New York Medicaid Expansion

Know Your Rights: What You Need to Know About NYS Medicaid Expansion in 2023

This year's Health Budget makes significant changes to New York's Medicaid program - expanding eligibility to 133% of the federal poverty law (FPL) and changing budgeting rules and enrollment processes for Medicaid and Child Health Plus (CHP) to conform to the Affordable Care Act. The budget also phases out the Family Health Plus (FHP) program in anticipation of coverage options that will be available through New York's Health Benefit Exchange (the Exchange).

This year's Health Budget also takes significant steps to solidify the Medicaid program's managed care service delivery structure -- expanding the Commissioner's authority to mandate enrollment of new populations, creating new capitated programs for dual eligibles and the developmentally disabled, and allowing the Commissioner to require that additional Medicaid services, including behavioral health services, be provided through managed care plans rather than by fee for service providers.

MEDICAID ELIGIBILITY EXPANSION

The changes to Medicaid eligibility expand the program's reach and, in combination with changes to enrollment processing, should streamline the application process considerably. The budget completely rewrites Subdivision 1 of Section 366 of the Social Services Law. Highlights are as follows:

- Medicaid applicants are divided into two major groups:
  - Those whose eligibility is based on their Modified Adjusted Gross Income or MAGI (this is the majority of applicants) and
  - Those whose eligibility is based on pre-existing Medicaid budgeting rules, the non-MAGI. This group includes SSI-related groups (age 65 and up, disabled, or blind), those utilizing spend down, those eligible for the Medicaid Buy-in for Working People with Disabilities program or Medicaid's Cancer Treatment programs.

- Household is redefined for the MAGI group as the tax filing unit, with limited exceptions to protect children who would be part of a Medicaid household under previous rules.

- Household income is redefined for the MAGI group to include the income of all members of the tax filing household, with some exceptions for members who are not required to file tax returns.

- Pregnant women and infants under one year are eligible for full Medicaid coverage up to 200% of the FPL. Family size includes household members plus the number of children the woman expects to deliver.

- MAGI groups have continuous eligibility for 12 months, despite changes in income.

The budget creates a new "benchmark benefit" within the Medicaid program and limits most MAGI applicants to this benchmark benefit in place of full Medicaid, referred to as "standard" Medicaid. The only difference between benchmark and standard Medicaid is that benchmark does not include institutional long term care. Fortunately, applicants and recipients in need of long term care services are eligible for standard Medicaid as non-MAGI, so the impact of the new benchmark on low-income clients should not be significant.

The budget adds the on-line application to the options persons requesting Medicaid can utilize to apply. Verification procedures at application are largely left to regulation as are renewal procedures, although the budget does specify that renewals are to be attempted administratively, without enrollee involvement. Enrollees will be asked to supply information only when the Health Department (or its agent) is unable to renew based on available data. We can expect to see the new Exchange portal and its "real time" verification capacity described in regulation, or at a minimum in Administrative Guidance, as the Department completes the technological builds and rolls out the new application process.

FAMILY HEALTH PLUS REPEALED

The budget repeals the FHP program, effective January 1, 2015. No new applications will be accepted after December 1, 2013. This does not pose a problem for single adults and childless couples currently eligible for FHP, as they will be eligible for Medicaid under the expansions described above, which take effect on January 1, 2014. The same will be true for parents, caretakers and 19 and 20 year-olds with income up to 138%[i] of the FPL.

There is a group of clients, however, who would have been eligible for FHP and will not qualify for expanded Medicaid. These are parents, caretakers and children age 19 and 20 with income between 138% and 150% of the FPL. While these individuals will be eligible to apply for federal affordability subsidies in the Exchange to help them purchase private health insurance through a qualified health plan (QHP), premiums and cost-sharing will still be considerably higher than they would have been in FHP.

In recognition of the potential loss of coverage for this group, the budget provides for assistance with premiums in the Exchange for those who would have been eligible for FHP and are not otherwise eligible for Medicaid. To receive the assistance, clients will need to enroll in sliver level coverage in the Exchange and apply for federal affordability subsidies. Premium assistance will be available on top of the federal advance premium tax credit such that enrollees should not face any premium cost at all.

The budget does not provide assistance with cost-sharing other than premiums however. Enrollees in silver plans who receive federal subsidies and the new state premium assistance can expect to see increases in co-payments after January 1, 2015. Hopefully, the premium assistance program is only an interim measure, since the federal government has promised to issue guidance on a new program option available under the ACA that

holds considerable promise for low-income New Yorkers unable to qualify for Medicaid - the Basic Health Program.

