



George E. Pataki
Governor

New York State
Office of Temporary and Disability Assistance
40 North Pearl Street
Albany, NY 12243-0001

Brian J. Wing
Commissioner

July 9, 2002

Dear WMS/CNS Coordinator:

The purpose of this letter is to provide local districts with an explanation of the WMS/CNS enhancements, which are scheduled to be migrated to the Training System July 8, 2002 and to become operational on the Production System on July 22, 2002. These changes are a result of Federal Welfare Reform reporting requirements and changes to the MA Family Health Plus (FHP) program.

For questions regarding the attached changes, please contact the following individuals at 1-800-343-8859:

Attachment I	Section
Patty Hanson @ extension 4-8753	1, 2, 3
Attachment II	
Bob Markham @ extension 4-2166	1, 2
Attachment III	
Robert Decker @ (518) 402-6682	1a, 3a, 3b
Kate Cahill @ (518) 474-5050	1b
Patricia Buttino @ (518) 402-6665	2
Michele Leonard @ (518) 473-4040	3c

Sincerely,

Wendy Dmitri

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Division of Temporary Assistance/WMS

Dennis DiMuria

Dennis DiMuria, Supervisor
Upstate Eligibility Systems
Office of Medicaid Management

Cc: Commissioner
FS Director
HEAP Liaison
TA Director
MA Director

1. The ability to register multiple applications for multiple programs (PA, FS, MA, HEAP) from a single source of input has been added to Upstate WMS. Data for each application will come from an existing application or an active, denied, or closed case. The following features have been modified:
 - a. The App Reg menu has been modified to allow workers to specify for which case types the applications are being made. In addition, the worker can now indicate the applicable office/unit/worker (if different) and the application registry number/case number of an existing application or case (see Attachment I, Pages 1 of 4 and 2 of 4 for examples of the new screens);
 - b. The system will produce App Reg/Version Numbers, Clearance Reports and App TADs for each case type for which an application is indicated. If the worker enters the app reg number or case number of an existing application/case on the revised App Reg Menu, individual information from that application/case will be used to fill in the app reg input screen. The workers, through individual app reg maintenance will be responsible for changing household composition by adding or deleting individual household members if necessary;
 - c. Workers may also enter an app reg number or case number from a different local district and the information will be brought over and used to fill in the app/reg input screen.

WAR001 Entry				
WMS Application Register Menu				
Function ^	Registry Num ^^^^^^	Version ^^	Withdrawal Date ^^^^^^	
	Case Num ^^^^^^^^^^^	Xdist ^^^^		Xmt ^
1 Initial Application Register Entry				
2 Application Register Maintenance				
3 Application Withdrawal Entry				
4 Application Turnaround Document				
5 Clearance Report				
6 Create App From Existing Case or App				

WAR008	Dist	Date				
App Generation From Case or App						
Case Num						
Default Case Information						
Ctr	AppDat	Unit	Worker	T	Case #	Case Name
New Case Information						
Ctr	AppDat	Unit	Worker	T	Case #	Case Name
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
Next Case Num _____		Next Registry Num _____		Xdist _____	Xmit _____	

- In an effort to prohibit entries in the Case Number field that are all alpha, all zeros or contain special characters resulting from keystroke errors, entries in this field are now being edited. At App/Reg, Opening (02), Denial (03), Open/Close (09) and Reopening (10), entries are limited to at least one, non-zero numeric character. Prior to implementation of this edit, a list would be sent to affected districts noting the cases that need to have new case numbers assigned.
- On Screen 6 of WMS, a second occurrence of Vendor ID and Customer Account Number has been added. The two occurrences will be labeled 'HVnd/Acct _____ Vnd/Acct _____'. The first occurrence will be used as has been done in the past for HEAP Vendor ID and Customer Account #. This field will continue to be pulled down and displayed for subsequent transactions. As in the past, this field will be used for the HEAP Autopay.

