# What's New
# What's coming


**Time: 10:00am – 11:30am**
**Dial-In Number: 1-855-897-5763**
**Conference ID: 35870066**

# Today's Webinar

- Dial in to listen to the audio portion of the webinar using the audio instructions on your WebEx control panel.
- All participants will remain muted for the duration of the program.
- Questions can be submitted using the Q&A function on your WebEx control panel; we will pause periodically to take questions.
- A recording of the webinar and any related materials will be available online and emailed to all registrants.

# PRESENTERS

## Welcome

| | |
|---|---|
| Gabrielle Armenia | Bureau Director of Child Health Plus Policy & Exchange Consumer Assistance |

## Today's Presenters

| | |
|---|---|
| Erin Bacheldor | Medical Assistance Specialist, Division of Eligibility and Marketplace Integration |
| Donna Frescatore | Executive Director, NY State of Health |
| Danielle Holahan | Deputy Director, NY State of Health |
| Mark Irlando | Assistant Attorney, NY State of Health |
| K. Pamela Lavillotti | Project Manager, Bureau of Child Health Plus and Exchange Consumer Assistance |
| Judith Layton | Health Program Administrator 2 |
| Sara Oberst | Eligibility Program Manager 2, Division of Eligibility and Marketplace Integration |
| Lisa Sbrana | Director, Office of Marketplace Counsel |
| Sonia Sekhar | Assistant Director of Policy and Planning, NY State of Health |

# What's new in the Medicaid Program?

- Spenddown
- Special Needs Plans (SNPs)
- Health Insurance Premium Payment (HIPP)
- MMC Auto Assignment

# SPENDDOWN

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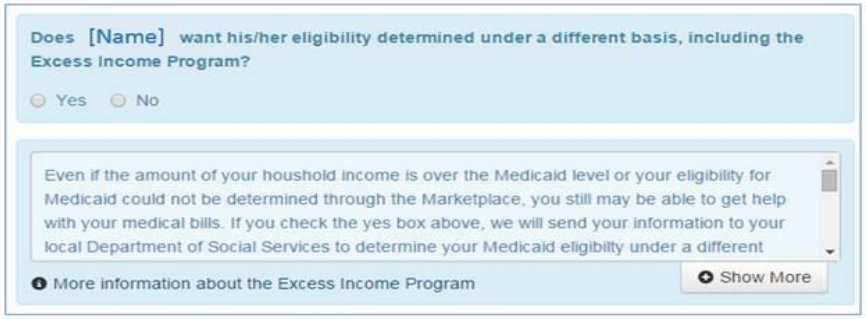
## Medicaid Excess Income Program AKA Spenddown

MAGI applicants with monthly income over the Medicaid level who have paid or unpaid medical expenses and who would like to have their eligibility determined on a different basis, will be systemically referred to the local department of social services for participation in the spenddown program if they check "Yes" on the screen shown below.

Once referred, the local department of social services will follow up with the consumer.




Individuals who meet the following criteria may participate in the spenddown program:

- Under 21 years
- 65 years or older
- Certified blind
- Certified disabled
- Pregnant
- Parent/Caretaker Relative of a child under 19

# SPENDDOWN

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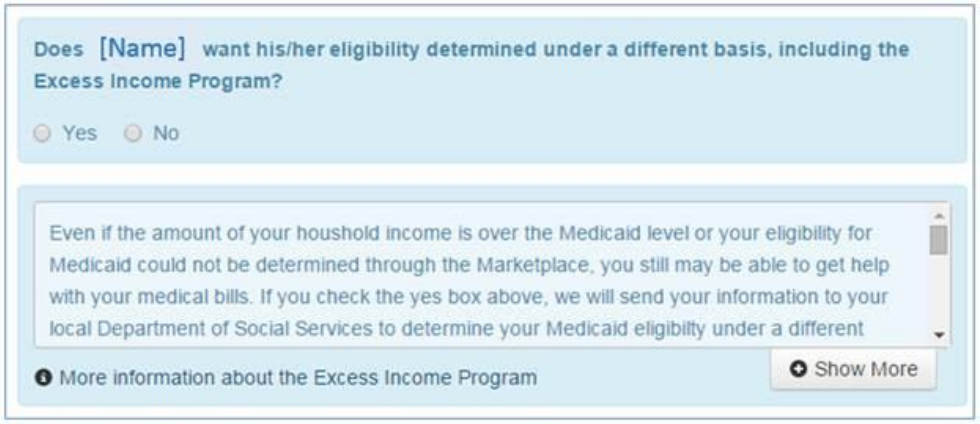
## Medicaid Excess Income Program AKA Spenddown




Screen appears for eligible individuals AFTER plan selection is completed.

- Must enroll in a plan
- Must confirm and checkout

# SPENDDOWN

Screen appears for eligible individuals AFTER plan selection is completed.

- Must enroll in a plan
- Must confirm and checkout

## My consumer needs a referral for Spenddown but does not wish to enroll in Essential Plan or a QHP. How do I help them?

1. Review eligibility criteria on slide 5 to ensure that they are eligible to participate in the program.
2. Enroll the consumer in a plan.
3. Proceed through the screens and answer "Yes" to the question to be determined for the Excess Income Program
4. Use 

button to cancel the coverage.

- Use this button only for this purpose.
- "Cancel Enrollment in Plans" button will terminate enrollment effective the end of the current month and could create a gap in coverage if consumer's goal is to switch plans.
- When switching plans always use 

# Special Needs Plans (SNPs)

## Special Needs Plans (SNPs)

On January 15, 2016 the Medicaid Managed Care SNPs were added as enrollment options on the plan selection page for individuals:

- who are found Medicaid eligible.
- who reside in the five (5) boroughs of NYC only.
    - The SNP plans currently operate in NYC only.


SNPs are options for:

- Individuals with HIV/AIDS and their eligible dependents
- HIV negative homeless individuals:
    - currently registered in NYC shelter system
    - Individuals who have an attestation from an organization providing homeless services.

