



STATE OF NEW YORK DEPARTMENT OF HEALTH

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Albany, New York 12237

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TRANSMITTAL: 08 OHIP/ADM-1

TO: Commissioners of
Social Services

DIVISION: Office of Health
Insurance Programs

DATE: January 25, 2008

SUBJECT: Family Health Plus Premium Assistance Program

**SUGGESTED
DISTRIBUTION:**

Medicaid Staff
Fair Hearing Staff
Legal Staff
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ATTACHMENTS:

- A. Applicant Fact Sheet
- B. Employer Fact Sheet
- C. Third Party Health Insurance Form
- D. Plan Qualifications and Cost Effectiveness Worksheet
- E. Manual Notice of Decision
- F. Dear Member Letter

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref. 369-ee	Manual Ref.	Misc. Ref.
05 OMM/ADM-4					GIS 07MA021
03 OMM/ADM-2					GIS 06MA026
02 OMM/ADM-5					GIS 05MA009
01 OMM/ADM-6					GIS 03MA025
05 INF-16					GIS 03MA020
93 ADM-29					GIS 03MA019
02 INF-02					GIS 02MA013
87 ADM-40					GIS 02MA017
					GIS 02MA018
					GIS 02MA019
					GIS 02MA025
					GIS 02MA033
					GIS 01MA014

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I. Purpose

This Administrative Directive (OMM/ADM) provides direction to local departments of social services (LDSS) regarding the implementation of the Family Health Plus Premium Assistance Program (FHP-PAP).

II. Background

Chapter 58 of the Laws of 2007 amended Section 369-ee of the Social Services Law by adding a new subdivision 3-a which specifies that individuals meeting the eligibility requirements for Family Health Plus (FHPlus) cannot enroll in or must disenroll from a FHPlus insurance plan if a determination is made that the individual has access to cost-effective employer sponsored health insurance. Such individuals eligible for FHPlus with access to cost-effective employer sponsored health insurance must enroll in the employer sponsored health insurance in order to receive or continue to receive health care services under the FHPlus Program. In addition, individuals who do enroll in cost effective employer-sponsored health insurance shall have available health care services including: payment or part payment of the premium, co-insurance, any deductible amounts, and the cost sharing obligations for the individual's employer-sponsored health insurance that exceed the amount of the person's FHPlus co-payment obligations. The individual will also receive services and supplies otherwise covered by the FHPlus program, but only to the extent that such services and supplies are not covered by the person's employer sponsored health insurance.

Persons eligible for the Family Health Plus Premium Assistance Program include individuals eligible for FHPlus who have access to qualified employer sponsored health insurance that has been deemed to be cost effective. This includes uninsured parents, aged 19-64, of a child under the age of 21 with gross family income up to 150% of the federal poverty level and countable resources that do not exceed 150% of the annual Medically Needy income standard based on family size. It also includes uninsured childless adults aged 19-64 with gross household income up to 100% of the federal poverty level and countable resources that do not exceed 150% of the annual medically needy income standard based on family size.

Individuals who are eligible for employer-sponsored health coverage through Federal, State, county, municipal or school district health benefit plans are not allowed to enroll in Family Health Plus. Therefore, these individuals are not eligible to participate in the Family Health Plus Premium Assistance Program.

III. Program Implications

Eligibility determinations for this program will be completed as part of the initial application and renewal processes.

At the time of initial Medicaid application or renewal, individuals will be asked if they have access to employer sponsored health insurance (ESHI). If they answer affirmatively, the requirement to enroll in qualified, cost effective employer sponsored health insurance will be explained to the individual. The individual will be asked to provide information about the available employer sponsored health

insurance coverage. Pending a final determination regarding the ESHI, individuals otherwise eligible for Family Health Plus will be enrolled, or continue to be enrolled in a FHPlus plan. Upon obtaining information about the ESHI coverage available to the individual, the (LDSS) will make a determination as to whether the coverage is deemed both qualified and cost effective. If the ESHI coverage is not deemed both qualified and cost effective, the individual will be allowed to remain in the FHPlus plan. If the coverage is deemed qualified and cost-effective, the individual will be enrolled in the ESHI and disenrolled from the FHPlus plan at the earliest opportunity; that is, at the time the individual both meets the employer's requirements for participation in the plan and is permitted to enroll. FHP PAP enrollment delays may occur if the ESHI has an annual open enrollment period or wait time for coverage. If the available employer plan(s) changes before the employee can enroll, the LDSS may need to determine whether the plan remains qualified and cost effective. However, the individual will not be forced to disenroll from his/her FHPlus plan until he/she can enroll in the ESHI Program; for example: during an ESHI open enrollment period or after a required "waiting period".

