TO: All Local District Commissioners, Medicaid Directors

FROM: Kathryn Kuhmerker, Deputy Commissioner, Office of Medicaid Management
SUBJECT: Family Health Plus Program

EFFECTIVE DATE: Immediately
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The purpose of this GIS is to provide further clarification on the processing of Family Health Plus (FHPlus) cases. As described in Administrative Directive 01-OMM/ADM-6 issued on November 2, 2001, all adults who apply for health care coverage and appear to be ineligible for Medicaid for reasons of excess income and/or resources are to be evaluated for their potential eligibility for FHPlus. Because FHPlus is a managed care product (without access to fee-for-service), applicants must select a health plan as a condition of eligibility, even in districts where only one plan is available. An application without a health plan selected is considered an incomplete application and should not be opened as a FHPlus case. The application should be pended on WMS while the applicant is provided a period of time to choose a plan, pursuant to local district procedures, e.g., ten days.

The SDOH has discovered instances where FHPlus cases were opened but no subsequent plan enrollment has taken place. In most cases, the applicant failed to select a health plan; other cases were opened as FHPlus with provisional coverage, but no new enrollment record had been recorded in the Prepaid Capitation Plan (PCP) subsystem, even though the applicant had selected a plan.

Local districts were instructed in a WMS/CNS Coordinator letter dated August 21, 2001 to use Coverage Code 06 (Provisional Coverage) when opening a FHPlus case (Case Type 24). Provisional Coverage allows the PCP record to be opened for a FHPlus individual and automatically changes the Coverage Code to 34 and the coverage From Date to equal the Enrollment Date on the PCP record. Opening a case with Provisional Coverage is not appropriate if an individual has not selected a health plan.

In addition, use of Coverage Code 06 is not appropriate for transitioning individuals. As instructed in 01 OMM/ADM-6, districts extend the individual's current Medicaid coverage to allow a reasonable amount of time for the individual to make the plan choice (if necessary) and for the LDSS to process the FHPlus case. Once a plan has been selected, the LDSS must time the opening of the new case type (with Coverage Code 34) to avoid gaps in coverage from Medicaid to FHPlus. A new PCP record reflecting the FHPlus enrollment and benefit package (70) must be entered. If the individual fails to make a timely choice, the case must be closed and a notice sent indicating that the individual failed to pick a plan.

As eligibility and enrollment are integral parts of providing health care coverage for FHPlus eligibles, the SDOH will continue to monitor this situation and will work with districts to resolve any problems.