# Special Needs Plans (SNPs)

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## Special Needs Plans (SNPs) for individuals with HIV/AIDS and their dependents

- All MMC plans cover HIV/AIDS treatment.
- SNPs cover the following as well:
  - Primary Care Providers and other medical providers who are HIV Specialists
  - Access to care at Designated AIDS Center hospitals
  - Additional HIV specialty services:
    - **HIV SNP Care Coordination**
    - **Treatment Adherence Services**
    - **HIV Prevention and Risk-Reduction Education**

## Special Needs Plans (SNPs) for HIV negative homeless individuals

May receive enhanced care management support for:

- accessing health care
- navigating health care

# Special Needs Plans (SNPs)


- There are no changes to the application and there are no additional eligibility questions or documentation requirements for people to enroll in SNPs. If a member believes they are eligible, they can enroll and the SNP will verify eligibility.

- The plans will confirm each enrollee's eligibility. If an enrollee is found to not be eligible, the enrollment will be terminated from the SNP effective on the last day of that month. The enrollee will be notified by the plan and the Marketplace that they need to enroll in a regular Medicaid Managed Care plan.

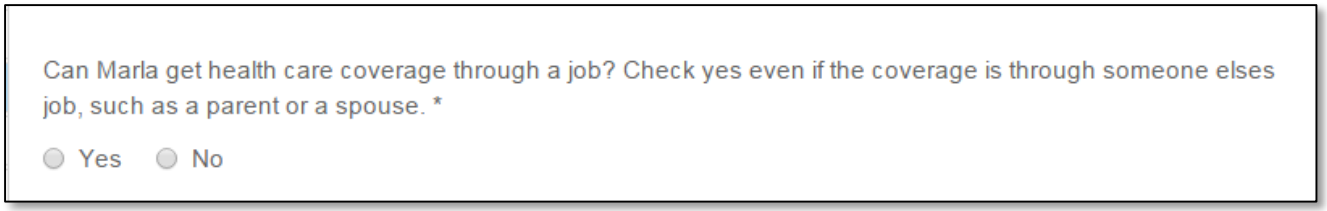
- The SNPs will cover all services for all enrollees, even if the enrollment is not appropriate and the enrollee is transitioning into a different MMC plan.

Assistors must not ask questions about the consumer's health status or SNP eligibility status.

- Should be sure that individuals considering a SNP understand the purpose of the program.
- Should explain the two (2) eligibility criteria
- May ask if the consumer feels that they meet the requirements to enroll in a SNP

# Health Insurance Premium Payment (HIPP)

## Health Insurance Premium Payment (HIPP)




This information is needed to determine if the consumer can get help to pay for all or some of their health insurance premiums once they are determined Medicaid eligible.

- Individuals requesting reimbursement to their premiums will only be reimbursed if the premium meets a cost effectiveness test. This test involves a review of the cost and benefits for the insurance the consumer has compared to the amount the Medicaid program would expect to spend to cover them.
- When a consumer enters in their Employer Sponsored Insurance (ESI) information on this screen and uploads documentation on their Third Party Health Insurance (TPHI), a referral is generated to evaluate for Health Insurance Premium Payment (HIPP).
- Consumers can also call the Service Center request to be referred for HIPP.

# MMC Auto Assignment

## Medicaid Managed Care (MMC) Auto Assignment REVIEW

Consumers who are eligible for Medicaid Managed Care will have Medicaid Fee-For-Service (MA FFS) until they select a plan or are auto enrolled in a plan.

- From the day they are determined eligible, consumers have 10 days to select the MMC plan of their choice. If they do not select a plan during the 10 day period, they will be automatically assigned to a MMC plan.
- Auto Assignment enrollment timing follows Medicaid rules
  - If auto assignment occurs between the 1st and 15th of the month, the MMC plan coverage will begin the first of the following month.
  - If auto assignment occurs between the 16st and the end of the month, the MMC plan coverage will begin the first of the subsequent month.

## Medicaid Managed Care (MMC) Auto Assignment

Functionality became operational on May 20, 2016.

- New applicants who do not pick a MMC plan within 10 days will be auto assigned a MMC plan.
- Existing Medicaid enrollees who have not chosen a plan and are currently in Medicaid Fee-For-Service (FFS) will have this functionality go into place upon running a Life Status Change (LSC) or when processing a renewal.
    - Once the LSC has been run, the consumer will have 10 days to pick a MMC plan. They will be auto assigned if they do not pick a plan.
    - Once the renewal is completed, and the consumer remains Medicaid eligible, they will have 10 days to choose a MMC plan. They will be auto assigned if they do not pick a plan.

# MMC Auto Assignment

## Medicaid Managed Care (MMC) Auto Assignment

Systematic steps for Auto Assignment:

- If there is only one plan in the county, enroll in that plan.

If more than 1 plan is available:

1. The system checks for family member enrollment, and enrolls in that plan.
2. If no family member enrollment exists, the system checks enrollment history in the past year, and enrolls in that plan only if it is a quality plan.
3. If no family member enrollment exists, and no enrollment history exists, enrollment is randomly assigned.

All consumers in the same household are assigned the same plan.

# MMC Auto Assignment

Some consumers may have a need to remain in Medicaid Fee-For-Service (MA FFS)

Medicaid Managed Care (MMC) Exemptions or Exclusions should be requested by calling the Call Center

1-855-355-5777

- Call Center will provide a form to be completed and returned. Upon review and validation of the information, an exemption or exclusion may be granted, if eligible.

# What's new – Medicaid:

- Spenddown
- Special Needs Plans (SNPs)
- Health Insurance Premium Payment (HIPP)
- MMC Auto Assignment

# Questions?

# What's new in the Qualified Health Plan (QHP) Program?

- Subsidized QHPs for age 65 and over without Medicare
- APTC Eligibility Exceptions
- SEPs:
  - Pregnancy
  - Divorce
  - Permanent Move to NY State

# Subsidized QHPs for age 65 and over without Medicare

Under Federal Guidelines APTC and CSR eligibility starts at 100% FPL for individuals who are not eligible for other programs.

3 levels of Cost Sharing Reductions (CSR) remain in place.

