STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

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
NYC: (212) 417-4500

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.

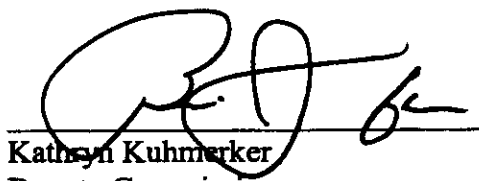
VI. SYSTEMS IMPLICATIONS

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 Management

CATEGORY	INCOME COMPARED	HOUSEHOLD SIZE		RESOURCE LEVEL		SPECIAL NOTES
		1	2	1	2	COLA 2.7%; Inflation rate 2.6% estimate 01/01/05
PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN	100% FPL 200%FPL	N/A N/A	1,070 2,139	NO RESOURCE TEST		Qualified provider makes the presumptive eligibility determination. Cannot spendown to become eligible for presumptive eligibility.
PREGNANT WOMEN	100% FPL 200%FPL	N/A N/A	1,070 2,139	NO RESOURCE TEST		If the woman is detemined eligible in any month of her pregnancy, she is guaranteed eligibility for the entire pregnancy (prospectively). If the A/R applies prior to the birth of the child she is entitled to a 60 day post-partum extension also. The baby will have guaranteed eligibility for one year. If the income is above 200% FPL the A/R must spenddown to the Medicaid income level.
CHILDREN UNDER ONE	200%FPL	1,595	2,139	NO RESOURCE TEST		If the income is above 200% FPL the A/R must spenddown to the Medicaid income level. One year guaranteed eligibility if mother is in receipt of Medicaid on delivery. Eligibility can be determined in the 3 months retro to obtain the one year extension.
CHILDREN AGE 1 THROUGH 5	133% FPL	1,061	1,422	NO RESOURCE TEST		If the income is above 133% FPL the A/R must spenddown to the Medicaid income level, resources will also be evaluated.
CHILDREN AGE 6 THROUGH 18	100% FPL	798	1,070	NO RESOURCE TEST		If the income is above 100% FPL the A/R must spenddown to the Medicaid income level, resources will also be evaluated.
UNDER 21, ADC-RELATED AND FNP	MEDICAID LEVEL	667	975	$4,000.00	$5,850.00	FNP parents cannot spenddown.
SINGLES/CHILDLESS COUPLES	PA STANDARD OF NEED	VARIES BY COUNTY	VARIES BY COUNTY	$2,000.00	$2,000.00	The A/R cannot spendown income or resources. Over age 60, resources are $3000.
LOW INCOME FAMILIES	PA STANDARD OF NEED	VARIES BY COUNTY	VARIES BY COUNTY	$3,000.00	$3,000.00	The A/R cannot spendown income or resources.
SSI-RELATED	MEDICAID LEVEL	667	975	$4,000.00	$5,850.00	Household size is always one or two.
BUY-IN (QMB)	100%FPL	798	1,070	$4,000.00	$6,000.00	Medicare Part A & B, coinsurance, deductible and premium will be paid if eligible.
COBRA CONTINUATION COVERAGE	100%FPL	798	1,070	$4,000.00	$6,000.00	A/R may or may not be eligible for Medical Assistance benefits.
AIDS INSURANCE	185%FPL	1,476	1,978	NO RESOURCE TEST		A/R must be ineligible for Medicaid, including COBRA continuation. Premium payments are FNP.
QUALIFIED WORKING & DISABLED INDIVIDUALS	200%FPL	1,595	2,139	$4,000.00	$6,000.00	Medicaid will pay Medicare Part A premium.
SPECIFIED LOW INCOME MEDICARE BENEFICARIES (SLIMBS)	BETWEEN 100% BUT LESS THAN 120%	798 957	1,070 1,283	$4,000.00	$6,000.00	If the A/R is determined eligible, Medicaid will pay Medicare Part B premium.
QUALIFIED INDIVIDUALS (QI-1)	BETWEEN 120% BUT LESS THAN 135% FPL	957 1,077	1,283 1,444	NO RESOURCE TEST		If the A/R is determined eligible, Medicaid will pay Medicare part B premium.
FAMILY HEALTH PLUS PARENTS LIVING WITH CHILDREN SINGLES/CHILDLESS COUPLES	 150% 100%	 1197 798	 1,604 1,070	 $12,000.00 $12,000.00	 $17,550.00 $17,550.00	The A/R must be ineligible for Medical Assistance. The A/R cannot spenddown to become eligible for Family Health Plus.
FAMILY PLANNING BENEFIT PROGRAM	200%	1,595	2,139	NO RESOURCE TEST		The A/R must be ineligible for Medical Assistance or Family Health Plus. The A/R cannot spenddown to become eligible for the Family Planning Benefit Program..

