactive coverage will only be provided on WMS for the retroactive period up to the start of coverage on NYSOH. Prospective coverage will be retained on NYSOH. This will require special handling by the local district.

IV. REQUIRED ACTION

A. FHPlus S/CC Conversion

To claim enhanced federal reimbursement (75%) on January 1, 2014 for FHPlus S/CCs eligible with income greater than the Medicaid income standard but at or below 100% of the FPL, a systemic conversion will take place. All such individuals with active coverage in December 2013 and January 2014 will have their coverage/benefit package converted to the Managed Care plan equivalent to their FHPlus plan. The conversion process will begin December 9, 2013, for New York City recipients and will run nightly until all affected individuals are converted. All converted recipients will receive a CBIC card. Upstate, the conversion process will occur December 15, 2013. CBIC cards will be issued for recipients if they have not previously been issued a card. The recipient will receive a notice (Upstate-CC7 "FHPlus to Medicaid," New York City-Paragraph Number U0253) informing the recipient of the change. A new Recipient Aid Category code "90" (75% FP) will be assigned to these cases. The conversion will not change the case Authorization or coverage "To" date but the Coverage Code will change from 34 (FHPlus) to 30 (PCP Full Coverage) when a corresponding Managed Care plan exists. Upstate, if there is no corresponding Managed Care plan, a Coverage Code of 01 (fee for service-full coverage) will be given until a plan is selected or assigned. For both Upstate and New York City, the Benefit Package code will change from 70 to the Managed Care Benefit Package code for the district. The effective date of the coverage change is January 1, 2014.

For Upstate districts, three daily reports will be available on the Health Commerce System (HCS) and Benefit Issuance Control System (BICS) entitled "Failed FHP Flip," "Failed Coverage to MAMC" and "FHP to MAMC Conversion Complete." The "Failed FHP Flip" report will include recipients whose benefit package did not change from "70" to the Mainstream Benefit Package code for the district. Districts must investigate these cases to correct any problems and convert the case to the Mainstream Benefit Package. Districts will also need to send these individuals the "FHPlus to Medicaid" notice using CNS Reason Code CC7. Recipients will be included on the "Failed Coverage to MAMC" report if there is no corresponding Managed Care plan or if the benefit package did change but the Coverage Code did not change to 01 or 30. The report will contain error messages indicating the corrective action that should be taken by the district. If the coverage changed to 01 but there was no corresponding Managed Care package, the recipient will be auto-assigned on December 20, 2013.

For New York City, error reports and a report of successful conversions will be made available on HCS. Downstate DOH systems staff will review the error reports and forward any cases requiring corrective action to NYC.

Applications/Renewals/Medicaid Separate Determinations with an S/CC FHPlus Eligible Individual Processed after the December Conversion

For Medicaid separate determinations for ineligible TA/Medicaid applicants, TA/Medicaid recipients discontinued from TA, Medicaid applicants who applied prior to January 1, 2014 (or reactivations), and Medicaid renewals (that did not meet the conversion criteria) processed after the December conversion under pre-ACA rules, the following procedures must be followed.

- Upstate districts: Cases with an Authorization "From" date of January 1, 2014 or later, if the individual is eligible for FHPlus as an S/CC, the case must be processed with a Case Type 20, an Individual Categorical Code (ICC) of 09 (Single Individual and Childless Couple) and Coverage Code 01 or 30, as appropriate.

  For initial eligibility determinations, re-activated FHP S/CC cases and retroactive activations prior to January 1, 2014 (Authorization "From" date prior to January 1, 2014 – eligible for FHPlus), the case must be processed with a Case Type 24, an ICC of 56 and Coverage Code 06 (provisional). The district worker must then enter a new Authorization "From" date of January 1, 2014, and manually enroll the person in a Managed Care plan with Coverage Code 30. If no Managed Care plan was selected, Coverage Code 01 should be entered and the case will be auto assigned a plan.

  If the individual is income ineligible for FHPlus, and the application date or Medicaid separate determination (applications and undercare) is processed and the determination notice sent prior to January 1, 2014, the district must deny/discontinue Medicaid due to being income ineligible (over the FHPlus income level). When the Medicaid separate determination is processed on or after January 1, 2014, or a Medicaid renewal "From" date (for cases that did not meet the conversion criteria) is on or after January 1, 2014, but prior to the availability of MAGI-like budgeting (February 18, 2014), the application must be pended until MAGI-like budgeting is available and for Medicaid separate determinations (undercare) and renewals, coverage must be extended until MAGI-like budgeting is available. See Section IV.C.2 of this directive for further information regarding the extension of Medicaid coverage pending the availability of MAGI-like budgeting.

- New York City: Cases with an Authorization "From" date of January 1, 2014 or later, if the individual is eligible for FHPlus as an S/CC, the case must be authorized with a Case Type 24, an ICC of 56 and an opening Reason Code of 067 or H67 (Eligible S/CC for FHPlus only). The individual must be enrolled in Managed Care through the PCP system with a Benefit Package value of 01 (or Benefit Package Code associated with the Managed Care plan). Coverage Code 30 will be generated. The PCP enrollment system will not allow entry of the BP value of 70 or Coverage Code 34 (FHPlus) for recipients with ICC 56.

