STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

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Chief of Staff

ADMINISTRATIVE DIRECTIVE

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
Audit Staff
Staff Development Coordinators

CONTACT PERSON:

Local District Liaisons
Upstate (518)474-8887 NYC (212)417-4500

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.	Manual Ref.	Misc. Ref.
05 OMM/ADM-4			369-ee		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 TPHI 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.

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

ATTACHMENT A

Who is Eligible?

You must be a resident of New York State between 19 and 64 years of age,

A United States citizen, national, Native American or an individual with satisfactory immigration status;

Not eligible for Medicaid based on income and/or resources and;

Eligible for, or enrolled in, employer based insurance.

Employer-based insurance includes standard scope of services and is determined to be qualified and cost effective by the department of social services.

You must meet income/resource and eligibility requirements for the Family Health Plus Program.

Co-payment schedule

Individuals enrolled in Family Health Plus are required to pay part of the cost of some medical care/services. If your employer's health insurance plan's co-payments are higher than those below, your physician can bill Medicaid or you can be reimbursed by your local department of social services.

Physician visits	$5.00
Brand Name Prescriptions	$6.00
Generic prescriptions	$3.00
Radiology services	$1.00
Lab tests	$ .50
Non-urgent ER visits	$3.00
Inpatient hospital stay	$25.00
Covered over-the-counter drugs; lancets, test strips, enteral formula	$1.00
smoking cessation products	$ .50
Dental visits (up to a total of $25.00/year)	$5.00

State of New York
Eliot Spitzer, Governor
Department of Health
Richard F. Daines, M.D., Commissioner

Family Health Plus

Premium Assistance Program

For individuals who qualify for Family Health Plus and have health insurance available through their employer

ATTACHMENT A

Is the Premium Assistance Program as good as Family Health Plus?

Comprehensive Health Care Coverage

Inpatient/outpatient health care

Physician services

Radiation therapy, chemotherapy, hemodialysis

Drug, alcohol, mental health services

Emergency ambulance services

Durable medical equipment

Prescription drugs

Lab tests, x-rays

Vision, speech and hearing services

Rehabilitative services

Hospice

Dental

You will get these benefits either through your Employer's Health Insurance or through your Medicaid benefit.

Are there additional benefits?

The Premium Assistance Program also pays for :

Your share of the Premium for your employer based insurance and

Reimburses for;

Deductibles;

Co-insurance;

Co-payments that exceed the Family Health Plus co-payment schedule.

What happens if I have to wait to join my employer's health insurance?

If you are eligible for this program, but are not yet enrolled in your employer's insurance, you may be enrolled in a Family Health Plus Managed Care Plan temporarily until your employer's insurance enrollment period allows you to sign up.

Children 18 years old and younger will also be evaluated for Medicaid or Child Health Plus while waiting to enroll in your employer's health plan.

Where can I apply?

You may apply using the Access NY Health Care application which can be printed from our website at: www.health.state.ny.us/nysdoh/fhplus/index.htm

Or call our toll free hotline at: 1-877-934-7587.

Or visit your local department of social services.

You may also apply through Facilitated Enrollers, which are available near you.

Call 1-877-934-7587 to find a Facilitated Enroller in your County, or visit: www.health.state.ny.us/nysdoh/fhplus/how_can_I_apply.htm

How do I apply?

You will need to complete an application, provide certain information on income and resources, and complete a personal interview before an eligibility determination can be made.

ATTACHMENT A

¿Quién reúne los requisitos?

Usted debe ser residente del Estado de Nueva York y tener entre 19 y 64 años de edad;

Ciudadano estadounidense, nacional, americano autóctono o un individuo con estado migratorio aprobado;

No reunir los requisitos de Medicaid basándose en ingresos y /o recursos; y

Reunir los requisitos para inscribirse, o estar inscrito en un seguro de salud patrocinado por el empleador.

El seguro patrocinado por el empleador incluye una gama de servicios estándar, y el departamento de servicios sociales lo considera aceptable y económico.

Usted debe de reunir los requisitos de ingresos y recursos establecidos por el Programa de Family Health Plus.

Tarifa de copagos

Las personas inscritas en Family Health Plus deben de pagar una porción de ciertos costos de servicios y atención médica. Si el monto de los copagos del seguro de salud de su empleador es más alto que los señalados a continuación, su médico puede facturar el seguro de Medicaid o el departamento local de servicios sociales le puede rembolsar a usted los pagos.

Visitas médicas	$5.00
Medicamentos recetados de marca	$6.00
Medicamentos genéricos recetados	$3.00
Servicios de radiología	$1.00
Pruebas de laboratorio	$ .50
Visitas no urgentes a sala de emergencia	$3.00
Atención de paciente interno (hospital)	$25.00
Medicamentos de venta libre comprendidos en el plan; lancetas, tiras reactivas, fórmulas intestinales	$1.00
Productos para cesar el hábito de fumar	$ .50
Visitas al dentista (hasta un total de $25.00/al año)	$5.00

Estado de Nueva York
Eliot Spitzer, Gobernador
Departamento de Salud
Richard F. Daines, M.D., Comisionado

Family Health Plus

Programa de Ayuda con Pagos de Primas

Este programa está disponible para aquellas personas que reúnen los requisitos de Family Health Plus y pueden afiliarse a un seguro de salud patrocinado por el empleador.

