Attachment

FAMILY HEALTH PLUS PREMIUM ASSISTANCE PROGRAM (FHP- PAP)

Frequently Asked Questions

I. POLICY:

1. Q: Are government employees eligible for FHP- PAP?
A: Individuals who are eligible for employer-sponsored health insurance (ESI) 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.

2. Q: Please define what it means to have "access" to employer sponsored health insurance.
A: An applicant with access to ESI is an individual whose employer offers health insurance benefits to its employees, and the individual is eligible for those benefits. For example, an employer may only offer benefits to employees who work full time. In addition, the ability of the applicant to enroll in those benefits must be reasonable and uncomplicated. For example, if the employer is not cooperative in providing necessary plan information to the applicant or to the district, then the district would be unable to determine if "access" exists.

3. Q: If an FHPlus eligible applicant has access to ESI and it is deemed qualified and cost effective, but the applicant fails to enroll, are there any consequences?
A: At this time there is no penalty for a FHPlus eligible applicant who has access, but does not enroll in ESI. The goals of the program are to provide participants with a choice of coverage and provider options. It may make health coverage more convenient and improve access to care by keeping family members together, under one plan, rather than having a parent(s) enrolled in ESI or be uninsured, and children enrolled in Medicaid or CHPlus. Premium Assistance also gives the State potential to save money by capturing employer contributions towards premiums. By helping low wage workers to pay for ESI, it may help employers reduce turnover and attract more qualified employees.

4. Q: Is NYS going to advertise or inform the public of this new program?
A: All FHPlus enrollees were sent a letter in December 2007, explaining the program. A Family Health Plus Premium Assistance Program brochure has been created for the districts to share with new applicants. It is Attachment A of OHIP 08 ADM-1. In addition, the Employer Fact Sheet (Attachment B) may be shared with employers.

5. Q: If a FHPlus member switches to their employer sponsored health insurance, what happens to the six month guarantee?
A: There is no loss of eligibility, so there is no need for the six month guarantee.

6. Q: If the parents have FHP-PAP, the Medicaid child has coverage code 01, and the parents lose their ESI, would the child get continuous coverage?
A: There would be no effect on a child if parents lose their ESI, as long as the child doesn't lose financial eligibility. If the case loses eligibility, the child would be entitled to any remaining months of continuous coverage.

7. Q: A recipient is interested in FHP-PAP because she/he has a new job and will be paying for insurance. The recipient was Medicaid eligible, but with the income from the new job is FHPlus eligible. Do they have to fill out an application to request the new program?
A: No new application is necessary.

8. Q: Will the Access NY application be changed?
A: A message will be added to the instructions and to Section E of the Access NY application to say, "We may be able to pay the cost of your health insurance premiums".

9. Q: Can the Access NY application be changed to tell members not to drop their commercial insurance when they apply for Family Health Plus?
A: The Applicant Brochure, Attachment A of OHIP 08 ADM-01, used in conjunction with the application, advises applicants not to drop their commercial insurance. The employer Fact Sheet, Attachment B, may be shared with employers who then can educate their employees as to where they can get premium assistance.

10. Q: If a self-employed person has purchased insurance though the Chamber of Commerce, is this considered Employer Sponsored Health Insurance?
A: It is not considered employer sponsored health insurance if the person insured is a sole proprietor. If the policy covers the proprietor and other employees, then it is considered employer based.

11. Q: If a person buys insurance through Healthy NY is this considered ESI?
A: If the Healthy NY policy is coverage purchased by a small employer, it is ESI. The policies available through Healthy NY for sole proprietors and individuals are not considered ESI.

12. Q: Can COBRA premiums be paid for under the FHP-PAP?
A: No. COBRA is not considered ESI because the employer is not contributing toward the cost of the premium.

13. Q: Who enrolls the individual in ESI, the individual or the LDSS?
A: The individual enrolls. The individual will have to supply the employer insurance information to the LDSS, the LDSS may mail the Request For Information Form to the employer. If the employer fails to return the form, the applicant cannot be penalized.

