

DOH Contact: Local District Support Unit (518) 473-6397

WMS Changes

Section I – MAGI Transition to NYSoH

Section II – Enhancements to BHP/EP

Section III – Exclude PCP Enrollments on R/E S1

Section IV – Upstate Newborn ICC Change

Section V - Adult CSD

Section I

On **July 2, 2016**, Upstate WMS will begin transitioning MAGI individuals on WMS to NY State of Health (NYSoH) at the time of their renewal. As part of the monthly renewal process, MAGI members will automatically be identified and a WMS transaction will occur to close the case or delete individual/s off the case. Non-MAGI case member remaining in WMS will be sent a renewal letter at the same time. A new report, "**WINR 4150 – MAGI Renewal Transition to NYSoH**" will be provided to inform districts of impacted individuals. Managed Care plans are also being made aware of impacted individuals by being provided files through the Health Commerce System (HCS).

Here are the steps for the MAGI process:

Step 1	Cases are identified that meet the MAGI criteria. At least one individual on case must meet the MAGI criteria. If there are no individuals who meet the MAGI criteria, the case will not be part of the MAGI process. BHP/EP process that began in March 2016 occurs at the same time as the new MAGI process. If case does not meet criteria for BHP/EP or MAGI, it will be processed by the usual renewal processes or the WINR 4133.
Step 2	Identify if MAGI cases contains FPBP individuals or if it is a child only case.
Step 3	Automated WMS Transaction occurs and CNS Notice is generated.
Step 4	File is sent to NYSoH. NYSoH processes the file and matches individuals to their system. NYSoH notices are sent to Account Holders instructing them how to access their NYSoH Account.
Step 5	WINR Report is provided to LDSS and Managed Care plans receive file through HCS.

Step 1 – MAGI Criteria

Exclude Case where at least one is met:

Case in Pending Status	Case in Clockdown Status
Transaction District = 97, 98 or 99	Recert Source Codes = D or X
RVI = 6	MBL Shelter Type = 15, 16, 28, 29, 42

Exclude Individuals where at least one is met:

Special Population = C (Chafee/Foster Care) or T (True Chafee)	Age 64 or greater (Does not apply if Individual Categorical Code = 13 or 94)
MA Restriction/Exception Type = H1-H6, H8-H9, N1-N7, S1, 23, 25, 30, 39, 44-49, 60, 62-77, 81, 84-86, 89, 90, 93-96, B7, M1 (new R/E to identify excluded MAGI)	Principal Provider = 01, 02, 03, 04, 05, 06, 07, 08, 10, 12, 14, 16
SSN Code = X	BVI Code = C or D

Include Individuals if:

- If the system sees a transaction that occurred since the last 4133 run with the Authorization date less than End of Month of target month (This is used to insure MA Extension cases due to TA Closing with shorter Authorization Periods are pulled in) AND
- Individual Status = 07 AND
- Case Type = 20 AND
- Individual Categorical Code = 01, 02, 03, 05, 06, 07, 08, 09, 13, 15*, 21, 22, 25, 26, 42*, 43*, 44, 45, 46, 47, 48*, 53, 54, 55, 58*, 59*, 67, 84, 92*, 93, 94, 95, 96 AND
- Individual is not enrolled in a PCP plan and has MA Coverage Code = 01, 11, 30 OR
- Individual is enrolled in a PCP plan and Provider ID is not LTC, PACE, MAP, FIDA OR HARP

*If ICC = 15, 42, 43, 48, 58, 59, or 92 and Unborn exists, Unborn will be closed or deleted off a case, but will not be sent on NYSoH File. Pregnancy questions will be asked when NYSoH account is accessed and Unborn will be added based on responses to those questions.

Step 2 – Identify if FPBP Individuals Exist on Case or if Child Only Case

FPBP Individuals on Mixed Household Cases

It will be determined if case consists of FPBP individuals (ICC = 68 or 69 and MA Coverage = 18). If FPBP individuals exists on the case with at least one MAGI individual that met the criteria in Step 1 it is considered a mixed household case and the FPBP individuals will transition to NYSoH. They will be put on the NYSoH file the same as the MAGI individuals. FPBP Only cases (all individuals are FPBP) will remain in WMS and will not be part of the MAGI process.

Child Only Cases

It will be determined if case consists of child/ren only. Child/ren only is defined as all active members being equal to or less than 18 years and 9 months. These cases will be closed and will be given reason code W4H. These cases will **not** be put on the file to NYSoH.

Step 3 – Automated WMS Transaction

Each month cases with all individuals meeting the defined MAGI criteria will be given a new closing reason code and mixed member cases (MAGI case members &/or non-MAGI case members) will be given new undercare reason codes.

