Public Health Emergency Unwind Questions Received from Stakeholders

July 2023

Note: this document will continue to be updated with new questions and/or updated information.

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General Questions

1. When does NYS plan to re-start recertification process with the potential for termed coverage? (i.e. sending re-cert materials in February for possible April terms, sending materials in March for May terms, etc.)

   Answer: Renewals for New York's more than 7.9 million Medicaid enrollees and nearly 1.5 million enrollees in Child Heath Plus and the Essential Plan, must be completed by the end of May 2024. New York's Medicaid program operates in three eligibility systems:

   - NY State of Health for MAGI-Medicaid cases administered by the State (including eligibility determinations for Essential Plan and Child Health Plus)
   - Human Resources Administration (HRA) for all cases within New York City
   - The Local Departments of Social Services (LDSS) for all counties outside of New York City

   Each system is working concurrently with different timing requirements, as shown in the timeline below, to ensure consumers get the proper notice and information of the upcoming changes to their insurance.

   Medicaid, Essential Plan, and Child Health Plus Continuous Coverage Requirement ends EFFECTIVE 3/31/23:

	Mar	Unwind Month Apr 2023	May 2023	1 Jun 2023	2 Jul 2023	3 – 8 Aug 2023 – Jan 2024	9 Feb 2024	10 Mar 2024	11 Apr 2024	12 May 2024	Jun 2024
HRA	HRA begins sending out renewal packets with 6/30/23 end dates		Case clock for 7/1 begins 10-day notice		HRA new apps return to normal rules First discontinuances are effective		LDSS sends out last unwind renewal packets for 5/31/24 end dates			LDSS processing last renewals	Last renewals are effective
Upstate LDSS		LDSS sends out renewal packets with 6/30/23 end dates		Case clock down for 7/1 begins 10-day notice	Upstate LDSS new apps return to normal rules First discontinuances are effective			LDSS sends out last unwind renewal packets for cases with 5/31/24 end dates		LDSS processing last renewals	Last renewals are effective
NYSOH			Renewal notices sent for cases with 6/30/23 end dates	System action to Trigger 7/1 discontinuances occurs midmonth (10-day notice)	NYSOH new apps return to normal rules. First discontinuances are effective				Renewal notices sent for cases with 5/31/24 end dates	NYSoH processing last renewals	Last renewals are effective

2. Could the State share its federally required unwinding plan, that was submitted to CMS on February 15, 2023?

   Answer: The Department plans to post 1902(e)(14) waiver approvals from CMS and a summary of the unwinding plan once final written approvals are received from CMS.

3. Will the State be sharing any documentation that stakeholders could refer to that outlines the process for returning to normal rules?

Answer: An updated General Information System (GIS) guidance, GIS 23 MA/14, has been posted to the Department's website.

4. What are your expectations for total exparte renewals % success?

   Answer: Approximately 40% of households on NY State of Health are expected to be ex parte renewed.

5. Will the ability to continue phone applications continue for all populations including ABD and NY State of Health for navigators or will it end with the Public Health Emergency (PHE)?

   Answer: Yes, assistors will be able to continue with phone enrollments for the NY State of Health assistor programs and the FE ABD program until further notice.

Resumption of Renewal

6. When recertifications resume, we understand the State will revert to enrollment rules and procedures that were in place prior to the public health emergency and discontinue many of the public health emergency flexibilities that may still be in effect. These include Section 1135 waivers, Disaster Relief SPAs, and other federal and state flexibilities. Could DOH provide a list of the Medicaid, Child Health Plus, and Essential Plan eligibility and enrollment flexibilities still in effect due to the PHE that will be discontinued and the timeline for discontinuation?

   Answer: During the PHE, the State automatically extended Medicaid (MA), Child Health Plus (CHPlus) and Essential Plan (EP) cases for an additional 12 months of coverage at renewal. Most enrollees have had their eligibility automatically extended since March 2020 regardless of:

   - Data sources which do not match the information in the application.
   - Outstanding verification document requests such as income, citizenship/immigration, or Medicare.
   - The consumer having an undeliverable mailing address.
   - The consumer not paying their premium contribution responsibility for EP (prior to June 2021 elimination premium contributions) and CHPlus, if applicable.

   These flexibilities will be discontinued for a consumer when it is their time to renew their coverage.

   For information on NY State of Health's redetermination process, we encourage you to review our two-part assistor webinar that goes into detail on the unwind process and timelines as well as a refresh on provision that will be reinstated. Presentations and recordings of that webinar can be found here: https://info.nystateofhealth.ny.gov/SpringTraining2023

   Flexibilities implemented by Local Departments of Social Services are detailed in GIS 20 MA/04. See GIS 23 MA/03 and GIS 23 MA/14 for details on the unwinding process.