The following edits will apply to occurrence #2 Vendor ID/Customer Account #:

If an entry is present in Occurrence #2 of Vendor ID, there must also be an entry present in Occurrence #2 of Customer Account Number and vice-versa, i.e. if there is an entry in Occurrence #2 of Customer Account Number, there must also be an entry in Occurrence #2 of Vendor ID. If an entry is present in one field and not the other, the following Error #/Message will be produced: '1609 – OCCURRENCE #2 REQUIRES ENTRIES IN BOTH VENDOR ID AND CUST ACCT NO'.

Additionally, if an entry is present in Occurrence #2 of Vendor ID, the Vendor ID entered must match the vendor ID field entered on the payline containing a pay type NOT equal to 'H1 – Regular HEAP Benefit'. Failure to match the Vendor ID with the Vendor ID on one of the paylines will result in Error # '1610 – VENDOR ID MUST MATCH NON-H1 PAYLINE VENDOR ID'.

Since entry in these fields is only a vehicle to move the entered information into BICS, entries in Occurrence #2 of the Vendor ID field and Customer Account # will only remain on Screen 6 for the duration of the transaction, i.e. they will print on the 3209 generated as a result of the transaction and will not be brought back at subsequent transactions, regardless of whether the payline they are associated with is a recurring payline or a single-issue.

CNS Changes (PA)

1. In order to increase the level of detail and specificity in CNS notices, concerning failure to comply with support requirements, while simultaneously streamlining and simplifying the old process, the PA Failure to Comply with IV-D Data Entry Screen (WCN050) has been extensively revised. The bottom of this page provides an example of the revised screen.

The individual reason code workers use when a client fails to comply with a child support requirement remains V30. As a reminder, V30 is an extensive fill reason code and therefore the pending notice number generated from the completion of this screen must be entered on the WMS transaction, along with the V30 individual reason code.

Following are instructions for data entry on the revised screen:

- a. The CSEU non-compliance date is required.
- b. At least one of the six possible failures must be selected. Workers should select all that apply.
- c. All selections except the fifth require the worker to enter a date or other necessary fill to complete the selection.
- d. All dates entered must not be in the future.
- e. The section at the bottom of the screen is used when a client has claimed that there is a good reason for non-compliance, but the agency rejected this good cause claim. The reason for rejection is entered by the worker.

WCN050	WMS/CLIENT NOTICE SUBSYSTEM	Date
	PA FAILURE TO COMPLY WITH IV-D DATA ENTRY SCREEN	Time
CASE NAME		
CASE NO		
INDV REASON : FAIL IVD REQ	LINE NO	
DATE NON-COMPLIANCE WAS DETERMINED BY CHILD SUPPORT ENFORCEMENT UNIT: _____		
SELECT (X) ALL THAT APPLY. CLIENT FAILED TO:		
<input type="checkbox"/> APPEAR FOR A CHILD SUPPORT INTERVIEW ON _____		
<input type="checkbox"/> PROVIDE REQUIRED INFORMATION OR ATTEST TO LACK OF INFORMATION AS FOLLOWS:		

<input type="checkbox"/> APPEAR TO PARTICIPATE IN A COURT OR OTHER HEARING ON _____		
<input type="checkbox"/> SUBMIT SELF AND/OR CHILD TO GENETIC TESTING ON _____		
<input type="checkbox"/> PAY TO THE SUPPORT COLLECTION UNIT ASSIGNED SUPPORT PAYMENTS RECEIVED DIRECTLY		
<input type="checkbox"/> OTHER _____		
IF CLAIMED, DESCRIBE WHY GOOD CAUSE IS BEING DENIED. COMPLETE THE SENTENCE:		
"WE DO NOT AGREE THAT THE REASON GIVEN FOR NON-COMPLIANCE IS A GOOD REASON		
BECAUSE..." _____		

Xmit _____		

WMS/CNS Changes (PA)

2. Two new PA case reason codes have been developed:

‘L92 – Restart Previously Notified Recoupment’ has been created to give workers the ability to resume a recoupment for which the client has previously received notification explaining the overpayment (TT = 05, 06).

Worker Entry: AMT1 – Current Recoup Balance

‘L99 – PA Overpayment Balance Statement’ has been created so that workers may include an outstanding recoupment balance statement with a closing notice, or send it separately subsequent to a case closing (TT = 07, 08, 00).