¿Es igual de conveniente el Programa de Ayuda con Pagos de Primas que el Programa de Family Health Plus?

Cobertura total de seguro de salud

Atención de salud como paciente interno / externo

Servicios suministrados por un médico

Radioterapia, quimioterapia, hemodiálisis

Servicios de tratamiento de salud mental, drogadicción y alcoholismo

Servicios de emergencia en ambulancia

Equipo médico duradero

Medicamentos recetados

Pruebas de laboratorio, rayos x

Servicios de vista, habla y audición

Servicios de rehabilitación

Cuidados paliativos

Servicios dentales

Usted recibirá estos beneficios ya sea, por medio del seguro de salud de su empleador o por medio de Medicaid.

¿Existen otros beneficios adicionales?

El Programa de Ayuda con Pagos de Primas también paga por:

La porción de su costo de la prima del seguro de salud patrocinado por su empleador y reembolsa por:

Deducibles

Coseguros

Copagos que sobrepasen las tarifas fijadas por Family Health Plus.

¿Qué pasa si tengo que esperar para inscribirme en el seguro de salud de mi empleador?

Si usted reúne los requisitos de este programa, pero todavía no se ha inscrito en el seguro de salud patrocinado por su empleador, usted puede inscribirse temporalmente en el Plan de Cuidados Administrados de Family Health Plus hasta que se habra el próximo periodo de inscripción en el plan de salud de su empleador.

Las personas de 18 años de edad o menor también se les evaluará para ver si pueden recibir Medicaid o Child Health Plus mientras esperan inscribirse en el seguro de salud de su empleador.

¿Dónde puedo solicitarlo?

Usted puede solicitarlo usando la solicitud de *Access NY Health Care*. Puede imprimir la solicitud desde la página web:

www.health.state.ny.us/nysdoh/fhplus/index.htm

O bien llámenos a la línea directa: 1-877-934-7587.

O visite la oficina local de servicios sociales.

Usted también puede solicitarlo por medio de los representantes especializados en el proceso de inscripción de su localidad.

Llame al 1-877-934-7587 para averiguar la ubicación del especialista en su condado, o visite: www.health.state.ny.us/nysdoh/fhplus/how_can_I_apply.htm

¿Cómo lo solicito?

Usted tendrá que rellenar una solicitud, suministrar ciertos datos relativos a ingresos y recursos, y ser entrevistado(a) antes de que tome una decisión.

ATTACHMENT B

EMPLOYER FACT SHEET

Family Health Plus Premium Assistance Program (FHP-PAP)
What employers need to know about FHP-PAP.

What is the Family Health Plus Premium Assistance Program:

The Family Health Plus Premium Assistance Program is the State's premium assistance program for Family Health Plus eligible individuals who have access to employer-sponsored health insurance.

The Family Health Plus Premium Assistance Program is a public/private partnership that helps lower-income employees participate in your company's health insurance plan. If your employee and your company's health insurance plan are qualified and the plan is cost effective, the Family Health Plus Premium Assistance Program will pay for the employee's share of your company's health insurance premium. The Family Health Plus Premium Assistance program will also cover the cost of any deductibles, coinsurance and co-payments associated with your company's health plan. This makes your offer of health insurance more affordable for your employees and their families.

How it helps you:

Participation in the Family Health Plus Premium Assistance program allows your employees to enroll in your company's health insurance at little or no cost to them and at no additional cost to you. This will help you attract and retain qualified employees by giving them access to affordable health insurance. This may also help decrease absenteeism and increase productivity, increase participation rates in your health plan, which may help your company maintain qualification for group insurance coverage, and improve overall employee satisfaction and health.

Premium Payments:

There is no additional cost to you to have your employee participate in the Family Health Plus Premium Assistance Program. You may be asked to agree to accept payments from Family Health Plus for your employee's share of his or her monthly premium, and to provide updated information to the LDSS on an annual basis regarding any changes to your health plan's insurance offerings or adjustments to premiums.

How it works:

Under the Family Health Plus Premium Assistance Program, individuals eligible for Family Health Plus with access to employer-sponsored health insurance will be asked to provide information about the costs and benefits of the health plan(s) available to them through their employer. You may be asked to complete a short form or questionnaire about the health plan(s) you offer. Your company's health insurance plan must meet

certain standards for covered benefits and costs. Most commercial plans in New York will meet these requirements. If the LDSS determines that your company's health plan meets certain standards for covered benefits and is cost effective, your employee will qualify for premium assistance, and reimbursement for deductibles, coinsurance and co-payments associated with the employer-sponsored health insurance. Employees eligible for the Family Health Plus Premium Assistance Program will also get a Medical Assistance Benefit card, which will allow them to access any Family Health Plus benefits which are not covered by your company's health insurance plan.

