

New Hampshire Health Protection Program: Marketplace Premium Assistance Program Overview

October 1, 2015

Agenda

- **New Hampshire Health Protection Program & Marketplace Premium Assistance Background**
- **Eligibility for Expansion Adults and the Premium Assistance Program and Enrollment**
- **Benefits**
- **Cost-Sharing**
- **Medical Frailty**
- **Appeals**

New Hampshire Health Protection Program

SB 413 outlined three programs through which NHHPP eligible individuals would be enrolled in Medicaid:



Health Insurance Premium Payment (HIPP) Program

(delivered through cost-effective ESI)

Aug 15, 2014 – Sept 1, 2015



The "Bridge" Program

(delivered through Medicaid managed care)

Aug 15, 2014 - Dec 31, 2015



Marketplace premium assistance program (PAP)

(delivered through qualified health plans)

Jan 1, 2016 - Dec 31, 2016

PAP Eligible Population

Expansion Adults



Ages 19 up until 65

Income below 138% FPL

Not pregnant at time of eligibility determination*

Not entitled to or enrolled in Medicare

Not in any other mandatory Medicaid eligibility group



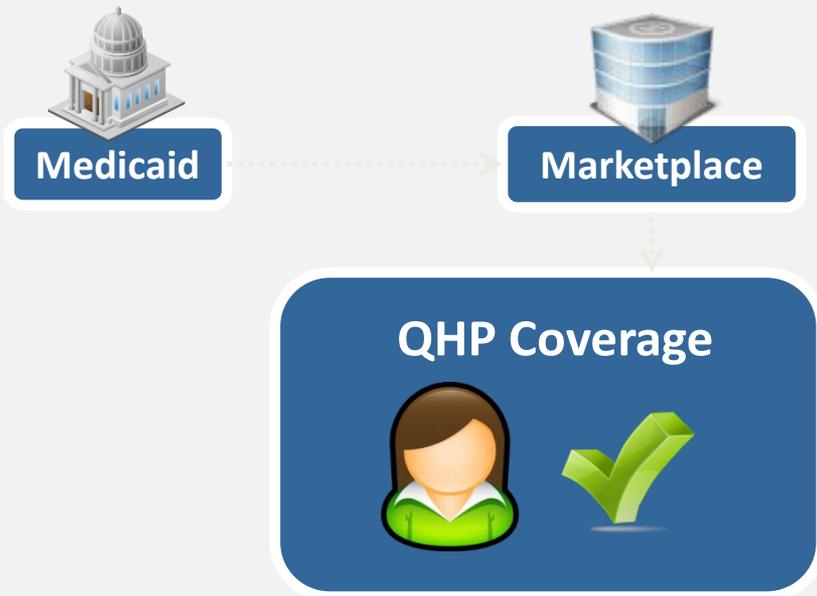
Except for the expansion adults:

- ❖ Who are identified as medically frail

**Individuals are treated as “not pregnant” unless they attest to being pregnant on the application*

Overview of Marketplace Premium Assistance Program

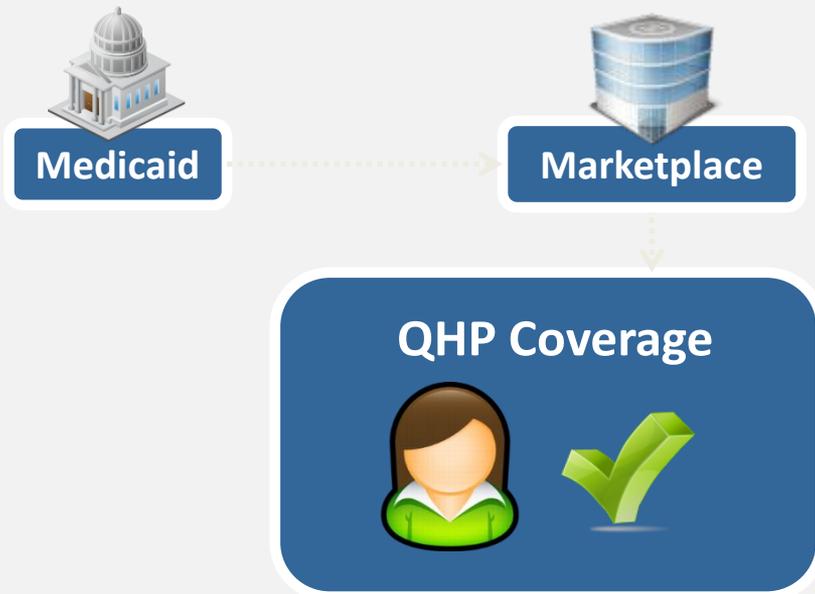
New Hampshire received approval on March 4, 2015 for a one-year Section 1115 Demonstration Waiver to establish the Marketplace Premium Assistance Program



New Hampshire will purchase qualified health plans (QHPs) certified to be sold on the Marketplace for PAP enrollees and assure that all Medicaid benefits and cost-sharing protections are met

Overview of Marketplace Premium Assistance Program

QHPs are individual commercial insurance plans certified by CMS for sale in New Hampshire's Insurance Marketplace



The five carriers who have sought certification for 2016:

- ❖ Ambetter- NHHF's commercial counterpart
- ❖ Anthem
- ❖ Community Health Options
- ❖ Harvard Pilgrim Health Care
- ❖ Minuteman Health

Comparing DHHS's Role in Premium Assistance and Managed Care Programs

DHHS's role in administering the Premium Assistance Program differs from its role in administering the Medicaid Care Management Program. In premium assistance, Medicaid is purchasing a QHP product, not requiring QHP carriers to design a Medicaid product.