- 100% - 150% FPL (94%AV)
- 150% - 200% FPL (87%AV)
- 200% - 250% FPL (73%AV)

- Consumers age 65 and over, who are not parent/caretaker relatives and are ineligible for Medicare and MAGI Medicaid, may be eligible for APTC starting at 100% FPL.
- Parent/caretaker relatives age 65 and over who are ineligible for Medicare and Medicaid may be eligible for APTC starting at 138% FPL.

Jane has a choice: Medicaid Spenddown or a Subsidized QHP

Jane:

- 65 years old
- HH size of 1
- Ineligible for Medicare
- 105% FPL in Marketplace

| Entity | Program |
|---|---|
| LDSS | Determined using Non-MAGI budgeting |
| Marketplace | QHP with APTC/CSR |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# APTC Eligibility Exceptions

## APTC eligibility for married individuals who are not filing jointly

1. The IRS allows a married couple to file "single" if they were legally separated by the end of the year.

2. Some married applicants who live apart may qualify for the Premium Tax Credit without filing a joint return.

3. Victims of domestic violence who are married but are unable to file taxes jointly with their spouse may be eligible for QHP subsidies when filing taxes as married filing separately if they are living apart from their spouse at the time of filing their tax return and are unable to file jointly.

- For more information on meeting these exceptions, the consumer should consult a tax advisor.
- Assistors are not permitted to provide tax advice.


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# New SEP - Pregnancy

## Special Enrollment Period (SEP) for Pregnancy

The option to choose "Pregnancy" on the SEP screen is available to newly applying consumers who are over income for Medicaid.

- Pregnant applicant must answer "yes" to pregnancy question.
- This SEP is available to women applying outside of open enrollment.
- Only opens SEP for pregnant individual
- Needs to enter the date the pregnancy was certified by a medical professional.
    - Options for enrollment start date are based on the certification date.
        - Coverage retroactive to the first of the month of the certification date listed
        - Coverage the 1st of the following month of the certification date listed

- NY State of Health will not require documentation. The plan in which she enrolls has the right to request documentation.

# Divorce

Divorce is not a Special Enrollment Period (SEP) for a newly applying individual.

- If a consumer loses insurance due to divorce, this opens an SEP.
  - It is the loss of Minimum Essential Coverage (MEC), not the divorce, that is the qualifying event.
- An individual cannot request an SEP to enroll in a QHP mid-year due to a divorce alone.

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# Permanent Move to NY State

The triggering event for this SEP as listed in the current Assistor training:

- A new Qualified Health Plan (QHP) becomes available to you as a result of a permanent move into or within NY State.

Updated guidance: Coming Soon – SEP reason will be updated in the application:

- The individual must have Minimum Essential Coverage (MEC) for 1 or more days in the 60 days preceding the permanent move. Exceptions to this rule will be provided for:
  - Individuals who were living outside of the United States prior to the permanent move.
  - Individuals who were living in a United States Territory prior to the permanent move.

# What's new – QHPs:

- Subsidized QHPs for age 65 and over without Medicare
- APTC Eligibility Exceptions
- SEPs:
  - Pregnancy
  - Divorce
  - Permanent Move to NY State

# Questions?

# What's new
# Which could apply to ANY program in NY State of Health

- Appeals
- Communication
- Household Composition
- COBRA

# What's new with Appeals?

# Appeals

If you attended the three (3) day certification training from 2013 through March of 2016, you may have learned that Assistors are not permitted to help with appeals.

## The role of the Assistor in the appeal process has changed.

Assistors may:

- Help the consumer identify and meet the deadline for filing an appeal
- Help the consumer understand their appeal rights
- Help consumers understand the steps in place to file an appeal and the overall process
- Help the consumer locate and access relevant exchange resources (forms, contact information and exchange guidance on appeals)
  - Forms are currently under revision and will be shared with Assistors once finalized.
  - Exchange Guidance on Appeals (webpage currently being updated, please revisit soon): http://info.nystateofhealth.ny.gov/sites/default/files/A%20Guide%20to%20the%20Appeals%20Process%20-%20Individuals%20%26%20Families_0.pdf
- Provide information about free or low cost legal help. www.lawhelpny.org
- Assist in collecting supporting documentation (screenshots of relevant information from the application)

# Appeals

It is important for Assistors to understand their role in helping with appeals.

Assistors may not:

- Provide legal advice
- Recommend specific action with respect to appeal rights
- Sign an appeal request
- Represent a consumer in an appeal