  For initial eligibility determinations, re-activated FHP S/CC cases and retroactive activations prior to January 1, 2014

(Authorization "From" date prior to January 1, 2014 – eligible for FHPlus), the case must be processed with a Case Type 24, an ICC of 56. Coverage Code 06 will be generated. The worker must then enter a new Authorization "From" date of January 1, 2014, and enroll the person in Managed Care via the PCP subsystem with a Benefit Package Code of 01 (or Benefit Package Code associated with the Managed Care plan). The system will generate Coverage Code 30. If no Managed Care plan was selected, Coverage Code 01 should be entered and the case will be auto assigned a plan.

If the individual is income ineligible for FHPlus, and the application date or Medicaid separate determination (applications and undercare) is processed and the determination notice sent prior to January 1, 2014, the individual must be denied/discontinued Medicaid due to being income ineligible (over the FHPlus income level). For Medicaid renewals with a "From" date of January 1, 2014 (cases that did not meet the conversion criteria), the appropriate excess income closing Reason Code should be entered. The closing transaction will be held and coverage will be extended by DOH Downstate WMS. As discussed further in Section IV.C.2 of this directive (and as notified in GIS 13 MA/021), a special mass re-budgeting will occur once MAGI-like budgeting is available. For Medicaid separate determinations (TA/Medicaid application date on or after January 1, 2014, and separate determinations processed on or after January 1, 2014), Rejection Code HH8 (HX Applicant Submission) should be used. The CNS notice will notify the applicant/recipient that his/her information was referred to NYSOH for an eligibility determination. NYC will send a daily file to NYSOH for further processing (see Section V, Systems Implications, for further information).

B. Applications/Sorting by Eligibility Groups

Beginning January 1, 2014, with the exception of TA/Medicaid separate determinations, PE cases, applications for nursing home residents, Managed Long Term Care (MLTC) applications from MLTC plans and hospital applications (with a date of service prior to January 1, 2014 or an application date prior to April 1, 2014 and a date of service in the three-month retroactive period) new applications filed with the district must be screened. Applicants in a non-MAGI eligibility group and individuals in certain living arrangements or who require certain services, will continue to be the responsibility of the district (see Attachment I, "MAGI and Non-MAGI Eligibility Groups," for a list of groups who remain the responsibility of the district). Applicants in a MAGI eligibility group, also listed in Attachment I, must be referred to NYSOH. To determine whether an individual's application will be processed at the district or referred to NYSOH, districts are encouraged to use the "MAGI Screening Tool" (Attachment II). This tool has been designed to also be the required cover sheet (for Upstate districts) when forwarding applications with MAGI members to NYSOH.

Note: For nursing home applications and MLTC applications from MLTC plans, any MAGI individuals on the application must be referred to NYSOH.

When using the screening tool for Access New York applications received by the district (or common applications for Medicaid only applicants, LDSS-2921), the district should list all MAGI individuals who are applying in Section 1 of the screening tool and check the MAGI category box that pertains to each applicant (e.g., pregnant woman). In Section 2, each non-MAGI household member should be listed and the non-MAGI category box checked that applies to each individual (e.g., "Other" single age 65 or older). For the statements in Section 2 regarding MAGI applicants that may have income in excess of the MAGI income levels (see Attachment III for MAGI income levels), districts are not required to perform this level of review for each application; however, if the district is aware of this situation, the district can retain the application for processing. If the MAGI applicant has income in excess of the MAGI income level, and the district retains the application for processing, that individual should not be listed in Section 1 of the Screening Tool. All MAGI group members listed in Section 1 must be referred to NYSOH for an eligibility determination. Applicants listed in Section 2 remain the district's responsibility for processing.

To record the receipt of an application containing applying MAGI household members and the referral to NYSOH, each application should be date stamped upon receipt and registered on WMS. For applicants being referred to NYSOH, data entry will be required and a denial using Transaction Code 03 (Denial) and Reason Code DD2 (upstate-available January 1, 2014). NYC will use Rejection Code HH8 "HX Applicant Submission" (Case Level) and HH9 (Line Level). The notice will notify the applicant that the application was referred to NYSOH for an eligibility determination. The completed MAGI Screening Tool, application and any documentation received must be mailed to NYSOH at the below address.

New York State of Health
P.O. Box 11725
Albany, New York 12211

Note: Upstate districts are to use mail only to send applications to NYSOH. All applications must include a name, signature and address. A MAGI Screening Tool must be attached to each application. In addition, the applicant's telephone number, when available, must be included on the MAGI Screening Tool.

New York City EDITS applicants will be referred to NYSOH via a daily file. A Turn Around Document (TAD) will be included which will indicate MAGI household members. Any documentation submitted to NYC with an application will also be forwarded. Non-EDITS New York City applicants will be referred to NYSOH via the mail process described above.