The federal government has said the Basic Health Program will be available as an option for states beginning in 2015. Under the Basic Health Plan option, states can utilize federal money that would have been paid in subsidies to low-income enrollees in QHPs and create a low-cost, state run option similar to Family Health Plus. New York stands to realize considerable savings from this option, since many immigrants currently ineligible for the federal share of Medicaid and receiving Medicaid paid for entirely with state dollars would qualify for the federal subsidies and could be enrolled in the Basic Health Program. The budget creates a work group to evaluate upcoming federal guidance and consider the Basic Health Program option for New York.

CONTINUED EXPANSION OF MEDICAID MANAGED CARE

The budget continues New York's steady march toward providing all Medicaid populations with all Medicaid services through private managed care plans. With regard to populations, all previously existing exclusions or exemptions from mandatory enrollment in managed care are eliminated and the Commissioner is given the discretion to mandate enrollment of new populations once the relevant state agencies determine that appropriate rates and program features are in place. Two new capitated service delivery programs are created within Medicaid - Fully Integrated Duals Advantage plans, or FIDAs, and; Developmental Disability Individual Support and Care Coordination Organizations, or DISCOs.

Consumer advocates worked with the Assembly on language that would have required public reporting of program features and readiness prior to further expansion but this language was not ultimately included in the budget. Advocates also worked with the Assembly on due process language for elderly and disabled Medicaid recipients who have been mandated into Medicaid managed long term care (MLTC). This language was not ultimately included either. The due process language would have:

a) eliminated the requirement that MLTC enrollees exhaust all internal plan appeals prior to requesting a fair hearing (no other Medicaid enrollees are subject to this requirement in any other managed care program), and

b) protected aid continuing while appeals are pending even if a service authorization period expires in the meantime.

The budget also provides the Commissioner of Health with the authority to include more services in the benefit package delivered by private plans, again after approval of program features and rates by relevant state agencies. Advocates for behavioral health providers won an important victory in establishing standards for Special Needs Managed Care Plans in statute, including network adequacy, plan penetration (access to SNPs for upstate consumers), evidence based tools for evaluating need, and consistent plan standards to ensure that prescribed services are adequate. Consumer advocates will need to continue to push for similar requirements for other managed care plans.

OTHER CHANGES

Other, less sweeping changes were a mix of provisions that, on balance, should increase access to care for Medicaid enrollees.

Charity Care. The budget advanced transparency and accountability in the distribution of Medicaid funds to hospitals caring for uninsured patients - making changes to the allocation formula that have long been championed by consumer advocates. The State will begin reimbursing hospitals based on the actual costs of caring for actual patients, and it will provide enhanced funding to safety net hospitals that care for higher numbers of Medicaid patients. Advocates pushed for a rapid phase in of the new methodology, as existing formulas are not in compliance with federal requirements, but the final language retains existing formulas during a three year phase in period.

Spousal Refusal. Advocates were successful in retaining New York's spousal refusal protections, which enable spouses and parents to refuse to make their income available to cover a spouse or child's medical expenses. This provision has been very important for low-income New Yorkers as well as those with higher incomes. Medicaid retains the right to seek recovery from the refusing spouse or parent.

Immediate Needs Medicaid. The Executive Budget had proposed to add language to Section 364-i of the Social Services Law that would completely negate the obligation imposed on local districts by SSL Section 133. Section 133 of the SSL requires districts to provide Medicaid applicants who present with an emergency need with "immediate need Medicaid" while their applications are pending. Advocacy efforts resulted in an compromise -- language added to SSl 364-i of the SSL now restates regulatory language that limits Medicaid reimbursement for care and services provided prior to an eligibility determination to the three month retroactive period for applicants who were eligible for Medicaid in that month. The effect of this language on immediate needs Medicaid remains to be seen.

Prescriber Prevails. Advocates were also successful in preserving and expanding Prescriber Prevails protections in Medicaid. In fee for service Medicaid, prescribers seeking prior authorization for a non-preferred drug can still override denials from the state Department of Health. In the managed care context, the budget preserved prescriber prevails for anti-psychotic drugs and expanded application of prescriber prevails to other classes of drugs, including anti-depressants, anti-retrovirals, anti-rejection, seizure, epilepsy, endocrine, hematologic and immunologic therapeutic classes. A prescriber can override a plan denial for these drugs, even when the drugs are not on the managed care plan's drug formulary.

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[i] MAGI budgeting utilizes a 5% income disregard. For this reason, the effective eligibility level is up to 138% FPL (133% FPL plus 5% disregard).

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