14. Q: If the employer provides the health insurance information can we enroll the A/R in the ESI on his or her behalf?
A: No.

15. Q: Should we end the FHPlus enrollment if we know the individual will be offered open enrollment through their employer insurance?
A: The FHPlus enrollment end date should be coordinated with the start date of ESI.

16. Q: How will the LDSS know the dates of a company's open enrollment period?
A: Ask the applicant and/or employer to complete the Employer Sponsored Health Insurance Form (Attachment C of OHIP 08 ADM-1).

17. Q: Would there be an overlap of coverage if an individual is enrolled in FHPlus and eligible to be enrolled in ESI?
A: The worker would coordinate closing the FHPlus with the enrollment in ESI. The MA Coverage From Date must be the first day of the month after T+14. If an overlap is unavoidable, pay the ESI premium and advise the recipient to use the FHPlus coverage during the overlap period.

18. Q: If an individual is FHP-PAP eligible, but the open enrollment period will not occur for several months into the future, how should the case be processed?
A: Determine eligibility for Family Health Plus without regard to Employer-Sponsored Health Insurance, following existing procedures. If otherwise FHPlus eligible, enroll in a FHPlus managed care plan. Advise the applicant to fill out the appropriate ESI 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 a health insurance Indicator (HII) of "7", "FHP-PAP Pending Open Enrollment", which will alert worker at renewal that follow-up is needed. Enter the Anticipated Future Action code of 913, "Open enrollment month for App", and the anticipated effective date of ESI enrollment in WMS to track enrollment date, and take necessary action to follow-up with recipient to ensure enrollment in ESI occurs.

19. Q: What should the district do when the individual is FHPlus eligible and has access to ESI, but it is not deemed qualified or cost effective
A: As long as the FHPlus eligible applicant is not enrolled in the ESI, the applicant is eligible for enrollment in a FHPlus managed care plan. At renewal, a re-determination of cost effectiveness of the ESI may be done as premium costs often change on an annual basis.

20. Q: If a parent and child(ren) apply and are covered by the absent parent's employer insurance, can the parent be FHP-PAP eligible?
A: Yes, as long as the parent can provide enough information about the policy to determine if it is deemed qualified. It will likely be cost effective, because she/he pays none of the premium.

21. Q: Can boyfriend, girlfriend and common child all be on the same case if one person is FHP-PAP?
A: Yes.

22. Q: Can a child in the household be Mehlered out to determine eligibility for the remaining family members?
A: Yes. In the cost effective calculation do not include that child in the household count.

23. Q: If the district discovers third party health insurance has been posted in eMedNY by HMS, (the State's third party contractor), should the recipient be disenrolled from FHPlus while a FHP-PAP determination is made?
A: Mail the "Employer Sponsored Health Insurance: Request for Information" form (Attachment C of 08 OHIP ADM -1) to the recipient, giving the recipient 10 days to complete. If the form is returned, complete the cost effectiveness calculation. If it is cost effective to pay the health insurance premiums, disenroll the recipient from FHPlus and pay the ESI premiums prospectively. If not cost effective, send a closing notice to the recipient citing equivalent health insurance. If the form is not returned, disenroll the recipient from FHPlus citing equivalent health insurance.

24. Q: If a recipient is enrolled in a FHPlus managed care plan and it is discovered she/he is also enrolled in that same plan through her/his employer, what are the steps for switching the case to FHP-PAP?
A: Individuals may be retroactively disenrolled from their MMC or FHPlus plan when they are simultaneously in receipt of comprehensive health care from the same MCO. As soon as you find out someone on FHPlus has duplicate insurance, do the cost effective/benchmark plan determination. If qualified and cost effective, move the individual(s) into FHP-PAP and retroactively disenroll the recipient from managed care, collecting any premiums using our current criteria, and pay the ESI premiums prospectively. If it is not qualified and cost effective, then retroactively disenroll the recipient per current procedure.

