

Frequently Asked Questions for NHHPP Premium Assistance Program

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Background & Eligibility

1. What is the NHHPP Premium Assistance Program?

The New Hampshire Premium Assistance Program (PAP) is the next phase of the New Hampshire Health Protection Program, which currently provides health coverage to many low-income adults in New Hampshire. Beginning in January 2016, DHHS will purchase Qualified Health Plans (QHPs) certified for sale on New Hampshire's Federally Facilitated Marketplace (FFM) using Medicaid funds. The QHPs will provide health insurance for the PAP eligible adults.

2. Who is eligible for the Premium Assistance Program (PAP)?

Most individuals in the "new adult group" will be eligible for the Premium Assistance Program. The "new adult group" includes all adults aged 19-64 with incomes up to 138 percent of the Federal Poverty Level (FPL) who upon application do not fall into any other Medicaid eligibility category and who do not qualify for Medicare. Adults who have access to cost-effective employer-sponsored insurance or who are medically frail will be ineligible for the Premium Assistance Program.

3. How will individuals apply for the NHHPP PAP?

Individuals can apply by mail, online through NHEASY, by phone or in person.

4. How will a premium assistance enrollee appeal an eligibility determination?

Individuals will appeal an eligibility determination directly through the Department of Health and Human Services' (DHHS) Medicaid Fair Hearing process.

Enrollment

5. When individuals that had been enrolled in the Bridge Program are "auto-enrolled" in their MCO's QHP (assuming their MCO elected to offer a QHP), can they opt out of that plan and choose another Marketplace plan?

Bridge enrollees whose MCO offers a QHP that features the standard cost-sharing design and that has been determined by NH DHHS to be cost effective, will be auto assigned to that QHP at the start of the private market open enrollment period (11/1/15). Enrollees will be notified of this auto-assignment, and will then have 30 days to select a different cost-effective QHP that features the standard cost-sharing design, if they wish.

6. How many days does a new applicant have to select a QHP before being auto-assigned?

Enrollees will have thirty (30) days to select a plan prior to being auto-assigned. PAP eligible enrollees who either: (1) were enrolled in a Managed Care Organization (MCO) that does not offer a QHP or (2) were never enrolled in an MCO will have 30 days to select a cost-effective QHP that features the standard cost-sharing design, prior to being auto-assigned. If they fail to elect a QHP during that time

frame, they will be auto-assigned to a cost-effective QHP featuring the standard cost-sharing design.

7. How many days will individuals who are auto-assigned be given to choose a different QHP?

Individuals will have 30 days to change plans after they have been auto-assigned. The 30-day time period will begin on the date listed on the notice.

8. What criteria are used to auto-assign a new applicant to a QHP?

Auto assignment will take into consideration the enrollee's relationship with an MCO that offers a QHP on the Marketplace, a family member's affiliation with either a QHP or an MCO, relationship with a primary care provider (if this information is available), and if no other factors are identified, the auto-assignment will be equally distributed among the available QHPs.

9. Will the PAP pay the premium if beneficiaries chose a different QHP from the one to which they were auto-assigned?

Yes. The State will pay the premium for any QHP in which the individual enrolls. PAP enrollees will be allowed to shop from and enroll in cost-effective QHPs only.

10. How will a PAP enrollee select a QHP?

PAP enrollees will be able to shop for a QHP online through NH EASY, by phone or in person. PAP enrollees will not be able to select a QHP using the healthcare.gov website.

11. Which QHPs will PAP enrollees be able to select?

PAP enrollees will be able to select from QHPs DHHS has deemed cost-effective, which feature the standardized cost-sharing design, and which are certified for sale on the NH Marketplace in the county of the enrollee's residence.

12. How will DHHS determine which plans are "cost-effective" and will be made available for PAP enrollment?

DHHS will review the premium rates of the non H.S.A., non-multi-state, silver QHPs certified for sale through the New Hampshire Marketplace in 2016. The final determination of cost-effectiveness will depend on the plans available in each county. There is not a precise numerical cutoff, because the market characteristics for 2016 are not yet known; however, if the premium of a reviewed QHP is approaching being 20 percent higher than the median premium of those reviewed, that QHP may be at risk of being deemed not cost-effective.