7. If a patient (consumer) is deemed ineligible, is there a grace period before coverage terminates?

Answer: If a consumer's coverage through NY State of Health is terminated because they failed to renew and they renew their case by the end of the month following their termination, if they continue to be eligible for coverage, their coverage will be restored. Example: Z's Medicaid coverage is scheduled to end on July 31, 2023. Z fails to renew their case on time. If Z renews their case before August 31, 2023, even though they are late, if they are still eligible for Medicaid, their coverage will be restored back to July 1st.

8. How will renewals be prioritized?

   Answer: Renewals will be completed based on the enrollee's eligibility end date. This means not everyone will renew their insurance at the same time. It will take 12 months to renew all cases. Instructions on how NY State of Health enrollees can find their enrollment end date are provided in question #5 of these Frequently Asked Questions. Medicaid enrollees who enrolled through their Local Department of Social Services (LDSS) or HRA can contact their LDSS or HRA to ask what their enrollment end date is.

9. What coverage options will be made available to consumers who are no longer eligible for Medicaid?

   Answer: If a consumer no longer qualifies for Medicaid, they may be eligible for Child Health Plus, the Essential Plan, or they may be eligible to enroll in a **Qualified Health Plan** (QHP) through NY State of Health. **Enrollment** in NY State of Health will remain open so anyone who loses their Medicaid, Child Health Plus or Essential Plan coverage during the redetermination process will be able to enroll in a QHP, if they qualify. NY State of Health offers a broad choice of QHPs with comprehensive benefits. More people than ever are qualifying for financial assistance to pay for their premiums.

10. Can you elaborate more about handling zero income for 2019 situations and how we use that to determine eligibility?

    Answer: If an individual applied or renewed in the 12 months prior to March 2020, and they attested to having no income, and that attestation was verified, and they haven't updated their NY State of Health account since then (because they weren't required to do so during the continuous coverage requirement) then we will use that attestation of zero income to administratively renew them during the unwind if we don't receive any conflicting income information from data sources.

11. Our organization works with primarily the homeless population, who tend to have changes in address as they move from shelter to shelter. Is there some sort of code that can be implemented so that they do not lose services due to return address changes?

    Answer: An enhancement was made to the NY State of Health system in August 2019 to not take action to terminate a consumer's coverage if mail is returned as undeliverable and they have indicated in their application that they have no fixed address and don't have a reliable mailing address. NYC HRA uses a special address when the person does not have a fixed address, so that there would not be undeliverable mail, however, they could still lose coverage if they fail to renew. This special address does not keep them open forever, it would prevent them from being closed for

whereabouts unknown/undeliverable mail. The Districts in the rest of the State did not make this change.

Administrative Renewals

12. What does "administrative renewal" mean?

    Answer: An administrative renewal is a renewal that can be processed without the enrollee needing to provide information, since information about the enrollee can be gathered from other trusted data sources. For example, NY State of Health can obtain the enrollee's most recent income information from the federal data services hub and use that to process the renewal.

13. Is the IRS data match for NY State of Health only or also Welfare Management System (WMS) (NYC HRA)?

    Answer: IRS data is only used for consumers in NY State of Health.

14. Will local districts also be able to do administrative renewal?

    Answer: Yes, DOH is pursuing multiple avenues to allow for administrative renewal at the local districts.

Transitions to Other Coverage

15. The state is expecting a large number of current enrollees will shift to employer sponsored coverage. Most companies only allow open enrollment into their insurance twice a year. People may find they have a gap from their public health insurance and when they can enroll with their employer. Is there a plan to bridge this coverage?

    Answer: If an enrollee is found to be no longer eligible for a public program due to having an offer of affordable employer sponsored coverage, this will be considered a loss of coverage, which is a qualifying special enrollment event, permitting eligible employees to request enrollment in their company plan. Enrollees should contact their employer immediately after finding out they are no longer eligible for their public health insurance, and this should avoid any gaps in coverage. Separately, the Department has disseminated information about the PHE unwind and potentially impacted employees to New York State employers and other agency partners to ensure eligible employees enroll in coverage on time.

16. Does DOH have information on how many Medicaid recipients currently have employer-sponsored insurance or other coverage?

    Answer: The Department has received estimates that over 1 million consumers will shift from Medicaid to Employer sponsored coverage.

17. For clients who are moving from Medicaid to a Qualified Health Plan (QHP), are they going to continue the 12 months extended Medicaid or they will be transferred to QHP in 2023? Is there any problem staying on Medicaid during PHE even if their income was updated?