25. Q: How long may the recipient continue to receive benefits under coverage code 20 after they no longer are enrolled in the ESI?
A: Send OHIP 0011, Notice of Decision for Family Health Plus – Premium Assistance Program to Discontinue. It gives the recipient 10 days to respond and choose a health plan or be closed. If the plan choice is returned, benefits under coverage code 20 may be provided until the enrollment in the FHPlus plan begins. We encourage FHP-PAP recipients to choose a health plan at the time of application in case this scenario occurs.

26. Q: When a recipient loses their ESI, and there is no managed care plan choice in the case record, or the plan choice is old or obsolete, can the recipient be auto-assigned into a FHPlus plan?
A: Auto-assignment into FHPlus will be available in undercare situations when system support is established. System support is anticipated to be available by February 2009. Additional information will be forthcoming. However, at this time, if the district has only one Family Health Plus plan available, the individual can be auto enrolled into that plan.

27. Q: A household consists of FHPlus eligible parents and children over age 6. The parents have access to an ESI policy that would cover the entire family. If the cost of the health insurance premium is given as an income deduction in the budget, the children are expanded eligible. If it is not in budget (and will be paid through the FHP Premium Assistance Program), the children are ineligible. What would be the best budget for the family in this situation?
A: The family should decide based on the medical needs of family members. If the premium is allowed as an income deduction (the parents continue to pay the premium), the children would be expanded eligible, receive commercial insurance coverage and get Medicaid fee-for-service. The parents would utilize the commercial insurance.

If the premium is paid by FHP-PAP, the children would utilize the commercial insurance, and the parents would be enrolled in FHP-PAP, which includes the services covered by the commercial insurance and wrap around benefits.

II. Employer Sponsored Health Insurance Form: Request for Information (Attachment C of OHIP ADM-1):

28. Q: If a recipient does not provide third party health insurance information from the employer, can we contact the employer for the information?
A: Yes, send the employer an ESI form. The applicant cannot be penalized if the employer does not return the form.

29. Q: Is it a condition of eligibility for the applicant to return the Employer Sponsored Health Insurance forms?
A: If the applicant indicates on the application that she/he is in receipt of employer sponsored health insurance, and the applicant is otherwise FHPlus eligible, the applicant or the employer must complete the ESI form. If the applicant is ***not*** enrolled in ESI and does not return the form, the applicant is not penalized at this time.

30. Q: When the LDSS knows an employer offers health insurance and the applicant indicates otherwise, is it okay for the LDSS to investigate this further?
A: Give the applicant the third party health insurance form to bring to their employer or mail the form to the employer.

III. COST EFFECTIVENESS:

31. Q: Is the cost effective calculation used for FHP-PAP the same as the calculation used for Medicaid cases?
A: The calculations are different. The cost effectiveness tool for FHP-PAP should only be used for FHP-PAP cases. Counties should continue to use the Medicaid cost effectiveness method for Medicaid cases.

32. Q: When a family is no longer FHPlus eligible but becomes Medicaid eligible, should a different cost effective determination be done to see if the ESI premiums should continue to be paid and if no longer considered cost effective, then terminate the payment and switch to Medicaid or Medicaid Managed Care?
A: The current methodology for determining cost effectiveness should be used on Medicaid cases, not the FHP-PAP method. If a Medicaid recipient/family has ESI and it is cost effective under Medicaid rules, the premium should be paid and the ESI should be entered in eMedNY. If the recipient/family is not eligible for managed care, they would get fee-for-service Medicaid per current rules.

33. Q: If a FHPlus eligible married couple applies and only one spouse is offered insurance, would that person be FHP-PAP and the other spouse remain in FHPlus?
A: Yes, if only single coverage is offered, one spouse can be eligible for FHP-PAP and the other for FHPlus.

34. Q: If someone is enrolled in ESI, but is not required to pay or contribute towards the premium, can they be eligible for FHP-PAP?

A: Yes, although they have no premium payment, they can benefit from the co-payments and deductibles being reimbursed to them. The plan must also be deemed qualified.