If the individual leaves employment, is laid off, or retires; or if the employer drops coverage or changes the coverage so that it no longer meets the criteria for being both qualified and cost-effective, and the individual is found to still meet the FHPlus income and resource eligibility criteria, the individual may enroll in a FHPlus plan for coverage.

For those individuals who enroll or who are enrolled in ESHI, the FHPlus Premium Assistance program will pay the portion of the premium not paid by the employer. Payments will be made by the LDSS as arranged between the district and the payee using current premium payment methods.

The FHPlus Premium Assistance program will also pay claims for ESHI deductibles, coinsurance and co-payments following the current Medicaid rules for deductibles and co-payments, when such claims are submitted to Medicaid by Medicaid enrolled providers.

The LDSS will reimburse FHPlus Premium Assistance program enrollees for ESHI deductibles, coinsurance and co-pays paid by the enrollee to non-Medicaid enrolled providers upon the submission of proper documentation to the LDSS. Deductibles and coinsurance paid by the enrollee to non-Medicaid enrolled providers will be reimbursed in full. Co-pays paid by the enrollee to non-Medicaid enrolled providers will be reimbursed to the extent that the co-pays exceed the amount of the enrollee's co-payment obligations under Family Health Plus.

FHPlus wrap-around benefits will also be provided on a fee-for-service basis to individuals enrolled in ESHI to the extent that such benefits are provided by a FHPlus plan, but are not covered by the individual's employer sponsored health insurance coverage.

Enrollees in the FHPlus Premium Assistance program are required to use Medicaid enrolled providers for FHPlus wrap-around services. Medicaid providers will be reimbursed for provision of FHPlus benefits that are not covered by the ESHI up to the Medicaid rate of payment minus the enrollee's applicable FHPlus co-payment. Payment will be made through eMedNY using current claims and remittance processes.

IV. Required Action

A. Definitions

Access to ESHI: For purposes of determining eligibility for FHPlus Premium Assistance Program, access to ESHI means that the ability for the applicant/recipient to enroll is reasonable and uncomplicated.

Cost-Effectiveness: To be deemed cost-effective, the employee's share of the premium cost plus the cost of other employee cost-sharing in the employer-sponsored health insurance, as well as any wrap-around benefits must be less than the cost of traditional Family Health Plus coverage.

Qualified (ESHI) Employer-Sponsored Health Insurance Coverage: To be considered a qualified employer-sponsored health insurance plan, the coverage must include, at a minimum: inpatient and outpatient hospital services, physician services, maternity care, preventive health services, diagnostic and x-ray services and emergency services. The plan does not have to include prescription drug benefits.

Wrap-Around Services: Services covered by Family Health Plus which are not provided by the ESHI. Enrollees in the Family Health Plus Premium Assistance Program must use Medicaid-enrolled providers for such wrap-around services. Pharmacy benefits will be considered a wrap around benefit when the ESI plan does not include a prescription drug coverage.

B. New Applications

Eligibility

If an applicant appears to be financially eligible for FHPlus, and indicates that they have access to employer sponsored health insurance the District must:

1. Explain to the applicant the requirement to enroll in ESHI and provide them with a copy of Attachment A, Applicant Fact Sheet; "Family Health Plus and Family Health Plus Premium Assistance Program (FHP-PAP)";
2. Collect from the applicant, documentation about the ESHI sufficient to determine if the coverage is both qualified and cost-effective. This information may be collected by requesting the individual have his/her employer complete the Third Party Health Insurance Form, Attachment C;
3. Determine if the applicant has access (as described above) to ESHI and the earliest date enrollment in the ESHI can occur.
4. Determine if the ESHI is qualified. This is done by reviewing the plan coverage to determine if it covers: inpatient and outpatient hospital services, physician services, maternity care, preventive health services, diagnostic and x-ray services and emergency services. Complete the Plan Qualification and Cost-Effectiveness Worksheet, Attachment D; and

5. Districts must determine if the ESHI is cost-effective by completing the Plan Qualification and Cost-Effectiveness Worksheet, Attachment D.