    Answer: During the PHE, consumers were allowed to remain in Medicaid regardless of circumstances such as income change. During the unwind, consumers can no longer remain in Medicaid if they are found ineligible at renewal. Consumers found eligible for a Qualified Health Plan at renewal will not be able to continue in Medicaid for an additional 12 months. They will need to enroll in a QHP, which currently offer enhanced financial assistance to eligible individuals under the Inflation Reduction Act.

18. What is the eligibility criteria for the transition of the MAGI consumers to NY State of Health?

    Answer: MAGI individuals with Medicaid through local districts were transitioned to NY State of Health at the end of April 2023. The basic criteria included cases with at least one adult member <65 years old who had eligibility ending 7/31/23 or later.

Data Questions

19. How will DOH get information from the districts for the monthly CMS reporting?

    Answer: DOH will retrieve information from the Medicaid Data Warehouse (MDW) and Welfare Management System (WMS) to support the monthly CMS reporting requirement for individuals with Medicaid through the local districts/NYC HRA.

20. Can you clarify if the monthly data reports will be on the 1/12 renewal cohort in that month, and/or a cumulative report?

    Answer: The monthly data reports will focus on each month's renewal cohort. They will not include cumulative data.

21. How will the cohorts be followed over time?

    Answer: DOH is working on creating reports and dashboards that will have the ability to follow cohorts over time.

22. Will the State provide Medicaid renewal data via State rosters to plans in order to minimize potential case closings?

    Answer: Rosters were ended in January 2021. NY State of Health and rest of state (ROS, formerly upstate) WMS send the recertification date on the 834/837. For HRA cases, HRA's Recertification and Case Management "RS" file is transmitted by NY Medicaid Choice to plans.

Opportunities for Health Plans to Support the Unwind

23. To facilitate more timely processing of renewals during the resumption of recertifications, would DOH allow plans greater use of electronic processes (i.e., enrollees e-signing renewal forms or enrollees receiving documents and notices via electronic means) when working with members to complete their renewals?

    Answer: Yes. HRA has added the ability to electronically submit Medicaid renewals through ACCESS HRA. LDSSs in the rest of the state that participate in NYDocSubmit will also be accepting renewals through the NYDocSubmit mobile application.

24. When recertifications resume, plans expect that there will be some cases where renewal applications are initiated but not completed or have outstanding documentation requirements that put the member at risk of a coverage lapse if not addressed. Is the State considering any new flexibilities that would apply to these cases, such as stipulated extensions or retroactive coverage up to a certain deadline that would help smooth coverage lapses?

    Answer: Consumers are provided at least 30 days to respond to renewal notices and these existing renewal timeframes provide time needed for consumers to return their renewals before the case authorization end date. If a consumer needs additional time to provide documentation, that is permissible if the consumer is making a good faith effort to obtain the documentation. Reminders of this information are found in GIS 23 MA/03. See response to #7 above regarding grace periods for failure to renew. This grace period also applies to cases in which enrollees fail to provide requested documentation

25. Prior to the PHE, the State allowed plans to outreach Medicaid managed care members who failed to renew their enrollment for a period of 60 days following their disenrollment. To promote coverage retention during the resumption of recertifications, would DOH consider temporarily allowing plans to outreach members who did not recertify beyond the standard 60 day outreach period?

    Answer: No, DOH is not considering allowing plans to outreach members beyond the standard 60-day period.

26. Could DOH confirm the following understanding: DOH outreach guidance indicates that plans may outreach to former members for a period of 60 days following their disenrollment. The FCC ruling permits state agencies and their partners to send text messages and make phone calls to individuals about enrollment-related issues. Consistent with the DOH outreach guidance and the FCC ruling, plans may continue to send text individuals after they fail to renew for up to 60 days following their disenrollment.

    Answer: DOH allows outreach during this timeframe, and plans may conduct outreach as allowable by state and federal law. DOH defers to health plans' legal counsel on how FCC rules related to texting impact them.

27. Plans appreciate that the State will produce lists and implement FE dashboard functions that enable plans to identify the members who will be renewed automatically through ex-parte so that they can identify, and prioritize resources for, members who were not renewed automatically and require manual intervention. Can DOH confirm when they will begin sharing these lists and that the lists will be shared via the issuer portal? Can DOH also confirm that the dashboard functionalities that distill this information will be reviewed during the forthcoming FE training on recertifications and resumption of old rules?

    Answer: A comprehensive unwind training was held for assistors on 4/19/23 and 4/26/23. Health plan assistors will be able to see the Client Renewal Reminder Notices posted to their dashboard beginning on May 18, 2023, for June 30, 2023, renewals. NY State of Heath will continue to post these notices monthly around the 18th of each month. These notices contain a list of accounts that are due to renew and differentiate between those in manual versus automatic renewal. The 4/26/23 training included a refresher to assistors on how to view accounts that need attention on their dashboard. Assistors can view the accounts that need to be manually renewed, need to select a plan, or have documentation due in the Individual Overview section in their dashboard. These dashboards refresh in real time. In addition, health plans that utilize the Assistor Oversight Manager functionality, have added reporting abilities in which Assistor Oversight Managers can produce reports of accounts due to renew, across all their assigned assistors. These reports can be exported and are available for download from the Health Commerce System the next day.