Worker Entry: AMT1 – Current Recoup Balance

Medicaid/Family Health Plus Related Changes

1. FAMILY HEALTH PLUS SYSTEMS

- a. Add new Anticipated Future Action (AFA) Codes to track FHP “Crowd Out”

Family Health Plus is intended to provide health insurance for uninsured individuals whose income or resources are above the MA Eligibility levels. When the legislation was written, there was concern that when Family Health Plus became available, employers might drop their existing health insurance and encourage their employees to apply for Family Health Plus, or, that employees might opt to drop existing optional coverage they were paying for through work and apply for Family Health Plus. This phenomenon is referred to as “crowd out”.

In an attempt to prevent crowd out, a provision was written into the legislation requiring the State to measure crowd out and implement a six month waiting period for applicants who had employer based health insurance if and when crowd out exceeded 8% of enrollment across the state.

In order to measure crowd out, six questions were added to the Access NY Health Care application (DOH 4220) in Section C, question 4. The answers to these questions need to be recorded in WMS for the State to measure “crowd out” on a statewide basis. Until a permanent method of collecting this information is developed, this will be accomplished by using the Anticipated Future Action Codes described below:

523 – NOT-EMPL – Formerly insured person, no longer works for employer

524 – STOP-HI – Employer stopped offering health insurance

525 – ST-HI-CH – Employer stopped offering health insurance for dependants but continues employee coverage

526 – COST-HI- Cost of health insurance no longer affordable

527 – CFHP-LS- CHPlus or FHPlus less costly than former health insurance

528 – CFHP-BN- Chplus or FHPlus provides better benefits than former health insurance.

These codes are valid with Case Types 24 and 20 only. They must be data entered without an AFA Date associated with them.

- b. A revision has been made to the FHP age edits. The current age requirements for FHPlus eligibility provide that a recipient must be 19 to 64 years of age. However, some recipients may be FHPlus eligible at 64 years old and turn 65 after eligibility is established. For those individuals turning 65 during the guarantee period the age edit had to be revised.

When opening a FHPlus case for an individual who will be turning 65 years old within the first six months of enrollment, the case should be authorized only through the PCP Guarantee Thru Date. When the recipient turns 65 years old, Guarantee Coverage (“36”) can now be authorized for the balance of the authorization period, and at the end of the six months the case should be closed or transitioned to Medicaid spenddown. When an individual will turn 65 after the guarantee period, but prior to the end of the 12-month authorization period normally provided to a FHPlus recipient, the case is authorized only to the end of the month in which the recipient turns 65 years of age. The individual will then be recertified prior to the end of his/her FHPlus coverage and can be transitioned to Medicaid spenddown, if appropriate.

2. FAMILY HEALTH PLUS/MEDICAID BUDGET LOGIC (MBL) CHANGES

- a. Family Health Plus legislation requires that, effective October 1, 2002, the Federal Poverty Level (FPL) standard for Parents and Single Individuals 19-20 Living with their Parents will increase from 133% to 150% FPL. Beginning July 22, 2002 any MBL budget with an Effective From Date of 10/01/02, or greater, and an Expanded Eligibility Code (EEC) of F or B will be calculate using the 150% standard. For further details see MBL Transmittal 02-2.
- b. The MBL EEC of “B” will now calculate and display eligibility for the value of “F” (FHP for Families/19-20 year olds Living with Parents). This change saves the districts from having to enter the “F” and re-transmitting the budget to test for the FHP standards when the individual is not eligible for Medicaid and other individuals in the case are eligible under expanded eligibility. For further details see MBL Transmittal 02-2.

3. WMS CHANGES

- a. Prior to this migration, WMS did not generate a Continuous Save Date for children 6-18 years of age at 100 – 133% of the FPL.

Since Individual Categorical Code 60 (Child 6-18 years of age 100-133% FPL) is an “expanded” Code it has now been included in the list of ICC’s for which a Continuous Save Date (CSD) can be generated if certain conditions are met (see 2/9/99 WMS/CNS Coordinator Letter for those conditions).