Employees must apply with a facilitated enroller or directly to the local social services district in the county where they live to determine if they qualify for the Family Health Plus Premium Assistance Program. If your employee qualifies for the Family Health Plus Assistance Program, the LDSS will work with you and your employee to ensure that he or she is enrolled in your company's health plan as soon as possible.

Are you allowed to release information to the Family Health Plus Premium Assistance Program and the LDSS about your employee's health benefits?

Yes. Employees who apply for the Family Health Plus Premium Assistance Program will have to sign a release authorizing their employers to release health benefits information to the New York State Medicaid /Family Health Plus Program, via the LDSS.

To speed up the process:

If you'd like to have your company's health plan pre-qualified for the Family Health Plus Premium Assistance Program for eligible employees in a given county or counties, just call the applicable county social services department(s).

To learn more about the Family Health Plus Premium Assistance Program:

Call the local Department of Social Services in your county:

ATTACHMENT C

REQUEST FOR INFORMATION
EMPLOYER SPONSORED HEALTH INSURANCE

Pursuant to Social Services Law Section 143, all employers of any kind doing business within the State of New York are required to furnish to the social services official information about employees including information regarding health insurance coverage. Failure to do so may result in court action and penalties.

Employee Name:

Address:

Does this individual have health insurance coverage through employment?
Yes ☐
No ☐

If YES, please complete Section A below. If NO, please complete Section B, reverse side

SECTION A

Carrier/Union Name: Policy No:

Address: Phone No:

Employee/Enrollee	Coverage	Coverage		Premium Cost to Employee
	Family/Couple/Individual	Start Date	End Date	
1				
2				
3				
4				
5				

Scope of Benefits: Please check all that apply or attach a plan summary

☐ Inpatient Hospital Services
☐ Outpatient Services
☐ Physician Services
☐ Ambulatory Surgery
☐ Maternity Care
☐ Outpatient Mental
☐ Health, Drug and Alcohol Treatment
☐ Emergency Services
☐ Prescription Drug
☐ Durable Medical Equipment
☐ Dental
☐ Transportation-Emergency
☐ Vision Care/Eyeglasses
☐ Diagnostic Lab / X-Ray

What are the standard: Deductibles _____

Co-Insurance _____

Co-payments _____

ATTACHMENT C

SECTION B

If employee is **not** enrolled in an employer-sponsored health care plan, please check the applicable box and provide the information requested.

A. ☐ Health insurance is not provided to our employees

B. ☐ Employee is not currently eligible to enroll, but may enroll on ___/___/_____

C. ☐ Employee is not eligible for health care coverage; please explain
_____
_____
_____
_____

D. ☐ Employee is eligible for health insurance, but has not enrolled *.

*** Attach the plan or plans, including the scope of benefits the employee would be eligible for, along with costs for Family, Couple, and Individual coverage, as applicable.**

If your employee is determined to be eligible to receive premium assistance in paying his/her share of the premium cost, would you accept direct payment from the Department of Social Service? YES___ NO___

Name of person completing form _____

Company Name and Title_____

Phone Number _____

Date _____

Return this completed form by __/__/____

Return form to: _____
_____
_____

ATTACHMENT D

Family Health Plus Premium Assistance Program (FHP-PAP)
Benchmark Benefits Check List/Cost Effectiveness Calculation

Employer Name: **Insurance Company:** **Member Name:**
Employer FEIN: **Health Plan Name:** **SS #:**
Group Number: **CIN#:**

Benchmark Services/ Required Benefits	**Description of Benefit**	**Evaluation**
Inpatient hospital	Medical and surgical, inpatient mental heath	Covered / Not Covered
Outpatient services	Diagnostic and Treatment Services	Covered / Not Covered
Physician Services	Primary care and specialists, diagnostic and treatment services, consultant and referral services, surgical services, anesthesia services, second surgical opinions	Covered / Not Covered
Ambulatory Surgery	Outpatient surgical facility charges	Covered / Not Covered
Maternity Care	Prenatal/Postpartum	Covered / Not Covered
Outpatient Mental Health, Drug and Alcohol Treatment		Covered / Not Covered
Emergency Services		Covered / Not Covered
Diagnostic laboratory and X-Ray Services		Covered / Not Covered

If all benchmark benefit requirements are met, the employer-sponsored health plan is considered qualified. Plans must cover all benchmark/required services to be considered qualified for FHP-PAP.

However, the LDSS shall also assess the degree to which the employer-sponsored health plan covers optional/non-required services to determine which FHPlus wrap around benefits are applicable and to calculate the cost effectiveness of the employer sponsored health insurance. See work sheet below. Only cost effective plans are eligible for FHP-PAP.

Qualification and Cost Effectiveness Determination

1. **Does the Employer-Sponsored Insurance cover all benchmark benefits?**

☐ **No. The Employer-Sponsored Insurance is not eligible for FHP-PAP.**

☐ **Yes. Go on to question 2.**

2. **Is the Employer-Sponsored Insurance cost Effective?**
   Complete the Cost Effectiveness Calculator.

