Basic Health Program Blueprint

Introduction

Section 1331(a) of the Affordable Care Act directs the Secretary to establish a Basic Health Program (BHP) that provides a new option for states to offer health coverage for individuals with family incomes between 133 and 200 percent of the federal poverty level (FPL) and for individuals from 0-200 percent FPL who are lawfully present in the United States but do not qualify for Medicaid due to their immigration status. This coverage is in lieu of Marketplace coverage

States choosing to operate a BHP must submit this BHP Blueprint as an official request for certification of the program.

States operating a BHP enter into contracts to provide standard health plan coverage to eligible individuals. Eligible individuals in such a state could enroll in BHP coverage and would not have access to coverage through the Health Insurance Marketplace. The amount of the monthly premium and cost sharing charged to eligible individuals enrolled in a BHP may not exceed the amount of the monthly premium and cost sharing that an eligible individual would have paid if he or she were to receive coverage from a qualified health plan (QHP) through the Marketplace. A state that operates a BHP will receive federal funding equal to 95 percent of the premium tax credit (PTC) and the cost-sharing reductions (CSR) that would have been provided to (or on behalf of) eligible individuals, using a methodology set forth in a separate funding protocol based on a methodology set forth in companion rulemaking.

Given the population served under BHP, the program will sit between Medicaid and the Marketplace, and while states will have significant flexibility in how to establish a BHP, the program must fit within this broader construct and be coordinated with other insurance affordability programs. Regulations for the BHP were finalized on March 12, 2014 and are available at www.Medicaid.gov/BHP.

The BHP Blueprint is intended to collect the design choices of the state and ensure that we have a full understanding of the operations and management of the program and its compliance with the federal rules; it is not intended to duplicate information that we have collected through state applications for other insurance affordability programs. In the event that a State seeks to make a significant change(s) that alter program operations described in the certified Blueprint, the state must submit a revised Blueprint to the Secretary for review and certification.

The BHP Blueprint sections reflect the final rule that codified program establishment standards, eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and Secretarial oversight relating to BHP.

Acronyms List

BHP	Basic Health Program
CHIP	Children's Health Insurance Program
CSR	Cost Sharing Reduction
ESI	Employer Sponsored Insurance
EHB	Essential Health Benefits
FPL	Federal Poverty Level
IAP	Insurance Affordability Program
MEC	Minimum Essential Coverage
OMB	Office of Management and Budget
PTC	Premium Tax Credit
QHP	Qualified Health Plan
SHP	Standard Health Plan

Section 1: Basic Health Program-State Background Information

State Name: New York

Program Name (if different than Basic Health Program):

BHP Blueprint Designated State Contact:

Name:	**Judith Arnold**
Title:	**Director, Division of Eligibility and Marketplace Integration**
Telephone number:	**518-474-0180**
E-mail	**Judith.Arnold@health.ny.gov**

Requested Interim Certification Date (if applicable) (mm/dd/yyyy):

Requested Full Certification Date (mm/dd/yyyy): April 1, 2015; Revision 1 requested for January 1, 2016

Requested Program Effective Date (mm/dd/yyyy): April 1, 2015; Revision 1 requested for January 1, 2016

Administrative agency responsible for BHP ("BHP Administering Agency"):
New York State Department of Health. Note: The NY marketplace, Medicaid and CHIP programs are also under the New York State Department of Health.

BHP State Administrative Officers:

Program Administration: (Management, Policy, Oversight)			
Position:	Title:	Location (Agency):	Responsible for:
Dr. Zucker	Commissioner of Health	Albany, NY	Program Oversight
Jason Helgerson	Medicaid Director	Albany, NY	Management Oversight, Policy

Donna Frescatore	Director, New York State of Health	Albany, NY	Management Oversight, Policy
Troy Oechsner	Department of Financial Services	Albany, NY	Health plan oversight
Program Operations: (Contracting, Eligibility Appeals, Coverage Appeals)			
Position:	Title:	Location (Agency):	Responsible for:
Judith Arnold	Director, Eligibility and Marketplace Integration	Albany, NY	Eligibility Policy, Eligibility and Enrollment operations, Customer Service
Jonathan Halvorson	Director, Systems	Albany, NY	Eligibility and Claims Systems
Lisa Sbrana	Director, Office of Exchange Counsel	New York, NY	Informal resolution process, appeals

Randi Imbriaco	Director, Plan Management	Albany, NY	Health Insurer Management, Contracting with Insurers
Finance: (Budget, Payments)			
Position:	Title:	Location (Agency):	Responsible for:
John Ulberg	CFO, Office of Health Insurance Programs	Albany, NY	Financial Management
Michael Nazarko	Director, Administration	Albany, NY	Payments
Frank Walsh	Division of Budget	Albany, NY	Budget

Governor/Governor's designee: Jason Helgerson

Signature: [redacted]

Date of Official Submission (mm/dd/yyyy): 12/31/2015

Section 2: Public Input

This section of the Blueprint records the state's method for meeting the public comment process required for Blueprint submission.

Date public comment period opened (mm/dd/yyyy): December 11, 2014; November 1, 2015 for the amendment.

Date public comment period closed (mm/dd/yyyy): January 12, 2015; January 16, 2016 for the amendment.

Please describe the public comment process used in your state, such as public meetings, legislative sessions/hearing, the use of electronic listservs, etc.

New York created a Basic Health Program (BHP) work group in 2013. The work group was comprised of legislative staff, consumer advocates, health plans, and providers. All meetings were open to the public. The work group's charge was to advise the Governor and the Legislature on the merits of pursuing a BHP in New York and the design features of a program. The work of the group led to the enactment of the BHP statute in New York in the 2014 Executive Budget.

Following enactment of the statute, the Department of Health held a series of stakeholder meetings on the implementation of the BHP. The stakeholder meetings are ongoing. The draft Blueprint was shared with stakeholders for public comment on December 11, 2014.

Provide a list below of the groups/individuals that provided public comment.

Coalition of New York State Public Health Plans
Community Health Care Association of New York State
Emblem Health Plan
Family Planning Advocates of New York State
Greater New York Hospital Association
Health Care for All New York (HCFANY)
Medicaid Matters
Legal Aid Society
Liz Kruger, State Senator
New York Health Plan Association

The state initiated a second public comment period for the blueprint amendment which replaces the 2015 health plans with the plans available in 2016. The plans were posted publicly on the NY State of Health website beginning November 1, 2015. No public comments were received on the public posting of the plans. The state also issued a public notice on January 6, 2016. The state will consider comments received after the effective date of the Blueprint and will submit a revised Blueprint addressing the comments, if needed.

If the state has federally recognized tribes, list them below. Provide an assurance that they were included in public comment and note if comments were received. The state initiated tribal consultation for the original blueprint submission and received no comments from the tribes. The state initiated a second tribal consultation for the blueprint amendment on December 18 and has not received comments. The state will consider comments received after the effective date of the Blueprint and will submit a revised Blueprint addressing the comments, if needed.

Federally recognized tribe:	**State Agency Solicited Input:**	**Input Received:**
Cayuga Nation of New York	Yes	No
Oneida Nation of New York	Yes	No
Onondaga Nation of New York	Yes	No
Saint Regis Mohawk Tribe	Yes	No
Seneca Nation of New York	Yes	No
Shinnecock Indian Nation	Yes	No
Tonawanda Band of Seneca Indians of New York	Yes	No
Tuscarora Nation of New York	Yes	No

Provide a brief summary of public comments received and the changes made, if any, in response to public comments:

The public comments were overwhelmingly supportive of the establishment of a Basic Health Program in New York. Most supported the policy decisions made by the State and believe the BHP will be an important, more affordable health insurance option to consumers. The comments focused on the following areas:

Affordability – Most comments praised BHP for providing a more affordable option to families below 200% of FPL. Some commenters thought the cost-sharing for the individuals with income greater than 150% of FPL but at or below 200% of FPL should be lower for certain services. In structuring the cost-sharing, the state aimed to create a tier between Medicaid level cost-sharing and the QHP Silver level cost-sharing while continuing to deter the use of emergency rooms. We modified the cost-sharing for PT/OT/ST therapies and urgent care in response to the comments.