	Medicaid Care Management	QHP Premium Assistance
Pay capitation or premium	✓	✓
Serve as single state agency	✓	✓
Ensure beneficiaries receive appeals rights and protections	✓	Consistent with the appeals process approved by CMS ✓
Contract with plans	✓	✗ DHHS and carriers will enter into MOU defining payment mechanics, reporting requirements, and a handful of administrative issues
Define benefits offered	✓	✗ DHHS will wrap any category of benefits listed in the ABP SPA that are not covered by QHP
Regulate plans	✓	✗ NHID regulates plans
Conduct readiness reviews of plans	✓	✗ NHID evaluates whether a carrier may offer coverage
Train providers about program	✓	✗ Carriers are responsible for educating providers in their networks

Eligibility Determinations for Expansion Adults

DHHS conducts eligibility determinations for expansion adults with two potential outcomes:

Premium Assistance Program

To include Bridge enrollees and new applicants as of 1/1/16



Medically Frail

Based on self-attestation; not permitted to enroll in QHPs*



If an individual wishes to appeal an eligibility determination, he/she can do so through the current DHHS processes.

Enrollment

How Will Enrollment in PAP Work?

Main Events

Early October - All NHHPP members will receive a heads up letter and detailed enclosure. This notice tells enrollees they will need to choose a QHP in November or be notified of their autoenrollment into Ambetter. The enclosure describes the unique features of the PAP program.

Early November – NHHF enrollees. Current NHHPP enrollees with NHHF will receive a notice of their autoassignment to Ambetter, the NHHF's QHP and that they have 30 days to select a different QHP if they like.

Early November – Well Sense enrollees. Current NHHPP enrollees with Well Sense will receive a notice that they need to choose a QHP within 30 days or they will be autoassigned.

Early November – QHP selection will be available through NHEasy, by contacting a **ServiceLink** Office, or by calling Maximus at **1-888-901-4999**. Enrollees cannot shop through healthcare.gov.

Early December - Well Sense enrollees who did not select a QHP will be noticed of their autoassignment and given another 30 days to choose a different QHP.

Auto-Assignment Methodology



Family affiliation to a QHP for those members where another family member is also enrolled in a QHP through the premium assistance program.



Family affiliation to a MCO for those members where another family member is enrolled in standard Medicaid through an MCO with a parent organization that has established a QHP.



Primary Care Provider affiliation to a QHP. This factor will only be used for current Bridge enrollees transitioning to a QHP for whom primary care provider history is available.



Tie-breaker. In cases where family and primary care provider affiliation are not applicable factors or there is a tie among affiliations, auto-assignment will be equally distributed among the available QHPs.

When Can Enrollees Switch QHPs ?

Enrollees may choose a different QHP in the Premium Assistance program:

- 1 Within 30 days of first choosing a QHP
- 2 Within 30 days of being auto-assigned to a QHP
- 3 Within 60 days of the beginning of a Special Enrollment Period

What Counts as a Special Enrollment Period?

Five Events

Permanent Move. Enrollee loses access to the QHP he or she is currently enrolled in because of a permanent move to a county where that QHP is not available.

Family Gains Member. Enrollee gains or becomes a dependent through marriage, birth, adoption, foster care, child support order, or court order.

Family Loses Member. Enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee's dependent, dies.

QHP Error. Enrollee adequately demonstrates to DHHS that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

DHHS Error. The PAP participant's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of DHHS, its instrumentalities, or a non-DHHS entity providing enrollment assistance or conducting enrollment activities

How To Show Eligibility for a Special Enrollment Period?

Enrollee must notify DHHS that he or she is in a special enrollment period. Enrollee must also provide documentation, such as:



Provide a copy of a new lease, utility bill, or other proof of a permanent move to a new county.



Provide a copy of birth certificate, marriage license, court order, etc. to show gain or loss of a dependent.



Provide evidence that the QHP violated the coverage contract with the enrollee.



Provide evidence that enrollee was enrolled or disenrolled in a QHP through a mistake made by DHHS or its vendors.