    This training has been archived and is posted at the following link: https://info.nystateofhealth.ny.gov/SpringTraining2023.

    Renewal reports are posted to the issuer portal each month for Child Health Plus, EP and Medicaid Managed Care (MMC). The 6/30 renewal reports were posted to the Issuer Portals on 5/16.

28. Will DOH be able to identify procedural denials to plans through specific denial reason codes so plans can conduct outreach to help reconnect these members to coverage? Could DOH review which codes these are and how they are populated?

    Answer: NY State of Health sends disenrollment reason codes on the 834s sent to plans. DOH can provide direction to plans on which of those codes are considered procedural. If assistance is needed, please contact nysoh_issuer_support@health.ny.gov.

29. As plans prepare for the resumption of renewals and identify when members will be renewed, plans have noticed that some of their WMS enrollees do not have a recertification date on their 834 file and that plans have to search for members recertification dates in ePACES. Would it be possible for DOH to include recertification dates on the 834 file for these enrollees?

    Answer: NY State of Health and ROS WMS send the recertification date on the 834. For HRA cases, HRA's Recertification and Case Management "RS" file is transmitted by NY Medicaid Choice to plans.

30. Plans have noticed that a number 834 enrollment files include missing or invalid email addresses, despite the majority of their members having their eligibility processed through the NY State of Health eligibility system, which requires an email address to have an account. Does the State have any technical enhancements planned to improve the sharing of valid email address data on the 834?

Plans are willing to partner with the State to test potential solutions to improve access to email address data.

Answer: Emails are collected, but the distribution of email addresses on the 834 is contingent on the communication preference selected by the member during their application. NY State of Health will have internal discussions on the options that we have regarding emails collected, but not sent.

31. Are their community resources available, such as MCO partnerships and Community Partnership opportunities? How would we engage them?

    Answer: We encourage Managed Care Organizations (MCO) to co-brand the educational materials we have available on our PHE Communications Toolkit, found here: **Unwinding from the COVID-19 Public Health Emergency: A Communications Tool Kit to Keep New Yorkers Covered | NY State of Health** Click on the section in the Table of Contents labeled: *Materials Available for Co-branding*.

    NY State of Health together with Assistors throughout the state participates in hundreds of events throughout the year promoting affordable health insurance coverage and the importance of renewing coverage. NY State of Health enrollment assistors are invited to participate in these events. For a list of scheduled, upcoming events, please see our events map here: **Events | NY State of Health**

32. Will the state send MCOs a redetermination letter template to notice members of the PHE unwind?

    Answer: DOH will not be providing MCOs with a specific redetermination letter template to notice members of the PHE unwind. MCOs are encouraged to utilize the resources found in the CMS Communications Toolkit: https://info.nystateofhealth.ny.gov/PHE-tool-kit.

33. Could DOH speak to how it is coordinating with OMIG to ensure OMIG has an understanding of the rules and processes during the unwinding period and that OMIG is adjusting its reviews appropriately and not initiating inappropriate compliance actions (e.g., recoupment of plan capitation payments)?

    Answer: DOH provides the Office of the Medicaid Inspector General (OMIG) with the same information as it does the MCOs on the rules and procedures during the unwind period. Additionally, OMIG attends the plan meetings where DOH provides information to the MCOs.

Health Plans Updating Contact Information

34. What is the State's target implementation date for the new process of updating enrollee contact information? When will the State be prepared to begin receiving updated enrollee contact information from plans?

    Answer: Implemented April 2023.

35. What specific address information should plans submit to the State (residence/eligibility address, mailing address, or all of the above)?

    Answer: Contact information includes the mailing address.

36. How will plans transmit confirmed updated contact information back to the State? Can DOH provide specifics such as the file specifications, frequency, and submission methods? Further, can DOH clarify how the new process will interact with the current Excel file sharing process plans are using to share updated contact information with the State?

    Answer: DOH provided MCOs with this information in April 2023. It is available here.

37. How far in advance of an enrollee's recertification notice mailing date will plans need to submit updated contact information to ensure that the recertification notice is sent to the enrollee's updated address?

    Answer: MCOs should submit the updated contact information when they become aware and verify it.