ATTACHMENT I

NEW YORK STATE INCOME AND RESOURCE STANDARDS AND FEDERAL POVERTY LINES EFFECTIVE JANUARY 1, 2005

HOUSE HOLD SIZE	MEDICAID INCOME LEVEL		100% FPL		120% FPL		133% FPL		135% FPL		150% FPL		165% FPL		200% FPL		250% FPL		RESOURCES		
	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONTHLY	ANNUAL	MONYHLY			
ONE	8,000	667	9,570	798	11,484	957	12,729	1,061	12,920	1,077	14,355	1,197	17,705	1,476	19,140	1,595	23,925	1,994	4,000	12,000	1
TWO	11,700	975	12,830	1,070	15,396	1,283	17,064	1,422	17,321	1,444	19,245	1,604	23,736	1,978	25,660	2,139	32,075	2,673	5,850	17,550	2
THREE	11,800	984	16,090	1,341			21,400	1,784			24,135	2,012	29,767	2,481	32,180	2,682	40,225	3,353	5,900	17,700	3
FOUR	11,900	992	19,350	1,613			25,736	2,145			29,025	2,419	35,798	2,984	38,700	3,225	48,375	4,032	5,950	17,850	4
FIVE	12,000	1,000	22,610	1,885			30,072	2,506			33,915	2,827	41,829	3,486	45,220	3,769	56,525	4,711	6,000	18,000	5
SIX	13,600	1,134	25,870	2,156			34,408	2,868			38,805	3,234	47,860	3,989	51,740	4,312	64,675	5,390	6,800	20,400	6
SEVEN	15,300	1,275	29,130	2,428			38,743	3,229			43,695	3,642	53,891	4,491	58,260	4,855	72,825	6,069	7,650	22,950	7
EIGHT	17,000	1,417	32,390	2,700			43,079	3,590			48,585	4,049	59,922	4,994	64,780	5,399	80,975	6,748	8,500	25,500	8
EACH ADD'L PERSON	1,700	142	3,260	272			4,336	382			4,890	408	6,031	503	6,520	544	8,150	680	850	2,550	-

SPOUSAL IMPOVERISHMENT	INCOME	RESOURCES
Community Spouse	2,378	95,100 *
Institutionalized Spouse	50	4,000
Family Member Allowance	1604 is used in the FMA formula the maximum allowance is 535	N/A

*In determining the community resource allowance on and after January 1, 2005, the community spouse is permitted to retain resources in an amount equal to the greater of the following $74,820 or the amount of the spousal share up to $95,100. The spousal share is the amount equal to one-half of the total value of the countable resources of the couple as of the date of the first continuous period of institutionalization of the institutionalized spouse on or after September 30, 1989.

** The FHPlus resource levels are effective August 1, 2005

You do not have to pay the co-payments if you are:

- Under age 21
- Pregnant
- A permanent resident of a nursing home
- A resident of community based residential facility licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disability
- Not able to pay the co-payment at any time and you tell the provider that you are unable to pay.

Family Health Plus members who cannot afford the co-payment may not be denied a service based on their inability to pay. Your provider cannot refuse to give you care or services because you are unable to pay. (However, you will still owe the unpaid co-pay amounts to the provider and the provider may ask you for payment later or send you a bill.)

VISION BENEFIT

Also as of September 1, 2005, the Family Health Plus vision benefit will change to include in any twenty-four month period: 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. Replacement of lost, damaged or destroyed eyeglasses is no longer a covered benefit. Contact your health plan with any questions about this benefit change.