If individuals present in person at a district office to apply for Medicaid, after screening the applicant for a MAGI or non-MAGI eligibility group, a district office with Certified Application Counselors (CAC) may assist a MAGI group applicant with the on-line application to NYSOH. If a mixed (MAGI and non-MAGI) household is applying for Medicaid, the district office with CACs should assist the

MAGI household members with applying on-line through NYSOH. The district should then process the application (DOH- 4220) for the non-MAGI members. If a district office does not have CACs, the district should inform the individual how to apply for Medicaid on-line or via telephone and let them know of the availability of a local Navigator or CAC who can assist in the application process.

Case processing for the MBI-WPD program remains the responsibility of the district. At application, the district should consider any individual who is certified or potentially disabled and working for the MBI-WPD program prior to sending the application to NYSOH for processing.

Referrals from the NYSOH to the district will not specifically indicate that someone is being referred for the MBI-WPD program; however, if an individual is referred and is certified disabled or chronically ill and working, consideration should be given for participation in the MBI-WPD program.

C. Applications and Renewals – MAGI-Like Budget

It should be noted that for applications filed prior to January 1, 2014, if an individual in a MAGI eligibility group is determined to be ineligible, and the decision is not made or notification is not sent by December 31, 2013, a second eligibility determination must be made for the period January 1, 2014 and later under MAGI-like rules. Districts should deny the application based on pre-ACA rules. Language has been added to denial notices to inform the individual that a separate eligibility determination will be made under the MAGI-like rules effective January 1, 2014. The application should then be registered with an application date of January 1, 2014, and pended until MAGI-like rules are available.

1. Applications

Effective January 1, 2014, districts continue to be responsible for processing certain applications which may include individuals in a MAGI eligibility group. These applications include: Medicaid separate determinations for TA denials; Presumptive Eligibility for pregnant women and children when an application is submitted; hospital applications until April 1, 2014, requesting retroactive coverage; and applications for Managed Long Term Care (MLTC) submitted by a MLTC plan (see Attachment I for a complete list). If one of these applications is for a mixed household (MAGI and non-MAGI applicants), districts must register two separate cases. The MAGI applicants are to be in "applying" status on their own case for transition to NYSOH at a later date. They will not be applying on the non-MAGI household members' case. Upstate districts can link the two cases for any undercare changes that may be required, by using the "Associated Case" field on WMS.

To ensure individuals in a MAGI eligibility group have eligibility determined under MAGI rules, a MAGI-like budget will be available on WMS following the February WMS/CNS Migration (February 18, 2014). Pending the availability of the MAGI-like budget, the State is receiving approval from the Centers for Medicare and Medicaid Services (CMS) to use pre-ACA rules, and if an applicant

is determined eligible under these rules, to authorize coverage for a regular 12-month authorization period. Therefore, until MAGI-like rules are available, districts are to use pre-ACA rules to determine eligibility, including FHPlus. If a S/CC is eligible for FHPlus, the instructions in Section IV.A of this directive must be followed for enrollment in Medicaid Managed Care. If a MAGI applicant is ineligible under pre-ACA rules, the application must be pended until eligibility can be determined under a MAGI-like budget. These procedures also apply to re-applications within 30 days of closing if on or after January 1, 2014, and the individual is ineligible under pre-ACA rules.

Once an eligibility determination has been made under pre-ACA rules for an application filed on or after January 1, 2014, but prior to the availability of MAGI-like rules (including determinations to pend an application due to being income ineligible under pre-ACA rules), any reported income change, person being added to a case or deleted from a case should be re-budgeted (pre-ACA rules). If the change results in eligibility, coverage should be continued or authorized. If the change results in ineligibility, coverage should be continued or the application/applicant pended until the availability of MAGI-like rules.

New York City will follow the same procedures; however, for individuals denied TA (*Reynolds*) on or after January 1, 2014, where the individual is determined to have excess income under pre-ACA rules, EDITS will convert excess income denial codes to Rejection Code HH8 (HX Applicant Submission – Case Level) or HH9 (Line Level), as applicable, and refer the individual/case to NYSOH for processing. If when making a separate Medicaid eligibility determination for an effective period of January 1, 2014 or later, but prior to the availability of MAGI-like rules, a discontinued TA or SSI recipient (*Rosenburg/Stenson*) who is in a MAGI eligibility group is determined to have excess income or is only eligible for FPBP, the NYC worker will use Rejection Code HH8 (Case Level) or HH9 (Line Level). The CNS notice will notify the individual that his/her information was referred to NYSOH for an eligibility determination. New York City will send a daily file to NYSOH containing information for these individuals/cases for further processing.