35. Q: In Section (a) of the FHP-PAP Cost Effective Calculator, question #2: "Does the employer policy include the Optional/Non-Benchmark required services listed in Column A, lines 2a through 2e?" If the answer is "No", there are instructions on how to proceed; however, there are no instructions for the "YES" option. Does one skip to Section B? What is the next logical step?
A: If "no" the regional cost of the service is added to the cost of the ESI and compared to the FHPlus managed care rate. If the answer is "Yes", the plan does cover the optional benefits, do not enter a cost. Skip to section B.

36. Q: When the family includes FHPlus eligible parents and non-Medicaid children over the age of 6, should the children be included in the FHP-PAP cost effectiveness calculation?
A: No, the children would not be included in the case count, but you would use the family premium to see if it is cost effective to pay the family premium. If not cost effective to pay the family premium, then do a cost effectiveness for just the parents, if the premium is different for the parents.

37. Q: If non-Medicaid eligible children are on the family policy, will Medicaid pay the deductibles, coinsurance and co-pays for the children?
A: The parents would pay the children's deductibles and co-pays. They would not be reimbursed for costs associated with non-Medicaid eligible children.

38. Q: What should the district do if it is determined cost effective to pay the family plan insurance and the children are on CHPlus?
A: If the children are enrolled in the ESI policy, the district should notify the CHPlus plan of the child's insurance.

39. Q: If there are CHPlus children in the household, should they be considered when doing the cost effective calculation?
A: Only costs for expanded Medicaid eligible children and FHPlus adults should be included in the FHP-PAP cost effective determination. If it is cost effective to pay for a family policy, CHPlus eligible children can be added to the ESI policy.

40. Q: If a household contains FHPlus eligible parents and CHPlus eligible children, should the children enroll in the ESI?
A: If the policy is a family policy (not just a "couples" policy) and it is cost effective, the district should encourage the parents to enroll the children in that policy. The district should notify the CHPlus plan of this enrollment.

41. Q: Will the parents be reimbursed for coinsurance, deductibles or co-payments made on behalf of the CHPlus children?
A: The parents will not be reimbursed for those costs.

42. Q: Can the parents refuse to enroll the children in ESI in order to avoid paying coinsurance, deductibles and co-payments?
A: We cannot force non-applying children to be added to the policy. If the children are enrolled in the ESI, the CHPlus plan should be notified. The districts may call the

CHPlus managed care plan or send proof of insurance coverage, such as a copy of the insurance card.

43. Q: If a recipient uses an Article 28 dental clinic for dental wrap around benefits do we use that in the calculations?
A: If an individual used an Article 28 dental clinic, we would cover it. The cost effective calculator will not use the Article 28 dental clinic rate. We cannot assume everyone will use a dental clinic.

IV. PAYMENTS:

44. Q: Which services are subject to FHPlus co-pays?
A: Per 05 OMM/ADM-4, effective September 1, 2005, Family Health Plus enrollees will be responsible for 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, ultra- sound, nuclear medicine, and oncology services)	$1 per radiology service
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 medication
Covered medical supplies (e.g., diabetic supplies such as syringes, lancets, test strips, enteral formula)	$1 per supply

Co-payments will **not** be applied to the following services:

- Emergency services
- Family planning services and supplies
- Mental health clinics
- Chemical dependence clinics
- Psychotropic drugs
- Tuberculosis drugs
- Prescription drugs for a resident of an Adult Care Facility licensed by the State Department of Health

Similar to the policy for Medicaid, the following people are exempt from making co-pays: pregnant women; individuals under age 21; permanent residents of nursing homes; and residents of community-based residential facilities licensed by the Office of Mental Health or Office of Mental Retardation and Developmental Disabilities. If a Family Health Plus enrollee cannot afford the co-payment at the time of the service, the provider cannot refuse to provide the care or service.

Other than the $25 annual cap for co-payments on dental services, Family Health Plus has no other cap on co-payments. Family Health Plus plans will be responsible for the implementation of applicable co-payments and tracking the annual dental cap.

The FHPlus recipient should be reimbursed the difference between the co-pay paid and the FHPlus co-payment schedule amounts. If there is a co-pay for a service for which there is no corresponding FHPlus co-pay, we would reimburse the whole amount.