	Cost Effectiveness Calculator			
Line	**Column A**	**Column B**	**Column C**	**Column D**
1	Employer Health Insurance Plan meets Benchmark/Core Benefit Qualifications on Page 1	Cost of Insurance for Adult	Cost of Insurance for Child	Totals
SECTION A	**COST OF WRAP BENEFITS**			
2	Does the employer policy include the Optional/Non-Benchmark required services listed in Column A, lines 2a through 2e? If "NO" add the ADULT regional rate for each service in Column B and the CHILD rate for each service in Column C.			
2a.	Prescription Drug			
2b.	Durable Medical Equipment			
2c.	Dental			
2d.	Transportation-Non Emergency-child only			
	Transportation-Emergency			
2e.	Vision Care/Eyeglasses			
3	Total cost of Wrap Benefits for each adult and child. Add lines 2a through 2e, enter the total on line 3.			
4	Enter the number of adults and children covered by the policy on line 4.			
5	Multiply the total cost of wrap benefits on line 3 by the number of people on line 4.			
6	Add totals in columns B and C, line 5. Enter in Column D.			
SECTION B	**MANAGED CARE COSTS**			
7	Enter adult FHP Monthly Regional Premium for one adult on line 7.			
7a	Enter the number of adults covered by the policy on line 7a.			
7b	Total FHP Monthly Premium: Multiply line 7 by line 7a.			
8	Enter the Monthly Regional Medicaid Managed Care premium for one child on line 8.			
8a	Enter the number of children covered by the policy.			
8b	Total monthly Managed Care cost for the children: Multiply line 8 by line 8a.			
9	Total Monthly Managed Care costs for adults and children: Add lines 7b and 8b.			
SECTION C	**COST OF EMPLOYEE SPONSORED HEALTH INSURANCE**			
10	Enter total employee monthly cost of premium for employer sponsored insurance.			
11	Enter the total ANNUAL deductible on line 11.			
12	Total monthly deductible: Divide the amount on line 11 by 12 months. Enter in column D.			
13	If known, enter the average monthly co-pay amount. If unknown, enter $37 in line 13.			
14	Multiply the amount on line 13 by the number of people coverd by the policy (children + adults). Enter in Column D.			
15	Administrative fee, fixed amount of $10.00.			**$10.00**
16	Add lines 6, 10, 12, 14 and 15 on line 16.			
SECTION D	**COST EFFECTIVENESS DETERMINATION**			
17	If line 9 is GREATER than OR EQUAL to line 16	COST EFFECTIVE TO PAY EMPLOYEE PREMIUM		
18	If line 9 is LESS than line 16	NOT COST EFFECTIVE TO PAY EMPLOYEE PREMIUM		
	Date:	Worker Name:		

Central	FHP Adult	Expanded Child
Monthly Managed Care Premiums 4/07 - 3/08	$330.03	$105.55
Cost of Wrap		
Vision	$1.88	$1.15
DME	$1.77	$0.48
ER Trans	$1.86	$1.49
Non ER Trans ($0 for adults)	$0.00	$2.31
Dental	$14.98	$11.34
Pharmacy	$77.00	$41.00
Counties in region:		
Cayuga		
Chenango		
Columbia		
Cortland		
Delaware		
Greene		
Madison		
Onondaga		
Otsego		
Schoharie		
Tompkins		

Finger Lakes	FHP Adult	Expanded Child
Monthly Managed Care Premiums 4/07 - 3/08	$348.29	$136.54
Cost of Wrap		
Vision	$1.82	$0.99
DME	$1.87	$0.70
ER Trans	$1.39	$0.78
Non ER Trans ($0 for adults & children)	$0.00	$0.00
Dental	$18.12	$0.00
Pharmacy	$78.19	$41.00
Counties in region:		
Allegany		
Broome		
Cattaraugus		
Chautauqua		
Chemung		
Livingston		
Ontario		
Schuyler		
Seneca		
Steuben		
Tioga		
Wayne		
Yates		

Long Island	FHP Adult	Expanded Child
Monthly Managed Care Premiums 4/07 - 3/08	$278.20	$123.15
Cost of Wrap		
Vision	$1.06	$0.79
DME	$0.96	$0.71
ER Trans	$0.26	$0.31
Non ER Trans ($0 for adults)	$0.00	$1.57
Dental	$15.13	$14.58
Pharmacy	$47.47	$41.00
Counties in region:		
Nassau		
Suffolk		

Mid-Hudson	FHP Adult	Expanded Child
Monthly Managed Care Premiums 4/07 - 3/08	$357.40	$143.01
Cost of Wrap		
Vision	$1.20	$0.99
DME	$1.30	$0.68
ER Trans	$1.47	$1.03
Non ER Trans ($0 for adults)	$0.00	$4.44
Dental	$15.19	$13.47
Pharmacy	$87.34	$41.00
Counties in region:		
Dutchess		
Orange		
Sullivan		
Ulster		