To determine eligibility for coverage of medical bills in the three-month retroactive period, the district must apply the budgeting rules (pre-ACA or MAGI-like) that are in effect for the month in which coverage is sought. If a six-month liability must be met for an inpatient hospital bill, and the bill is prior to January 1, 2014, the individual must meet a six-month liability as determined under pre-ACA rules. Further information regarding retroactive periods can be found in Section IV.F of this directive.

2. Renewals

a. Renewals Mailed in October, November and December with an Authorization "From" Date of January, February or March 2014

Instructions for renewals mailed out in October, November and December 2013, for individuals in a MAGI eligibility group were issued in GIS 13 MA/021. Since the instructions were issued after renewals were mailed out in October 2013, a renewal may have been denied due to excess income or a change to Family Planning Benefit Program (FPBP). For New York City, the special mass re-budgeting that will occur following the February Migration (as discussed in GIS 13 MA/021), will identify November 2013 - February 2014 closings due to excess income. Upstate districts are instructed to re-activate any affected case that is brought to their attention and extend coverage pending the availability of MAGI-like budgeting.

In accordance with CMS authority to reauthorize MAGI individuals who are determined eligible under pre-ACA rules, and to authorize coverage for a regular 12-month period, any income change reported after renewal and prior to April 1, 2014, on a case renewed under pre-ACA rules with a "From" date of January, February or March 2014, cannot be considered until the next renewal. If an income change is reported on or after April, 1 2014, the change must be considered (budgeted). If any person is added to a case or closed from a case after renewal, but prior to the availability of MAGI-like rules, the case should be re-budgeted under pre-ACA rules. If eligible under pre-ACA rules, coverage should be authorized for a regular 12-month period (FHPlus cannot be authorized beyond December 31, 2014). If an individual in a MAGI eligibility group is not eligible when re-budgeted, coverage should be extended if the case was previously eligible under pre-ACA rules. Any person added to a case that is not eligible when re-budgeted, should have eligibility pended until eligibility can be determined under a MAGI-like budget. If the case was previously ineligible under pre-ACA rules and a determination was not made prior to January 1, 2014, including notification sent, and the case continues to be ineligible when re-budgeted based on the person being added to the case or closed from the case, coverage must continue to be extended until a MAGI-like budget can be calculated. Any person added to the case must have eligibility pended until MAGI-like rules are available.

b. Renewals Processed January through February 18, 2014 with an Authorization "From" Date of April 1, 2014

For renewals mailed out in January 2014 with an Authorization "From" date of April 1, 2014, that are processed by the district between January and the availability of MAGI-like budgeting (February 18, 2014), the district must follow the instructions in 13 GIS MA/021.

NOTE: The instructions in 13 GIS MA/021 also include how to process individuals added at renewal. If when closing an individual from a case, individuals in a MAGI eligibility group are ineligible based on pre-ACA rules, coverage must be extended and re-budgeted once MAGI-like rules are available. Effective April 1, 2014, any reported income change can be considered (budgeted).

c. Renewals Processed on or After February 18, 2014

For renewals processed on or after February 18, 2014, with a "From" date of April 1, 2014, or later, that include an individual in a MAGI eligibility group, districts must use a MAGI-like budget in re-determining eligibility. Income changes reported prior to renewal cannot be considered until eligibility is re-determined at the regularly scheduled renewal. If a person is added to a case or closed from a case prior to a regularly scheduled renewal, the case must be re-budgeted under pre-ACA rules. If the case is eligible under pre-ACA rules, coverage must be authorized (FHPlus cannot be authorized beyond December 31, 2014). If the case is ineligible under pre-ACA rules, a MAGI-like budget must be calculated. If the case is eligible under the MAGI-like budget, coverage is to be authorized. If the case is ineligible under the MAGI-like budget, coverage should be discontinued (see Section IV.C.4 of this Directive for further instructions for MAGI-like eligibility determinations that result in financial ineligibility).

For cases closed due to an unreturned renewal or failure to provide required documentation, where the individual submits the required information within 30 days of the effective date of closing, the district should continue to process the individual's eligibility. For individuals who respond to the renewal notice or request for information after 30 days from the closing date, the individual must re-apply for Medicaid through NYSOH as a new applicant.

3. MAGI-Like Budget

For individuals who meet the criteria for one of the MAGI eligibility groups, the application or renewal information received by the district will not include the individual tax filer information needed to determine a MAGI household; therefore, the MAGI-like budget will be run using pre-ACA household size rules. A pregnant woman is counted as herself plus one. Effective January 1, 2014, documentation of pregnancy is not required for any Medicaid eligibility determination for a pregnant woman. Original documents for citizenship status are also no longer required for any Medicaid category of assistance, including Medicaid MAGI-eligibility groups. The following instructions apply to the calculation of a MAGI-like budget on MBL.

The MAGI-Like Budget Type (01):

- Household size is determined using pre-ACA Medicaid counting rules(EDC date will continue to add one to the household size);
- An Expanded Eligibility Code (EEC) of "M" is used to display the cascade of eligibility;
- Shelter Type may be left blank;
- Gross Income is entered; minus the unearned incomes listed in Attachment IV, "Income Excluded from MAGI," of this directive. If a worker enters one of the following unearned

incomes in the gross amount, MBL will exclude the amount in calculating the MAGI-Like budget but this applies only to those unearned income types listed below. It does not apply to all the unearned income types contained in Attachment IV.