38. The information DOH shared on the waiver flexibility specifically identifies Medicaid managed care (MMC) plans and managed long term care (MLTC) plans as being able to provide updated enrollee contact information to the State. Plans assume that DOH would also want these plans to share updated contact information for Child Health Plus and EP members, as members in those program will also need to recertifying coverage during the unwind. Could DOH please confirm they will also accept updated contact information for Child Health Plus and EP enrollees from MMC plans?

    Answer: This is confirmed in the April 2023 guidance to MCOs.

39. Could DOH please provide an overview of their expectations of and processes for plans supporting updated contact information for each program (Medicaid, Child Health Plus, and EP)? Does the (e)(14) extend to Child Health Plus and EP?

    Answer: Plans across all lines of business must update NY State of Health and LDSSs when they receive an updated mailing address and other contact information for a member.

    Health Plans with assistors (Marketplace Facilitated Enrollers), along with all other assistor agencies have been receiving reports of accounts with undeliverable mail since 2021. The intention of these reports was to have assistors help consumers update their mailing address. Distribution of these lists will continue through the unwind.

    Assistors can view accounts on their dashboard that have flags on their account such as undeliverable mail and invalid email addresses in the "Communication Events" tab of their dashboard. We included an overview of how to review this as part of the unwind training.

40. Under the current processes, plan updated contact information is sometimes overridden by the State if it is not verified by the next time 834s are sent to plans and member contact information

reverts back to outdated information. Going forward, could the State expedite the timeline for updating this information in its systems and included in the 834s to ensure that plans have access to members' most recent contact information when they need to conduct outreach?

Answer: Updating address information in all systems (WMS and NY State of Health) is a manual process and the volume of address updates being reported by plans is higher than expected. The Department has enlisted additional help to complete the address updates and is working to streamline the process, so hopefully plans have seen, and will continue to see, improvements in the timeliness of these updates.

Dual Eligibles

41. Multiple stakeholders have raised concerns about the processes in place for dual eligibles during the unwinding. Dual eligible individuals may be at higher risk for administrative denials, for example. The eligibility requirements for this population are complex and there are more moving parts: people who are dual eligible would not only have their overall Medicaid eligibility redetermined but – in some but not all cases – be transferred from Medicaid managed care to fee-for-service. Prior to the PHE, people who become dual eligible were disenrolled from their managed care plan. However, there are many members who became newly dual eligible *during* the PHE, but remained in managed care because of continuous coverage requirements.

    Currently, there are members of managed care plans who, under standard rules, would have been disenrolled from Medicaid managed care (but remain enrolled in Medicaid) when they became dual eligible; however, under the continuous coverage requirements these individuals have remained enrolled in Medicaid managed Care (MMC). We understand that, as part of unwinding, these individuals will be transitioned to Medicaid fee-for-service (FFS). We are seeking to confirm that, to align potential transitions, this population's disenrollment from Medicaid managed care will be aligned with their Medicaid coverage recertification date, correct?

    i. For example, if a person who is dual eligible but in a managed care plan has a recertification date of July 31, 2023. This person is re-determined eligible for Medicaid and Medicare and this person would be disenrolled from Medicaid managed care and enrolled in Medicaid fee-for-service effective July 1, 2023.

    Answer: It is correct that these individuals with Medicare will be transitioned to Medicaid FFS, unless the member is in the Integrated Benefit (IB)-Dual program. The IB-Dual program was created during the PHE for members who are in MMC/Health and Recovery Plan (HARP) who are also Medicare eligible and in an aligned Medicare and Medicaid plan.

    It is also correct that a dual eligible's disenrollment from Medicaid managed care will be aligned with their Medicaid coverage recertification date. However, in the example provided, if the consumer is due to recertify by July 31, 2023, they will be disenrolled from Medicaid managed care effective July 31, 2023 and enrolled in Medicaid fee-for-service effective August 1, 2023. The only exception would be if a dual eligible consumer currently has coverage in NY State of Health and they

come in to update their account prior to their coverage recertification date. In that scenario the consumer may be disenrolled from their Medicaid managed care plan and enrolled in fee-for-service prior to their coverage recertification date.

42. We understand that DOH is seeking additional flexibility for this population, with the hopes of keeping unaligned duals on the NY State of Health eligibility system through the unwinding period but would appreciate any further detail you provide. DOH noted that there are approximately 60K of these "unaligned duals" that will move from managed care to FFS but remain in NY State of Health. Could DOH please clarify the makeup of this group? Are these mainly duals that have opted out of (or have not been default enrolled into) an IB-Duals plan? Does this group include any duals that are not currently a member of an integrated plan? A more specific breakdown of these 60K enrollees would be helpful.

    Answer: DOH has received approval from CMS to allow all duals and members over 65 who are in NY State of Health to remain in NY State of Health throughout the unwinding period. There are approximately 86,000 duals in MMC or HARP and in the NY State of Health system.