# New Questions

# COMMUNICATION

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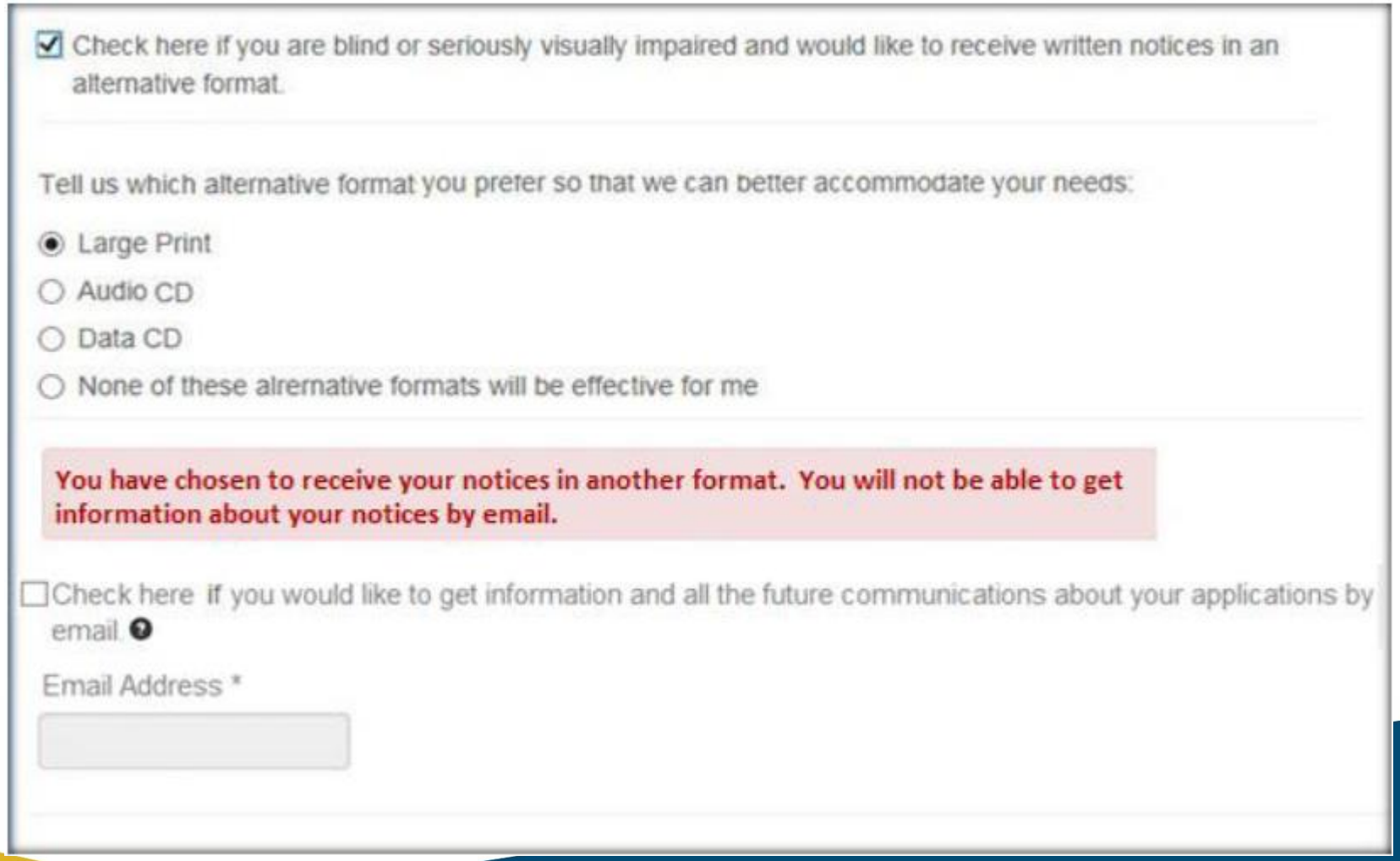
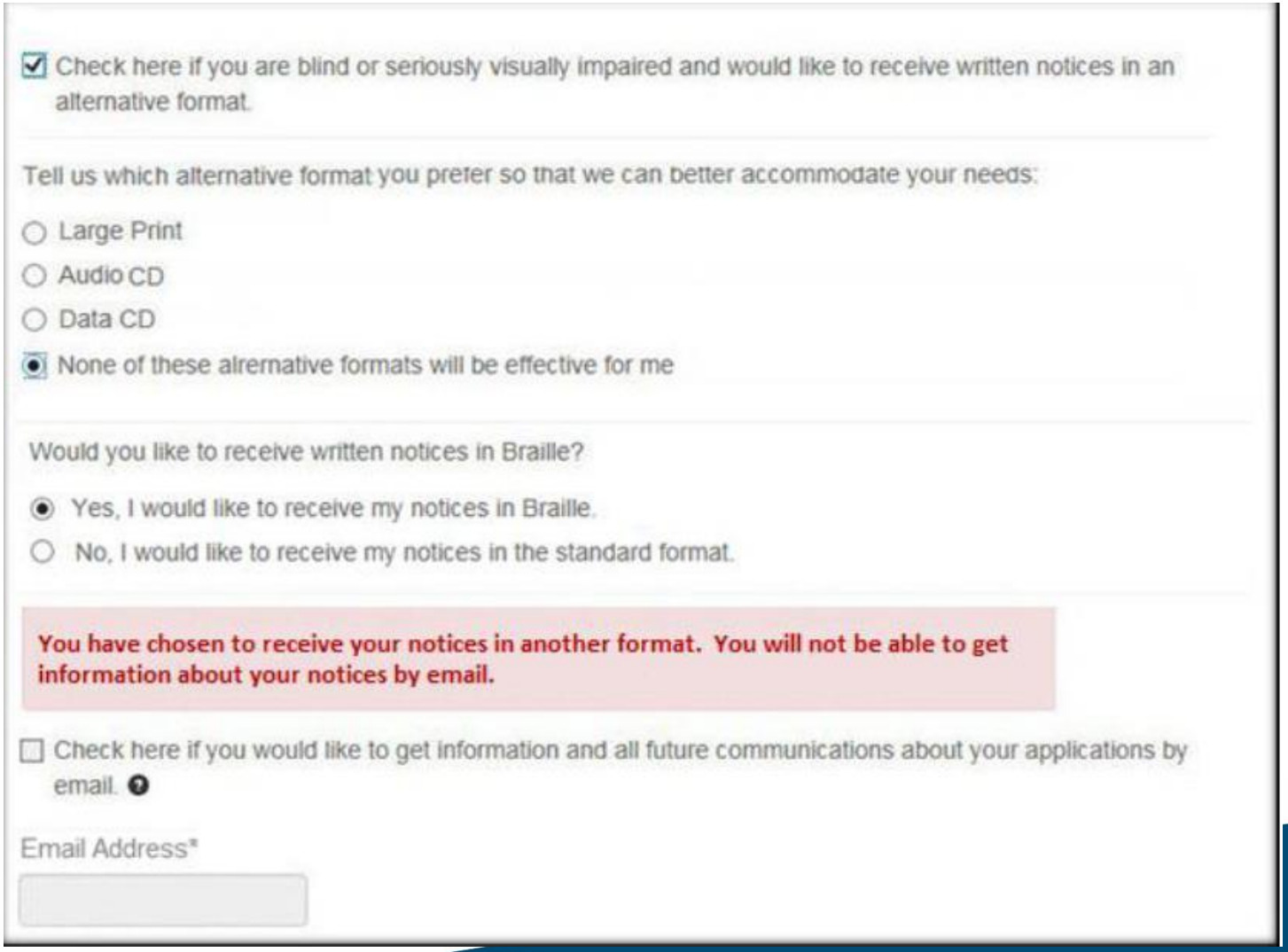
Account & Identity Screen – Notice preferences.