- o 04 Black Lung Disease
- o 06 Child support payments
- o 07 & 11 Disabled Veterans Benefits
- o 28 German or Austrian Reparation Payments
- o 55 Veteran's Pensions or Benefits
- o 59 Worker's Compensation
- o 93 Burial Funds/Burial Arrangements and Veteran Payments
- o 94 State or Local Relocation Assistance
- o 96 Disaster Relief
- o 97 Insurance Payment

A revised Self-Employment Worksheet (see Attachment V of this directive) must be used to obtain Gross income from a self-employed individual if the individual does not have a tax return or the last tax return is not representative of current income. This worksheet was changed from a three month calculation to one month, and all of the expenses that IRS allows are now listed. For seasonal income or when income varies, individuals can use additional Self-Employment forms to calculate their average monthly business income.

NOTE: There is no resource test for a MAGI-like budget.

The Expanded Eligibility Screen for the "M" budget displays expanded eligibility levels as follows.

Group	Determination	FPL	Amount
Pregnant Woman	Ineligible/Eligible	223%	$XXXX
Infant	Ineligible/Eligible	223%	$XXXX
Child 1-5 Years	Ineligible/Eligible	154%	$XXXX
Child 6-18	Ineligible/Eligible	154%	$XXXX
	Ineligible/Eligible	110%	$XXXX
Parent/Caretakers	Ineligible/Eligible	138%	$XXXX
Family Planning	Ineligible/Eligible	223%	$XXXX
19 and 20 Year Olds			
Living with Parents	Ineligible/Eligible	155%	$XXXX
	Ineligible/Eligible	138%	$XXXX
S/CC, 19 and 20 Year			
Olds Living Alone	Ineligible/Eligible	138%	$XXXX
	Ineligible/Eligible	100%	$XXXX

Coverage is entered in WMS using the codes provided in the "MAGI Eligibility Categorical and Coverage Codes" chart (see Attachment III of this directive). Coverage is entered for a 12-month period.

A MAGI-like notice must be issued for every MAGI-like eligibility determination. See Section V, Systems Implications, for a list of Reason codes and titles for MAGI-like CNS and manual notices.

4. MAGI-Like Determinations that Result in Financial Ineligibility - Two Notice Options Available to LDSS

When a MAGI-like budget is performed and an individual is income ineligible (excess income or eligible for FPBP-only), the worker

must take a further step to determine if the individual may be categorically eligible in a non-MAGI eligibility group; including the excess income program (SSI-related or ADC-related). If the individual is eligible to participate in the excess income program, the notice sent advising the person of ineligibility under the MAGI-like budget must also include the option to participate in the excess income program. The district has two options to provide this notification.

a. Option One

A district can use a CNS notice to inform an individual of the option to participate in the excess income program. CNS Denial Reason Code (DD1) or Closing Reason Code (DD4) informs the individual that he/she may have eligibility for Medicaid determined under another basis, including the excess income program. If the individual elects to have Medicaid eligibility determined for the excess income program, the individual must contact the district within 30 days of the date of the denial/closing notice. The notice also informs the individual that he/she may apply to NYSOH for health insurance. At NYSOH, an individual may be eligible to receive health insurance using Advanced Premium Tax Credits.

b. Option Two

The second option a district has is to notify the individual of both his/her ineligibility under the MAGI-like budget and inform him/her of the excess income amount. In this situation, MBL information cannot be pulled for a CNS notice. This option requires that the district calculate a spenddown budget and send a manual notice. Although the MAGI-like budget has an output screen that shows a spenddown amount for ADC-related individuals, the district must review the input screen and list of income not counted for a MAGI-like budget (Attachment IV – income sources that do not have a source code) to determine if income needs to be added to the input screen to calculate the correct spenddown amount. If child support was excluded for a MAGI budget and the child is applying for Medicaid (even if eligible on a MAGI budget), the child support must be included in the spenddown budget. If no income has been excluded, the spenddown amount on the output screen will reflect the correct amount of spenddown for an ADC-related individual. For an SSI-related individual, the district will need to calculate an SSI-related budget to arrive at the correct spenddown amount. Once the spenddown amount is obtained, the district must choose the manual notice that applies based on the specifics of a case. There are several manual notices available depending on whether the situation is a denial or discontinuance and whether the individual was previously eligible for Medicaid or FHPlus. The notices also indicate that an individual is ineligible for the FPBP if that option was elected. See Section V.C for a list of notices that are available.