Northeast	FHP Adult	Expanded Child
Monthly Managed Care Premiums 4/07 - 3/08	$315.21	$113.10
Cost of Wrap		
Vision	$2.24	$1.48
DME	$2.91	$1.14
ER Trans	$0.88	$1.45
Non ER Trans ($0 for adults)	$0.00	$3.59
Dental	$15.52	$12.02
Pharmacy	$79.00	$41.00
Counties in region:		
Albany		
Fulton		
Montgomery		
Rensselaer		
Saratoga		
Schenectady		
Warren		
Washington		

Northern Metro	FHP Adult	Expanded Child
Monthly Managed Care Premiums 4/07 - 3/08	$319.27	$127.44
Cost of Wrap		
Vision	$1.36	$1.29
DME	$1.05	$0.69
ER Trans	$0.75	$0.48
Non ER Trans ($0 for adults)	$0.00	$2.54
Dental	$15.99	$17.45
Pharmacy	$65.99	$41.00
Counties in region:		
Putnam		
Rockland		
Westchester		

New York City	FHP Adult	Expanded Child
Monthly Managed Care Premiums 4/07 - 3/08	$242.99	$117.08
Cost of Wrap		
Vision	$1.07	$0.73
DME	$0.58	$0.51
ER Trans	$0.29	$0.37
Non ER Trans ($0 for adults)	$0.00	$0.24
Dental	$14.19	$10.47
Pharmacy	$50.86	$41.00
Counties in region:		
NYC		

Utica-Adirondack	FHP Adult	Expanded Child
Monthly Managed Care Premiums 4/07 - 3/08	$350.95	$119.80
Cost of Wrap		
Vision	$1.73	$1.11
DME	$1.51	$0.60
ER Trans	$1.30	$1.08
Non ER Trans ($0 for adults & children)	$0.00	$0.00
Dental	$20.64	$13.78
Pharmacy	$77.49	$41.00
Counties in region:		
Clinton		
Essex		
Franklin		
Hamilton		
Herkimer		
Jefferson		
Lewis		
Oneida		
Oswego		
St. Lawrence		

Western	FHP Adult	Expanded Child
Monthly Managed Care Premiums 4/07 - 3/08	$300.60	$114.38
Cost of Wrap		
Vision	$2.02	$0.85
DME	$2.47	$0.44
ER Trans	$1.98	$1.28
Non ER Trans ($0 for adults)	$0.00	$0.81
Dental	$13.73	$13.93
Pharmacy	$65.41	$41.00
Counties in region:		
Erie		
Genesee		
Monroe		
Niagara		
Orleans		
Wyoming		

ROS	FHP Adult	Expanded Child
Monthly Managed Care Premiums 4/07 - 3/08	$316.01	$121.25
Cost of Wrap		
Vision	$1.63	$1.02
DME	$1.71	$0.64
ER Trans	$1.19	$0.88
Non ER Trans ($0 for adults)	$0.00	$1.77
Dental	$16.01	$15.67
Pharmacy	$67.75	$41.00
Counties in region:		
All counties except NYC		

ATTACHMENT E
OHIP-0011

NOTICE OF DECISION FOR FAMILY HEALTH PLUS – PREMIUM ASSISTANCE PROGRAM

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE
CASE NUMBER	Unit or Worker Name	
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP **OR** Agency Conference _____ Fair Hearing Information and Assistance _____ Record Access _____ Legal Assistance Information _____

The Local Department of Social Services (LDSS) has made a decision concerning your eligibility for Family Health Plus Premium Assistance Program.

This Department will:

☐ **ACCEPT** the application dated _____ for (name(s)) _____.

Effective: _____,the premium assistance program will pay $_____ ☐weekly ☐bi-weekly ☐ monthly ☐quarterly

☐ **CONTINUE** the premium payment for (name(s))_____, effective _____.The premium assistance program will pay $_____☐weekly ☐bi-weekly ☐monthly ☐quarterly

☐ **TAKE NO ACTION** on the application dated _____, since it was withdrawn.

☐ **CHANGE** from Family Health Plus Managed Care to Family Health Plus Premium Assistance Program for (name(s)) _____. You will be disenrolled from _____Health Insurance Plan effective:_____ and enrolled in your Employer's Health Insurance Plan _____,effective: _____.The Premium Assistance Program will pay $_____☐ weekly ☐bi-weekly ☐monthly ☐quarterly

☐ **DISCONTINUE** Premium Assistance Program for (name(s))_____ Effective _____. The **reason** for this action is as follows:

☐ You no longer have access to your employer's health insurance plan; you will be enrolled into the Family Health Plus plan you chose on your application.

☐ It is not cost effective for Medicaid to continue paying the premium for your employer's health insurance plan. You must notify us **within 10 days** to tell us if you will remain in the employer sponsored health insurance and pay the cost of the premium yourself. If you fail to respond your coverage will end. If you choose to discontinue your health insurance, you must provide us with written proof of your termination date, and you must choose a Family Health Plus plan **within 10 days** if you want to receive Family Health Plus benefits.