Determination

1. If the ESHI plan is not qualified **OR** is not cost-effective or both, and the applicant is not currently enrolled in an ESHI plan:

- Determine eligibility for Family Health Plus without regard to Employer-Sponsored Health Insurance, following existing procedures.

2. If the ESHI plan is not qualified and/or cost effective and the applicant is currently enrolled in an ESHI plan, the applicant is not eligible for FHP premium assistance or for enrollment in a FHP managed care plan.

3. If the ESHI plan is **BOTH** qualified and cost-effective, the applicant is **currently** enrolled in an ESHI plan and the individual is otherwise eligible for Family Health Plus, districts must:

- Authorize the case for twelve months as a Case Type 24 with Coverage Code 20 (community coverage without long term care) for adults and Coverage Code 01 (full coverage) for Medicaid expanded eligible children;
- Pay the ESHI premium each month, as determined by agreement between LDSS and the payee, beginning the month of application;
- Issue OHIP-0011 Attachment E, "Notice of Decision For Family Health Plus-Premium Assistance Program;" for the adults and an expanded eligibility notice for the children;
- Enter the EPI code of A on screen 4 in WMS; and
- Follow current procedures to enter the third party health insurance information into the eMedNY Third-Party Sub-system for each recipient covered under the ESHI.

NOTE: In situations where the district is currently paying the premium for ESHI family coverage for children who are eligible under the expanded eligibility provisions, the procedures in 2 above must be followed to enroll the parent(s) in the FHP PAP.

4. If the ESHI is **BOTH** qualified and cost-effective but the applicant is **NOT** currently enrolled in the ESHI, the district must:

- Authorize the case for one year as a case type 24 and enroll the individual in the FHP MC plan chosen on the application;
- Advise the applicant to fill out the appropriate ESHI enrollment forms with the employer, to enroll in the employer plan as soon as eligible, and to provide proof of enrollment to the district;

- Enter Anticipated Future Action code of 913 "Open enrollment month for App" and anticipated effective date of ESHI enrollment in WMS to track enrollment date and take necessary action to follow-up with Applicant/Recipient (A/R) to ensure enrollment in ESHI occurs;
- Enter an HII indicator of "7";

The applicant/recipient must select a FHP managed care plan on the application in case the client loses ESHI in the future.

C. Renewals

Continued Eligibility

The Upstate Renewal form was modified as of the October 2007 migration. Section 9 includes the following new question and message:

"If you are not insured by your employer now, does your employer offer health insurance?" Yes/No.

"If yes, give employer name and phone number."

"We may be able to pay the cost of your health insurance premiums if it is cost effective."

When a recipient selects "Yes" (his/her employer does offer health insurance), districts must do the following:

1. Mail to the recipient a copy of the Applicant Fact Sheet, "Family Health Plus and Family Health Plus Premium Assistance Program (FHP-PAP)" Attachment A, to explain the Premium Assistance Program and include a copy of the Third Party Health Insurance Form, Attachment C.

And/or:

Mail to the employer a copy of the Family Health Plus Premium Assistance Program Employer Fact Sheet Attachment B, and include a copy of the Third Party Health Insurance Form, Attachment C.

2. Once the TPFI form is received, Districts must determine if the ESHI is qualified. This is done by reviewing the plan coverage to determine if it covers: inpatient and outpatient hospital services, physician services, maternity care, preventive health services, diagnostic and x-ray services and emergency services. Use Attachment D, Plan Qualification and Cost Effectiveness Worksheet.
3. Districts must determine if the ESHI is cost-effective by completing the Plan Qualification and Cost Effectiveness Worksheet, Attachment D.