    - Approximately 20,000 of these duals are in the IB-Dual program, and 66,000 are not
    - These 66,000 will remain in NY State of Health but go to Medicaid FFS while the 20,000 will be able to remain in NY State of Health and in their MMC/HARP through the IB-Dual program

    The 66,000 unaligned enrollees in MMC and HARP represent a number of populations, including:

    - Members whose plans did not offer default enrollment at the time the member became Medicare eligible
    - Members whose plans did not offer default enrollment and still do not
    - Members who opted out of default enrollment
    - Members who did not reside in a county where their plan offered default enrollment
    - Therefore, this 66,000 are all duals that are not in an integrated plan, which is the reason they cannot remain in MMC/HARP while having Medicare

43. Will people be able to go into Medicare if eligible with a special enrollment period?

    Answer: The requirement to apply for Medicare when someone first becomes eligible was not eased as a result of the PHE, however, individuals who did not apply for Medicare when they first became eligible during the PHE, will not have incurred penalties.

    Starting 7/1, if consumers, who did not apply for Medicare when first eligible during the PHE update their account, they will be notified again of the requirement to apply for Medicare and to provide proof.

    If consumers, who did not apply for Medicare when first eligible during the PHE, do not make any updates to their account, they will be notified of the requirement to apply for Medicare when they renew. Consumers who do not apply for Medicare after receiving this notice, could have to pay a late enrollment penalty or higher premium if they later apply for Part A and/or Part B.

44. What does "unaligned duals" mean?

Answer: Unaligned duals means dual eligibles who are in MMC or HARP but are not in the same plan's Medicare Dual Eligible Special Needs Plan (D-SNP).

45. What is the timeline for unaligned duals to transition to FFS? Will it happen at renewal, or all at once in July?

    Answer: Members currently enrolled in Medicare and MMC and HARP, who are not in an approved aligned Medicare Dual Eligible Special Needs Plan (D-SNP), will be disenrolled to FFS upon their renewal date.

46. There was a discussion of maintaining non-assigned duals with NY State of Health unless they require Medicaid Managed Long Term Care (MLTC). What impact will that have on Medicare Savings Program (MSP) enrollment?

    Answer: Individuals in the NY State of Health who have Medicare have been being enrolled as Qualified Medicare Beneficiary (QMBs) eligible since January 2023 in the Medicare Buy-In. Ongoing Medicare Insurance Premium Payments (MIPP) ended.

47. Will dual eligibles who were auto-renewed, for example, in February, be eligible for 12 full months of Medicaid, or could they receive a renewal notice for Medicaid within the unwinding period?

    Answer: If they were found fully eligible then they will be pulled into renewal at the end of their 12 months. In the example provided, they would receive a renewal notice in December 2023 to renew their coverage for February 2024. This would be during New York's unwinding period, which lasts until May 31, 2024.

48. For the consumers who are currently enrolled through NY State of Health with Medicare and have mainstream managed care but qualify for nursing home services which would typically be MLTC services, will they be transitioned to the district?

    Answer: Yes, when the Department is notified that someone needs MLTC or long term care and support services they will be transitioned to the district through an existing manual process.

49. Has there been any talks about the renewals of populations over 65 and possibly automatically extending their Medicaid coverage instead of them renewing yearly?

    Answer: The current plan is to continue renewals of the populations over 65, but to expand opportunities to administratively renew this population throughout the course of the unwind and beyond.

HARP Eligibles

50. People who are eligible for HARP may also present a complex recertification scenario, in which there is a higher threat of disenrollment (from Medicaid and/or their current managed care plan), even if the person may still be eligible for Medicaid.

a. Will there be any changes to regular enrollment practice for HARP eligibles during the resumption of recertification process?

Answer: There are no changes specific to HARP eligible consumers during the resumption of the recertification process.

b. If a MMC member who is HARP eligible fails to renew *during recertification,* and a plan FE assists them with regaining coverage, will plans be able to enroll that individual directly into HARP? Will the member be able to select HARP as their coverage from the onset?

Answer: The member will continue in their former MMC plan unless they decide on another plan. HARP eligibles can choose to join a HARP at any time.

Special Needs Plans

51. I heard several references to mainstream Medicaid, but no mention of the Special Needs Plans (SNP). Will these changes apply to individuals insured under these plans as well?

Answer: Yes.

52. Will there be any efforts made to assist dually eligible individuals in Mainstream/HARP plans move into an aligned D-SNP before transferring them to Medicaid fee for service (especially since only a few Mainstream/HARP plans have an aligned D-SNP)?

