Description of Program Changes to the Partnership Plan 1115 Demonstration Waiver (Project Number 11-W00114/2) and the Federal-State Health Reform Partnership (F-SHRP) (Project Number 11-W-00234/2)

Overview

New York is seeking approval from the Centers for Medicare & Medicaid Services (CMS) to amend New York's Medicaid section 1115 Demonstrations, entitled "Partnership Plan" (11-W-00114/2) and "Federal-State Health Reform Partnership (F-SHRP) (11-W-00234/2). There are several changes necessary to these Waivers as the result of the implementation of Affordable Care Act (ACA).

Public Input

New York State, Department of Health, Office of Health Insurance Programs will submit the required public notice on changes outlined in this amendment request to the Federal Register, and will distribute informational letters to the official representative leaders of the recognized Federal Native American tribes located within our state. These notices will solicit input and public comment.

All commenters will be advised to provide input by submitting comments and questions to man08@health.state.ny.us.

I. Phase-Out of Family Health Plus

Family Health Plus (FHPlus) was established by the NYS Health Care Reform Act of 2000. FHPlus exists as a Medicaid Expansion program, providing access to comprehensive health insurance to uninsured New Yorkers with low income, and even adults with no children. FHPlus enrollment is currently 428,200. Prior to this legislation, many working, low income New Yorkers went without medical coverage because they did not have access to health insurance through employment and could not afford to purchase it.

New York has voluntarily elected to expand Medicaid under the ACA. This expansion will extend Medicaid to groups currently eligible for FHPlus, eliminating the coverage gap that made this program a necessity for many state residents. New York is planning a phase-out of enrollment and FHPlus coverage. There has been extensive evaluation to ensure affordable coverage options will exist for all recipients upon the sun-setting of FHPlus.

New York will ensure affordable health coverage options exist for all current recipients, and those who would have otherwise been eligible under current rules. It is anticipated that most current recipients will be eligible for Medicaid coverage. However, due to changes of circumstances and variances with income eligibility methodologies, some current recipients will be determined eligible only for enrollment in a Qualified Health Plan using Advanced Premium Tax Credits to assist with the cost of premiums.

For new applicants, New York will continue to accept and, if determined eligible, process applications for FHPlus through December 31, 2013. The program will end on December 31, 2014, and no coverage will be authorized past that date.

For current FHPlus recipients, Modified Adjusted Gross Income (MAGI) eligibility rules are effective April 1, 2014. However, prior to that date:

- All current single adults or childless couples (S/CC) FHPlus recipients will be transitioned into Medicaid Managed Care effective January 1, 2014.
- For FHPlus parents, caretaker relatives, and 19 & 20 year olds who live with their parents, renewing from January 1, 2014 through March 31, 2014, if determined eligible, will continue in FHPlus for maximum of twelve months, but no later than December 31, 2014.

With the introduction of MAGI eligibility determinations as of April 1, 2014, some recipients will begin transitioning into other coverage:

- FHPlus parents, and caretaker relatives, and 19 & 20 year olds who live with their parents, with income up to 138% FPL, will be renewed at LDSS, using MAGI eligibility rules to the maximum extent possible in the legacy system, for at least six months or until the new eligibility system is fully automated.

As previously discussed, New York is planning to transition most current FHPlus enrollees to Medicaid using MAGI eligibility rules at their scheduled annual renewal. For those enrollees determined not eligible for Medicaid, they would be directed to the New York Health Benefit Exchange for enrollment in a Qualified Health Plan (QHP).

New York has identified an income range of parents and caretaker relatives with income over 138% FPL to 150% FPL, who will no longer qualify for FHPlus. The State is seeking waiver expenditure authority to pay for the cost of the QHP premium for these individuals to ensure that they are not significantly worse off under the ACA than they would have been under FHPlus. New York intends to establish a Designated State Health Program (DSHP) to pay the cost of the premium for individuals who would have been eligible for FHPlus but who are now eligible for APTC/CSR as long as the individual selects a silver plan and applies their full APTC to the cost of the premium. The State is seeking federal financial assistance toward the cost of the DSHP.

Beneficiary and Provider Education and Outreach

Recipients will be informed through mandatory notices of the changes in their coverage.

An information update will be submitted for publication in the upcoming Medicaid Update to alert all Medicaid providers of these changes.