Eligibility and Enrollment – Several commenters requested the state implement continuous eligibility in 2016 instead of evaluating it for consideration for later implementation. Given the frequency with which enrollees make changes to their accounts that affect eligibility, continuous eligibility has a cost associated with it. New York intends to evaluate the costs of continuous eligibility to ensure the state can support it within the trust fund dollars before committing to implementing it. The decision not to implement it in 2016 stands. Advocates also suggested continuous eligibility be optional for consumers. It is our understanding from CMS, which CMS has confirmed, that if a state elects continuous eligibility, it cannot be optional. It must apply in a uniform matter to all consumers.

Consumer advocates also recommend that BHP income eligibility be based on current income like Medicaid. It is the State's understanding, which CMS has confirmed, that BHP must be based on projected annual income. One commenter expressed preference for retroactive coverage instead of prospective coverage. The State is maintaining the prospective effective date of coverage because BHP is an exclusively managed care program with no fee-for-service component with which to manage retroactive enrollment. Under state law, retroactive coverage

is available for someone who would have been eligible for Medicaid at state costs prior to the effective date of coverage in BHP. The retroactive coverage will be at full state costs.

Provider Rates – A large number of comments concerned provider rates under the BHP. The Federally Qualified Health Centers expressed concern that they not lose their Medicaid reimbursement rate under a BHP. The traditional Medicaid managed care plans expressed interest in BHP being defined, under New York law, as a public program as opposed to a commercial program. Hospitals expressed concern that rates be negotiated between insurers and providers and not be pegged to the Medicaid rates.

Section 3: Trust Fund

Please provide the BHP Trust Fund location and relevant account information:
BHP Trust Fund Location (Institution, address, phone number)

Institution: The New York State Department of Health, in conjunction with New York State Department of Taxation and Finance and the New York State Office of the Comptroller

Address: Room 2701 Corning Tower, Empire State Plaza, Albany NY 12237

Phone Number: (518) 473-4263

Account Name: As with all federally granted funds, and as authorized by Federal Title 42 – Public Health, Section 600.705, the BHP Trust Fund will be in a segregated account within New York State's fund structure. Chart of account coding specific to the BHP will be created within the state's accounting system which will enable tracking of all activities against this fund. A state appropriation will be created specific to BHP federal funds; funds will be segregated within a specified fund and subfund and will not be comingled with other funding.

Account Number: The specific fund and subfund coding structure will be provided to CMS once it is set up within the NY Statewide Financial System (SFS).

Trustees:

Name	Organization	Title	May authorize withdrawals?
Howard Zucker, M.D.	Department of Health	Acting Commissioner	Yes
Sally Dreslin	Department of Health	Executive Deputy Commissioner	Yes
Michael Nazarko	Department of Health	Deputy Commissioner for Administration	Yes

Robert LoCicer	Department of Health	Deputy Director for Administration	Yes
Edward Cahill	Department of Health	Director, Fiscal Management Group	Yes

Is anyone other than Trustees indicated above able to authorize withdrawals? No. Upon authorization by a Trustee, transactions related to the Trust Fund will be processed by those staff normally delegated to perform such transactions. Such delegations are made in writing and are maintained in a database kept by the NYS Office of the State Comptroller.

If yes, please include the name and title of everyone with this authority.

Name	Organization	Title

If there is separation between the entity holding the trust fund ("Trustees") and the entity operating the trust fund, please describe the relationship below. Include the name, and contacts for the entity operating the trust fund. Also include a copy of a written agreement outlining the responsibilities of the entity operating the trust fund.

The State of New York will be both the holder and operator of the Trust Fund. The fund will be subjected to a high level of internal controls and separation of duties as with all New York State accounts. Trustees will authorize withdrawals from the Trust Fund; authorized staff within the Department of Health will then process transactions that will access funds in the Trust for purposes of processing appropriate Basic Health Program expenditures; these transactions will be submitted to the Office of the State Comptroller for their review and approval before any

funds are transferred out of the Trust. The primary contact from the Department of Health is provided below.

Name	Organization	Title	Contact
Thomas Davies	Department of Health		518-473-4263 Thomas.Davies@health.ny.gov

Please name the CMS primary contact for the BHP trust fund and provide contact information.

CMS Primary Contact Name: Thomas Davies

CMS Primary Contact Phone Number: 518-473-4263

CMS Primary Contact E-mail Address: Thomas.Davies@health.ny.gov

Please describe the process of appointing trustees.

Trustees will consist of three categories of individuals. These individuals have primary responsibility over all accounts within the purview of the NYS Department of Health.

1. The Commissioner or Acting Commissioner of Health
2. The Director of the Department of Health's Fiscal Management Group
3. Those individuals specifically authorized by the Commissioner of Health, pursuant to Section 110 of the State Finance Law, to designate individuals to perform financial transactions related to Department accounts.

Provide a list of all responsibilities of Trustees.

Trustees are responsible for providing oversight over all activities related to use of funds within the Trust. Trustees specify those individuals who will have authorization to perform transactions related to the Trust and will be responsible for ensuring funds are used only for specified purposes, that appropriate records and reports are created and maintained, that appropriate review activities, such as reconciliation and audits, are performed in a timely and complete manner, and that an annual certification is made regarding appropriate use of funds from within the Trust.

Has the state made any arrangements to insure or indemnify trustees against claims for breaches of fiduciary responsibility? Yes
If yes, what are they?

Section 17.3 of the New York State Public Officers Law provides for indemnification of state officers and employees.

Trust Fund Attestation		Attest that the Agency is immediately ready and able. (yes/no)	Date the Agency commits to being ready to perform task if not immediately able. (mm/dd/yyyy)
The BHP Administering Agency will:			
600.710(a)	Maintain an accounting system and fiscal records in compliance with Federal requirements for state grantees, including OMB circulars A-87 and A-133 and applicable federal regulations.	X	
600.710(b)	Obtain an annual certification from the BHP Trustees, the State's CFO, or designee, certifying the state's BHP Trust Fund FY financial statements, and certifying that BHP trust funds are not being used for the non-federal share for any Federally-funded program, and that the use of BHP trust funds is otherwise in accordance with Federal requirements (including that use of BHP funds is limited to permissible purposes).	X	

Trust Fund Attestation		Attest that the Agency is immediately ready and able. (yes/no)	Date the Agency commits to being ready to perform task if not immediately able. (mm/dd/yyyy)
The BHP Administering Agency will:			
600.710(c)	Conduct an independent audit of Trust Fund expenditures over a 3-year period in accordance with chapter 3 of GAO's Government Auditing Standards.	X	
600.710(d)	Publish annual reports on the use of funds within 10 days of approval by the trustees.	X	
600.710(e)	Establish and maintain BHP Trust Fund restitution procedures.	X	

600.710(f) and (g)	Retain records for 3 years from the date of submission of a final expenditure report or until the resolution and final actions are completed on any claims, audit or litigation involving the records.	X	

Section 4: Eligibility & Enrollment

This section of the Blueprint records the state's choices in determining eligibility procedures for BHP and records assurances that demonstrate comportment with BHP standards. The state must check all pertinent boxes and fill in dates where applicable.

Note: Blacked out areas indicate that there are no choices available.