D. Advanced Premium Tax Credit (APTC) Premium Payment Program

Social Services Law was amended to continue to provide assistance for parents and caretaker relatives with incomes in excess of 138% of the FPL (applicable MAGI income level) but at or below 150% of the FPL

(the FHPlus income level). This program will only be available through NYSOH. The program is available to an individual who:

- is a parent of a child under 21 years old;
- has MAGI household income greater than 138% but less than or equal to 150% FPL for the applicable family size;
- is otherwise ineligible for Medicaid;
- is enrolled in a qualified health plan in the Silver level; and
- is applying the full APTC to the cost of the plan.

These individuals will be eligible for State payment of the enrollee's share of the premium for a qualified health plan in the Silver level (after application of advanced premium tax credits). Federal reimbursement (50%) is available for the cost of the premium. This program does not cover any cost-sharing expenses incurred by the individual. A FHPlus discontinuance notice will include a message that extra benefits may be available through NYSOH.

E. FHPlus Premium Assistance Program (FHP-PAP)

The FHP-PAP will be phased out similar to the FHPlus program. No new applications will be processed for FHP-PAP effective January 1, 2014, with the exception of applications submitted on or before December 31, 2013, that are not processed prior to January 1, 2014, and applications submitted on or after January 1, 2014 that are ready to be processed by the district but MAGI-like budgeting is not yet available. In this situation, pre-ACA rules are to be used to determine eligibility, including eligibility for FHP-PAP. If the individual is ineligible under pre-ACA rules, initial eligibility determinations must be pended until MAGI-like budgeting is available, and for an active case, coverage/payment of health insurance premium must be extended until eligibility can be determined under a MAGI-like budget.

Once MAGI-like budgeting is available, if the FHP-PAP case is determined to have MAGI-like income equal to or less than 138% of the FPL and it is determined to be cost effective to pay the premium for the employer-sponsored health insurance, the individuals on the case must be authorized fee-for-service Medicaid (Case Type 20, Categorical Code 94 and Coverage Code 01) and the premium amount reimbursed. If the premium is not determined to be cost effective, the case is still enrolled in fee-for-service Medicaid (Case Type 20, Categorical Code 94 and Coverage Code 01) since income is at or below 138% of the FPL (the applicable MAGI income level). Individuals with income over 138% of the FPL are no longer eligible for premium assistance and must be denied or discontinued, as applicable. See Section V.C. for a list of available notices. These cases are not eligible for the APTC Premium Payment program through NYSOH, nor are they eligible for APTC because the individual is already enrolled in insurance that disqualifies him/her for APTC.

F. Referrals from NYSOH for Coverage in the Retroactive Period

As outlined in 13 OHIP/ADM-03, individuals applying at NYSOH who request Medicaid coverage for medical bills in the three-month retroactive period will be included on the referral file to the

district. The referral file will contain the individual's application date and demographic information.

When the district receives the referral, an application is registered using the application date from the file, a Transaction Code 00 and Reason Code TT1 on Screen 11 in the CNS subsystem. This triggers the mailing of a CNS notice that contains a Medicaid application (DOH-4220) and Supplement A. The notice explains that the individual needs to complete and sign the application and Supplement A and return it with appropriate documentation. The checklist in the Access NY application lists the types of acceptable proof to be sent to the agency within 15 working days. New York City will process these referrals through EDITS, which will register an application and send the appropriate notice and enclosures.

If the application is returned without complete documentation, a request for missing documentation should be sent. If the application is returned completed and signed, including all required documentation, the district will process the case using the budget rules indicated in the below examples. If the application is not returned, a denial notice must be sent for failure to submit required documentation. Upstate districts should use CNS Reason Code U20 "Failure to Provide Verification of Factors which Affect Eligibility." This notice is a worker-fill notice that should be completed with the language "You failed to send your Access New York application to this agency."

As districts receive cases referred by NYSOH for Medicaid coverage in the three-month retroactive period it is important that coverage dates on WMS do not overlap Medicaid coverage dates established by NYSOH. Effective (date to be separately announced), district workers will see on the Clearance Report a NYSOH individual's Client Identification Number (CIN) and the status of "Active" in District 78 if the individual has active Medicaid coverage. The application month will be the start of Medicaid coverage on NYSOH. For active NYSOH Medicaid recipients, the district should only authorize coverage on WMS for the three-month period prior to application. Once the WMS Clearance process includes NYSOH individuals, the coverage and authorization period is to go no further than the begin date of coverage generated by NYSOH. For referrals received in December 2013, coverage can be established for the three-month retroactive period and for the month of December, if eligible, since coverage will not begin on NYSOH until January 1, 2014.

For individuals referred to the district for payment of medical bills in the three-month retroactive period, the district applies the budgeting rules that are applicable for the earliest month in the retroactive period for which coverage is sought (see below examples).

Effective (date to be separately announced), data entry for a retroactive case involves opening and closing the case. Upstate

districts should use Transaction Code 09 (Open and Close) and Reason Code 091 (Medicaid Spenddown). New York City workers must enter a new Opening Code (H60-Retroactive Medicaid Coverage) and a three month authorization period. Cases with Opening Code H60 that have an expired Authorization "To" date will be automatically closed the month following the month in which the authorization expired using Closing Code H61. Upstate, a manual notice must be issued for each individual processed for whom retroactive only eligibility is authorized (see Section V.C of this directive).