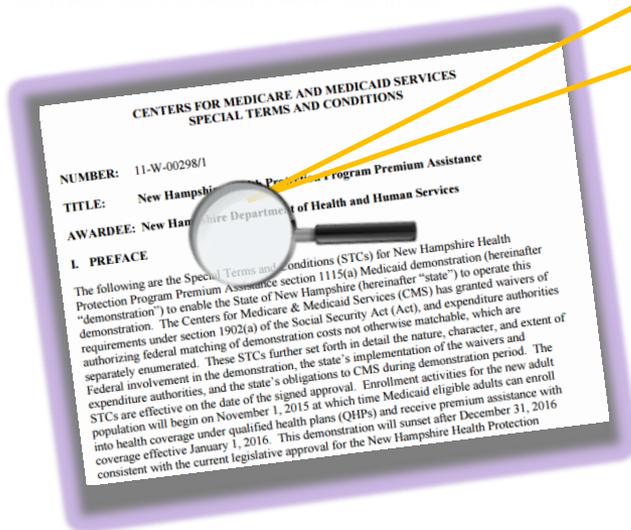
Benefits

Expansion Adults Receive the Alternative Benefit Plan



“...Individuals who are eligible under section 1902(a)(10)(A)(i)(VIII) of the [Social Security] Act must enroll in an Alternative Benefit Plan to receive medical assistance.”

– 42 C.F.R. §440.305



“The state will provide through its fee-for-service Medicaid program wrap-around benefits that are included in the ABP but not covered by qualified health plans. These benefits include non-emergency medical transportation (NEMT), early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21, family planning services and supplies, and certain limited adult dental and adult vision services.” – Special Terms and Conditions of the New Hampshire Health Protection Program Premium Assistance Demonstration

Alternative Benefit Plan

The Alternative Benefit Plan (ABP):



10 Essential Health Benefits (EHBs)



Vision and limited dental



Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for 19 and 20 year olds



Non-emergency medical transportation



In-network Federally Qualified Health Centers



Free access to family planning services and providers

Prescription drugs
Rehabilitative and habilitative services and devices
Laboratory services
Hospitalization
Ambulatory patient services
Pediatric services, including oral and vision care
Maternity and newborn care
Mental health and substance use disorder services
Preventive and wellness services and chronic disease management
Emergency services

The ABP is currently being provided through Medicaid managed care plans in the Bridge Program.

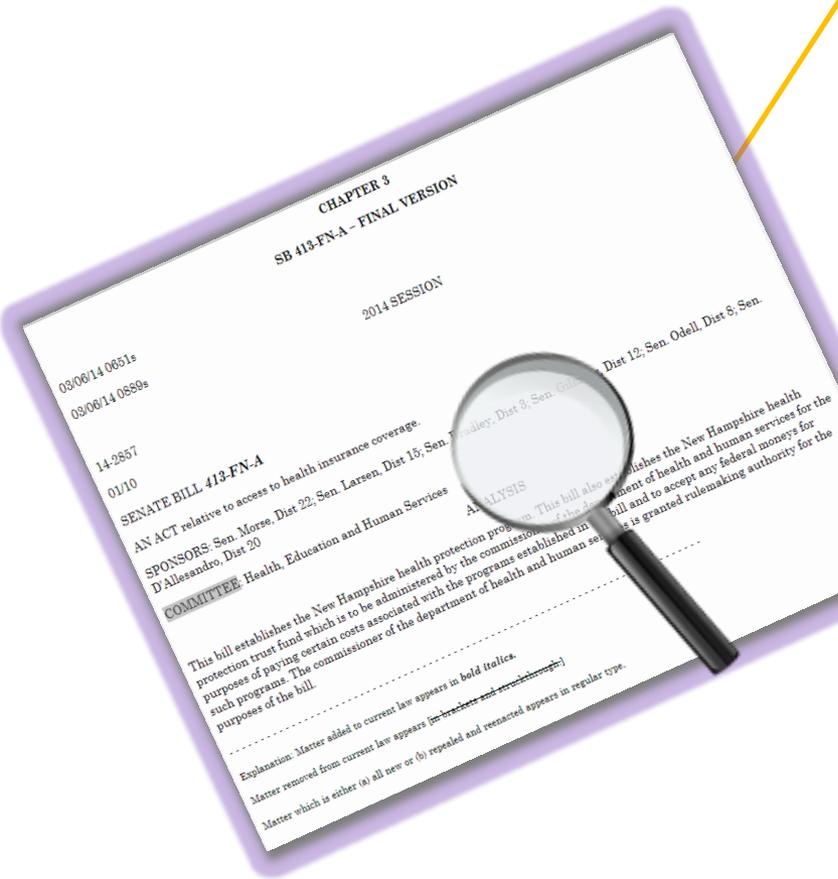
Extra “Wrap” Medicaid Benefits in PAP

Category	Covered Services
Transportation:	Access transportation to and from medical appointments if the enrollee has no other way of getting there.
Additional Support for 19 and 20 Year Olds:	Eligible to receive additional benefits if provider prescribes them as medically necessary. This standard of benefit is called Early Periodic Screening Diagnostic and Testing Services (EPSDT).
Family Planning Services and Supplies:	Family planning services and supplies from a Medicaid enrolled provider that is not in the QHP network, at no charge.
Limited Vision:	May be eligible for one pair of eyeglasses once a year if prescription changes enough.
Limited Dental:	Treatment for severe dental pain or dental infections.