Determination

1. ESHI is not qualified **OR** is not cost-effective or both:

Determine continued eligibility for Family Health Plus without regard to Employer-Sponsored Health Insurance following existing procedures.

2. ESHI is **BOTH** qualified and cost-effective and the applicant is **currently** enrolled in ESHI.

If the individual remains eligible for Family Health Plus, districts must:

- Re-authorize the case for one year as a case Type 24 with Coverage Code 20 for adults, and Coverage Code 01 for Medicaid expanded eligible children;
- Pay the ESHI premium each month, as determined by agreement between LDSS and the payee, effective the month of recertification;
- Enter EPI code of A on screen 4 in WMS;
- Follow existing procedures to enter the third-party health insurance information into the eMedNY Third Party Sub-system for each recipient covered by the ESHI;
- Issue OHIP-0011 Attachment E, "Notice of Decision For Family Health Plus-Premium Assistance Program" for adults and a "continue unchanged" notice for children.

NOTE: In situations where the district is currently paying the premium for ESHI family coverage for children who are eligible under expanded eligibility provisions, the procedures in 2 above must be followed to enroll the parent(s) in the ESHI.

3. ESHI is **BOTH** qualified and cost-effective but the applicant is **NOT** currently enrolled in ESHI, the district must:

- Reauthorize the case for one year as a case type 24 with coverage code 34;
- Advise the applicant to fill out the appropriate ESHI enrollment forms with the employer, to enroll in the employer plan as soon as eligible, and to provide proof of enrollment to the district;
- Enter Anticipated Future Action code of 913 "Open enrollment month for App" and anticipated effective date of ESHI enrollment in WMS to track enrollment date and take necessary action to follow-up with Applicant/Recipient (A/R) to ensure enrollment in ESHI occurs;
- Enter an HII indicator of "7";

When the A/R notifies the district of enrollment in ESHI:

- Enter the new MA coverage FROM date of FHP PAP enrollment
- Change the coverage code to Coverage Code 20 for adults and Coverage Code 01 for Medicaid expanded eligible children;

- Enter the EPI code of A on screen 4 in WMS. This will result in a system-generated disenrollment from the FHP managed care plan with an effective date as of the MA coverage FROM date, which will be the first day of the month after T+14;
- Follow current procedures to enter the Third-Party health insurance information into the eMedNY Third-Party Sub-system for each recipient covered under the ESHI.
- Pay the ESHI premium each month, as determined by agreement between LDSS and the payee;
- Issue OHIP-0011 Attachment E, "Notice of Decision For Family Health Plus-Premium Assistance Program;" for the adults and an expanded eligibility notice for the children;

4. If the TPHI form is not returned:

- If FHPlus eligible, reauthorize the case for one year as a case type 24 with coverage code 34; continuing enrollment in a FHPlus managed care plan;
- Enter Anticipated Future Action code of 913 "Open enrollment month for PAP" and anticipated date of ESHI enrollment in WMS to track open enrollment period and take necessary action to follow-up with Applicant/Recipient for future eligibility and enrollment in ESHI. Open enrollment periods generally occur in November for January and April for June.
- Enter an HII (health insurance indicator) of "7" on screen 1 in WMS;
Using the AFA codes and HII indicator as a tickler system, the district should mail to the recipient a copy of the Applicant Fact Sheet, "Family Health Plus and Family Health Plus Premium Assistance Program (FHP-PAP)" Attachment A, to explain the Premium Assistance Program and include a copy of the Third Party Health Insurance Form, Attachment C, prior to the applicable open enrollment period of November or June.

And/or:

Mail to the employer a copy of the FHP PAP Employer Fact Sheet Attachment B, and include a copy of the Third Party Health Insurance Form, Attachment C, prior to the applicable open enrollment period of November or June.

D. Transitions

In instances where a transition is made from a Family Health Plus managed care plan to the Family Health Plus Premium Assistance Program **OR** from the Family Health Plus Premium Assistance Program to a Family Health Plus managed care plan, the district must ensure that no gaps in coverage occur.

Therefore, if a FHPlus recipient enrolls in an ESHI and an overlap of coverage occurs, the district must reimburse the A/R for the premium directly and instruct the A/R to use the FHP coverage during the transition month. Disenrollment from FHPlus managed care must be processed as timely as possible to avoid a gap in coverage.