# COMMUNICATION



# COMMUNICATION

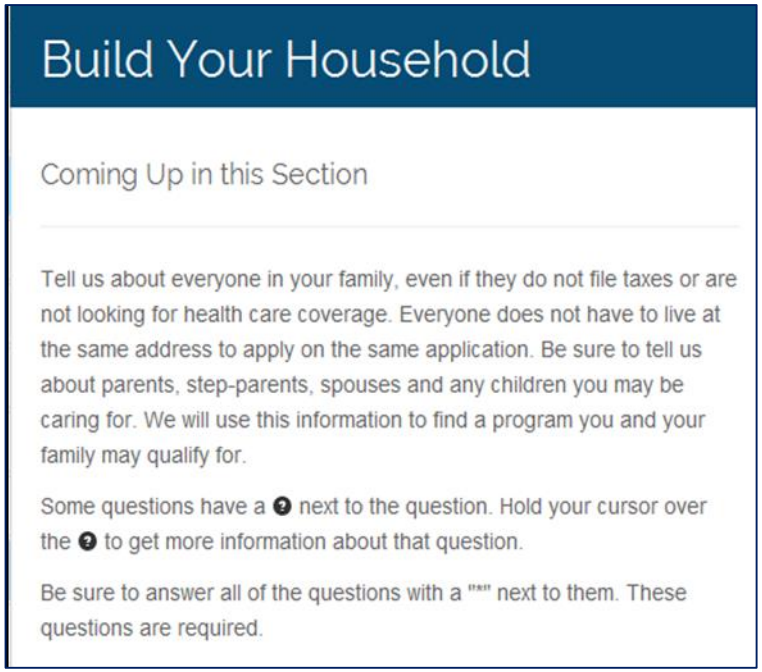
If the questions on the previous slide were answered indicating that an alternative format of notices has been requested by the consumer

This screen will appear when reviewing the application. You can edit the information by clicking on "Edit Account Information"


- DAI Code indicates the format the consumer selected. Example: "Large Print"
- DAI Effective Date is the date that the alternative format was selected.

# Household Composition

# Household Composition




- Assistors should advise the consumer to include everyone in their family who lives with them on their application.
  - All members of the household may not actually be counted in the applicant's household size, the Marketplace will determine who should be included.

- Assistors should NEVER provide tax advice to consumers or advise who should be in the household.

# COBRA Coverage

# COBRA

## If the consumer is losing employment and COBRA is available to them, what are their options?

1. Elect to continue coverage through their employer under COBRA
   - Consumer will usually (but not always) pay full cost of the premium (plus a small administrative fee), but will remain in their previous employer's group health plan.
     - Same Network of providers
2. Elect <u>not</u> to participate in COBRA and apply for a SEP through NY State of Health.
   - Consumer can apply 60 days before or after losing Minimum Essential Coverage (MEC).
   - Subsidies may be available
   - Marketplace coverage will effectuate for the consumer without a gap in coverage, if the consumer enrolls in a plan and pays their premium before their employer coverage ends.
3. Seek coverage elsewhere
   - Examples: Individual Market outside the Marketplace, or through a spouses job.

# COBRA VS. NY State of Health

Considerations for the consumer:

- The network of doctors and hospitals available in each plan.

- The total monthly premium for the consumer and their dependents.
  - Subsidies may be available in the Marketplace: https://nystateofhealth.ny.gov/individual/searchAnonymousPlan/search


- The copays and deductibles in the various plans.

# COBRA

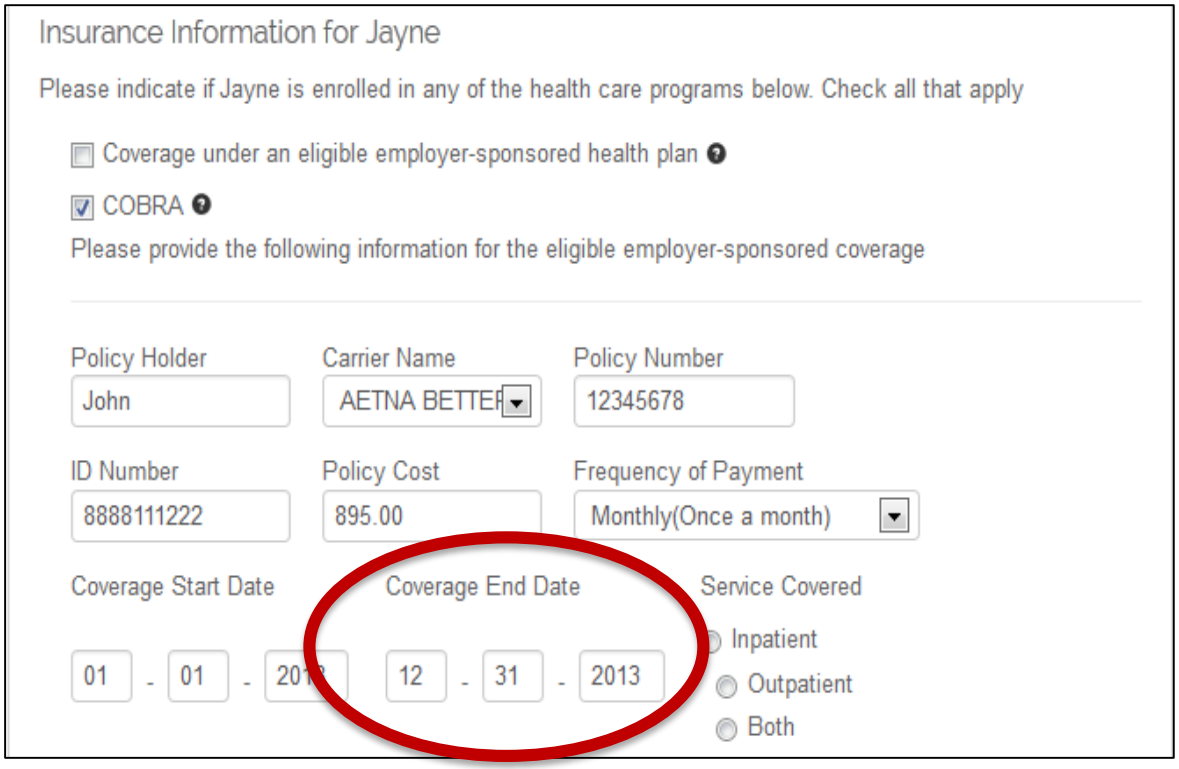
**Question:** Once enrolled in COBRA and the consumer's 60 day SEP in the Marketplace lapses, Can they voluntarily drop it and apply for a Special Enrollment Period (SEP) in NY State of Health?