Please name the agency with primary responsibility for the function of performing eligibility determinations: Department of Health

Attestation		Completed	If No, Expected Completion date (mm/dd/yyyy)	Marketplace Policy	Medicaid Policy
Eligibility Standards					
The state can enroll an individual in a Standard Health Plan who meets ALL of the following standards.		No	9/1/15		
305(a)(1)	Resident of the State.				
305(a)(2)	Citizen with household income exceeding 133 but not exceeding 200% FPL **or** lawfully present non-citizen ineligible for Medicaid or CHIP due to immigration status with household income below 200% FPL.				
305(a)(3)	Not eligible to enroll in MEC or affordable ESI.				
305(a)(4)	Less than 65 years old.				

Attestation		Completed	If No, Expected Completion date (mm/dd/yyyy)	Marketplace Policy	Medicaid Policy
305(a)(6)	Not incarcerated other than during disposition of charges.				
Application Activities					
310(a)	Single streamlined application includes relevant BHP information.	No	9/01/2015		
310(b)	Application assistance, including being accessible to persons who are limited English proficient and persons who have disabilities consistent with 42 CFR435.905(b), is equal to Medicaid.	Yes			
310(c)	State is permitting authorized representatives; indicate which standards will be used.	Yes		X	
315	State is using certified application counselors; indicate which standards will be used.	Yes		X	
Eligibility Determinations and Enrollment					
320(c)	Indicate the standard used to determine the effective date for eligibility.			X	
320(d)	Indicate the enrollment policy used in BHP (the open and special enrollment periods of the Exchange OR the continuous enrollment process of Medicaid).				X

Attestation		Completed	If No, Expected Completion date (mm/dd/yyyy)	Marketplace Policy	Medicaid Policy
335(b)	Indicate the standard used for applicants to appeal an eligibility determination.			X	
340(c)	Indicate the standard used to redetermine BHP eligibility.			X	
345	Indicate the standard to verify the eligibility of applicants for BHP.			X	

1) **Please indicate whether the state will implement the option to redetermine enrollees every 12 months as long as enrollees are under 65, not enrolled in alternative MEC and remain state residents. If no, please explain redetermination standards. (These standards must be in compliance with 42 CFR 600.340(f).)**

   The state plans to redetermine enrollees every 12 months as long as enrollees are under age 65, not enrolled in MEC and remain state residents. Enrollees are required to report changes in circumstances within 30 days and the state plans to act on changes in circumstances during the 12 month period. The state will evaluate the cost of providing continuous eligibility to BHP enrollees for possible implementation in 2017.

2) **Please list the standards established by the state to ensure timely eligibility determinations. (These standards must be in compliance with 42 CFR 435.912 exclusive of 435.912(c)(3)(i)).**

   New York has established the standard of determining eligibility 45 days from the date of receipt of the application as required in 45 CFR 435.912. However, most applicants receive an eligibility determination in much less time. The online eligibility system makes real time eligibility determinations for Medicaid, CHIP, and QHPs with and without financial assistance.

   The BHP verification rules will follow the Marketplace rules, and unlike Medicaid, applicants will not be pended for income inconsistencies. BHP applicants will receive temporary enrollment for 90 days while the inconsistency is resolved.

3) **Please describe the state's process and timeline for incorporating BHP into the eligibility service in the state including the State's Marketplace (if applicable). Include pertinent timeframes and any contingencies that will be used until system changes (if necessary) can be made.**

New York has an integrated, automated eligibility system that determines eligibility for Medicaid, CHIP, APTC, APTC-CSR, and full-pay QHPs. The system permits seamless transitions between programs. For BHP, eligibility for tax filers will be determined using the MAGI rules for APTC eligibility, while Medicaid non-filer rules will be used for applicants who do not plan to file taxes. As non-filer rules can create small differences in household size, both to the advantage and disadvantage of the state's BHP payment, New York will evaluate a sample of non-filer applicants and construct tax households using APTC rules to determine the difference it makes, and adjust the payment methodology, if necessary. New York expects the difference to be negligible given the small percentage of applicants who do not file taxes, have a household size greater than 1, and where the tax household will be different from the non-filer household.

The eligibility rules for BHP will be incorporated into the integrated eligibility system and completed by September 2015 in time for 2015 open enrollment for 2016 BHP coverage when the state will launch its full BHP program up to 200% FPL. The system modifications will include changes to the rules engine to incorporate the BHP eligibility levels and rules, changes to the screens to reflect the new BHP option, adding the BHP plans to the plan management data base and ensuring the BHP plans display to consumers correctly, and adding key messages to the notice templates to reflect the new BHP eligibility determination and plan selection. The state does not anticipate any difficulty meeting the September target date.

From April 1-August 30, 2015, during the transition plan period, when the state is covering non-citizens, ineligible for Medicaid, up to 138% FPL, the system will not determine BHP eligibility or display BHP eligibility results for new applicants. As described in the transition plan below, any new applicants that meet the definition of the transition population will be determined eligible for Medicaid without federal financial participation ("NY-MA") using MAGI rules for APTC eligibility for tax filers. Non-filers will be handled as described above. These NY-MA enrollees will be coded in the system as BHP enrollees for proper claiming. The transition population in NYSOH as well as the QHP enrollees between 133 and 200% FPL will be administratively renewed in the new system during open enrollment. Non-citizen enrollees under 138% already enrolled in NY-MA system (WMS) will remain in the legacy system during transition period, and transition into the NYSOH system as described in the Transition Plan.

4) Please describe the process the state is using to coordinate BHP eligibility and enrollment with other IAPs in such a manner as to ensure seamlessness to applicants and enrollees.

New York has a single eligibility system for MAGI Medicaid, CHIP and Marketplace programs and has aligned program rules as much as possible under the regulations. An applicant that applies for financial assistance can receive an eligibility determination for any insurance affordability program for which he/she is eligible and enroll in health plans for that program. There are no referrals to other agencies for the MAGI population. Non-MAGI Medicaid are

referred to local departments of social services until those rules can be programmed into the New York State of Health (NYSOH) system.

When enrollees report a change, eligibility is re-run and they can seamlessly transition to another program without a gap in coverage. Enrollees are administratively renewed to the extent feasible with the data available. BHP will be incorporated into the eligibility system as a new insurance affordability program with eligibility levels of 138%-200% of FPL and 0-200% of FPL for lawfully present non-citizens who are not eligible for Medicaid. Applications, updates and changes, and renewals for BHP will be handled in the same manner as other insurance affordability programs in 2016 and thereafter.

5) **If the state is submitting a transition plan in accordance with 600.305(b), please describe the transition plan in the box below. The plan must include dates by which the state intends to complete transition processes and convert to full implementation.**

Overview

New York is submitting a transition plan for BHP. The State intends to phase in the implementation beginning on April 1, 2015 with individuals between 0-138% of FPL who are lawfully present non-citizens and do not qualify for federal financial participation in Medicaid due to their immigration status. These individuals are enrolled in Medicaid in New York, if otherwise eligible, without federal financial participation (NY-MA) and will now be eligible for the BHP. Beginning in the 2015 open enrollment period for coverage that begins January 1, 2016, enrollment in BHP will be open to all individuals under age 65 between 138-200% of FPL who are not eligible for Medicaid or CHIP and do not have minimum essential coverage.

Transition Timing and Eligibility

The transition would begin April 1, 2015. Lawfully present non-citizens who are BHP eligible and currently enrolled in NY-MA, but who are not eligible for federal financial participation will be transitioned to BHP coverage. They would receive that coverage through the same managed care plan through which they are currently enrolled during calendar year 2015 and, for those individuals found eligible through the legacy WMS system, would receive BHP coverage through those managed care plans until their eligibility renewal date in 2016. New applicants that meet the definition of the transition population will be determined eligible for BHP coverage and receive BHP coverage through enrollment in those same managed care plans during calendar year 2015. Except for the legacy WMS population, BHP coverage starting January 1, 2016 will be provided through standard health plans procured through the process described in Section 5 below.