Referrals to the district by NYSOH for retroactive coverage will continue through the end of March 2014. After that date, referrals for retroactive coverage will be made when a NYSOH applicant is determined to be ineligible for Medicaid and states that income was the same in the three-month retroactive period. If the individual states that income was different in the retroactive period, income documentation will be obtained by NYSOH. The individual may subsequently be referred to the district if it is determined that the individual's income is over the MAGI income level. The following scenarios offer guidance to districts for processing retroactive coverage.

The first example refers to a scenario in which an individual is applying through NYSOH in 2013 and seeks retroactive coverage in 2013.

a. In December 2013, the district receives a referral from NYSOH for an applicant seeking coverage for a hospital bill in September. Medicaid coverage begins January 1, 2014, through NYSOH. The district determines that the individual is Medicaid eligible with a spenddown and documentation indicates that the individual's hospital bill would cover the six-month liability for inpatient care (spenddown).

   Even though the applicant met his/her six-month spenddown, the district worker only authorizes coverage on WMS from September 2013 through the end of December 2013 because Medicaid coverage on NYSOH begins January 1, 2014.

The next scenarios refer to retroactive coverage for individuals applying in 2014 to the NYSOH.

b. The district receives a referral from NYSOH for an applicant who applied February 1, 2014, and is seeking retroactive coverage for medical bills in November and December, 2013 and in January 2014. Medicaid coverage begins February 1, 2014, through NYSOH. The district applies pre-ACA rules to determine eligibility for November 2013 and the individual is found to be fully eligible. The worker then authorizes coverage in WMS for November 1, 2013, through January 31, 2014.

Using the same example, if the individual was determined ineligible under pre-ACA rules for November and December, the case would require a MAGI-like budget for January 2014. The district will need to calculate a MAGI-like budget once it is available on February 18, 2014, and, if eligible, retroactive coverage will be authorized for January 2014.

c. The district receives a referral from NYSOH for an applicant who applies in March 2014 and is seeking retroactive coverage for January and February. Medicaid coverage begins March 1, 2014, through NYSOH.

The district applies MAGI-like budgeting to determine eligibility because the first month of the retroactive period for which the individual is seeking coverage is January 2014. If the individual is determined eligible, coverage is authorized for January and February 2014 only because coverage through NYSOH begins March 1, 2014. If the individual was determined ineligible under MAGI-like rules, the individual would be evaluated for the excess income program if ADC-related or SSI-related.

G. Presumptive Eligibility (PE) for Pregnant Women and Children

Providers will continue to submit Presumptive Eligibility screenings and applications to the district. If the application is prior to January 1, 2014, pre-ACA budgeting rules apply. If an application is dated on or after January 1, 2014, MAGI-like rules must be used to determine eligibility. Similar to other situations covered in this directive, prior to the availability of MAGI-like budgeting, pre-ACA rules can be used to determine eligibility. If a pregnant women or child is found ineligible under pre-ACA rules due to income, and the application is on or after January 1, 2014, the application must be pended until MAGI-like budgeting is available.

NOTE: A Medicaid Update article will inform providers of the January 1, 2014 changes to PE and eligibility per the ACA. Provider training is also being updated based on the changes. The changes are being modeled after the MAGI-like budget.

H. Third Party Health Insurance/Medicare Savings Program

For Medicaid renewals performed by the district under a MAGI-like budget, the evaluation of the cost effectiveness of any Third Party Health Insurance (TPHI) remains the responsibility of the district. Districts must follow the instructions set forth in GIS 13 MA/012 "Changes to the Criteria Used for Determining the Cost Benefit of Paying Health Insurance Premiums."

The Medicare Savings Program (MSP) must also be considered for individuals in a MAGI eligibility group who have Medicare, such as

parents and caretaker relatives. In this situation, the district must perform the MAGI-like budget and then perform an SSI-related budget for MSP eligibility. If eligible under the MAGI-like budget and MSP, the MAGI-like budget should be stored and the case is coded in WMS accordingly for Medicaid and MSP. A copy of the MSP budget must be printed and stored in the case file. The coding for MSP is the same as pre-ACA coding. The MSP Qualified Individual (QI) program will remain the responsibility of the district.

V. SYSTEMS IMPLICATIONS

In order for districts to carry out the new responsibilities required under the ACA (MAGI-like budgeting), WMS will be modified to accommodate a new Clearance Report, new Categorical Codes, a new Expanded Eligibility Code (EEC) "M" and new CNS notices.

A. WMS Implications

1. Clearance Reports

As detailed in 13 OHIP/ADM-03, "Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010" a new, centralized clearance process has been developed for NYSOH and WMS.

