TO: All Local District Commissioners, Medicaid Directors

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

EFFECTIVE DATE: Immediately
CONTACT PERSON: For Eligibility and Reimbursement Questions:
Local District Liaison: Upstate (518)474-8216
NYC (212)268-6855
For Enrollment Questions:
Managed Care Representative: (518)486-9015

The purpose of this GIS is to clarify existing policy as it relates to the Family Health Plus program (FHPlus), concerning reimbursement for medical expenses paid by an applicant when agency error or delay causes the applicant to pay medical expenses before their FHPlus plan enrollment becomes effective.

Background

Generally, reimbursement for medical expenses paid by a Medicaid applicant prior to the issuance of a Medicaid card is limited to the Medicaid rate in effect at the time the service was rendered. However, 18 NYCRR 360-7.5(a)(1) and the Greenstein court decision provide that reimbursement in excess of the Medicaid rate may be provided to a recipient when an error or delay on the part of the agency causes the recipient to pay for services that should have been paid by the Medicaid program. Because the FHPlus statute **(**SSL §369-ee(5)(c)**)** provides that, except where inconsistent, the provisions of Title 11 (Medicaid) apply to applicants/recipients of FHPlus, this regulation and the Greenstein decision apply to cases of agency error or delay relating to FHPlus case processing.

Agency Error

In situations where the agency made an error in their initial determination, the recipient is eligible to be reimbursed for reasonable out-of-pocket expenses paid after the date of the agency's error. In determining the date on which an error occurred, the agency should use the date on the decision notice. Therefore, reimbursement for reasonable out-of-pocket expenses would be provided from the date of the decision notice until the first day the person's FHPlus enrollment is effective.

Agency Delay

Department regulation 360-2.4(a) requires the social services district to determine eligibility within 45 days of the date of the application for adults and within 30 days of the date of the application when it includes pregnant women or children under the age of 19. The date of application is the date a signed completed application is received by the district. For applications submitted by facilitated enrollment entities, the date of application is the date the application was signed by the applicant, which generally should correspond to the application completion date found on the DOH-4220. When the district cannot make a determination within the required number of days because the applicant has delayed taking, or has not taken a

required action as described in 18 NYCRR §360-2.4(b)(1), the district has a reasonable period of time from receipt of all required documentation to make an eligibility determination. However, such determination should be completed as close to the 30-45 day timeframe as possible.

After eligibility for FHPlus has been determined, the agency must process the plan enrollment by the 45th day following the eligibility decision, if timely, or by the 45th day following the day the decision should have been made, if not timely. When enrollment does not occur within these timeframes, the applicant is entitled to be reimbursed for reasonable out-of-pocket expenses paid from day 45 until the date enrollment is actually effective.

NOTE: In Administrative Directive 01 OMM/ADM-6, Eligibility Requirements of the Family Health Plus Program, districts were instructed that, if there is a delay in receipt of a completed application from a facilitated enrollment entity which causes the 30/45 day timeframe for determination to be exceeded, districts should document this circumstance in the case record. This would hold the district harmless in the event of an audit or other administrative review. However, regardless of whether the delay is the result of a district's or an enrollment facilitator's inaction, the applicant must be offered reimbursement under the guidelines of this GIS. Districts should bring to the Department's attention any facilitated enrollment entities that consistently exceed recommended guidelines for submission of applications.

Reimbursement

The recipient should be reimbursed directly and in full for reasonable out-of-pocket expenses, provided that the services he/she received are those that would have been covered under FHPlus. Reasonable charges are those usual and customary amounts charged for such services. There is no requirement that the provider be participating in a FHPlus plan or be an enrolled Medicaid provider.

Local districts have the option of issuing reimbursement to eligible individuals themselves, or having the New York State Department of Health process the reimbursements. Requests for reimbursement must be handled in accordance with the procedures set forth in the New York State Fiscal Reference Manual for Local Departments of Social Services, Volume I, Chapter 7, pages 15–18, dated February 10, 2002, and Volume II, Chapter 5, pages 10-15, dated May 10, 1999. Districts requesting the Department to issue reimbursements should indicate "Family Health Plus" in the "Court Case Name" field on the DSS 3664, Claim Transmittal Form.