In situations where a client loses ESHI, the LDSS worker must end date the third-party health insurance information from the eMedNY Third-Party sub-system and continue coverage with Coverage Code 20 until the FHP managed care plan enrollment is processed.

Medicaid units need to inform managed care units of transitions to ensure timely enrollments/disenrollments and appropriate notice to health plans if necessary.

E. Payment

1. Employee Premium

Upstate Local Departments of Social Services must reimburse the amount of the employee premium for ESHI through the Benefit Issue Control System (BICS) system. Reimbursement may be made to the employer, insurance carrier, or to the employee if the premium is deducted from the employee's pay check.

Districts wishing to provide reimbursement outside the BICS system must request in writing an exception to this requirement. The request, along with a written proposal of the alternative methods the district wishes to employ, must be sent to:

New York State Department of Health
Third Party Liability Unit
99 Washington Avenue
Albany, New York 12210

2. Co-pays, Deductibles and Coinsurance

Family Health Plus Premium Assistance Program enrollees should be encouraged to use ESHI providers that are also enrolled in the Medicaid/FHPlus programs. This will allow deductibles, coinsurance and co-payments (that exceed those normally paid by FHPlus enrollees) to be paid through the eMedNY system, following Medicaid rules for payment of deductibles, coinsurance and co-pays.

For information on how Medicaid enrolled providers may submit claims for deductibles, coinsurance and co-pays, please refer to page 21 of the January 2007 Medicaid Update. Under the heading: Medicaid Recipients with Medicare Managed Care (HMO/MCO) Coverage.

In instances where a non Medicaid/FHPlus provider is used, reimbursement of co-pays, deductibles, and coinsurance will be made to the enrollee upon submission of documentation that demonstrates that the deductible and coinsurance and/or the co-pay was paid. No payment for incurred, but not paid, deductibles or co-payments will be made to the recipient. Documentation may include cancelled checks and/or billing statements from providers. Such reimbursement to the recipient must be made through the BICS system. (See number #1 above) Deductibles and coinsurance payments may be made directly to the provider by the LDSS if the district has a vendor ID for the provider and proof that the ESHI plan applied the service fee to the deductible.

3. FHPlus Co-Pay Schedule

As of September 1, 2005, individuals enrolled in Family Health Plus are required to pay part of the cost of some medical care/services through the following co-payments:

- Brand Name prescription drugs, \$6 for each prescription and refill
- Generic prescription drugs, \$3 for each prescription and refill
- Clinic visits, \$5 per visit
- Physician visits, \$5 per visit
- Dental service visits, \$5 per visit up to a total of \$25 per year
- Lab tests, \$0.50 per test
- Radiology services (e.g., diagnostic x-rays, ultrasound, nuclear medicine, oncology services) \$1 per x-ray
- Inpatient hospital stay, \$25 per stay
- Non-urgent emergency room visit, \$3 per visit
- Covered over the counter drugs (e.g., smoking cessation products, insulin) \$0.50 per drug
- Covered medical supplies (e.g., diabetic supplies such as syringes, lancets, test strips, enteral formula), \$1 per supply

Pregnant women or individuals under age 21 do not have to pay the co-payment. In addition, enrollees do not have to pay co-payments for family planning services, including birth control, or if they are a permanent resident of a nursing home, a resident of an Intermediate Care Facility for the Developmentally Disabled, or an Office of Mental Health or Office of Mental Retardation and Developmental Disabilities Certified Community Residence.

V. Communication with Employers

Local Departments of Social Services through the Third Party Resources Unit, or other Unit of the Department may communicate with employers. Local districts may:

- Advise employers of the Family Health Plus Premium Payment Program. The LDSS may mail to employers in their district Attachment B Employer Fact Sheet; "Family Health Plus Premium Assistance Program (FHP-PAP) What employers need to know about FHP-PAP"
- As necessary, obtain information from employers to examine the scope of services and make determinations of cost effectiveness.

- As appropriate, make payment to employers through BICS for ESHI premiums.