Enrollees should call 844-275-3447 to ask for these services and use their NH Medicaid card when accessing them

Cost-Sharing

SB413 Requirements: Personal Responsibility



“To the greatest extent practicable the waiver shall incorporate measures to promote continuity of health insurance coverage and personal responsibility, including but not limited to: **co-pays, deductibles, disincentives for inappropriate emergency room use, and mandatory wellness programs.**”

- SB 413-FN-A 3:2 XXIV (b)

Premium & Deductible Payments

Premiums & Deductible Payments

Enrollees do not pay a premium or deductible



Co-Payments: What is Changing

Changing

Which services require co-payments and the amount of the co-payment are changing in 2016. All Medicaid enrollees, in and out of the PAP demonstration, will experience the same, updated cost-sharing obligations.

Co-Payments

Co-Payment Obligations*

Medicaid enrollees with incomes < 100% FPL

- No cost-sharing obligations

Medicaid enrollees with incomes >100% FPL

- Charged specific co-payments for certain services (see next slide for list of co-payments)



Co-Payments for PAP Enrollees

- No matter which QHP an enrollee selects, the co-payments will be the same, and all of the charges are compliant with Medicaid requirements
- Maximum out-of-pocket expenses for co-payments may not exceed 5% of total household income on a quarterly basis. DHHS and carriers will agree on a method for tracking and suspending co-payments for an enrollee who has reached his/her maximum in any quarter.

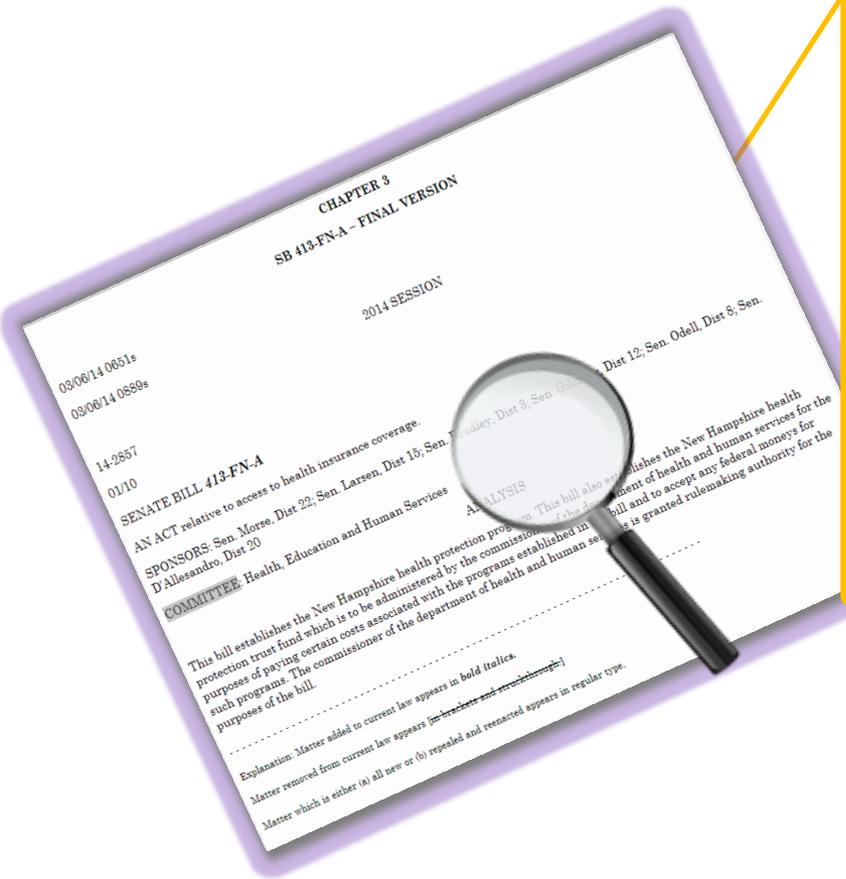
**Any individual who is exempt from cost-sharing (e.g., pregnant women) will continue to be exempt from cost-sharing both in and out of the PAP demonstration*

PAP Standard Co-Payment Plan Effective as of January 1, 2016

Service	Co-Pay
Primary Care Physician Visit	\$3
Specialty Physician Visit	\$8
Other Medical Professional Visit	\$3
Generic Prescription Drug (primarily Tier 1)	\$4
Preferred Brand Prescription Drugs (primarily Tier 2)	\$8
Non-Preferred Brand Prescription Drugs (primarily Tier 3)	\$8
Specialty Prescription Drugs (primarily Tier 4)	\$8
Behavioral Health Outpatient Visit (MH and SUD)	\$3
Behavioral Health Inpatient Admission (MH and SUD)	\$125
Hospital Inpatient Admission	\$125
High Cost Imaging (CT/PET Scans, MRIs)	\$35
Durable Medical Equipment	\$0
Lab and Radiology	\$0
Skilled Nursing Facility	\$0
Emergency Room Visit	\$0
Physical Therapy/Occupational Therapy	\$3
Chiropractor Visit	\$3