Eligibility for new applicants (and renewals) will be based on the MAGI rules for tax filers. Non-filers will be determined using Medicaid non-filer rules.

The lawfully present non-citizens who would transition to BHP include those in the five year bar, certain PRUCOL, and certain temporary non-immigrants. Medicaid enrollees in these categories under 138% FPL who receive long-term care services and those with MEC where

Medicaid pays the premium would remain in NY-MA. Some lawfully present non-citizens in NY-MA will not be eligible for BHP due to their immigration status and will remain in NY-MA.

Transition Population with Income Inconsistencies

Transition population applicants with a preliminary determination of Medicaid eligibility may be pended for income documentation prior to receiving a final eligibility determination. Those eligible for Medicaid based on their attestation with income data sources not reasonably compatible will be given 15 days to document the inconsistency. If they fail to document, they will be denied eligibility for NY-MA (and therefore will not be coded as BHP). Phone applications and paper applications are also processed in the online eligibility system using the same rules.

Benefits during Transition

The transitional BHP benefit package will be the Alternative Benefit Plan (ABP) for the new adult group approved by CMS. Enrollees will remain in their current Medicaid managed care plans, but clearly identified as BHP enrollees with a separate BHP rate paid to the plans for 2015. This transitional BHP program would run from April 1-December 31, 2015 to allow the State time in 2015 to procure BHP products for 2016.

A small number of those eligible for BHP in the transition period may be in Medicaid fee-for-service until they are enrolled in a BHP plan. These individuals include those who under Medicaid rules are either in the retroactive eligibility period or are excluded or exempt from enrollment in a Medicaid managed care plan. For administrative convenience, they will continue to be funded by state dollars and remain in NY-MA until BHP functionality is developed in the system. Individuals who become BHP eligible will no longer be excluded or exempt from enrollment in managed care.

Renewals

Transition Population who were New Applicants during Transition Period ("Transition New Applicants"): Individuals who newly apply between April 1 and November 15, 2015 and are in the transition population will be enrolled in Medicaid coverage in NYSOH for 12 months based on MAGI rules for tax filers and treated as transition enrollees coded as BHP enrollees as described above. The eligibility for non-filers will be based on Medicaid non-filer rules. For those who remain continuously enrolled, in November, their eligibility will be converted from Medicaid to BHP with a January 2016 effective date. Some enrollees may be required to return to select a standard health plan, if their plan is not available in BHP. All individuals who apply by December 15 and select a BHP plan will be enrolled in BHP plans by January 1, 2016.

Transition Population who were Renewed in NYSOH during Transition Period ("Transition NYSOH Renewals"): Transition individuals who applied through NYSOH and received NY-MA prior to April 1, 2015 will be administratively renewed during the transition period for another 12 months. For example, a lawfully present non-citizen under 138% FPL is due to renew their coverage in May. If they continue to remain eligible under the NY-MA, they will be renewed into the program for another 12 months, through May 2016. Eligibility will be determined based on MAGI rules for tax filers and Medicaid non-filer rules for non-filers.

Their eligibility status, however, will be changed in NYSOH from Medicaid to BHP prior to January 1, 2016 without consumer involvement. Just like for the transition new applicants, the state will work to auto-enroll consumers from their Medicaid plan to a BHP plan when the issuers are the same for January 1 coverage. If the Medicaid plan is not available in BHP, the consumer will be notified to return to select a new plan. The state expects significant overlap between Medicaid managed care plans and BHP plans.

Transition Population in WMS who were Renewed during Transition Period ("Transition WMS Renewals"): Some enrollees in the BHP transition period reside in the WMS legacy system because they were eligible for NY-MA prior to December 31, 2013 and have remained eligible. These individuals will need to be transitioned to NYSOH for enrollment in BHP in 2016. To ensure that their care is not disrupted, New York is requesting to transition these enrollees at their renewal in 2016. For example, if a lawfully present non-citizen enrolled in Medicaid in WMS renews coverage in July 2015, he/she will be given 12 months of coverage through June 2016. Eligibility determinations for populations in the legacy system follow Medicaid non-filer rules. The State will make adjustments to the financial methodology based on the results of the sampling described in Question 3. APTC MAGI rules will be followed once this population transitions to NYSOH in 2016. The state would like to extend the transition for these individuals a few months into 2016 and transition them to BHP in NYSOH at the end of their 12 month period in 2016. The state will explore options for accelerating the transition of these enrollees to NYSOH, but given that some of these enrollees are among the most vulnerable of the transition population as they are also in receipt of cash assistance, the state would prefer to phase in the transfer and ensure individuals have assistance in providing any additional information required for eligibility and enrollment in the BHP program.

Full implementation: January 1, 2016
Beginning January 1, 2016 BHP eligibility levels will increase to 200% of FPL. All new applicants with incomes below 200 percent of FPL, not eligible for Medicaid or CHIP, under age 65, and without MEC, will be determined eligible for BHP and permitted to select a BHP plan.

The APTC Premium Assistance program, part of the state's 1115 waiver, will end on December 31, 2015.

In April 2015, the State plans to issue an invitation to health plans to participate in the BHP for products available in 2016. The 2014 plan invitation for QHPs can be found at http://info.nystateofhealth.ny.gov/invitation. The 2015 plan invitation for QHPs will include the option of choosing to participate in the BHP. The BHP product will be modeled after the standard Silver product on the Marketplace. There will be two premium and cost-sharing tiers, below 150% of FPL and 150-200% of FPL.

- At or below 150%: $0 premium contribution and cost-sharing at Medicaid levels
- Greater than 150 to at or below 200% of FPL: $20 per month premium contribution and higher cost-sharing, but lower than the standard Silver QHP.

Those BHP enrollees in Medicaid managed care plans as part of the transition will be automatically enrolled in the BHP plan on the Marketplace if the plan they are in has chosen to participate in BHP. For those whose plans do not participate in BHP, the state will send the consumers a notice to return to the Marketplace and select a new plan.

Because of requirements under state law, once BHP plans for 2016 have been selected through a procurement in 2015, the transition population of lawfully present non-citizens up to 138% FPL will receive the same benefit package as the non-long term care benefits they had in Medicaid. This will be accomplished by using the QHP Essential Health Benefit (EHB) plan approved by CCIIO with additional wrap-around benefits for the income tier between 0-138% of FPL. As stated, those in need of long-term care services will remain in Medicaid and not transition to BHP. All other BHP enrollees will receive the QHP EHB benefit.

Under NY law, the transition population must be given retroactive eligibility even after full implementation. Therefore, the NY-MA will continue to provide fee-for-service coverage to BHP eligibles who are lawfully present non-citizens under 138% FPL in the three month retroactive period, if eligible in 2016 and thereafter and these individuals will not be coded as BHP during the retroactive eligibility period.

Section 5: Standard Health Plan Contracting

This portion of the Blueprint collects information about the service delivery system that will be used in the state as well as how the state plans to contract within that system.

Delivery Systems

1) Please fill out a separate row for each plan participating in the BHP:

   The plans below are the current Medicaid managed care plans that will transition membership into the BHP throughout 2016 as well as the plans participating in the BHP as of January 1, 2016. There is a Basic Health Plan in every county of the state.

   The state used the actuarial calculator to compute the actuarial values of the benefit packages. For the transition period, the AV is 99 percent. For full implementation of the BHP, the actuarial value is 99 percent below 150% of FPL and 93 percent for the group between 150-200% of FPL.