A new Individual Categorical Code 67 (Continuous Coverage – Expanded Child 100%-133% FPL) has been added to identify those individuals 6 up to 19 years of age no longer eligible under 133% of FPL but entitled to Continuous Coverage. The corresponding Recipient Aid Category, which appears on WMS MA Coverage Inquiry Screen (WINQ55), will be 81 (Child-Continuous Coverage 6-18 (100%-133%) FPL).

A new WMS edit associated with this code has been added. For all Transaction Types the MA Coverage From Date must be 4/1/02 or greater if the ICC is 60 or 67. The new error number/message will read: 1530 - CAT CD 60 OR 67 REQUIRE COV FROM DATE = OR > 4/1/02.

The following existing Error Numbers/Messages have been modified:

- 875 – ICC’s 60 and 67 are now included in this edit. The message now reads: MA FROM DATE > LAST DAY OF 19TH BIRTHDAY MONTH FOR CAT CODE 47, 53, 54, 60, 67. When the ICC is 47, 53, 54, 60, or 67, the MA Coverage From Date must not be greater than the last day of the month in which the 19th birthday falls.
- 876 – ICC 67 is now included in this edit. The message now reads: CONT SAVE DATE MUST BE > OR = COV FROM DATE FOR CAT CD 53, 54, 55, 67. WMS will not allow the entry of ICC 53, 54, 55 or 67 unless the CSD is equal to or greater than the MA Coverage From Date.
- 877 – ICC 67 is now included in this edit. The message now reads: WARNING – COV TO DATE MUST BE < OR = THE > OF T+10 OR CSD. When the ICC is 53, 54, 55, or 67, the MA Coverage To Date must be equal to or less than the CSD or Today’s date plus 10 days, whichever is greater.

Also, Citizenship Indicator Code is not a required entry for ICC 67.

- b. The WMS Report of Transitional Medical Assistance (TMA) activity has been revised.

In order to improve the accuracy of the monthly WMS WINR9153 Report, “Statistical Summary: Disposition of MA Extension Cases”, it has been revised to include a count of MA cases given TMA due to the loss of MA LIF eligibility as the result of increased earnings or child support. That is, in addition to counting MA cases system-generated with MA Opening Reason Codes 088 and 090 due to PA cases closed for increased earnings or child support respectively, the new report will also include the number of MA cases reauthorized with codes E08, Y78, and Y79. There will also be a column heading entitled “PA Closings Due to Earnings or Child Support”, which will give statistics by county of the number of cases closed with reason codes E31, E32, M92, and M93.

The number of PA cases closed with reason codes E31, E32, M92, and M93 may not correspond with the numbers under the heading, “MA Extensions from PA Closings” (088 and 090), since not all of these PA closings will result in a TMA opening. The last column of totals (broken down by county) represents the total number of extension cases opened with Reason Codes 088 or 090 or reauthorized with CNS Undercare Reason Codes E08, Y78, or Y79 as the result of loss of LIF eligibility on a PA or MA case due to increased earnings or child support during the previous month.

- c. A new Restriction/Exception Code has been added.

To support the OMRDD redesign of its Home and Community Based Services (HCBS) waiver mandated by the Division of Budget, a new Restriction/ Exception Code is being added to the WMS Restriction/Exception Subsystem beginning July 1, 2002. The purpose is to convert OMRDD’s Individual Residential Alternative (IRA) Residential Habilitation Services from a per diem to a monthly unit of service. The new WMS Exception code will have the value of “49” and be defined as “IRA Res Hab Consumer”. The entry of the value “49” will require an appropriate associated provider ID to be added to the R/E subsystem. Only one provider will be authorized to provide and bill for IRA services at a given time.

The definition for the remaining HCBS waivers (Exception Codes 46, 47, and 48) for the WMS Restriction/Exception Subsystem are also being changed to read as follows:

- 46 – changed from “Pure Waiver” to “OMRDD HCBS Waiver (IRA, FC or at Home)
- 47 – changed from “CR Waiver/Sub A” to OMRDD HCBS Waiver (CR and Sub A)”
- 48 – changed from “CR Waiver” to OMRDD HCBS Waiver (CR and Sub A)”

These changes will be available for data with a subsystem “Begin Date” of 7/1/02 or greater.