Vision Benefits
Currently, the Family Health Plus vision benefit is similar to the Medicaid vision benefit. The Family Health Plus vision benefit will cover the following once every 2 years: 1) one eye exam; 2) either one pair of prescription eyeglass lenses and a frame, or prescription contact lenses where medically necessary; and 3) one pair of medically necessary occupational eyeglasses. Lost eyeglasses are no longer a covered benefit.

45. Q: What is the difference between coinsurance and co-payment?

A: Having a health plan that includes a coinsurance, or percentage participation rate, means that the member and insurance carrier each pay a specified percentage of the healthcare cost.

For instance, if the health plan has an 80/20 coinsurance rate, the insurance plan pays for 80% of the eligible medical expense and the member is responsible for the remaining 20%. A co-payment, on the other hand, is a fixed dollar amount ($5.00 for example) that the member is required to pay regardless of the cost of the service received.

To compensate for the possibility that a catastrophic medical loss could cause a member severe financial distress, many major health insurance carriers include what is known as a “coinsurance cap”, or stop-loss limit in their plans. The provision sets limits on the member’s potential out-of-pocket costs per year. Such caps generally range from $2,000 to $3,000, depending on the plan, but limits can be as low as $1,000.

46. Q: Who will the district pay the premium payments to?
A: Premium payments can be made to the applicant, the employer or the carrier as arranged with the payee. Per 08 OHIP/ADM-1, Upstate district are instructed to make payments via the Benefit Issue Control System (BICS).

47. Q: Who is responsible to pay the co-pays, coinsurance and deductibles?
A: The recipient pays the co-payments, coinsurance and deductibles and brings the receipt into LDSS for reimbursement.

48. Q: Can an individual with FHP-PAP refuse to pay a co-pay, for example at the pharmacy, and still receive their prescription?
A: If the recipient is using the New York State Benefit Identification card (because drugs are not included in the ESI) to obtain prescriptions, the recipient may refuse to pay the co-pay per current Medicaid rules. If the individual is using the ESI commercial insurance card, she/he may not refuse to pay the co-pay. The district will reimburse the recipient for the co-pay paid minus the FHPlus co-pay amount.

49. Q: Is there a hardship provision if the member says they cannot pay the co-pays and deductibles up front for services?
A: There is no hardship provision in the FHP-PAP legislation.

50. Q: When the commercial policy has a co-payment that is greater than the FHPlus co-payment, how much should the district reimburse the member?
A: The member pays the ESI co-payment to the provider. The district reimburses the member the ESI co-pay amount minus any applicable FHPlus co-pay amount.

51. Q: If a member requests cash to pay a co-pay prior to seeing a provider should the district authorize payment prior to the appointment?
A: No, only paid receipts may be submitted to the district for reimbursement.

52. Q: Will this program reimburse coinsurance, deductibles, and/or co-pays for benefits which are not provided by FHPlus even though they are provided by the ESI?
A: No. We will not pay or reimburse for a service not otherwise covered by Family Health Plus.

53. Q: If a member goes out of network for a service that is provided under the employer's plan (it is also a service covered under FHPlus), and the member pays cash for it, can the district deny reimbursement because the member went out of network?
A: The member may be reimbursed, but must present an Explanation of Benefits (EOB) from the plan showing the amount the plan paid towards the claim. The reimbursement would equal the amount which would not be paid by the plan minus the FHPlus co-payment.

54. Q: If a member goes for a non-FHPlus benefit, such as chiropractor, is the member entitled to reimbursement for a co-payment paid?
A: No. We will not pay or reimburse for a service not otherwise covered by Family Health Plus.

55. Q: Is reimbursement required to a recipient who does not use their own ESI provider, or a Medicaid provider? Or will it be a patient "out of pocket" expense? Is Payment Type code U4 used in this instance? At what rate is the claim reimbursed?
A: There may be times when a service is not covered under the employer's policy and the recipient used a non-Medicaid provider for a benefit that would otherwise be covered by FHPlus. The recipient would have to provide the LDSS with an Explanation of Benefits (EOB) showing the claim was denied by the employer plan. In these instances the recipient can be reimbursed for payment made, minus the FHPlus co-payment amount for the service. U4 is the BICS pay type to be used.