- A Unique Authorization Number of '9---MAG' will be produced
- 3209 Authorization will be produced
- If RFI flags exist automated transaction will batch

Cases with all MAGI Case Members

Cases that contain all MAGI case members will be CLOSED using the criteria below. The new CNS notice **W3H – Used for MAGI individuals transitioning to NYSoH** or **W4H – Used for Child/ren Only Cases** will inform individuals that have been closed that renewal is needed at NYSoH and additional information will be sent to them by NYSoH:

- Transaction Code = 08
- Transaction Office/Transaction Unit/Worker = MAG/NYDOH/00000
- Case Reason Code = W3H or I90 if Unborn Exist with Pregnant Woman or W4H for Child/ren Only Case

- Notice Indicator = A
- Authorization To Date = Current Date
- Individual Reason Code if Case Reason Code = I90
 - MAGI case member (includes PW ICCs)= W3H or MAGI case member (includes PW ICCs) who exist on Child/ren Only case = W4H
 - Unborn (Sex = U) with PW ICC (15, 42, 43, 48, 58, 59, or 92) = Y70
- Individual Status = 20
- MA Coverage To Date = Unchanged if it is the Current Date + 2 months (End of Month-EOM). If less than or greater than Current Date + 2 months (EOM) then it will be set to Current Date + 2 months (EOM)
- If payment lines exist and Payment Period To date is greater than Transaction Input Date + 2 months the Payment Period To Date will be truncated

OR

- If payment lines exist and Payment Period greater than Transaction Input Date + 2 months (EOM) another Payment Line will be created to cancel out future payment line.

Cases with mixed member cases (mix of MAGI & non-MAGI) will have MAGI individuals DELETED.

- Transaction Code = 05
- Transaction Office/Transaction Unit/Worker = MAG/NYDOH/00000
- Case Reason Code = I90
- Notice Indicator = A
- Individual Reason Code if
 - MAGI case member (includes PW ICCs)= W3H
 - Non-MAGI case member/s with coverage not equal to 18 = S4N (MA Renewal for individual(s) to remain with LDSS)
 - Non-MAGI case member/s with coverage = 18 = W3H
 - Unborn (Sex = U) with PW ICC (15, 42, 43, 48, 58, 59, or 92) = Y70
 - MAGI Case Member (includes PW ICCs) who exist on Child/ren Only Case = W4H
- Anticipated Future Action – If the following AFA codes exist they will be blanked out Z49, Z59, Z82, Z83, Z85, Z86, or Z87 as well as the corresponding Line# in the screen 4 AFA field. No AFAs are set for renewal
- Individual Status if
 - MAGI or Unborn with PW ICC case member or FPBP with coverage 18 = 15
 - Non-MAGI case members = no change

- MA Coverage To Date if
 - MAGI or Unborn with PW ICC case member or FPBP with coverage 18 = Unchanged if = Current Date + 2 months (End of Month-EOM). If less than or greater than Current Date + 2 months (EOM) set to Current Date + 2 months (EOM)
 - Non-MAGI case members = Unchanged

Step 4 – NYSoH File

Shortly after the WMS transaction is produced a file will be created and delivered to NYSoH. The file will contain individuals that were closed or deleted off of WMS. NYSoH will match individual to their system and send a notice to the individual informing them of the action they need to take in NYSoH. As noted above Unborns and Child Only cases are not sent on the file.

Step 5 – Monthly Report for LDSS and File for Managed Care Plans

Monthly Report for LDSS

A new monthly report (WINR 4150) will be created for the LDSS to identify cases selected for MAGI. WINR 4150 Report will be titled "MAGI Renewal Transition to NYSOH" and will consist of four sections:

- Section I – MAGI Case with Pending Transaction Needs Review for Extension (**LDSS Action Needed:** Review pending case. If errors exist they should be resolved. Case should be extended for two additional months which will allow it to be picked up in future MAGI renewal process)
- Section II – MAGI Closings - Transactions resulting in a closing will be listed
- Section III – MAGI Deletions – Transactions resulting in a deletion will be listed
- Section IV – MAGI Cases that failed to process due to other reasons

The WINR 4150 report will be sorted by: District/ Local Office/Unit/Worker/Authorization Period To Date/Case Name (Alphabetically)

Each section will contain: Case Number, Case Name, Case Type, Authorization To Date, CIN, Total Cases

Monthly File for Managed Care Plans

A new monthly comma delimited file will be delivered to the Managed Care plans via the Health Commerce System (HCS). The purpose of the report is to identify to the Managed Care Plans the individuals that will be transitioning out of WMS to NYSoH due to the MAGI Transition. File will be titled "MAGI Renewal Transition to NYSOH" and report name sent to HCS will be 'mgmummy' (mmyy is month/year). The file will be sorted and distributed by Managed Care Provider. File format will consist of District, Case Number, CIN and MA Coverage To Date.