Medically Frail

SB 413 Requirement: Medically Frail



“The commissioner shall submit to CMS any necessary waiver application to implement the provisions of this paragraph, including provisions to address **individuals determined to be medically frail after completion of a health questionnaire screening process.**”

- SB 413-FN-A 3:2 XXIII (b)

Identification of Medically Frail

Medically Frail Individuals

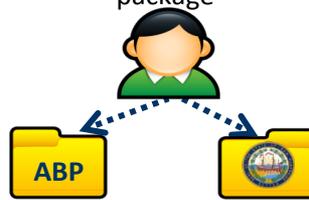
Individuals **self identify** as Medically Frail on single, streamlined application



Medically Frail individuals will **not be permitted** to enroll in QHPs



Individuals will enroll through managed care and have **option** of ABP or **standard Medicaid** package



Individuals will be identified as medically frail if they indicate that they either:

1. Have a physical, mental or emotional condition that causes limitations in daily activities; or,
2. Reside in a medical facility or nursing home

All Others

DHHS will notify non-Medically Frail individuals they can **self-identify as Medically Frail at any point**



Medically Frail Choice of ABP or Standard Medicaid

Medically frail individuals are excluded from the PAP

In the NHHPP, Medically frail expansion adults will be enrolled into Medicaid managed care.

As required by the Affordable Care Act (ACA), Medically Frail beneficiaries must be offered a choice of the Medicaid Standard benefit package or the ABP.



Differences Between the ABP and Medicaid Standard

Health Benefit Differences	Medicaid Standard	Medicaid ABP
Access to long-term care services (e.g., nursing homes)		
Help with everyday tasks, like bathing, getting dressed, and preparing meals		
Services to help the enrollee stop using drugs or alcohol		
Limits on the number of visits for some services, like care in a hospital outpatient clinic but there are no limits on emergency care, urgent care, or walk-in care		

If a Medically Frail expansion adult selects the Medicaid standard, the State will receive the enhanced match for all services he/she accesses, including long-term care services.

Change in Medically Frail Status During Plan Year

Need Identified by Individual



Individuals may **self identify** as Medically Frail at any point in the year

Need Identified by Carrier & DHHS



Carriers may identify **to DHHS** individuals who have requested services that are **not** covered by the QHP but may be covered by Medicaid

- Long-term care services will likely be the most commonly requested service that are not covered by the QHP but are covered by Medicaid standard



DHHS may choose to inform these individuals of their right to self-identify as medically frail



The ultimate decision to identify as medically frail is the enrollee's

Medically Frail Identification at Renewal

Renewal Notices



Renewal notices will include an individual's Medically Frail status and provide the opportunity to update the status

The notice will also remind enrollees of the right to self-identify at any point during the year should their health status change

Appeals

What Do Enrollees Need To Know About Appeals?

PAP Appeals

For Eligibility or Wrap Benefits. Enrollees can appeal directly to DHHS. Enrollees do not have to go to the QHP or NHID first about eligibility or wrap benefit issues.

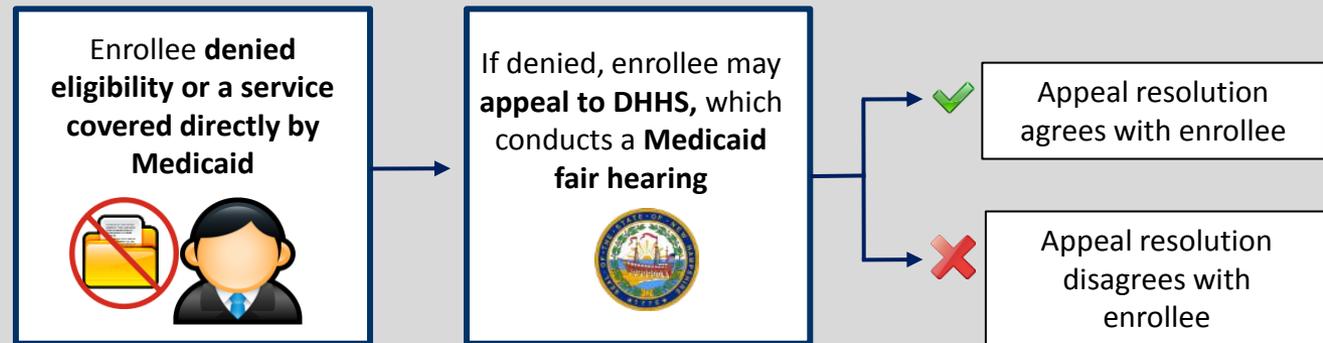
For QHP covered services. Enrollees must use the QHP internal review process first. Enrollees can ask for assistance with this from NHID if they want, but they don't have to. **Enrollees can appeal to DHHS directly about QHP covered services only AFTER they have exhausted all of the steps of the QHP appeals process.**