VI. Systems Implications

Upstate

Effective with the February 2008 migration:

A. WMS

Individuals Pending Enrollment

Individuals that are waiting for the open enrollment period to enroll in their employer-sponsored health insurance can be identified by entering a Health Insurance Indicator (HII) of "7 - FHP PAP Pending Open Enrollment" on screen 1 and entering a new Anticipated Future Action code of "913 - Open Enrollment Month for PAP", along with the month and year of when the open enrollment begins. If a recertification is made prior to the open enrollment period, **WMS error 1220 - EMPLOYER HEALTH INSURANCE** will appear, alerting the worker that there is a pending open enrollment. This error is overrideable.

Enroll Individuals

If the enrollment is pending as described above, the HII of 7 and the AFA of 913 should be removed.

EPI Code

Individuals can be identified as being in PAP by entering an "A" Client has FHP Premium Assistance Plan" in the EPI field on Screen 4. This allows for tracking the number of enrollees in the FHP PAP.

Categorical Codes

Adult Categorical Codes 56 and 57 on Case Type 24 and 15, 42, 48, 58 and 59 for Case Type 20 can be utilized. Expanded Categorical Codes for children 44, 45, 46 and 47 on Case Type 20 or 24 can be utilized.

Pregnant women with Case Type 20, Coverage Code 15 or 01 can be utilized.

Coverage Codes

Individuals in FHP PAP receiving their employer's insurance are also entitled to a wrap benefit that will pay for services not covered under the employer's plan. In order to provide the wrap benefit, once an adult is enrolled in FHP PAP, Coverage code "34" should be change to "20" and children should have Coverage Code "01" if they don't already.

The MA coverage From date will be the first day of the month after the transaction date plus 14 days (T + 14) to change coverage and cannot be prior to 1/1/08.

BICS Pay Types

Five new BICS pay types have been created to identify payments for PAP:

U1 - FHP PAP Premium - Premium payments can be made using this code. Issuance can be recurring, once only or prorated. Payment schedule can be monthly, quarterly, semi-monthly or weekly. Method of payment can be unrestricted or vendor as authorized. No special claiming code should be used.

U2 - FHP PAP Deductible - Deductible payments can be made using this code.

U3 - FHP Co-Pay Differential - The difference between a FHP/MA co-pay and the plan's co-pay can be made using this code.

U4 - FHP PAP Other - Other would be used to make payments under special circumstances for FHP medical services that were not provided by the plan nor by a Medicaid provider.

U5 - FHP PAP Coinsurance -Reimbursements for coinsurance can be made using this code.

U2, U3, U4 and U5 issuance will be once only. Payment schedule should be blank. Method of payment can be unrestricted or vendor as authorized. No special claiming code should be used.

Change to 3209 Printing

The TPHI will print on the last column in screen 4 that has the heading "UNIQ POP". The heading will be changed to "TPHI" at a future date. The EPI field may be added to the 3209 in the future.

B. PCP

If an adult or child is identified by being in PAP with the entry of an EPI code of "A" and has an existing PCP enrollment, a system-generated disenrollment will occur with an effective date as of the MA Coverage "From" date, which as described above will be the first day of the month after T+14.

PCP Exclusion

Updates to the eMedNY Third-Party subsystem are transmitted to WMS daily. As the individual's insurance will be entered in Third Party an update will be sent to WMS and a "Y" will be populated in the TPHI field. Individuals with a TPHI code = Y will be excluded from managed care auto-enrollment.

C. CNS

CNS notices to support the Family Health Premium Assistance Program will be developed in the future.

D. EEDSS

The EEDSS question set will be modified to collect information about employer sponsored health insurance.

E. eMedNY

Third Party Subsystem

The employer's insurance is third party insurance, and must be entered like other commercial insurance in the Third-Party Subsystem in eMedNY.

New York City

New York City systems instructions will follow separately.

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VII. Schedule E

Premium, deductible, coinsurance and co-payments made on behalf of recipients under the Family health Plus Premium Assistance Program must be included in Line 18 of Schedule E.

VIII. Effective Date

The provisions of this Directive are effective January 1, 2008.

Deborah Bachrach, Deputy Commissioner
Office of Health Insurance Programs