If this application is being denied or discontinued for financial reasons, the following information explains the calculation of eligibility. The income, resources and allowable deductions/exemptions are as follows:

INCOME		**RESOURCES**	
Gross monthly income	$ _____	Countable resources	$ _____
Deductions	- $ _____	Exemptions	- $ _____
Net monthly income	$ _____	Net resources	$ _____
Allowable standard	$ _____	Allowable standard	$ _____
Excess income	$ _____	Excess resources	$ _____

The law(s) and/or regulation(s) which allow us to do this are SSL 369-ee.

If any of these actions were taken because of financial circumstances, we have enclosed a budget worksheet(s) so that you can see how we determined eligibility for benefits.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

ATTACHMENT E

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing***. If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL); **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735; **OR**

3) **On-Line:** Complete and send the online request form at: **http://www.otda.state.ny.us/oah/forms.asp; OR**

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because: _____

_____

_____

_____

Print Name: _____ Case Number: _____

Address: _____ Telephone: _____

Signature of Client: _____ Date: _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

☐ I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS: To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file, which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file, which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of page 1 of this notice or write us at the address printed at the top of page 1 of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

INFORMATION: If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of page 1 of this notice or write to us at the address printed at the top of page 1 of this notice.

ATTENTION: Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

ATTACHMENT E

OHIP-0011 SP

AVISO DE DECISIÓN TOMADA CON RELACIÓN AL PROGRAMA DE AYUDA CON PAGOS DE PRIMAS - FAMILY HEALTH PLUS

FECHA DE LA NOTIFICACIÓN:	FECHA DE VIGENCIA:	NOMBRE Y DIRECCIÓN DE LA AGENCIA / CENTRO U OFICINA DEL DISTRITO
NÚMERO DE CASO	UNIDAD O NOMBRE DEL TRABAJADOR SOCIAL	
CASO A NOMBRE DE (y nombre de la persona a cargo, si está presente) Y DOMICILIO		NO. DE TELÉFONO GENERAL PARA HACER PREGUNTAS O PEDIR AYUDA
		Conferencia con la Agencia _____
		Audiencias Imparciales Información y asistencia _____
		Acceso a los Archivos _____
		Información sobre Asesoramiento Legal _____

El departamento local de servicios sociales ha tomado una decisión pertinente a su habilitación para recibir beneficios del Programa de Ayuda con los Pagos de Primas de Family Health Plus.

Este departamento tomará la siguiente acción:

☐ **ACEPTARÁ** la solicitud de fecha _____ para (nombre[s]) _____.
A partir del: _____, el programa de ayuda con los pagos de primas pagará $_____
☐ semanalmente ☐ cada dos semanas ☐ mensualmente ☐ trimestralmente

☐ **CONTINUARÁ** los pagos de primas para (nombre[s]) _____, a partir del _____. El programa de ayuda con los pagos de primas pagará $_____ ☐ semanalmente ☐ cada dos semanas ☐ mensualmente ☐ trimestralmente

☐ **NO SE TOMARÁ DECISIÓN ALGUNA** sobre la solicitud de fecha _____dado que ésta fue retirada.

☐ **CAMBIARÁ** de Cuidados Administrados de Family Health Plus, a Programa de Ayuda con los Pagos de Primas de Family Health Plus para (nombre[s]) _____. Usted será retirada(o) del seguro de salud _____, a partir del _____ y se le inscribirá en el seguro médico de su empleador _____, a partir del: _____. El Programa de Ayuda con los Pagos de Primas pagará $_____
☐ semanalmente ☐ cada dos semanas ☐ mensualmente ☐ trimestralmente

☐ **SUSPENDERÁ** los beneficios del Programa de Ayuda con los Pagos de Primas para (nombre[s]_____ _____a partir del_____. El **motivo** de esta decisión es la siguiente:

- ☐ Usted ya no tiene acceso al seguro médico de su empleador; a usted se inscribirá en el plan de Family Health Plus que usted seleccionó en la solicitud.
- ☐ No es eficaz, en función de los costos, que Medicaid continúe pagando la prima del seguro médico que usted recibe por parte de su empleador. Usted nos debe notificar **dentro de 10 días** si usted decide retener el seguro médico que recibe por parte de su empleador y continuar pagando usted mismo(a) el costo de las primas del seguro. Si usted no responde, cesará su cobertura. Si usted decide suspender su seguro médico, usted debe suministrarnos un comprobante por escrito que muestre la fecha en que la cobertura cesa. Además, usted debe escoger un plan de salud de Family Health Plus **dentro de 10 días** si desea recibir beneficios del seguro médico de Family Health Plus.

Si la presente solicitud se rechaza o se suspende por razones económicas, a continuación explicamos cómo se evaluaron los requisitos El ingreso, los recursos y las deducciones permitidas / excepciones son las siguientes:

INGRESOS		**RECURSOS**	
Ingresos brutos mensuales	$ _____	Recursos contables	$ _____
Deducciones	- $ _____	Exenciones	- $ _____
Ingreso neto mensual	$ _____	Recursos netos	$ _____
Estándar permitido	$ _____	Estándar permitido	$ _____
Ingresos en exceso	$ _____	Recursos en exceso	$ _____

La(s) ley(es) y/o reglamentación que nos permite(n) hacer esto son SSL 369-ee.