Answer: Dually eligible individuals who wish to move to a plan with an Integrated Benefits for Dually-Eligible Enrollees Program (IB-Dual) option can get assistance from New York Medicaid Choice. These individuals will need to also join the plan's Medicare D-SNP plan to enroll.

Child Health Plus

53. The State had previously gathered plan feedback on retroactive enrollment in Child Health Plus during the unwinding process and longer term. PHP Coalition plans responded positively to the retroactive enrollment in Child Health Plus during the unwinding period, with a number of questions about how the policy would be operationalized. The State conveyed that this functionality already exists in Medicaid and will also be extended to EP.
    a. Has the State decided whether they will move forward with retroactive enrollment in Child Health Plus?

    Answer: Yes, we are moving forward with retroactively enrolling a child if they renew a month late. We anticipate this being in place by 7/1/23.

    b. If so, could the State please provide technical guidance on how the 834 transaction file sequence would work (so that plans can work quickly to update systems)?

Answer: For Child Health Plus, a New Enrollment 834 will be sent, followed by a change 834 changing the start date of enrollment to be retroactive to the month the renewal was due.

c. During the unwinding period, what are the State's expectations for Child Health Plus accounts that have outstanding balances (i.e., premiums)?

Answer: On May 10, 2023, New York State received approval from the Centers for Medicare and Medicaid Services (CMS) to allow children to remain enrolled in the Child Health Plus program despite having unpaid family premium contribution payments, until a full renewal has been completed. Please note, this policy only applies to subsidized enrollments. Once the child's renewal has been completed, either by completing their renewal or by running a Life Status Change (LSC) on or after 7/1/2023, rules previously in place regarding collection of the family premium contribution resumes including providing a one (1) month prospective coverage grace period for subsidized enrollees.

Under Child Health Plus, for a brand-new enrollment (first time), if there is a premium contribution due, coverage is not effectuated until the first month's premium is paid (if applicable). If after the first month's premium contribution has been paid and the Child Health Plus coverage has been effectuated, the family must continue to pay their premium contribution amount each month per child, up to 3 children in the household. If the payment is not received by the health plan after the child's coverage has been effectuated, then a one (1) month prospective grace period will be applied.

Essential Plan

54. How will the governor's plan to increase Essential Plan eligibility to 250% of the FPL impact renewals? If the budget is passed for this initiative, when might this increase take effect?

Answer: The target implementation date is January 1, 2024.

55. What are the five-year bar renewals from the Essential Plan to Medicaid?

Answer: Individuals who have incomes up to 138% of FPL who are in EP instead of the Medicaid due to the Federal "5-year bar" are moved to Medicaid at the end of the 5-year bar systematically.

56. The Aliessa population would not have to verify their current immigration status to transition to Medicaid? They just have to be on Essential Plan for five years?

Answer: If they have already verified their immigration status then they will not be asked to verify it again when they move from EP to Medicaid at the end of their 5-year bar.

Consumers enrolled in Medicaid through NY State of Health versus enrolled through HRA

57. How do I know which system my client's Medicaid is through?

    Answer: Health care providers can see which eligibility system their clients are enrolled in by checking ePACES.

58. Are both systems requiring recertification?

    Answer: Yes.

59. Why are some consumers enrolled with Medicaid through HRA versus NYS? Is there a difference?

    Answer: New York's Medicaid program operates in three eligibility systems – NY State of Health for MAGI-Medicaid cases administered by the State, downstate Welfare Management System (WMS) for New York City Human Resources Administration (HRA), ROS WMS for all counties outside of New York City. (NY State of Health also processes all eligibility determinations for the Essential Plan and Child Health Plus.) Descriptions of which Medicaid cases are MAGI and which are non-MAGI are provided at https://www.health.ny.gov/health_care/medicaid/how_do_i_apply.htm.

60. Is there a reason for why some individuals are in one system versus the other?

    Answer: In general individuals who are under 65 and do not have Medicare or Temporary Assistance for Needy Families (TANF) are eligible for MAGI-Medicaid which is obtained through NY State of Health. Individuals who receive Supplemental Security Income (SSI), TANF, Medicare and/or are 65 years or older generally receive Medicaid through Local Departments of Social Services or HRA.

61. Can both NYS and HRA recertification applications be completed online?

    Answer: Renewals for New Yorkers enrolled through NY State of Health can be completed online. Renewals for New Yorkers enrolled through HRA can be submitted online through ACCESS HRA. Renewals for New Yorkers enrolled through their Local Department of Social Services can be submitted via the NYDocSubmit mobile application. You can learn more about the renewal process for each system through the "Learn about the steps to renew your insurance" links posted on this page with information for Medicaid enrollees: https://www.health.ny.gov/stayconnected.