**Answer:** Individuals **cannot** voluntarily drop COBRA outside of open enrollment and apply for an SEP using the reason "Loss of Minimum Essential Coverage"

The SEP states:

- Loss of Minimum Essential Coverage
  - this does not include loss of coverage due to non-payment of premium.

# COBRA




If dropping COBRA during open enrollment, the applicant must enter the end date of the coverage on the screen.

If no "Coverage End Date" is entered, the Marketplace will make a determination as if the consumer remains covered.

# What's new
# Which could apply to ANY program in NY State of Health:

- Appeals
- Communication
- Household Composition
- COBRA

Questions?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# Updates to Special Instructions provided in last year's webinars

- Age 65 and over/or Medicare
- Entering in a Business Loss

# AGE 65 AND OVER/OR MEDICARE
# NOT A PARENT/CARETAKER RELATIVE


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# Existing Medicaid Consumers who turn 65

- Each month, the Marketplace runs a systematic check to identify individuals who are turning 65 by the end of the following month.
- Eligibility will be re-run and a referral will be made to the LDSS .
- Marketplace Medicaid coverage will end at the end of the month in which the individual turns 65 (similar to CHPlus and turning 19)
  - Upon referral to the LDSS, the district will authorize MA coverage in order to allow sufficient time to renew the individual's eligibility under a non-MAGI eligibility group at the LDSS.
    - 4 months (month of referral plus 3 months)
    - 5 months for NYC (month of referral plus 4 months)
      - ✓ The districts may shorten this time period if the information is received and the consumer is determined ineligible.

# AGE 65 AND OVER/OR MEDICARE

## Existing Essential Plan Consumers who turn 65

- Essential Plan coverage will end at the end of the month in which the individual turns 65 (similar to CHPlus and turning 19)
- Eligibility will be re-run:
  - NY State of Health may find the consumer is eligible for a subsidized QHP if the consumer does not have Medicare. (Reference Slide 18)

AND/OR

| Essential Plan 3 & 4 enrollees | Essential Plan 1 & 2 enrollees |
|---|---|
| A referral will be made to the LDSS<br>• Upon referral to the LDSS, the district will authorize MA coverage in order to allow sufficient time to renew the individual's eligibility under a non-MAGI eligibility group at the LDSS.<br>✓ 4 months (month of referral plus 3 months)<br>✓ 5 months for NYC (month of referral plus 4 months)<br>➢ The districts may shorten this time period if the information is received and the consumer is determined ineligible. | A referral will be made to the LDSS<br>• Upon referral to the LDSS, the district will mail an application to the consumer who can then apply for a Spenddown determination. |

# AGE 65 AND OVER/OR MEDICARE

Existing Qualified Health Plan (QHP) Consumers who enroll in Medicare

- Once the consumer is enrolled in Medicare, they will no longer qualify for APTC & CSR.
- If the consumer no longer wants coverage through their QHP due to having Medicare, the Assistor should help them to mark "No" for "Need Health insurance?"



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# AGE 65 AND OVER/OR MEDICARE

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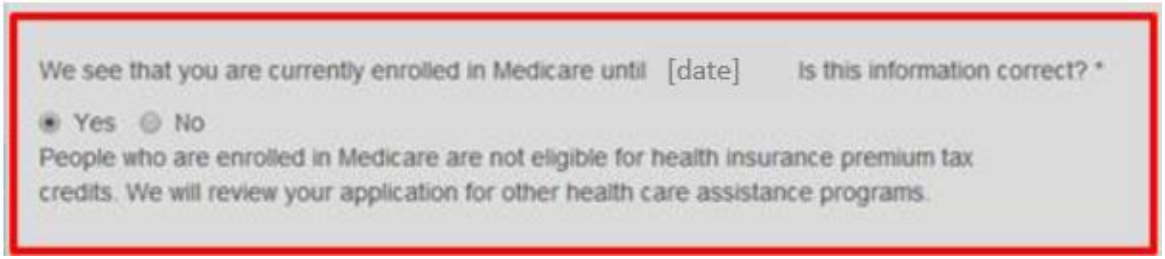
## Existing Qualified Health Plan (QHP) Consumers who enroll in Medicare

Once the consumer is enrolled in Medicare, they will no longer qualify for APTC & CSR.

- What if the consumer wants to remain enrolled in a Full Pay QHP along with their Medicare?
  - Run a Life Status Change (LSC).
    - Answer the question about "Other Public Health Care Coverage".




- If consumer answers "Yes", NY State of Health will determine that they are eligible for a Full Pay QHP and will automatically enroll them in the Full Pay version of the same QHP (previously subsidized QHP), which will be effective the first of the following month.
  - Example: If consumer answers "Yes" I am currently enrolled in Medicare on May 30th. Their coverage in the full pay QHP will begin as early as June 1st.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# AGE 65 AND OVER/OR MEDICARE

## Life Status Change (LSC) & QHP Enrollees

Currently enrolled in a Couple plan through NY State of Health

- Phillip (65) – ***Subscriber.*** Eligible for Medicare.
- Vivian (64) – Household member, spouse of Phillip.