Si alguna decisión fue tomada por circunstancias financieras, hemos adjuntado una hoja de cálculo de presupuesto para que usted pueda ver cómo calculamos su habilitación para recibir beneficios.

USTED TIENE EL DERECHO DE APELAR EN CONTRA DE ESTA DECISIÓN.
ASEGÚRESE DE LEER EL DORSO DE ESTA NOTIFICACIÓN PARA INFORMARSE SOBRE CÓMO APELAR EN CONTRA DE ESTA DECISIÓN

ATTACHMENT E

DERECHO A UNA CONFERENCIA: usted puede solicitar una conferencia para examinar la decisión tomada. Si desea solicitar una conferencia, hágalo lo más pronto posible. Si en la conferencia nos percatamos que nuestra decisión es incorrecta; o si según la información que usted nos brinde, decidimos modificar la decisión tomada, tomaremos la medida correctiva y le enviaremos una nueva notificación. Puede solicitar una conferencia llamando al número de teléfono que aparece en la primera página de esta notificación o enviándonos una carta a la dirección que aparece en esa misma página. Ese número es solamente para solicitar una conferencia con la agencia. ***y no es la manera de solicitar una audiencia imparcial*** Tiene derecho a una audiencia imparcial aunque solicite una conferencia. Si desea que sus beneficios continúen sin cambios (asistencia ininterrumpida) hasta que se tome una decisión de su caso en la audiencia imparcial, debe solicitar una audiencia imparcial de la manera descrita a continuación. Lea la siguiente información sobre audiencias imparciales.

DERECHO A UNA AUDIENCIA IMPARCIAL: si usted cree que la decisión descrita anteriormente es incorrecta, puede solicitar una audiencia estatal imparcial de las siguientes maneras:

5) **Por teléfono:** llame al número de teléfono estatal: 800 -342-3334 (FAVOR DE TENER A MANO ESTA NOTIFICACIÓN CUANDO LLAME)

6) **Por fax:** envíe una copia de esta notificación al (518) 473-6735

7) **Por internet:** rellene una petición electrónica en el siguiente sitio: **http://www.otda.state.ny.us/oah/forms.asp; OR**

8) **Por escrito:** rellene este aviso en su **totalidad** y envíe una copia a: *Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201.* Favor de quedarse con una copia.

☐ Deseo una audiencia imparcial. La decisión de la agencia es incorrecta porque: _____

_____

_____

Nombre en letra de imprenta: _____ № de Caso: _____

Domicilio: _____ Teléfono: _____

Firma del Cliente: _____ Fecha: _____

USTED TIENE 60 DÍAS, CONTADOS A PARTIR DE LA FECHA EN ESTA NOTIFICACIÓN, PARA SOLICITAR UNA AUDIENCIA IMPARCIAL

Si usted solicita una audiencia imparcial, el Estado le enviará una notificación informándole dónde y cuándo se llevará a cabo la audiencia. Usted tiene derecho a ser representado por un asesor legal, un pariente, un amigo(a) u otra persona, o de representarse así mismo(a). En la audiencia, usted, su abogado u otro representante tendrán la oportunidad de presentar evidencia escrita y oral que demuestre por qué no se debe tomar la medida, como también la oportunidad de interrogar a toda persona que comparezca a la audiencia. Además, usted tiene el derecho de presentar testigos que avalen su caso. Le sugerimos traer consigo todo documento pertinente que le ayude a avalar su caso, tales como: talonario de cheques de pago, recibos, facturas médicas, facturas de calefacción, comprobantes médicos, cartas, etc.

CONTINUACIÓN DE SUS BENEFICIOS: si usted solicita una audiencia imparcial antes de la fecha de vigencia indicada en esta notificación, continuará recibiendo sus beneficios sin cambios hasta que se tome una decisión en la audiencia imparcial. Sin embargo, si la audiencia no se decide a su favor, podríamos pedirle que nos devuelva la cantidad correspondiente a los beneficios de Asistencia Médica que usted recibió y que no tenía que haber recibido. Si no quiere que esto ocurra, marque la siguiente casilla indicando que no quiere que continúen sus beneficios, y mande esta hoja junto con la petición de audiencia. Si marca la casilla, la medida descrita anteriormente se llevará a cabo en la fecha fijada arriba.

☐ Estoy de acuerdo en que se tome la decisión indicada en esta notificación con respecto a mis beneficios de Asistencia Médica antes de la decisión de la audiencia imparcial.

ASISTENCIA LEGAL: si necesita asesoría legal gratuita, podría obtenerla llamando al número local de la Sociedad de Ayuda Legal u otra asociación de defensa legal. Puede localizar la Sociedad de Ayuda Legal o un grupo de abogacía en las Páginas Amarillas del directorio telefónico bajo *«Lawyers»* (abogados), o llamando al número que aparece en la primera página de esta notificación.