Benefits

13. What is the Alternative Benefit Plan?

The alternative benefit plan or ABP is the required group of benefits that the New Hampshire Medicaid program must provide to individuals in the new adult group. The ABP consists of the Essential Health Benefits provided through the QHPs, plus a smaller group of additional benefits provided directly

through Medicaid called wrapped benefits.

14. What benefits will PAP enrollees receive?

What benefits will be provided by the QHP?

Ambulatory patient services,
Emergency Services,
Hospitalization,
Maternity and Newborn Care,
Mental Health and Substance Use Disorder Services,
Prescription Drugs,
Rehabilitative and Habilitative services and devices,
Laboratory Services,
Preventive and wellness services,

What benefits will be provided directly through Medicaid under a separate wrapped benefit?

Non –emergency medical transportation
EPSDT services for 19 & 20 year olds
Family Planning services from any Medicaid enrolled Provider outside of the QHP network
Emergency dental extractions
Eyeglasses

15. How will PAP enrollees access wrapped benefits provided by Medicaid?

To request any of these additional benefits, enrollees should call 1- 844-275-3447 or 1- 844-ASK-DHHS.
When accessing these benefits, enrollees should have their NH Medicaid card.

16. What provider networks will PAP enrollees use?

The PAP enrollees will use the network of the QHP for the services provided by the QHP. QHP providers are not required to be Medicaid providers. Enrollees will use Medicaid enrolled providers for accessing the wrapped services provided through Medicaid.

Carrier Participation

17. If a QHP is determined to be not cost effective, and therefore not available to the PAP population, does that mean that QHP will not be sold on the Marketplace?

No. The QHP review and certification process conducted by NHID and CMS is separate from the NH DHHS determination of whether a QHP is cost-effective for the PAP program. If a QHP is determined not to be cost-effective for the PAP program, it will not be made available to PAP eligible individuals for enrollment, but will still be available to Marketplace purchasers, if it is certified as a QHP by CMS.

18. If a carrier decides not to participate in the PAP, does that prohibit the carrier from offering QHPs on the Marketplace?

Yes. Please refer to the New Hampshire Insurance Department's Premium Assistance Draft Bulletin, which can be found at http://www.nh.gov/insurance/lah/documents/draft_pap_bull.pdf and which states:

"RSA 126-A:5, XXV(a) provides that adults eligible for the New Hampshire Health Protection Program (NHHPP) who are ineligible for the Health Insurance Premium Payment program shall choose from any qualified health plans offered on the New Hampshire Marketplace if cost-effective. As such, issuers offering QHPs on the NH Marketplace in 2016 must accept NHHPP participants as enrollees" (Page 2, paragraph III)

And

"As such, issuers must offer at least one 94% AV high silver plan that conforms with the standard cost-sharing design developed for the NHHPP by New Hampshire DHHS for each unique combination of product type and network used in a silver-level QHP." (Page 2, paragraph IV)

Medical Frailty

19. Will medically frail and other excluded individuals receive coverage under the ABP via managed care or FFS Medicaid under the State Plan? In general, how will they be covered and receive care?

Medically frail individuals will be permitted to choose to receive either the ABP benefit package or the standard Medicaid state plan benefit package at their option, administered through the managed care delivery system.

20. How will DHHS determine whether an applicant is medically frail, and as a result, exempt from the PAP?

Enrollees may self-attest to being medically frail during the application process or at any time during the calendar year by contacting DHHS. Additionally, if PAP enrollees ask for services that the QHP does not cover but that may be covered by DHHS, the QHP carrier may notify DHHS. DHHS will then reach out to those identified enrollees and remind them that they can identify themselves as medically frail at any time and gain access to Medicaid state plan services or ABP services.

21. Are enrollees permitted to attest to medical frailty throughout the year?

Yes. Enrollees can identify as medically frail at any time and gain access to the ABP or Medicaid state plan services, depending on their needs.