56. Q: Can the district tell the recipient they have a limited time to bring in receipts for reimbursement?
A: No. However, recipient education is key. Advise them to bring in receipts in a timely manner. Local districts are also required to process reimbursements in a timely manner.

57. Q: If a case is closed due to failure to recertify, who should notify the employer or Insurance Company that the district will no longer pay the premium?
A: The district should notify the employer or insurance company that premium payments will be discontinued.

58. Q: If the cost of the premium for the employer's dental coverage is more than the regional wrap around rate, should the recipient enroll and pay for it? After completing a cost effectiveness determination, it was found that the total cost of insurance (including dental) added in through either the employer or the wrap is still less than the FHPlus monthly premium.
A: Since cost of the dental is less than the total cost of the FHPlus monthly premium, give the recipient the choice whether it is paid through the recipient's premium or added to the wrap. The recipient may want the private policy because there may be more providers available than there are Medicaid providers. The recipient can choose not to enroll and get it through Medicaid.

59. Q: Is there a letter that goes out with the payments that are authorized in screen 6?
A: BICS does not produce the letters. The Manual Notice of Decision for FHP-PAP may be used to notify recipients of the decision, premium amount to be reimbursed and frequency of those payments.

60. Q: If the recipient notifies the district of their enrollment in a qualified, cost effective ESI several months after they actually enrolled (but were in receipt of FHPlus during this time), should the district reimburse the premium (co-pay, coinsurance, deductibles) for the months prior to the notification? Or should the reimbursement start with the month they notify the district?"
A: Prospective ESI premiums can be reimbursed for months following disenrollment from FHPlus MC. Under FHP-PAP, the disenrollment from FHPlus is supposed to be coordinated with the enrollment in ESI, so that there is no overlap. Also refer to questions number 23 and 24.

V. WRAP:

61. Q: What will the wrap around benefit cover?
A: Wrap around benefits will be provided on a fee-for-service basis for benefits provided by a FHPlus plan, but are not covered by the individual's ESI.

62. Q: Can the district request the member go to a Medicaid provider to pay for the wrap around services?
A: Yes.

63. Q: If there are no Medicaid providers available to provide wrap around services, can the recipient use a non-Medicaid provider?
A: The local districts are directed in the ADM to advise recipients to use Medicaid providers for wrap services. This is an easement for the districts, since these claims can be billed directly through eMedNY. A recipient using a non-Medicaid provider may still be reimbursed via the manual process by the districts. A BICS pay type (Upstate) of "other" has been created for these situations. This is explained in the BICS portion of the ADM.

64. Q: What insurance cards would the member have and what order should they use them in?
A: The recipient would have a commercial insurance card from the ESI plan and a New York State Benefit Identification card for wrap around benefits. Both cards should be presented to the provider. The provider should always bill the commercial insurance plan first, and then bill Medicaid.

65. Q: Individuals will need a Benefit card to access wrap around services. Will they require a photo ID?
A: FHPlus eligibles are not required to have a photo ID.

66. Q: If the FHPlus plans in our district do not cover dental, will FHP-PAP enrollees get dental coverage?
A: Yes, the wrap will cover dental. The recipient will use the Benefit card.

67. Q: If a FHP-PAP person has ESI, that does not cover dental, do they get the benefit of dental with the wrap?
A: Yes.

68. Q: We do not have any providers in our district that accept Medicaid. If we reimburse the recipient for dental expenses, what type of services do we reimburse, and how do we determine how much to reimburse?
A: Dental care includes preventive, prophylactic, and other routine dental care, services, supplies and dental prosthetics required to alleviate a serous health condition, including one which affects employability. Orthodontic services are not covered. Reimburse what the member paid minus the FHPlus co-pay.

69. Q: Is Medical Transportation part of the wrap around service?
A: FHPlus members are not eligible for non-emergency transportation. Most commercial insurances cover emergency transportation. If the commercial insurance does not provide coverage for emergency transportation, the wrap around coverage will.

