



STATE OF NEW YORK DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

August 15, 2002

Dear WMS Coordinator:

The purpose of this letter is to clarify some Family Health Plus instructions as described in the WMS Coordinator Letter of August 21, 2001. It also addresses some procedures to assist you in transitioning individuals between Temporary Assistance and Family Health Plus Cases.

For questions regarding the attached items, please contact the following individuals at 518-473-7439.

Attachment I Dennis DiMuria

Attachment II Robert Decker

Sincerely,

DDM

Dennis DiMuria, Manager
Upstate Eligibility Systems
Office of Medicaid Management

WD

Wendy Dmitri
Division of Temporary Assistance/WMS

cc: Commissioner
TA Director
MA Director

Attachment I

Family Health Plus (FHP) instructions were initially published in the WMS Coordinator Letter of August 21, 2001. The following provides clarification of some of the instructions published in that letter.

In Attachment #1, Section A, it states that “Whenever a Prepaid Capitation Plan (PCP) record is opened for a FHP individual with 06 (Provisional) Coverage the MA Coverage Code will be set to 34 (FHP) and the MA Coverage “FROM” Date will be set equal to the Enrollment Date on PCP”. To be more precise, this process only generates the proper date of the first day of the following month if enrollment is entered prior to PCP pulldown. If enrollment is after pulldown, the system will change the Coverage Code to 34 and the MA dates will be set to the subsequent month. Therefore, if enrollment for the following month is desired after pulldown, the MA Coverage Code must be manually changed to 34 and the MA “FROM” Date entered equal to the first day of the following month. For example, if PCP enrollment is entered on 6/24 (after pulldown), the MA “FROM” Date generated by this enrollment will be 8/1. However, if coverage is to be effective on 7/1, you must manually enter the “FROM” Date of 7/1 and the MA Coverage Code of 34 on Screen 5. In addition, it is also stated that the MA Coverage “TO” Date will be set equal to the last day of the month, plus 11 months. The “TO” Date is not extended; it remains unchanged.

Also, in Attachment #1, Section A, bullet 4, it states that “...if the Closing Reason Code is U10 (Failure to Comply with Recertification Procedures), the MA Coverage Code is 34, and the MA Coverage “TO” Date is less than 12 months from the MA Coverage “FROM” Date, the system will generate the MA Coverage “TO” Date equal to the last day of the “FROM” Date Month, plus 11 months”. This gives the impression that the individual is entitled to 11 months of FHP Guaranteed Coverage and that the system extends the Dates. Both of these assumptions are incorrect.

Attachment II

Since the implementation of Family Health Plus, the following procedures have been developed to assist in the transition of individuals from one program to another.

The following information describes the process required to transition an individual(s) from TA to FHP and FHP to TA.

TA to FHP

1. The TA worker processes the TA case closing using the appropriate closing code (excess income and/or resources).
2. A separate determination/Medicaid extension case is generated (Case Type 20) based on the ABEL budget with opening code of 700, effective for one month.
3. If the TA case has Managed Care coverage, the MA Coverage Code of 30/32 from the TA case will be brought over to the MA case (Case Type 20). If the TA Case has 01 (Full Coverage), the MA Coverage Code of 01 will be reflected on the MA Case.
4. The LDSS will designate the responsible unit to process the new MA case (Case Type 20) to the FHP case (Case Type 24), if eligible.

FHP to TA (34 to 30/32 or 01 MA Coverage)

1. FHP client applies for TA.
2. TA worker registers TA application. The CLEARANCE REPORT, which is generated from the TA registration, will verify if the client is active FHP. If client is active FHP, the PCP sub-system (screen 25) should be checked to verify what plan the client is enrolled in. If the client is eligible for TA, DISCUSS next steps with the unit responsible for the PCP sub-system (PCP responsible unit is designated by LDSS). PCP needs to be adjusted by the designated unit prior to TA opening, or errors will occur.
3. Client determined eligible for TA. Open the TA case and input the correct MA Coverage Code (30, 32, 01). MANUALLY ADJUST THE MA COVERAGE DATES (should not allow the system to generate back to the beginning of the TA authorization period). The MA "FROM" date should be the first of the month after the FHP disenrollment. Remember to check pulldown dates; FHP and MA coverage should not overlap.
4. When the TA case is opened, the FHP case will be force closed effective the end of the transaction month of the TA opening. VERIFY THAT THERE IS NO GAP IN COVERAGE.
5. The following day, the PCP responsible unit must enter a new enrollment line on the PCP sub-system to reflect the Medicaid Managed Care benefit package code if Medicaid Managed Care is available. Again, MANAGED CARE PULLDOWN DATES MUST BE CONSIDERED.
6. The Managed Care unit at LDSS must contact the plan if changes are made to the roster after the first pulldown but before the 1st of the following month. Each LDSS should have a mechanism to inform the Managed Care unit of these changes.