- Phillip answers "Yes, I am currently enrolled in Medicare" → Full Pay Qualified Health Plan

OR

- Phillip marks "No" for "Need Health Insurance" → Is not applying - Will not be determined

- Both Phillip and Vivian will be redetermined.
  - If LSC is completed on 7/13/2016
  - If LSC is completed on 7/29/2016

→ Couple will both be dis-enrolled in their subsidized QHP effective 7/31/2016.

- If Vivian needs to remain in her subsidized QHP, assist the family by re-enrolling her.
  - Mark "Loss of Current Health Coverage" on SEP screen.
- Assist the family by submitting the case to CACMail@health.ny.gov to:
  - Ensure that there is no gap in Vivian's coverage (if LSC was completed after 15th of the month).
  - Ensure that Vivian continues contributing to her deductible and MOOP for the year. She does not need to start over.



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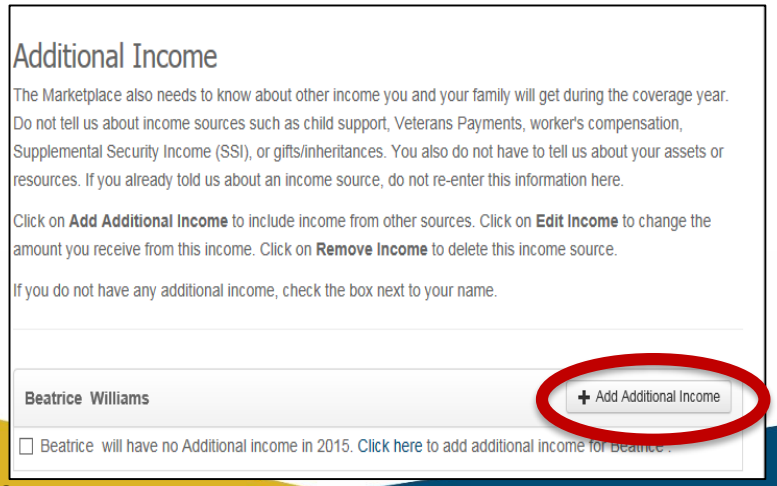
# ENTERING A BUSINESS LOSS

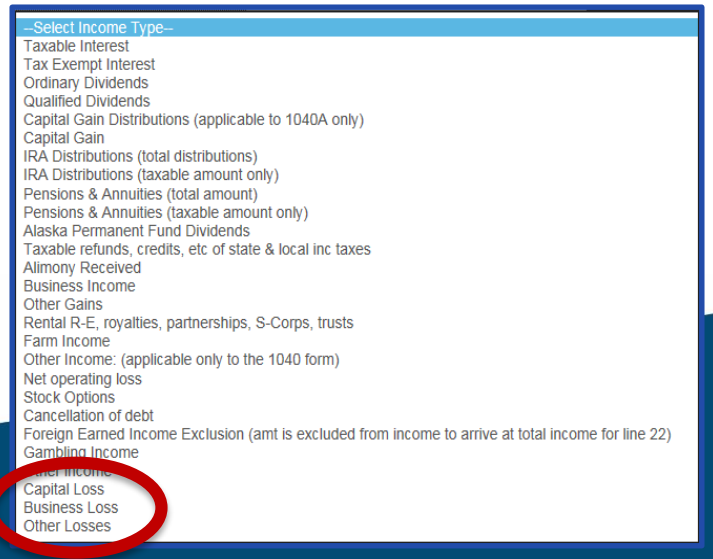
# Business Loss

Last year in the Self-Employment webinar we provided Special Instructions for entering "Business Loss"

Assistors should help consumers to report a business loss in the "Deductions" section of the application as "Other adjustments".

Assistors can now enter a "Capital Loss", "Business Loss" or "Other Loss" under Additional Income. NY State of Health will be able to calculate the loss by subtracting the amount from the total household income.





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# Updates to Special Instructions:

- **Age 65 and over/or Medicare**
- **Business Loss**

Questions?

# NY State of Health Updated Functions affecting Applications

- Transition of MAGI Medicaid Enrollees from Enrollment Center Counties
- Newborn Interface

# Transition of MAGI Medicaid Enrollees from Enrollment Center Counties

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Starting in July of 2016

Approximately 9000 cases per month will be transitioning from Medicaid coverage through LDSS to Medicaid coverage in NY State of Health.

Process will be the same process we have been experiencing with the Aliessa population.

- Notice from Medicaid Services Division
- Notice from the Marketplace. Three (3) different types of notices depending on case circumstances.
  1. **Shell account renewal notices** are for applications that are pre-populated with information received from local district databases (basic demographic information, and completed verifications that won't need to be duplicated)
  2. **Matched account renewal notices** are for consumers that are matched against an existing account (for example Mom had coverage through the local district, her children were enrolled with NY State of Health, mom was the non-applying account holder, this notice will send her the account number of the account she is already known to)
  3. **Temporary account renewal notices** are for consumers who were matched using the "probabilistic match" criteria, so these might be people with no SSNs where we think they might be already on an existing account, but can't be entirely sure due to limitation of the data available for matching. These consumers will be told to log in to the account they already have, or if they do not remember their log on information to call customer service. If these people aren't really on NYSOH, customer service will be able to convert the temporary account to a shell account.

# Transition of MAGI Medicaid Enrollees from Enrollment Center Counties

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## If the MAGI consumer is receiving Temporary Assistance (TA) at the local district, they will not transition to NY State of Health.

- Remain in Medicaid through the LDSS.
  - If the consumer loses their TA, they will be transitioned to NY State of Health, with a shell account.
  - If a consumer applies for TA at the LDSS, and the TA is denied, the consumer will be transitioned to NY State of Health without a shell account.
    - Information and documentation will be forwarded to NY State of Health to assist with creating the application.

- If the consumer is in need of care and services that can only be provided through the local district, they will not transition to NY State of Health.
  - If the consumer was enrolled in, but no longer needs certain services (such as Waiver or Nursing Home services) and they remain MAGI, they will be transitioned to NY State of Health at renewal.

# TRANSITION OF MAGI MEDICAID ENROLLEES FROM ENROLLMENT CENTER COUNTIES

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## What should Assistors be doing to help?