New & Modifications to WMS Errors

New edits - Two new WMS edits have been created. They both use similar criteria used in Step 1 above to identify MAGI.

1943 – IDENTIFIED MAGI INDIVIDUAL, TRANSACTION NOT ALLOWED

Undercare transaction (05 or 06) is not allowed due to a MAGI individual on the case. (Can be overridden)

1944 – IDENTIFIED MAGI INDIVIDUAL, OPENING NOT ALLOWED

Opening transaction (02 or 10) is not allowed due to a MAGI individual on the case. (Can be overridden)

Edit Table 133

The following system-generated codes are valid but may not be data entered:

Case Reason Codes: 758, 761, 802, 923, 941, 942, BBB, CTP, EEE, FFF, W2H, **W3H, W4H**, TLM, V01, V02, ZZZ

PA/MA Reason Codes: 700, 705, 707, 710, 715, 753 - 756, 758, 760 - 769, 771, 788, 789, 790 - 795, 797, 800, 802 – 805, 820, 821, 827, 858, 859, 861, 941, 942, W2H, **W3H, W4H**

Edit Table 359

PA/MA Individual Reason Codes

The following system-generated Individual Reason Codes are valid but may not be data entered:

753 - 756, 758, 760 - 769, 771, 789-795, 797, 802-803, 805, 820, 821, 858, 859, 901, 920-924, 941, 942, F4N, S4N, W2H, **W3H, W4H**

Section II – Enhancements to BHP/EP

The BHP/EP process that began in March 2016 had the following enhancements:

- BHP/EP and MAGI case members who have an SSN = X or a BVI = C or D are now excluded
- MAGI case members that have R/E 35 are now included
- MAGI case members that have ICC 44 are now included
- Closing transactions (08) with individual reason codes will now have Case Reason Code I94 instead of I89. Change transaction (05) will continue to have the Case Reason Code of I89. This was modified to resolve a noticing issue related to Unborns.

For the June 2016, BHP/EP run the following enhancement is planned:

- Include MAGI case members with Medicaid Coverage = 11.

Section III – Exclude PCP Enrollments on R/E S1

eMedNY has implemented a new Restriction/Exception of "S1 – Surplus Client not MMC/MA Eligible". This R/E can be used to identify a surplus client and allow editing for PCP enrollment. Enrollment for an individual with R/E S1 is allowed into a MLTC (MA Advantage Plus, PACE, and Partial Cap Plans) or FIDA plan. It is not allowed for a Mainstream Managed Care, HARP, SNP or Medicaid Advantage plans as PCP edit **057 – No MC Enroll – R/E S1 EXCLUDED** will be displayed.

Section IV – Upstate Newborn ICC Change

The Newborn process has current logic to assign the Newborn's Individual Categorical Code (ICC) based on the Mother's ICC. Over the years new ICCs have been added that could be used by the mother, yet were not updated in the Newborn logic. To rectify a default ICC of 45 will be generated for the Newborn.

Section V - Adult CSD

Chapter 58 of NY Social Service Law provides 12 months of continuous coverage for all individuals determined eligible under the MAGI eligibility criteria. All individuals determined eligible for Medicaid using MAGI guidelines are entitled to 12 months of continuous coverage regardless of increase in income or change in household composition although there are several exceptions as noted below:

R/C – Definition

E60 – Unable to Locate

E63 – Not a State Resident

E90 – Client Request

E95 – Death

V31 – Failed to Provide SSN

V17 – Incorrect or Fraudulent SSN

E79 – Individual Lives in a Public Institution which Provides Medical Care

C53 – Incarceration

C88 – Failed to Document Citizenship

Y90 – Determined in Error (no notice sent)

To support worker's authorizing 12 months of continuous coverage, the following WMS edit has been modified, for MA Case Types only, to occur when an individual is deleted from a case and the MA Coverage TO date is greater than the transaction date plus 2 months, end of month:

ERROR 0573 – MA COVERAGE DATE(S) INVALID

In addition, since error 0163 (AUTH PERIOD TO DATE MUST NOT EXCEED LAST DAY OF NEXT MNTH IN CLOSING) is applied to other case types than just MA a new error was created, specific to MA case types, as listed below:

ERROR 1126 - AUTH PERIOD TO DATE MUST NOT EXCEED TRANS DATE + 2 MONTHS END OF MONTH