After Internal Review: Medical Necessity Question. If, after a QHP internal review of a question about whether or not a service was medically necessary, enrollees want to further appeal because their issue is still unresolved, they have to ask for an **external review** process from the NHID. **If the external review process does not resolve the issue, then enrollees can directly appeal to DHHS.**

After Internal Review: Coverage Dispute Question. If, after a QHP internal review of whether or not a covered service was provided, enrollees want to further appeal because their issue is still unresolved, they can either file a grievance with NHID or appeal directly to DHHS.

Appeal of Eligibility or a Wrap Benefit

Process for an appeal for eligibility or a wrap benefit provided directly by Medicaid



To ask for an appeal about eligibility or wrap benefits, call the Administrative Appeals Unit directly at 800-852-3345 extension 4292. Or you can go to www.dhhs.nh.gov/oos/aau and get an appeals form. Or you can write your own letter and send it to us at Central Scanning Unit, NH Department of Health and Human Services, P.O. Box 1810, Concord, NH 03301

PAP Eligible Population

Expansion Adults



Ages 19 up until 65

Income below 138% FPL

Not pregnant at time of eligibility determination

Not entitled to or enrolled in Medicare

Not in any other mandatory Medicaid eligibility group



Except for the expansion adults:

- ❖ Who are identified as medically frail

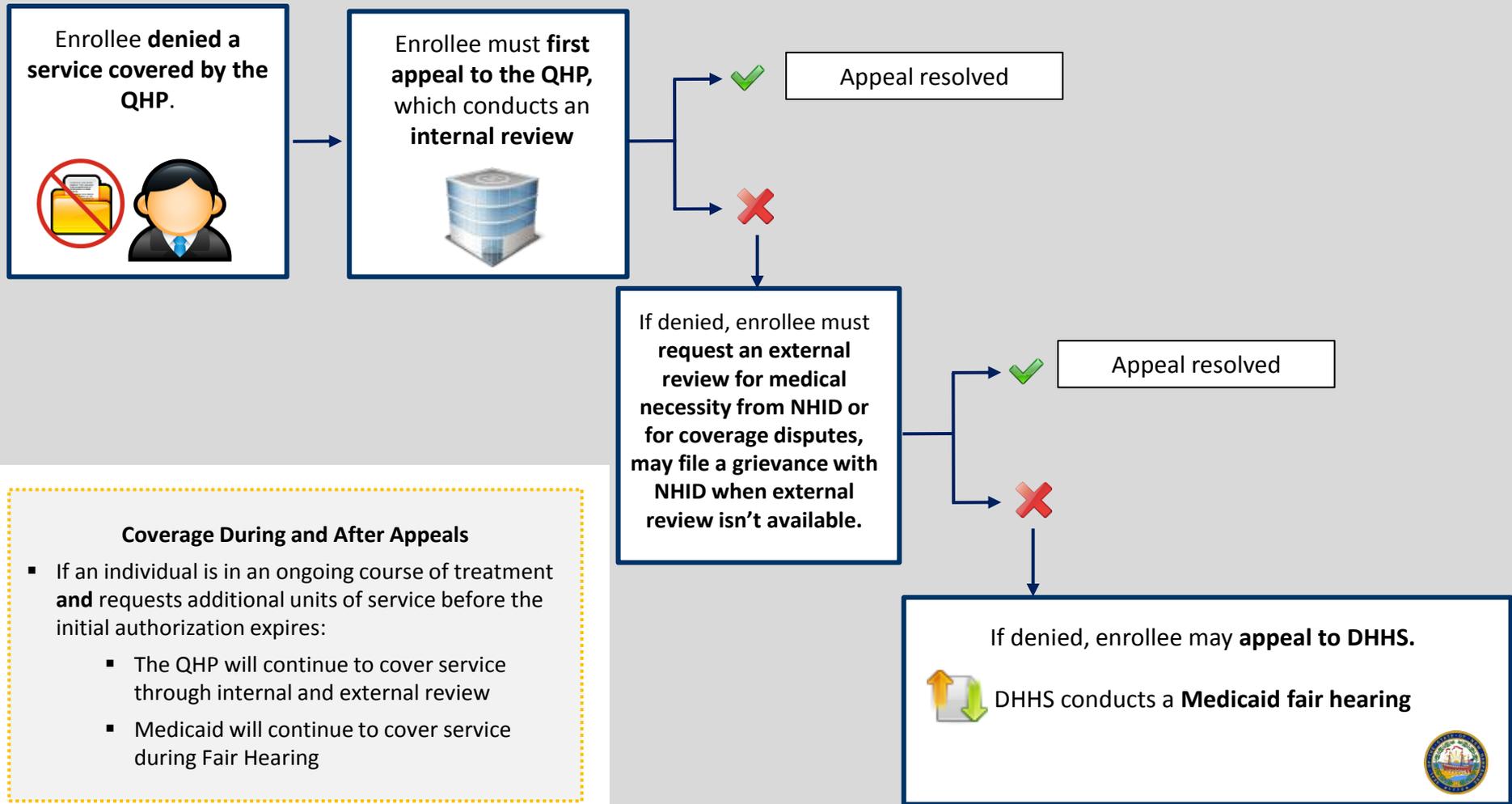
Disagreements about whether or not an individual is eligible for NHHP can be appealed to DHHS