ACCESO A SU ARCHIVO Y COPIAS DE DOCUMENTOS: en preparación para la audiencia imparcial, usted tiene derecho a revisar el archivo de su caso. Si nos llama o nos escribe, le brindaremos, sin cargo, copias de documentos contenidos en su archivo; los mismos que entregaremos al funcionario a cargo de la audiencia imparcial. Además, si nos llama o nos escribe, le brindaremos, sin cargo, copias de otros documentos contenidos en su archivo y los cuales usted considere necesarios en preparación para la audiencia imparcial. Si desea solicitar documentos o averiguar la modalidad a seguir para consultar su archivo, llámenos al número de teléfono de Acceso a Archivos que aparece en la parte superior de la página 1 de esta notificación. o mande una carta a la dirección indicada en esa misma página.

Si desea copias de documentos que figuran en su archivo, solicítelas con anticipación. Se le proporcionarán dentro de un lapso de tiempo razonable antes de la fecha fijada para la audiencia. Los documentos se le enviarán por correo sólo si usted específicamente los solicita.

INFORMACIÓN: si desea información adicional sobre su caso, cómo solicitar una audiencia imparcial, cómo consultar su archivo o cómo obtener copias adicionales de documentos, sírvase llamarnos al número de teléfono señalado en la primera página de este aviso o mande una carta a la dirección que figura en esa misma página.

ATENCIÓN: los niños menores de 19 años de edad que no reúnen los requisitos de Child Health Plus A o de algún otro seguro médico, podrían reunir los requisitos del Seguro de Salud Child Health Plus B (Child Health Plus B). El seguro brinda atención y cuidados de salud para niños. Si desea información llame al 1-800-522-5006.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

December 1, 2007

Dear Family Health Plus Member:

A new STATE LAW, Social Services Law, Section 369-ee, has changed certain rules for FAMILY HEALTH PLUS eligibility. It is important to read this notice to understand how the change may affect you.

When it is time for you to renew your eligibility for the Family Health Plus program in 2008, you will be asked if your employer offers health insurance that can cover you or you and your family. If your employer does offer health insurance you will be asked to give your local department of social services (LDSS) information about the health insurance available to you through your employer. The LDSS will then determine if the insurance is cost-effective.

If the employer-sponsored health insurance is found to be cost-effective and you continue to be eligible for the Family Health Plus program, the Family Health Plus program will pay the cost of your share of the premium, and any deductibles and co-pays that are greater than what you currently pay for Family Health Plus coverage. You will also continue to receive Family Health Plus covered services that are not covered by your employer-sponsored health insurance, if you use a Medicaid enrolled provider. If you can only join your employer-sponsored health insurance plan at certain times of the year, you will stay in your Family Health Plus plan until you can enroll in the employer-sponsored health insurance plan.

If your employer does not offer health insurance, this change in Family Health Plus eligibility rules does not affect you.

For more information about changes to the Family Health Plus eligibility rules, call TOLL-FREE 1-877- 934-7587 (1-877-898-5849 TTY line for the hearing impaired) between 8:30 am and 5:00 pm or call your LDSS Medicaid office.

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Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Chief of Staff

1 de diciembre de 2007

Estimado miembro de Family Health Plus:

Una nueva LEY ESTATAL, Ley de Seguro Social, Sección 369-ee ha producido una modificación a las reglas de habilitación de FAMILY HEALTH PLUS. Es importante que lea esta notificación para entender de qué manera esta modificación le afecta a usted.

Cuando sea el momento de renovar su habilitación para el Programa de Family Health Plus en el 2008, se le preguntará si su empleador ofrece seguro médico que lo pueda cubrir a usted y a su familia. Si su empleador ofrece seguro médico, se le pedirá que suministre al departamento local de servicios sociales (LDSS), los datos sobre el seguro médico disponible a usted por medio del empleador. Consecuentemente, el departamento de servicios sociales decidirá si el seguro es económico.

Si se determina que el seguro médico patrocinado por el empleador es económico, y usted continúa reuniendo los requisitos del Programa de Family Health Plus, el Programa de Family Health Plus pagará la porción del costo de la prima, como también todo deducible y copagos que sobrepasen la cantidad que usted actualmente paga por cobertura del Programa de Family Health Plus. Usted continuará recibiendo los servicios, comprendidos en el seguro de Family Health Plus, que el seguro médico por parte de su empleador no cubra, siempre y cuando usted utilice un suministrador de servicios afiliado a Medicaid. Si solamente puede inscribirse en el seguro médico de su empleador durante cierto periodo del año, permanecerá en el plan de Family Health Plus hasta que usted pueda inscribirse en el plan de seguro médico de su empleador.

Si su empleador no ofrece seguro médico, la presente modificación en las reglas de habilitación de Family Health Plus no le afectará a usted.

Si desea más información sobre las modificaciones a las reglas de habilitación de Family Health Plus, llame LIBRE DE CARGOS AL 1-877-934-7587 (1-877-898-5849 línea TTY para las personas con dificultades auditivas) entre las 8:30 am y las 5:00 pm o llame a la oficina local de servicios sociales de Medicaid.