Cost-Sharing

22. Will beneficiaries below 100 percent FPL and those above 100 percent FPL be subject to different cost sharing obligations? Will cost-sharing exceed 5 percent of annual family income?

There is no cost sharing for any NH Medicaid enrollees with income below 100 percent FPL, including enrollees in the NHHPP. Beginning in January 2016, Medicaid adults with incomes above 100 percent FPL, who are not otherwise exempt from cost-sharing, will have co-pays for certain services, some of which are listed below. Cost-sharing will not exceed 5 percent of household income on a quarterly basis. PAP enrollees will receive information about required copayments from DHHS during the plan selection period and from the QHP carrier once they are enrolled.

Primary Care Outpatient	\$3
Mental Health Outpatient	\$3
X Rays and Diagnostic imaging	\$0
Generic Drugs	\$4
Brand Drugs	\$8

23. Will individuals who are not otherwise exempted from cost-sharing have to pay cost-sharing for the period in which they are receiving coverage via FFS Medicaid pending enrollment in a QHP?

Yes. Medicaid adults with incomes above 100 percent FPL who are not otherwise exempt from cost-sharing will be subject to the same cost-sharing, regardless of which delivery system they use to access care (premium assistance for Employer Sponsored Insurance (referred to as “HIPP”), QHP Premium Assistance, fee-for-service, or managed care).

24. Regarding the 5 percent cap for cost sharing for the 100 percent-138 percent FPL (counting the income disregard), is it the consumer’s responsibility to track that and report when cumulative cost share is 5 percent of their quarterly income? Or provider? Or PAP?

The State has the overarching responsibility to track out of pocket costs for PAP enrollees against the quarterly cap. The State is working with carriers to establish a tracking process.

25. Will PAP enrollees have to pay any premiums?

The State of New Hampshire will pay the premiums to the carriers for the QHP coverage. The PAP enrollees will not pay premiums.

26. Does NH pay the deductible and co-insurance or does the member?

The State of New Hampshire will make advance cost-sharing reduction payments to carriers to buy down the cost-sharing to either the 94 percent or 100 percent A/V levels.

27. It is possible for DHHS to have an HRA solution for PAP to pay for the out-of –pocket costs?

No. The state is not able to administer an HRA at this time.

Appeals

28. How will premium assistance program enrollees appeal a denial of benefits covered under their QHP?

Enrollees will use the QHP appeals process at first. As with any other QHP enrollee, they will receive notice from the carrier of their appeal rights if a claim is denied. In addition, they will be advised that they can seek assistance in filing the appeal from the NHID’s Consumer Services staff. After exhausting the entire QHP appeals process, enrollees who are still aggrieved will be able to access the Medicaid Fair Hearing process if they wish to pursue a further appeal.

29. How will premium assistance program enrollees appeal a denial of Medicaid wrap benefits?

Denial of wrap benefits can be appealed directly through the Medicaid Fair Hearing process at DHHS. To ask for an appeal about a wrap benefit enrollees can call DHHS at 1-844-275-3447 or go to www.dhhs.nh.gov/oos/aaq to get an appeals form. Enrollees can write their own letter and mail it to Central Scanning Unit, NH Department of Health and Human Services, P.O. Box 1810, Concord, NH 03301.

Additional Miscellaneous Carrier Questions

30. Are there any Medicaid specific rules in addition to the cost share tracking, Medicaid fair hearing, and medically frail that insurance plans enrolling premium assistance program members need to follow for the PAP population? For example, are there specific requirements for Member Services call handling, member materials, medical management, etc .

As a general matter, there are no Medicaid-specific requirements for the call center handling and member materials. Because the QHPs into which the Medicaid eligible persons will be enrolled are commercial products, all private market insurance laws and regulations, both state and federal, will apply, including those applicable to customer communications. The Medicaid care management regulations (generally found at 42 CFR 438) do not apply to the Premium Assistance Program, as the coverage is provided through fully insured commercial plan, not Medicaid-specific plans.