1. If contacted for an appointment, try to work with the consumer to identify the date range that they are supposed to apply in NY State of Health. Page 2 of sample notices…
   - If they received a letter but do not have it, the Call Center can assist.

> An account has been started for you. Log into the account between June 16, 2016 and July 15, 2016 to complete the renewal process for anyone who needs health coverage.

2. Consumers can have their account assigned/transferred to the Assistor of their choosing by logging-in and answering "Yes" to the question "Would you like to authorize a Navigator/Broker" or by calling the Call Center.
   - If the consumer gets the notice for a matched account or a temporary account, ask them if they already have an account. If so, use that account. If they are not sure, the consumer can contact the Call Center ahead of time to access the account and authorize the Assistor, if needed.

3. Follow the instructions in the notice, and be sure to use the invitation code in the notice to access the correct account.

If the consumer wants or needs to access the account and the timeframe specified in the notice has passed, it remains important that they still use the shell account and invitation code in order to avoid creating duplicate accounts.

# What should Assistors be doing to help?

## Key Takeaway

It is always important to ask clients if they have already started an application on the Marketplace or if they have received any notifications by mail from NY State of Health.

**WELCOME TO NY STATE OF HEALTH**

**IT'S TIME TO RENEW YOUR COVERAGE!**

You and/or members of your household need to renew your coverage through NY State of Health. This letter tells you what steps you need to take **before** your Medicaid coverage ends. Read it carefully to find out what you need to do so that your household members continue to have health coverage. If you do not take action, you will not have health insurance after your Medicaid ends.

# Newborn Interface

## What is the Newborn Interface?

The newborn interface is an automated process to systematically provide Medicaid coverage to babies born to mothers who have active Medicaid.

The newborn interface was developed and deployed in 2000. The interface to automatically add babies is now operational for NY State of Health applications as of June 27th, 2016.

- **Policy**- If a baby is born to a mother who has active Medicaid at the time of delivery or in 1 of the 3 months prior to the delivery, that baby is considered "deemed".
  - A "deemed" baby is given 13 months of Medicaid coverage to cover them from the month of birth through the end of the month of their 1st birthday.
    - Example: A "deemed" baby in the Marketplace who was born on July 13, 2016 would have coverage granted from July 1, 2016 through July 31st 2017.
  - The baby's Medicaid coverage will match the mother's Medicaid coverage.
    - If the mother of a "deemed" baby is enrolled in MMC, then the baby will be covered by the same MMC plan from DOB. If the mother was enrolled in MA FFS only, the baby will be covered by MA FFS from DOB.

- Hospitals report all births to Vital Records/Statistics via the newborn reporting system.
- If the birth was reported by the hospital as a Medicaid birth, that birth will then come through on the interface to NY State of Health.

# Newborn Interface

## What action do I need to take as an Assistor?

Check the account to see if the baby was systematically added (interface).

- If so:
  - Mother's previous answer of "yes, I am pregnant" will automatically be changed to "No".
  - Baby will be automatically added to the account and Medicaid coverage will be provided to match the mother's Medicaid coverage from DOB.
  - Notice of eligibility will be posted to the account (more to come)
  - Infant CIN will be generated and CBIC card will be mailed to the home.
- If not, evaluate the family and their needs:
  - One options for the Assistor would be to run a LSC and manually add the baby to the account.
  - Or could wait a week to 10 days for the hospital to report the birth and allow the interface to work.
- Once the report has been processed by NY State of Health, it will be returned to the hospital. Each baby will have an indicator:
  - Match Found
  - No Match Found
  - No Eligibility

# Newborn Interface

- No Match Found – This could occur if the mother is enrolled in Essential Plan/QHP (at or under 223%FPL) and never reported her pregnancy.
  - DOH investigates these cases to try to find the account and provide coverage, if eligible.

- No Eligibility – This could occur if the Mother did not have Medicaid at the time of the delivery or in 1 of the 3 months prior to the delivery.
  - If Assistor knows this is the case OR if the interface is not able to provide coverage for the baby, help the family by running a LCS ASAP.
  - Update the mother's pregnancy status (if needed).
  - Manually add the baby to the account.
  - Can request retroactive Medicaid coverage for the baby, if needed. **Will need to submit income verification documents for requested months.
  - Baby is not "deemed" (not automatically Medicaid eligible).
  - Eligibility is processed as any other applying individual.

# Newborn Interface

## The Notice

**How we made our decision**

You are eligible for Medicaid until the end of the month of your first birthday because your mother had Medicaid when you were born (or within the three months prior).

If the mother was enrolled in MMC

**Using your health coverage** – You do not need to pick a health plan. Infants are automatically added to the same plan that their mother had when they were born. You will receive information about the plan in a separate notice. If you want to change plans, please call NY State of Health for assistance. Information about benefits can be found in the "Additional Information about Medicaid" section of this letter.

Additional Information about Medicaid – Important information about newborns:

- If the newborn has other health insurance, run LSC to enter information about "coverage the child has" and complete the "Insurance Information" section
- Social Security Number may be added at any time, but is not required until renewal.

# Eligibility for the Mother

Can I help the mother get full Medicaid coverage after she has delivered if she is enrolled in a QHP, EP Plan, or Emergency Medicaid Only?

| | | |
|---|---|---|
| She would have been eligible if she had reported her pregnancy. | No. | Is she entitled to 60 day's post partum Medicaid coverage? |

As the mother was enrolled in NY State of Health, she has been informed that she is required to update her account if her circumstances change (i.e. if she becomes pregnant).

- Eligibility for the baby will be determined at the time the baby is added to the account.

# Functionality:

- Transition of MAGI Medicaid Enrollees from Enrollment Center Counties
- Newborn Interface

# Questions?

# Reminder
# Recertification Process

- All Assistors must view all webinars to be recertified.
  - Please keep track of the date that you watched this webinar
- The reporting process for recertification is currently being finalized and information will be forthcoming.


nystateofhealth
The Official Health Plan Marketplace

# Thank you for joining us!

## Next Recertification Training:

Title: Privacy & Security

Date: August 17th