These are the “Wrap” Medicaid Benefits in PAP client can appeal directly to DHHS

Category	Covered Services
Transportation:	Access transportation to and from medical appointments if the enrollee has no other way of getting there.
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Appeal of QHP-Covered Service

Process for an appeal for a service covered by a QHP

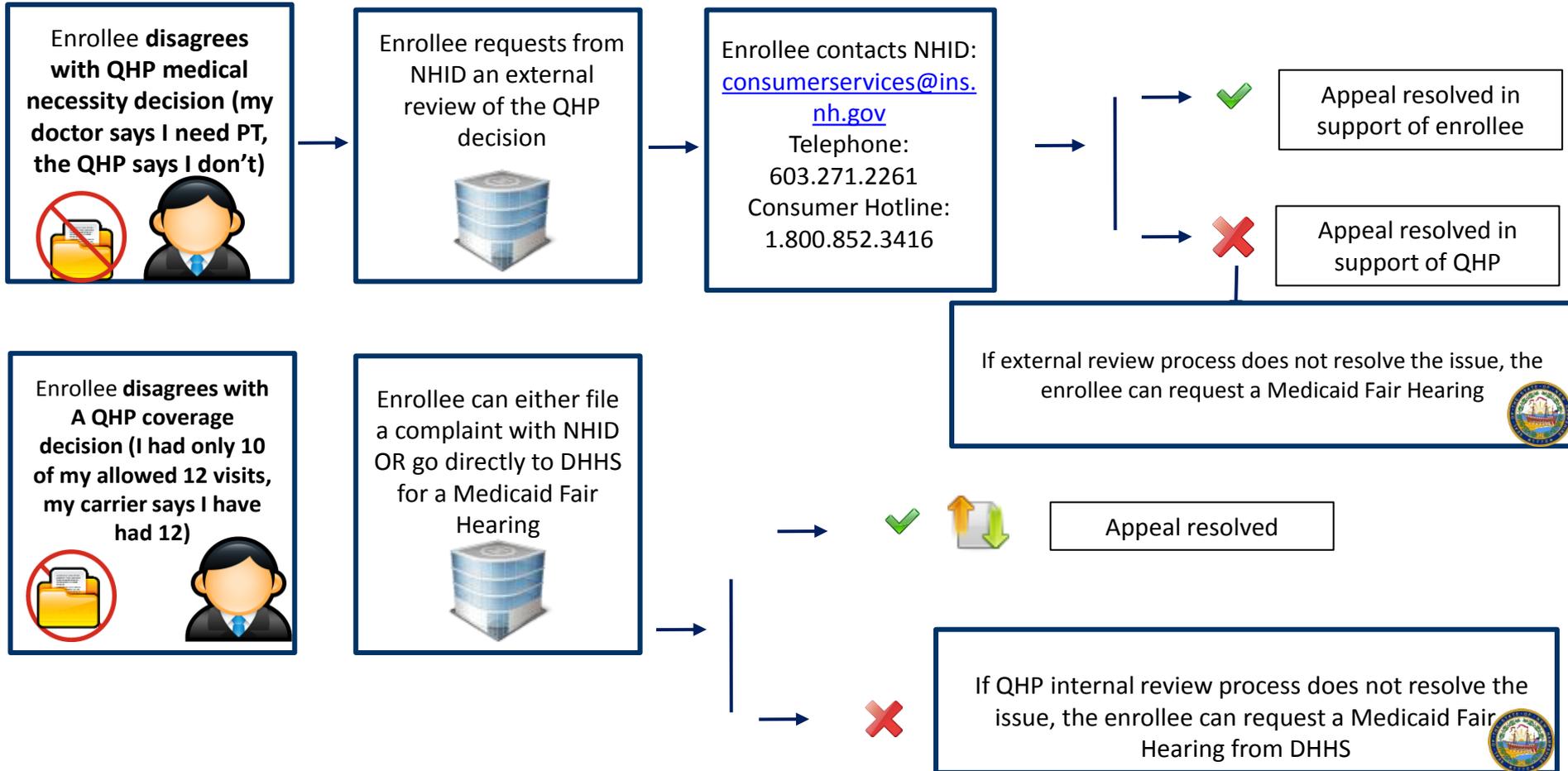


Coverage During and After Appeals

- If an individual is in an ongoing course of treatment **and** requests additional units of service before the initial authorization expires:
 - The QHP will continue to cover service through internal and external review
 - Medicaid will continue to cover service during Fair Hearing