Effective December 2, 2013, when an application is registered, a centralized clearance process will check NYSOH and WMS for an existing Client Identification Number (CIN) and active Medicaid status. New York City WMS will clear against NYSOH and Downstate WMS. Upstate WMS will clear against NYSOH, Downstate WMS and Upstate WMS. The printable Clearance Report will not show Upstate districts the results for Downstate WMS until a later enhancement is implemented. See the WMS/CNS Coordinator Letter for the 13.3 migration.

2. Individual Categorical Codes for MAGI Eligibility Groups

Five new Individual Categorical Codes have been assigned to MAGI eligibility groups. The following is a list of all Categorical Codes applicable to the MAGI eligibility groups. New codes are in bold type. The new Categorical Codes should be used when eligibility has been determined under a MAGI-like budget.

92 Pregnant Women (223% FPL)
45 Infants (223% FPL)
46 Child 1 – 5 years of age (154% FPL)
47 Child 6 – 18 years of age (115% FPL)
84 Child 6 – 18 years of age (>115% ≤154% FPL)
94 Parents/Caretaker Relatives (138% FPL)
95 19 & 20 year olds living with parents (150% FPL)
96 19 & 20 year olds living with parents (≤ 138% FPL)
09 S/CC & 19 & 20 year olds living alone (100% FPL)
93 S/CC & 19 & 20 year olds living alone (>100% ≤138% FPL)
68, 69 Family Planning Benefit Plan (223% FPL)

3. Rejection/Denial Codes

a. New York City

Rejection Code HH8 (new) "HX Applicant Submission" (Case Level) and HH9 (Line Level)

Two new Rejection/Denial Codes are available to refer MAGI applicants to NYSOH. When a case containing one or more individuals meeting the MAGI criteria apply, HH8 should be used to reject the case and default to the individual level.

In a situation where the household size is greater than one and at least one person does not meet the NYSOH referral criteria, the case will be processed using existing rules and accepted or rejected using existing Rejection Codes. Those individual(s) in the household who do meet NYSOH referral criteria will be rejected at the individual level using Rejection Code HH9.

b. Upstate

Upstate districts must use Transaction Code 03 (Denial) and Reason Code DD2 when referring MAGI applicants to NYSOH.

B. MBL Implications

See Section IV.C.3 of this directive for a description of the new EEC code "M".

C. Notices

1. Upstate CNS

The following is a list of Upstate CNS "MAGI-like" Reason Codes and Titles:

- UU7 - Family Health Plus-Premium Assistance Program to Medicaid
- UU8 - Family Health Plus to Medicaid
- UU1 - Woman at 60 Days Post-Partum to Family Planning Extension Program (24 months extension), Ineligible for Medicaid/Family Planning Benefit Program Due to Income Exceeding 223% FPL
- UU2 - Family Planning Benefit Program (Post-Partum Extension) to Family Planning Extension Program Due to Excess Income
- UU5 - Family Health Plus/Family Health Plus-Premium Assistance Program to Family Planning Benefit Program Due to Excess Income
- UU3 - Medicaid to Family Planning Benefit Program Due to Excess Income
- DD1 - Deny Medicaid Due to Excess Income, Family Planning Benefit Program Ineligible Due to Excess Income or Eligible but Declines
- DD2 - Application Received after 1/1/2014 for Categorically MAGI Individuals
- DD4 - Discontinue Medicaid Due to Excess Income, Family

Planning Benefit Program Ineligible Due to Excess Income or Eligible but Declines

- DD5 - Discontinue Family Health Plus/Family Health Plus-Premium Assistance Program Due to Excess Income, Family Planning Benefit Program Ineligible Due to Excess Income or Declined
- DD6 – Discontinue Family Planning Benefit Program Coverage Due to Excess Income
- SS1- Accept Family Planning Benefit Program, Medicaid Ineligible Due to Excess Income
- CC7 - FHPlus to Medicaid

2. Upstate Manual

- OHIP-0077 "Notice of Intent to Discontinue Medicaid" (Used to discontinue Medicaid when income exceeds the new eligibility levels.)
- OHIP-0078 "Notice of Intent to Discontinue Medicaid/Family Health Plus" (Used to discontinue FHP when income exceeds new eligibility levels.)
- OHIP-0079 "Notice of Decision on Your Medicaid Application" (Used to deny Medicaid separate determination applications when eligibility is determined using MAGI-like budgeting.)
- OHIP-0080 "Notice of Decision on Your Medicaid Application for Retroactive Coverage" (Used to notify NYSOH applicants who request an eligibility determination for the retroactive period.)
- OHIP-0081 "Notice of Decision on Your Medicaid Application/FPBP Acceptance" (Used to authorize FPBP coverage on Medicaid separate determination applications if income is below 223% FPL and applicant elected FPBP coverage.)

3. New York City – CNS and manual notices to be provided under separate cover.

VI. EFFECTIVE DATE

The provisions of this Administrative Directive are effective January 1, 2014, except where otherwise noted.

Jason A. Helgerson
Medicaid Director
Office of Health Insurance Programs