IMPORTANT CHANGE AFFECTING EMPLOYEES OF FEDERAL, STATE, OR COUNTY GOVERNMENTS, MUNICIPALITIES AND SCHOOL DISTRICTS

If you are eligible for employer-sponsored health benefits through your own or a family member's employment with the Federal, State, or County government, a municipality or a school district, your Family Health Plus benefits will stop at the end of your benefit year. A change in State Law provides that individuals who have access to health care coverage through such employers are no longer eligible to enroll in Family Health Plus. Your coverage will terminate upon your next annual renewal date occurring after September 1, 2005. You will receive another notice before your Family Health Plus is terminated. You may wish to contact your employer to find out about enrolling in their plan, to avoid a gap in your health care coverage.

For more information about these changes to your Family Health Plus benefits and applicable co-payments, call the Medicaid Helpline at 1-877-873-7283 between 8:30 am and 5:00 pm, or your Family Health Plus plan.

If you wish, you can have a meeting (conference) to talk about this action, or you can ask for a "State Fair Hearing." To learn how to do this, please read the sheet that says "RIGHT TO A CONFERENCE OR FAIR HEARING."

Sincerely,

Kathryn Kuhmerker
Deputy Commissioner
Office of Medicaid Management

RIGHT TO A CONFERENCE OR FAIR HEARING
FAMILY HEALTH PLUS CHANGES (SP29)

RIGHT TO A CONFERENCE: You may have a conference to review this action. If you want a conference you should ask for one as soon as you can. At the conference, if we find that we took the wrong action or if you give us new facts that cause us to change our decision, we will give you a new notice. You may ask for a conference by calling or sending a written request to your local social services department.

RIGHT TO A FAIR HEARING: These changes in your Medical Assistance coverage are based on changes in state law and policy. You have a right to a fair hearing if you think we made a mistake, but not just because you think the new law or policy is unfair. The hearing officer at the hearing may decide that you do not have a right to a hearing if the only issue at the hearing is the change in State law or policy.

If you live anywhere in New York State, you may request a Fair Hearing by telephone, fax, online, or by writing to the address below.

Telephone: Statewide toll-free request number is 800-342-3334. Please have this notice with you when you call.

Online: Complete online request form at http://www.otda.state.ny.us/oah/forms.asp

In writing: Fill in the space below and send a copy of this notice to:

Fair Hearing Section
NYS Office of Temporary and Disability Assistance
Fair Hearings
P.O. Box 22023
Albany, New York 12201-2023

Please keep a copy for yourself.

Fax: Send a copy of this notice to (518) 473-6735.

If you live in NYC, you may also make your request in person by walking into the offices listed below.

Walk-In (NYC ONLY): Bring a copy of this notice to the Office of Administrative Hearings, of the Office of Temporary & Disability Assistance, 14 Boerum Place, Brooklyn, New York, or 330 W. 34th Street, 3rd Fl., New York, NY.

I want a Fair Hearing. This action is wrong because _____

_____

Client Signature: _____ Client print name here: _____

Client Address: _____

Phone Number: _____ Case Number: _____ CIN Number: _____

YOU MUST ASK FOR A FAIR HEARING WITHIN 60 DAYS FROM THE DATE OF THIS NOTICE.

IF YOU ASK FOR A FAIR HEARING, the State will send you a notice with the time and place of the hearing. You have a right to bring a person to help you like a lawyer, a friend, a relative or someone else. At the hearing, this person can give the hearing officer something in writing or just tell why the action should not be taken. This person can also ask questions of any other people at the hearing. Also, you have the right to bring people to speak in your favor. If you have any papers that will help your case (e.g. birth certificate), you should bring them with you.

IF YOU NEED FREE LEGAL HELP, you may be able to get such help by calling your local Legal Aid Society or advocate group. To locate a lawyer, check your Yellow Pages under "Lawyers."

YOU HAVE A RIGHT TO SEE YOUR CASE FILE to help you get ready for the hearing. You may call or write for free copies of the documents from your files which we will give to the hearing officer. Also, if you call or write to us we will give you free copies of other documents from your file, which you may want for your Fair Hearing. To ask for these documents or to find out how to see your file, contact your local Department of Social Services or, in New York City, the New York City Human Resources Administration. You should ask for these documents before the date of your Fair Hearing. They will be provided to you within a reasonable time before the date of the Hearing. Documents will be mailed to you only if you ask that they be mailed.

FOR MORE INFORMATION ON YOUR CASE, if you want to see your file, to find out how to ask for a Fair Hearing or to find out how to ask for copies of your file, contact your local Department of Social Services or, in NYC, contact the NYC Human Resources Administration.