Standard HIOS Plan ID (14 digits + 2 digit variants)	Name of Issuer(s)	Delivery Mechanism (e.g., Licensed HMO, Health Insurance, Network of Health Care providers, Non-licensed HMOs participating in Medicaid/CHIP	Standard Plan Actuarial Value (please include for individuals < 150% FPL and for individuals > 150% FPL)
57165EP1000001	Affinity Health Plan	Prepaid Health Services Plan (PHSP)	<150 99% >150 93% All other plans are same as above
60001EP0000001	HealthPlus, Amerigroup	HMO	
73886EP0000001	Crystal Run Health Plan	HMO	
88582EP1000001	EmblemHealth Plan	HMO	
78124EP1000001	Excellus Health Plan	HMO	
25303EP1000001	Fidelis Care (New York State Catholic Plan, Inc)	PHSP	
91237EP0000001	Healthfirst PHSP, Inc	PHSP	
18029EP0000001	Independent Health	HMO	
11177EP0000001	MetroPlus	PHSP	

56184EP0000001	MVP Health Care	HMO	
54235EP0000001	United Healthcare	HMO	
78124EP1000001	Univera Healthcare	HMO	
39595EP0000001	Wellcare of New York	HMO	
68008EP0000001	YourCare Health Plan	HMO	
97488MC1000001	CDPHP	HMO	
65005MC1000001	Total Care, A Today's Options of New York Health Plan	HMO	

2) Please assure that standard health plans from at least two offerors are available to enrollees.

   New York is requesting an exemption from this requirement for the 2016 coverage year as there will be only plan offered in Putnam, Tompkins and Washington counties. New York is working to see if options can be expanded to these counties in 2016.

3) If applicable, please describe any additional activities the state will use to further ensure choice of standard health plans to BHP enrollees.

   For 2016 there will be choice of plans in 59 counties, all but 3 counties that represent 1% of the total expected BHP enrollment. The State is seeking an exemption from this requirement for BHP in 2016 consistent with the rural exemption in the Medicaid Managed Care program. DOH is actively working with health plans to secure expansion of plan service area to provide choice in these 3 counties. One issuer is continuing negotiations with the one hospital in the county to allow it to provide services as the second plan in the county.

   New York's contracting process for the Essential Plan is consistent with the process utilized for QHP contracting. The Marketplace released an Invitation for Plan Participation in the spring of 2015 outlining the criteria for participation in Essential Plan. The Department has reviewed its competitive contracting process and confirms that the process was open and flexible to encourage issuers to participate. The invitation was open to all licensed issuers in the state. Insurers had the option of which programs to participate in: Medicaid, Children's Health Insurance Program (Child Health Plus), Qualified Health Plans, and the Essential Plan. Health insurer program participation varies from one to all four programs with 10 insurers participating in all four programs. Essential Plan has greater participation than Medicaid Managed Care, with only three counties with one plan compared to six counties for the Medicaid program. Essential Plan was a new program requiring issuers to modify systems and products under a very short time frame. The Department will continue to work with issuers to expand their service areas with the goal of providing choice in each county.

   Each health plan insurer that participates on the Marketplace as a Medicaid, Child Health Plus, QHP and now Essential Plan has an approved service area where they offer coverage throughout the state. Furthermore, the insurers must have an adequate network in each county of its service area to offer coverage in each specific county. Access to an in-network

hospital is one of the most fundamental network adequacy criteria and is consistent the federal framework of the BHP as indicated in §600.415(b).

4) If the state is not able to assure choice of at least two standard health plan offerors as described in question 2, please attach the state's exception request. This exception request must include a justification as to why it cannot assure choice of standard health plan offeror and demonstrate that it has reviewed its competitive contracting process in accordance with 42 CFR 600.420(a)(i) – (iii).

Attached

5) Is the state participating in a regional compact? NO
If yes, please answer questions 6 – 10. If no, please skip questions 6 – 10.

6) Please indicate the other states participating in the regional compact.

7) Are there specific areas within the participating states that the standard health plans will operate? If yes, please describe.

8) If a state contracts for the provision of geographically specific standard health plans, please describe how it will assure that enrollees, regardless of location within the state, have choice of at least two standard health plan offerors. Please indicate plans by area.

9) Please assure that the regional compact's competitive contracting process complies with the requirements set forth in 42 CFR 600.410.

10) If applicable, please indicate any variations in benefits, premiums and cost sharing, and contracting requirements that may occur as a result of regional differences between the participating regional compact states.

Contracting Process

States must respond to all of the following assurances. If the state has requested an exception to the competitive process for 2015, the State is providing the following assurances with regard to how it will conduct contracting beginning in program year 2016.

New York is requesting an exception to the competitive contracting process for the 2015 BHP transition population, so that it may utilize the Medicaid Managed Care plans for this population. The State will engage in a state-regulated competitive contracting process for plans available January 1, 2016, which follows the contract approval process in NY Finance Law Section 112. The assurances agreed to below are for the 2016 coverage year.

The State assures that it has or will:		
Assurance (These are mandatory elements. Each box below must be checked to approve Blueprint)	Conducted the contracting process in a manner providing full and open competition including:	
X	45 CFR 92.36(b)	Following its own procurement standards in conformance with applicable federal law.
X	45 CFR 92.36 (c)	Conducting the procurement in a manner providing full and open competition.
X	45 CFR 92.36(d)	Using permitted methods of procurement.
X	45 CFR 92.36(e)	Contracting with small, minority and women owned firms to the greatest extent possible.
X	45 CFR 92.36(f)	Providing a cost or price analysis in connection with every procurement action.
X	45 CFR 92.36(g)	Making available the Technical specifications for review.
X	45 CFR 92.36(h)	Following policies for minimum bonding requirements.
X	45 CFR 92.36 (i)	Including all the required contract terms in all executed contracts.
	Included a negotiation of the following elements:	
X		Premiums and cost sharing.
X		Benefits.
X		Innovative features, such as: • Care coordination and care management
X		• Incentives for the use of preventive services
X		• Maximization of patient involvement in health care decision making

		• Other (Specify)
X		Meeting health care needs of enrollees.
	Included criteria in the competitive process to ensure:	
X		Local availability of and access to providers to ensure the appropriate number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area so that access to services is at least sufficient to meet the standards applicable under 42 CFR Part 438, Subpart D, or 45 CFR 156.230 and 156.235.
X		Use of managed care or a similar process to improve the quality accessibility, appropriate utilization and efficiency of services provided to enrollees.
X		Development and use of performance measures and standards.
X		Coordination between other Insurance Affordability Programs.
X		Measures to address fraud, waste and abuse and ensure consumer protections.
	Established protections against discrimination including:	
X		Safeguards against any enrollment discrimination based on pre-existing condition, other health status related factors, and comply with the nondiscrimination standards set forth at 42 CFR 600.165.
	Established a Medical Loss Ratio of at least 85% for any participating health insurance issuer.	
X		The minimum standard is reflected in contracts.

Standard Health Plan Contracting Requirements

States are required to include the standard set of contract requirements that will be incorporated into its Standard Health Plan contracts. Please reproduce in the text box below. Standard Health Plan contracts are required to include contract provisions addressing network adequacy, service provision and authorization, quality and performance, enrollment procedures, disenrollment procedures, noticing and appeals, and provisions protecting the privacy and security of personally identifiable information. However, we have given states a "safe harbor" option of re-using either approved Medicaid or Exchange contracting standards. If the state has adopted this safe harbor, it may fulfill this requirement by simply indicating that Medicaid or Exchange contracting standards will be used.