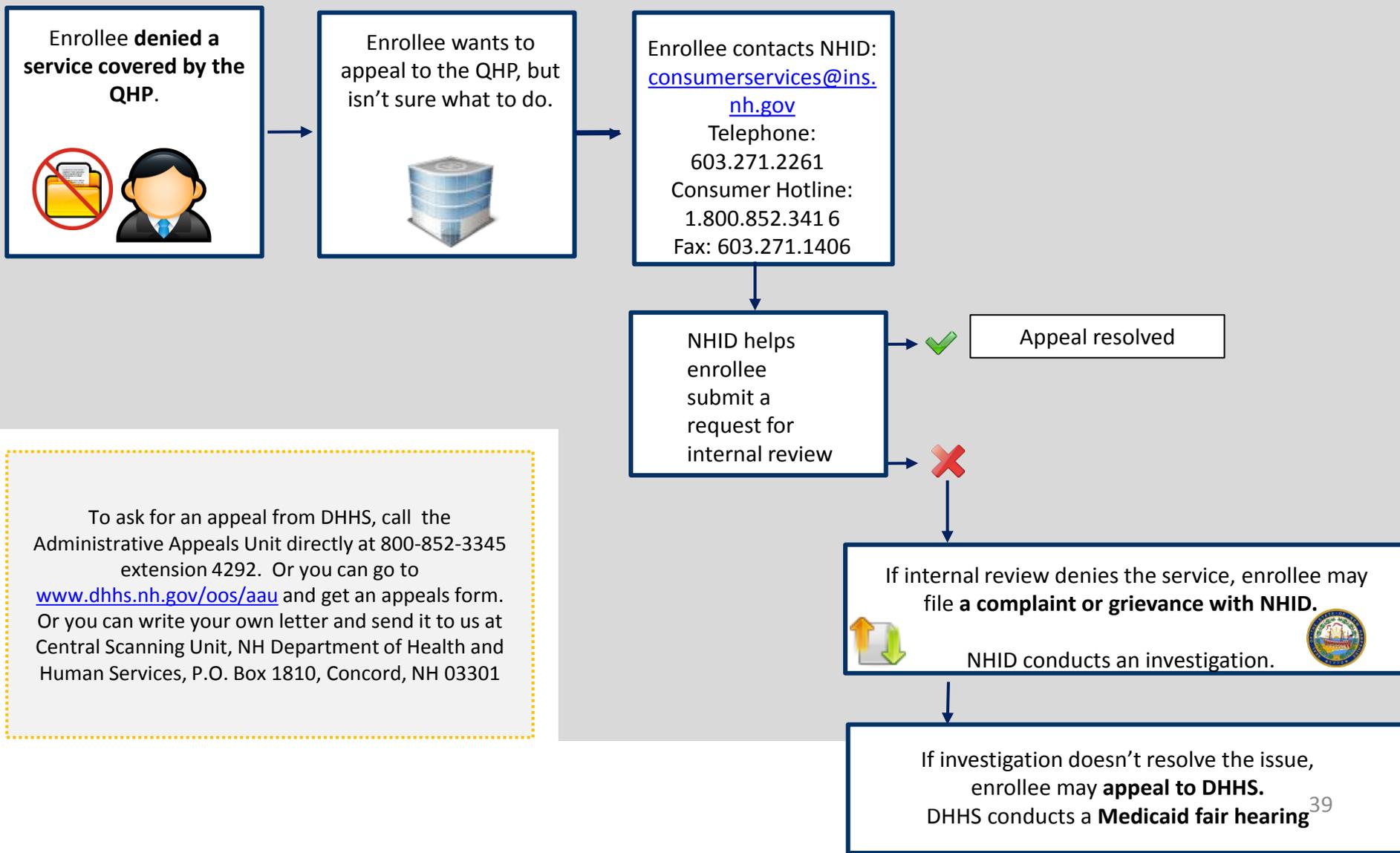
Appeals and the Premium Assistance Program

Enrollees can appeal medical necessity and coverage decisions made by QHPs



Enrollees can get consumer assistance with an appeal of QHP-covered service from NHID

Contact the New Hampshire Insurance Department (NHID)



To ask for an appeal from DHHS, call the Administrative Appeals Unit directly at 800-852-3345 extension 4292. Or you can go to www.dhhs.nh.gov/oos/aau and get an appeals form. Or you can write your own letter and send it to us at Central Scanning Unit, NH Department of Health and Human Services, P.O. Box 1810, Concord, NH 03301

Resources and Important Dates

- **PAP webpage:**
www.dhhs.state.nh.us/ombp/pap.
 - **Heads up Letters Delivered This Week**
 - **Shopping for QHPs in PAP opens on November 2, 2015**
 - **Coverage under PAP begins January 1, 2016**
-