62. Can an individual recertify over the phone for either system?

    Answer: Renewals for New Yorkers enrolled through NY State of Health can be completed by telephone by contacting the Customer Service Center. HRA and Local Department of Social Services are available to answer questions about renewals by phone, but renewals cannot be submitted by phone. You can learn more about the renewal process for each system through the "Learn about the steps to renew your insurance" links posted on this page with information for Medicaid enrollees: https://www.health.ny.gov/stayconnected.

63. If an individual has SSI disability, will they have to recertify too?

Answer: No. Individuals with SSI are automatically eligible for Medicaid because of their eligibility for SSI.

Local Departments of Social Services (LDSS) or the New York City Human Resources Administration (HRA)

64. Can consumers apply for Medicaid through Access HRA?

    Answer: No. ACCESS HRA is currently limited to renewals.

65. Why haven't upstate districts received an online renewal process similar to ACCESS HRA?

    Answer: Districts outside of New York City currently operate in a different eligibility system than HRA which does not support online renewals.

66. Will HRA allow consumers to print their renewal forms on Access NYC?

    Answer: Yes.

67. Will local districts be responsible to ensure auto-renewals are accurately budgeted?

    Answer: Auto-renewals are achieved by comparing data sources and approving the case based on the data source. Budgets are not updated as part of the process.

68. Will the Navigators be able to enroll new senior consumers into Medicaid through NY State of Health or they will have to apply directly with HRA for Medicaid coverage?

    Answer: New applicants who are over the age of 65 will continue to apply through HRA.

69. If states have 14 months to renew, how long can local districts allow recipient cases to remain pending even when diligent efforts are being made to provide verification (i.e., may it go beyond 14 months)?

    Answer: The 14 month time frame is for the state to renew everyone enrolled in Medicaid. The process must be completed by the end of May 2024. Separately, states are required under federal law to renew individuals not more than every 12 months for MAGI Medicaid and at least every 12 months for non-MAGI Medicaid. Since the processing of renewals is streamlined by increasing administrative renewals through SNAP and the waiver of the resource test for most renewals the process should be completed within the May 2024 required timeline.

Fair Hearings

70. Have you developed additional resources (ALJs) for the expected large increase in Fair Hearing requests?

Answer: We are doing everything we can to ensure adequate staffing for the unwind.

71. Will you track on your dashboard the number of hearings requested, heard and completed?

    Answer: Not at this time.

Outreach

72. As a provider organization, what can our public affairs department do to help with outreach (e.g., social media)?

    Answer: New York State invites all partners and stakeholder organizations to help with our outreach efforts. The online **Communications Tool Kit** includes many resources you can use in your office, on social media, and on your website. The resources are available in 14 languages. You could print the poster and fact sheet to display at your check-in area. You could use the pre-written social media posts and images to share information through your social media account(s). You could use the drop-in articles to add this information to your website. If you have TVs in your waiting room, you could play the videos while your patients wait. The Tool Kit also includes other materials that can be used, such an email message you can send to your listservs and a call script you can share with your staff to ensure they are prepared to answer patient questions about keeping their insurance.

73. Will these communication campaigns be continuing through the entire 14 months? Isn't the key that people need to re-enroll at the right time?

    Answer: The advertising campaign and outreach efforts will continue throughout the 14-month unwinding period. The ad campaign is being designed strategically and will use data for each month's renewal cohort to target communities with large numbers of enrollees who need to renew. Additionally, the phase 3 ads (which launched when renewals began this Spring), emphasize that enrollees will be notified when it is their time to renew.

Text Messages

74. For the text messaging option, is it in the selected language on the consumers application or is it in English only?

    Answer: Currently, NY State of Health alerts are available in English and Spanish. To subscribe for text in alerts in English, text START to 1-866-988-0327. To subscribe for text alerts in Spanish, text INICIAR to 1-866-988-0327.

75. On available materials it states "Sign up for text alerts. Sign up to receive SMS/MMS Text alerts from NY State of Health so you don't miss important health insurance updates, including when it's time to renew your coverage. To subscribe, text START to 1-866-988-0327." Will this only work for those who use NY State of Health or will it also work for those who go through their LDSS?

    Answer: These text alerts are available only to people who are enrolled through NY State of Health.

76. Can carriers also ask members to recertify or receive notices via text messages?

Answer: DOH defers to health plans' legal counsel on how FCC rules related to texting impact them.

77. Just to clarify, everyone is receiving texts?

Answer: Recently, the Federal Communications Commission ruled that states may send text messages to public health insurance program enrollees who provided their cell phone number on their application for health insurance. NY State of Health will follow this ruling and send text messages to public program enrollees who provided their cell phone number on their application as another way to reach them (in addition to sending their renewal notices) when it is their time to renew.