For 2016 and thereafter, DOH will leverage the NYSOH contracting standards. The NYSOH contract can be found here:

http://info.nystateofhealth.ny.gov/2014invitation (QHP and Dental Plan Model Agreement with NYSOH (the "QHP Agreement.")). The BHP Agreement follows the format of the QHP Agreement and includes the required provisions listed above and in 42 CFR 600.415(b), including network adequacy, service provision and authorization, and quality and performance. In addition, the BHP Agreement includes certain additional provisions to ensure adherence to the BHP regulations, including:. (1) Insurers must offer the standard BHP to all populations eligible for the program. The standard health plan will be based on the EHB benchmark plan chosen by the State. [BHP Agreement, Section VII(B)(1)]

(2) Insurers must accept the rate approved by the State and apply the applicable cost-sharing as outlined in Attachment B. [Section XX(A)]

(3) Insurers must utilize innovative features, such as features that incentivize preventive services, provide care coordination and care management for those with chronic health conditions, and features that maximize patient involvement with decision-making. Insurers will be permitted to substitute wellness benefits as permitted under the federal regulations in order to provide such incentives. [Section III(B)]

(4) Insurers must submit financial reports to the State in a manner and form that is consistent with the Medicaid Managed Care Operating Report and achieve an 85% Medical Loss Ratio beginning 1/1/16. [Section XIV(C)]

(5) Insurers will be obligated to adhere to the New York State Out-of-Network Bill, which includes the requirement that insurers permit consumers to obtain referrals to see out-of-network providers when there is no provider that is geographically accessible, or obtain a standing referral when the enrollee has a chronic condition. [Section IV(E)(2)]

(6) Insurers must adhere to the eligibility appeals set forth in the Agreement, and must adhere to the benefit appeals process that is available to the QHP population, and found in more detail in the enrollee's policy. A sample of the benefit appeals process that will be found in the BHP enrollee policy agreement is attached here as "BHP Blueprint Attachment D – Benefit Appeals Process." Please note, these sections will be modified to include consumers' right to appeal an out-of-network referral that is denied by insurer, which takes effect on April 1, 2015. [Section VII(B)]

(7) All BHP federal laws, rules, regulations and guidance, as well as any state laws and guidance, not specifically delineated. [Section II(C)]

(8) Given that many of the provisions in the QHP Agreement were adopted from the Medicaid Model Contract and apply to both Medicaid and QHP populations, most of the sections of the

QHP Agreement will also be included in the BHP agreement, and only modified to the extent not applicable (e.g., provisions that are unique to the Small Business Marketplace).

Coordination of Health Care Services

Please describe how the state will ensure coordination for the provision of health care services to promote enrollee continuity of care between BHP and Medicaid, CHIP, the Exchange and any other state administered health insurance programs. Describe below:

New York has significant overlap of health plans and providers across programs to promote continuity of care. Enrollees who transition to another program can obtain information about the plans in the new program that include their providers. Individuals may be able to receive care from their current provider if they are in the middle of a course of treatment or are more than three months pregnant. In addition, insurers that offer QHPs, as well as the BHP, will be required to permit consumers to finish their course of treatment when the consumer selects them as a new insurer.

Please provide copies of all notices that will be issued for BHP applicants and beneficiaries.

Notices will be modified to reflect BHP by September 2015. Attachment C includes notices in use today for Medicaid. The notices are generated from the test environment and include message codes that do not appear on the notices received by consumers. Attachment C includes an eligibility determination notice, enrollment notice and renewal notice.

Risk Adjustment

Is the state proposing a health risk adjustment protocol as part of the payment methodology? The State is not proposing a health risk adjustment protocol between the State and HHS for 2015. We are looking into proposing a risk adjustment protocol for 2016.
If so,

Has the state submitted the health risk adjustment protocol to CMS? No

Will the payments to plans be adjusted retrospectively based on the outcome of the health risk adjustment? No

If yes, how will they be adjusted?

Is this reflected in the contracts to plans? No

Section 6: Premiums and Cost-sharing

This section of the Blueprint collects information from the state documenting compliance with requirements for establishing premiums and cost-sharing. Additionally, it provides CMS general information about the states planned premium and cost sharing structures and administration.

Premiums

Premium Assurances	
The State assures that (check all that apply):	
X	The monthly premium imposed on any enrollee does not exceed the monthly premium the individual would have been required to pay had he/she been enrolled in the applicable benchmark plan as defined in the tax code.
X	When determining premiums, the State has taken into account reductions in the premium resulting from the premium tax credit that the enrollee would have been paid if he/she were in the Exchange.
X	It will make the amount of premiums for all standard health plans available to any member of the public either through posting on a website or upon request. Additionally, enrollees will be notified of premiums at the time of enrollment, reenrollment or when premiums change, along with ways to report changes in income that might affect premiums.

Please provide the web address or other source for public access to premiums.

Web Address: nystateofhealth.ny.gov once BHP is publicly available on the web site

Other Source: The BHP statute specifies the premiums (Section 369-gg of Social Service Law).

Please describe:

1) The group(s) of enrollees subject to premiums.

In 2016, all individuals between 150-200% of FPL will have a monthly premium of $20/month. Individuals between 138 – 200% of FPL will have premium for the dental and vision portion of their premium if they choose to purchase a plan with dental and vision included. A QHP with dental and vision services offered through the marketplace cost between $70 and $80 for an individual at 139% FPL who applies the maximum tax credit

available. The optional BHP plans with dental and vision cost at most $46.56 for enrollees between 150 and 200% FPL and $30.77 for those between 138 and 200% FPL

2) The collection method and procedure for the payment of premiums.

Premiums are collected by the health plans. The premium for the first month of coverage is required to be paid to effectuate coverage. For the first month's payment, individuals have until the 10th day into the month of coverage to make that payment. Subsequent monthly payments are sent by health plans prior to the month of coverage. Individuals have a 30 day grace period until the end of the month of coverage to pay the premium.

3) The consequences for an enrollee or applicant who does not pay a premium, including grace periods and re-enrollment procedures.

Premiums are due at the end of the month before the month of coverage. Consumers have a 30 day grace period to the end of the month of coverage before they are disenrolled retrospectively to the beginning of the month. Enrollees who are disenrolled may re-enroll the following month. The State does not have a lock out period for failure to pay premiums, though if an individual is disenrolled for failure to pay premiums and applies again, he/she will have a gap in coverage.

Cost-Sharing

Cost-Sharing Assurances	
The State assures that (check all that apply):	
X	Cost sharing imposed on enrollees meets the standards imposed by 45 CFR 156.420(c), 45 CFR 156.420(e), 45 CFR 156.420(a)(1) and 45 CFR 156.420(a)(2).
X	Cost sharing for Indians meets the standards of 45 CFR 156.420(b)(1) and (d).
X	The State has not imposed cost sharing for preventive health services or items as defined in accordance with 45 CFR 147.130.
X	The State has provided the amount and type of cost-sharing for each standard health plan that is applicable to every income level either on a public website or upon request to any member of the public, and specifically to applicants at the time of enrollment, reenrollment or when cost-sharing and coverage limitations change, along with ways to report changes in income that might affect cost-sharing amounts.

Please provide the web address or other source for public access to cost-sharing rules.

Web Address: http://info.nystateofhealth.ny.gov/invitation

Other Source: http://info.nystateofhealth.ny.gov/EssentialPlan

Please describe:

1) The group(s) subject to cost sharing.

In 2016, individuals below 100% of FPL have no cost sharing.. Individuals above 100 through 150% of FPL will have very limited cost sharing for prescription drugs, consistent with the cost sharing for the population above 100% FPL enrolled in Medicaid. Individual above 150 through 200% FPL will have cost sharing below the similar Silver CSR level for QHPs. Specific cost sharing amounts can be found on the Invitation Page of the NYSoH website: http://info.nystateofhealth.ny.gov/invitation. The state will not revise the cost-sharing amounts listed on the website without submitting a revised Blueprint.