70. Q: If an employer plan covers the same service as FHPlus (e.g., outpatient mental health counseling), but the number of covered visits is less than what a FHPlus plan would allow, can the recipient be reimbursed for visits in excess of what the ESI plan allows?
A: Yes. The recipient would be reimbursed for visits in excess of what the ESI would cover up to the FHPlus limit of 60 visits.

71. Q: If an employer plan covers eye exams but not lenses or frames, should the cost of vision care be added to Section A of the cost effectiveness calculator?
A: Since this plan only covers eye exams, it does not meet the standard for vision care. It should be added to the wrap. It also should not be entered as a commercial benefit on eMedNY. However, remind the recipient to present his commercial insurance card first so any covered services can be paid by the ESI.

VI. WMS:

72. Q: What Health Insurance Indicator (HII) code should be used when registering or opening a FHP-PAP case?
A: HII code 09 may be used. This code may be removed at the time of renewal as it is not required on 05 and 06 transactions.

73. Q: Should a special claiming code be used for FHP-PAP?
A: On page 12 of the ADM, under the heading of Systems Implications, BICS pay types are discussed. The ADM states that "no special claiming code should be used". This information has changed. Workers should enter a special claiming code of "V", which means "all other FP" when using pay types U1 through U5. Additional information about claiming codes is outlined in the January 30, 2008 WMS Coordinator's letter.

74. Q: The new Pay Type U1 will not allow the use of 03 (vendor as billed). Can that be added? Or can we continue to use the pay type 24?
A: Pay type U1 is for a FHP-PAP premium payment. The districts should use Method of Payment 01 or 02, which require an amount on the pay line. Method of Payment 03 is not used because if the vendor/recipient were to bill for an increased premium amount, it would automatically get paid by the district. The districts should instead complete a new cost effectiveness determination when a premium amount has changed. Pay type 24 should never be used with a FHP-PAP case.

75. Q: How will the EPI code system generate a disenrollment from FHPlus?
A: When an individual notifies you they have enrolled in ESI, you will change the coverage code to 20 and the EPI code to A in WMS. This will system generate a FHPlus disenrollment in T+14 days.

76. Q: When LDSS does reimbursements, payment will be made on BICS. Does LDSS have the option of sending a transmittal with information to the State for reimbursement as is done for some of the other reimbursements, e.g., court cases like Krieger vs. Perales?
A: No. All claiming for the FHP-PAP should be done on line 18 of Schedule E.

VII. EMEDNY:

77. Q: Does the district enter the employer sponsored insurance into eMedNY?
A: Yes, you would enter the commercial insurance in the Third Party screens in eMedNY, just like any other commercial insurance. Be sure to check off all the benefits that the plan covers.

VIII. Facilitated Enrollment:

78. Q: What is the FE's role in this program?
A: The FE should ask the applicants if they have or can get ESI. If the applicant has other health insurance, the FE should instruct them not to drop it as Medicaid may be able to pay the cost of the premiums. The applicant should be given the Employer Sponsored Health Insurance form to fill out.

79. Q: Should the FE hold the application until the insurance information form is returned?

A: Do not hold up the application for the insurance form if the applicant is not already enrolled in ESI. If the applicant is currently enrolled in other health insurance, the form should be included with the application. If it is not, the local district must follow up with the information received.

80. Q: Can applications be taken by an FE when a person is already enrolled in ESI?

A: Yes, as the applicant may be eligible for the Premium Assistance Program.

81. Q: If an applicant is enrolled in ESI or has access to it, should the FE make sure the applicant fills out the FHPlus managed care selection form?

A: Yes, if the applicant is eligible for FHPlus and has access to ESI, the applicant will be enrolled in a FHPlus plan until the individual can be enrolled in the employer insurance. Even if an applicant is already enrolled in ESI, she/he may later lose ESI, but remain otherwise eligible for FHPlus. In this situation, the recipient can be more efficiently enrolled in FHPlus if a plan choice is on record.