Benefit Package

For those current FHPlus recipients who transition into Medicaid, they will move into a more generous package, full Medicaid without institutionalized long term care. The subset of enrollees who will be eligible for a QHP will see a change in their benefits.

Budget Neutrality

The budget neutrality is forthcoming.

II. Health Coverage for Single Adults and Childless Couples (S/CC)

As mentioned previously in discussion of the FHPlus repeal, New York is modifying the authority under which coverage for low-income Single Adults and Childless Adults is offered. New York currently utilizes Waiver authority to provide this option through Medicaid and FHPlus. These individuals will qualify under the new "Adult" eligibility group, under the Medicaid State Plan, in accordance with the ACA. Therefore this authority should be removed from the Waiver.

Budget Neutrality

The budget neutrality is forthcoming.

III. Express Lane Eligibility Determinations

We are seeking to implement expanded use of Express Lane Eligibility (ELE) to include enrollment of adults. This process is already utilized successfully in our state to enroll children in Medicaid.

New York is seeking to utilize the eligibility determination of Temporary Assistance in order to enroll Adults into Medicaid. Household income data used to make determinations for Temporary Assistance (TA) must be current and rigorously verified; therefore our Medicaid program considers the income data from TA to be reliable. Income requirements for TA are more stringent than Medicaid's, and despite some differences in household compositions and income-counting rules, the majority of the non-elderly and non-disabled individuals who would qualify for TA are exceedingly likely to be financially eligible for Medicaid. Enrolling these participants without having to conduct a separate MAGI-based income determination will help ease administrative burdens, especially in anticipation of the increased volume of new applicants.

New York is seeking to implement this policy in January 2015.

New York plans to fulfill the requirement of a signature for Medicaid application. The application for TA will be revised to include a check-box that would allow applicants to opt-out of a Medicaid eligibility determination. Leaving the box unmarked would indicate that the applicant is interested in applying for coverage. The signature provided by the applicant on the TA application would authorize the request for a Medicaid determination, if that applicant is determined eligible for TA.

Budget Neutrality

The budget neutrality is forthcoming.

IV. Twelve Months Continuous Coverage

New York has used twelve month continuous eligibility for several years to simplify enrollment and keep qualified recipients in coverage. New York has been successful in using 12-month continuous eligibility for children and other eligibility groups, guaranteeing a stable source of health coverage, regardless of income or household changes. This has helped to minimize "churning," and its associated costs and the administrative burden of enrolling and disenrolling otherwise eligible individuals for procedural reasons or slight changes in circumstances.

We are seeking authority to make changes to our 12-month continuous eligibility policy to align with MAGI eligibility groups. The authority for all non-MAGI eligibility groups should be removed from both the Partnership and the F-SHRP Waivers.

To be removed from waiver:

12-month continuous eligibility groups (currently w/in F-SHRP and Partnership Waivers)
• Medically needy pregnant women, children and parents/caretaker relatives, the aged, blind and disabled
• Disabled children who lose SSI due to a change in the SSI definition of disability
• Individuals who meet the income and resources requirements of SSI but are not in receipt of cash
• Disabled widows/widowers who lost SSI or state supplements due to Social Security benefit increases in 1984 and who applied for continued Medicaid coverage before 1988
• Disabled adult children who lose SSI due to Old Age, Survivor's and Disability Insurance (OASDI)
• Disabled widows and widowers aged 60 through 64 who would be eligible for SSI except for early receipt of social security benefits
• Individuals who are ineligible for SSI or optional state supplements because of requirements that do apply under Medicaid
• Individuals eligible for Medicaid in December 1973 as an essential spouse of an aged, blind or disabled individual who was receiving cash assistance
• Individuals otherwise eligible for SSI or a state supplement except for the increase in OASDI under Pub. L. 92-336(July 1, 1972) raised include over the limit allowed under SSA ("pre-Pickle people")
• Individuals otherwise eligible for SSI or a state supplement, except that OASDI cost-of-living increases received after April 1977 raised their income over the limit allowed under SSI ("Pickle people")

The remaining eligibility groups in the waiver will be revised into new MAGI eligibility groups:

12-month continuous eligibility groups (to be included w/in F-SHRP and Partnership Waivers)
• Pregnant women
• Children <19 or 20, if full time student
• Children 19 & 20 living with parents
• Parents/Caretaker relatives
• Adult group (not pregnant, age 19-64, no Medicare, not a caretaker relative)

Budget Neutrality

The budget neutrality is forthcoming.