2) The system in place to monitor compliance with cost-sharing protections described above.

The cost-sharing protections are included in the contracts with the Managed Care Organization and the Exchange Insurer Participants. In 2016, every insurer will adhere to the standard BHP exhibit which will clearly outline the services that have no cost-sharing and those that do have cost-sharing. Every insurer will submit templates demonstrating their adherence to these cost-sharing protections and separate HIOS IDs (or separate HIOS ID variations) for the two categories of individuals and their respective cost-sharing obligations. The Managed Care Organizations and Exchange Insurer Participants will be monitored through consumer complaints and regular audits to ensure adherence to the cost-sharing protections.

Disenrollment Procedures for Non-Payment of Premiums

Has the state elected to offer the enrollment periods equal to the Exchange defined at 45 CFR 155.410 and 410?

No

If yes, the state assures that it will comply with the premium grace periods standards at 45 CFR 156.270 prior to disenrollment and that it will not restrict reenrollment beyond the next open enrollment period.

If no, the state assures that it is providing a minimum grace period of 30 days for the payment of any required premium prior to disenrollment and that it will comply with reenrollment standards set forth in 457.570(c). Yes

If the state is offering continuous enrollment and is imposing a premium lock-out period, the lock-out period in number of days is: There is no lock-out period. However, if an enrollee fails to pay the premium by the end of the 30 day grace period and is disenrolled and applies again, he/she will have a minimum of a one month gap in coverage, as coverage is prospective. For example, an individual fails to pay their premium for March coverage by March 30. The person is disenrolled from the plan at the end of March. If he/she returns to apply on April 10, the new coverage will begin May 1, creating a one month gap in coverage.

Section 7: Operational Assessment

The State assures that it can or will be able to:		
Full Assurance	Contingent Assurance	**Eligibility and Renewals**
X		Accept an application online, via paper and via phone and provide in alternative formats in accordance with 42 CFR §600.310(b).
	X	Return an accurate and timely eligibility result for all BHP eligible applicants.
X		Process a reported change and redetermine eligibility.
X		Comply with the ex-parte renewal process.
X		Issue an eligibility notice and share such notice with CMS.
X		Issue a renewal notice and share such notice with CMS.
	X	Ability to terminate/disenroll from BHP for a variety of reasons, such as reaching age 65, obtaining MEC
X		Issue termination/disenrollment notice to enrollees
		Benefits and Cost-Sharing.
X		Exempt American Indians from Cost-sharing.
X		Apply appropriate cost-sharing amounts to enrollees subject to cost-sharing limits.
		Premium Payment and Plan Enrollment.
	N/A	Issue an accurate and timely premium invoice.
	N/A	Receipt and apply the premium payment correctly.
	X	Notify enrollee of health plan choices and complete plan enrollment.
	X	Issue a health plan disenrollment notice.
		Coordinate enrollment with other Insurance Affordability Programs.
	N/A	Transfer accounts and provide notification in accordance with 42 CFR 600.330(c) through (e).

Contingency Descriptions

Please describe the contingency or dependency that limit full assurance.

New York has an integrated eligibility system for all Insurance Affordability Programs. The full assurance provided above reflects the functionality of the NYSOH eligibility system today. The eligibility rules for NYSOH need to be modified to return an eligibility determination for BHP for 2016 coverage. The system today returns an accurate and timely eligibility determination for Medicaid, CHIP, APTC-PP, APTC/CSR, APTC and full pay QHPs. The eligibility rules will be changed in 2015, prior to 2015 open enrollment, such that some individuals who currently receive an eligibility determination for Medicaid, APTC-PP, or APTC/CSR will receive an

eligibility determination for BHP. The online application screens also need to be modified for BHP. New York anticipates achieving full assurance by 2015 open enrollment for 2016 coverage.

The eligibility rules for NYSOH need to be modified to terminate/disenroll from BHP due to aging out (reaching age 65) or obtaining MEC. This will also be completed by 2015 open enrollment.

New York does not collect premium payments on behalf of the plans. Health plans send out invoices and collect premiums. As an integrated system, the state does not transfer accounts.

Please describe any mitigation steps that will be in place and the date by which a full assurance will be possible.

New York's transition plan represents its mitigation strategy. Full assurance will be achieved by September 2015 in time for administrative renewal for 2015 enrollees and by open enrollment for new enrollees for the 2016 coverage year.

Section 8: Standard Health Plan

The final section of the BHP Blueprint is an attachment that allows a state to define the standard health plan(s) that will be offered under the BHP. The standard health plan is the set of benefits, including limitations on those benefits for which a state will contract. States are required by statute to offer the Essential Health Benefits (EHB) that are equally required in the Marketplace. States are also required to define those benefits using any of the base-benchmark or reference plans set forth at 45 CFR 156.100 (which could be a different base-benchmark or reference plan than is used for Marketplace or for Medicaid purposes).

The Blueprint will not be a complete submission without the attachment defining the standard health plan offered under BHP.

The BHP Essential Health Benefits are provided in Attachment A and are based on the NY base benchmark Oxford EPO. The cost-sharing is provided in Attachment B.
New York has opted to offer an additional optional product to BHP enrollees that will allow enrollees to access dental and vision services for an additional premium. QHPs with the highest enrollment in the marketplace include these services and many BHP enrollees would lose access to these services by transitioning to the BHP if they are not offered. The enrollee is responsible for the full vision and dental premium in addition to any other premium owed.

- The state has compared the benefits available under this approved plan and the benefits available under a base benchmark plan as described in 45 CFR 156.100. The State assures that all services in the base benchmark have been accounted for throughout the benefit chart submitted as Section 8 of its Blueprint below.

- The comparison demonstrated that the benefits in the Basic Health Plan are as robust, if not more robust with regards to amount, duration, and scope, in each of the ten Essential Health Benefit categories as those provided by the base benchmark plan.

Section 9: Secretarial Certification

Interim Certification:

Secretary/Secretary's Designee

Vikki Wachino, Director
Center for Medicaid and CHIP Services

Date of Interim Certification (mm/dd/yyyy)

Implementation Date (mm/dd/yyyy)

Full Certification:

Secretary/Secretary's Designee

Vikki Wachino, Director
Center for Medicaid and CHIP Services

Date of Full Certification (mm/dd/yyyy)

Implementation Date (mm/dd/yyyy)

Revised Certification:

Secretary/Secretary's Designee

[redacted]

Vikki Wachino, Director
Center for Medicaid and CHIP Services

Date of Revised Certification (mm/dd/yyyy)
DEC 3 0 2015

Implementation Date (mm/dd/yyyy)
JAN 0 1 2016

New York Essential Health Benefits

SERVICE	LIMIT
Outpatient Services	
PCP Office Visits (Injury or Illness)	No Limit
Specialist Visits	No Limit
Other Practitioner Office Visit (Nurse, Physician Assistant)	No Limit
Outpatient Surgery Physician/Surgical Services	No Limit
Hospice Services	210 days/year; also includes 5 Bereavement Counseling sessions for members family either before or after the death of the member.
Home Health Care Services	40 visits/year
Emergency Services	
Emergency Room Services	No Limit
Urgent Care Centers or Facilities	No Limit
Emergency Transportation/Ambulance	No Limit
Hospitalization	
Preadmission Testing	No Limit
Inpatient Hospitalization	No Limit
Inpatient Physician and Surgical Services	No Limit
Skilled Nursing Facility	200 days/year
Delivery and all Inpatient Services for Maternity Care	No Limit
Mental Health and Substance Use Disorder Services	
Mental/Behavioral Health Outpatient Services	No Limit
Mental/Behavioral Health Inpatient Services (including residential treatment)	No Limit
Substance Use Disorder Outpatient Services	No Limit
Substance Use Disorder Inpatient Services (including residential treatment)	No Limit
Prescription Drugs	
Enteral Formulas	No Limit
Generic Drugs	30 day supply per month *Mail Order up to a 90 day supply optional benefit
Preferred Brand Drugs	30 day supply per month *Mail Order up to a 90 day supply optional benefit
Non-Preferred Brand Drugs	30 day supply per month *Mail Order up to a 90 day supply optional benefit
Specialty Drugs	30 day supply per month *Mail Order up to a 90 day supply optional benefit
Off Label Cancer Drugs	30 day supply per month