31. Will PAP trigger any of the Medicaid Criteria under NCQA?

The Medicaid care management regulations do not apply to the Premium Assistance Program. Instead, in this instance, the carrier must meet the NHID and CMS QHP certification requirements to offer products through New Hampshire's Marketplace, including the requirement to be accredited by NCQA, URAC, or the Accreditation Association for Ambulatory Health Care.

32. What, if any, financial reporting requirements are there for the PAP, i.e. CMS Payment Workbook?

Issuers will do the same financial reporting for all QHP enrollees.

33. Please describe how and when payments are made.

Payments will be made monthly. The State will generate an 820 payment file, as well as a monthly enrollment roster that the Issuer may use to verify the accuracy of the payments.

34. What are the requirements for maternity care coverage? For newborns, NH requires 30-90 days of coverage under the mother's policy. How will this work for the PAP members?

The same rules regarding newborn coverage for commercial market enrollees apply to PAP enrollees. Carriers must provide 31 days of newborn coverage, under RSA 415:22.

35. What plans are the members who qualify for PAP on today? Can we get a plan summary?

Many individuals who will qualify for PAP when it is launched on January 1, 2016 are currently covered through Medicaid Care Management. We can provide a copy of the plan contract, but the current plan contract has no implications for the Issuers.

36. What are the servicing requirements for these members? Can carriers adhere to existing and established standard service hours or is it different for NH? This includes hours of customer service

operation or any other call standards including average handle time, quality, ASA – average speeds to answer. Does PAP have call standards that carriers are required to meet?

The same servicing requirements apply for all QHP enrollees.

37. Are there any requirements from CMS on timing of answering an incoming call (ASA standards? – average speed to answer)?

The same servicing requirements apply for all QHP enrollees.

38. Will there be HICS cases for any complaints from CMS?

The same HICS requirements apply for all QHP enrollees.

39. What are the guidelines regarding member materials? For example, if a member is terminated, what is the Issuer’s responsibility in communicating that to the member?

The same notification requirements apply for all QHP enrollees. DHHS may also follow-up with an enrollee to provide additional information.

40. What are the rules in NH regarding continuation of coverage under the law? If a PAP member has an income change and he or she is no longer eligible for Medicaid, are Issuers required to offer a commercial product in the individual market?

The same rules would apply for all QHP enrollees. If an individual becomes ineligible for Medicaid, they would qualify for a special enrollment period because they had lost minimum essential coverage. At that point, they would have access to all individual market QHPs.

41. Are PAP members allowed to obtain services outside of the state of NH if non-emergent?

The same coverage rules apply for all QHP enrollees.

42. If a traditional Medicaid member in MA moves to NH, is that member eligible for the program? What are the residency requirements?

The individual would apply to NH for Medicaid coverage; DHHS would determine whether the individual meets its Medicaid eligibility requirements.

43. There is legislation in NH that providers are paid within 30 days. What are the rules should a provider put a member in collections for non-payment. How does an issuer ensure servicing providers are paid appropriately?

The Issuers must pay providers within 30 days. The provider would then seek payment of applicable co-payments from the enrollee. The Issuer is not involved in collecting co-payments.

44. Is it possible that a NH Member in the Bridge population will have dual eligibility for both Medicaid and Medicare?

Dual eligibles are expressly excluded from the “new adults group” which is the group eligible for coverage under the Bridge plan, currently, and PAP in 2016.

45. Do accumulator counters begin on 1/1/or are they based on the rolling anniversary of the member?

Accumulator counters begin on 1/1. All individuals in the PAP program will be enrolling in individual market coverage that is offered on a calendar year basis.

46. We assume the anniversary date of a PAP member is based on the calendar year with group effective date of 1/1.

All plan years begin on 1/1. All individuals in the PAP program will be enrolling in individual market coverage with plan years beginning on 1/1. There is no "group effective date."

47. Is it possible for DHHS to have an HRA solution for PAP to pay the out-of-pocket costs?

No. The state is not able to administer an HRA at this time.

48. Will the amount set for quarterly OOPM be variable from year to year?

Yes, to the extent the federal poverty line increases.

49. Do the 3Rs apply to the Premium Assistance Program?

Yes.