SERVICE	LIMIT
Rehabilitative and Habilitative Services and Devices	
Outpatient Rehabilitation Services	60 visits per condition per lifetime
Habilitation Services	60 visits per condition per lifetime
Chiropractic Care	No Limit
Durable Medical Equipment	**Coverage for standard equipment only. DME defined as Equipment which is 1) Designed and intended for repeated use, 2) primarily and customarily used to serve a medical purpose, 3) Generally not useful to person in the absense of disease or injury, and 4) is appropriate for use in the home.
Inpatient Rehabilitation Services	1 consecutive 60 day period per condition per lifetime in a rehabilitation facility.
	* Inpatient Short Term Rehabilitative Services (Physical, speech and occupational therapy).
Hearing Aids	Limited to a single purchase (including repair/replacement) every three years.
	*Bone anchored hearing aids are excluded except when either of the following applies:
	For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
	For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
	Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.
Prosthetic Devices - External	1 external prosthetic device per limb per lifetime
	*Coverage for external repairs or replacement in adults.
	**Additional coverage for external device replacement for children for devices that have been outgrown
	Coverage includes wigs for members suffering from severe hairloss due to injury or disease or treatment of a disease (e.g. chemotherapy); coverage is available only for synthetic wig materials unless member is allergic to all synthetic wig materials
Internal Prosthetic Devices	Covered if improves or restores function of internal body part; includes implanted breast protheses; includes repair and replacement.
Laboratory and Imaging Services	
Diagnostic Test (X-Ray and Lab Work)	No Limit
Imaging (CT/PET Scans, MRI'l)	No Limit

SERVICE	LIMIT
Preventive and Wellness Services and Chronic Disease Management	
Preventive Care/Screening/Immunization	Mammography (limits based on age), cervical cytology, gynecological exams, bone density, prostate cancer screening, etc. per NYS mandates and ACA.
Gym Membership Reimbursement	$200/$100 every 6 months for member/spouse
	* Partial reimbursement for facility fees every 6 months if member attains at least 50 visits. ** May be substituted for other wellness benefits
Prenatal and Postnatal Care	No Limit
Pediatric Vision	
Vision examinations performed by a physician, or optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription.	The vision examination may include, but is not limited to:
	* Case history
	* Internal and External examination of the eye
	* Ophthalmoscopic exam
	* Determination of refractive status
	* Binocular balance
	* Tonometry tests for glaucoma
	* Gross visual fields and color vision testing
	* Summary findings and recommendations for corrective lenses
Prescription Lenses	At a minimum, quality standard prescription lenses provided by a physician, optometrist or optician are to be covered once in any twelve month period, unless required more frequently with appropriate documentation. The lenses may be glass or plastic lenses.
Frames	At a minimum, standard frames adequate to hold lenses will be covered once in any twelve month period, unless required more frequently with appropriate documentation.
Contact Lenses	Covered when medically necessary.
Pediatric Dental	
Emergency Dental Care	Includes emergency treatment required to alleviate pain and suffering caused by dental disease and trauma.
Checkup for Children (Preventive Dental Care)	Includes procedures which help prevent oral disease from occurring, including but not limited to:
	* Prophylaxis: scaling and polishing teeth at 6 month intervals
	* Topical fluoride application at 6 month intervals where local water supply is not fluorinated
	* Sealants on unrestored permanent molar teeth
	* Space Maintenance: unilateral or bilateral space maintainers will be covered for placement in a restored deciduous and/or mixed detention to maintatin space for normally developing permanent teeth.

SERVICE	LIMIT
Basic Dental Care - Child (Routine Dental Care)	* Dental examinations, visits and consultations covered once within 6 month consecutive period (when primary teeth erupt)
	* X-ray, full mouth x-rays or panoramic x-ray at 36 month intervals, bitewing x-rays at 6-12 month intervals; and other x-rays as required (once primary teeth erupt)
	* All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization including preoperative care and postoperative care
	* In office conscious sedation
	* Amalgam, composite restorations and stainless steel crowns
	* Other restorative materials appropriate for children
Major Dental Care - Child (Endodontics and Prosthodontics and Periodontics)	Includes all necessary procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.
	Removable: Complete or partial dentures including six months follow-up care. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.
	Fixed: Fixed bridges are not covered unless
	1) Required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
	2) Required for cleft-palate treatment or stabilization; or
	3) Required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.
Orthodontia (Orthodontics)	NOTE: Refer to the Medicaid Management Information System (MMIS) Dental Provider Manual for a more detailed description of services.
	Includes procedures which help to restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.
	Orthodontia coverage is not covered if the child does not meet the criteria described above.
	Procedures include but are not limited to:
	* Rapid Palatal Expansion (RPE)
	* Placement of component parts (e.g. brackets, bands)
	* Interceptive orthodontic treatment
	* Comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted)
	* Removable appliance therapy
	* Orthodontic retention (removal of appliances, construction and placement of retainers)

SERVICE	LIMIT
Other Services	
Infertility Treatment	Member must be between ages of 21 and 44.
	* Covered services include: initial evaluation, evaluation of ovulatory function, postcoital test, hysterosalpingogram, treatment of ovulatory dysfunction, ovulation induction and monitoring with ultrasound, artificial insemination, hysteroscopy, laparoscopy and laparotomy, semen analysis, laboratory evaluation, endometrial biopsy, pelvic ultrasound, sono-hystogram, testis biopsy, blood test
	** Advanced Infertility is not covered.
Elective Termination of Pregnancy	1 treatment/year
	* Therapeutic termination of pregnancy unlimited
Family Planning Service for Women	No Limit
Sterilization Procedures for Men	No Limit
Chemotherapy	No Limit
Dialysis	No Limit
Breast reconstructive surgery following mastectomy, lumpectomy, or lymph node dissection	No Limit
Mastectomy Care	Length of stay for lymph node dissection, lumpectomy or mastectomy as determined by the patient and physician.
Diabetic equipment, supplies, education and self-management	No Limit
Autism spectrum disorder screening, diagnosis and treatment	680 hours per plan year for ABA treatment and coverage for Assistive Communication Devices
Reconstructive and corrective surgery	Surgery to correct a congenital birth defect of dependent child or incidental to surgery or follows surgery necessitated by trauma, infection or disease.
Second Opinion (surgical)	Second surgical opinion on the need for surgery.
Second Opinion (Specialist - cancer)	Second opinion by appropriate specialist, including one affiliated with a specialty care center for cancer.
Medical Supplies	As required for the treatment of a disease or injury, including maintenance supplies
Bariatric Surgery	No Limit

SERVICE	LIMIT
Other Services	
Transplants	No Limit
	* Solely for transplants for surgeries determined to be non-experimental and non-investigational.
Oral Surgery	No Limit
	* Oral Surgery due to injury is limited to sound natural teeth only; oral surgery due to congenital anomaly; removal of tumors and cysts requiring pathological examination of jaws/cheeks/lips; for the correction of a non-dental physiological condition which has resulted in a severe functional impairement and surgical/nonsurgical medical procedures for temporomandibular joint discorders and orthognathic surgery