

Transcript of Provider Training:

***What Providers and Their Clients Need to Know about the NHHPP,***

Held July 30, 2014 in the Brown Building Auditorium, Concord, NH

(Nicholas Toumpas, DHHS Commissioner): "All of you here – I've only had one cup of coffee this morning – and we also have a sizable number of people on the, on the phone through the webinar. My name is Nick Toumpas. I'm the Commissioner of the Department of Health and Human Services and again, I want to welcome you all here to learn about the New Hampshire Health Protection Program. This is the second in a series of information sessions that we will be holding on this very important program. This one is really focused on providers, as there will be other ones that will be getting into greater levels of details regarding business processes and so forth. It is a complex problem, a challenge and a series of issues that people need to be aware of, so what we wanted to do is make sure we try to provide as much information as we, as we are able to do. So, today, we had the first session last week up in Littleton and if the session up in Littleton, which was also well attended by people up there as well as on the webinar. I underscored after we went through the formal presentation, we went right up until the last minute with questions, either from the audience that were with us here personally as well as those of you on the webinar. On July 1st, we began the first step in the implementation of the New Hampshire Health Protection Program by beginning the eligibility and enrollment process. This is the biggest expansion of healthcare in the state since the New Hampshire Children's Health Insurance Program that was done back in the '90s. Then as now we need your help, and we'll go through why and how you can help us in this because it's really, you're the frontline working with a number of different of the clients that are in this program. We need to provide you with what information you need to know for your organizations as well as what you will do in order to basically help the clients. At DHHS our mission is really around health and independence and there are a number of factors that go into achieving a higher level of health for people. Perhaps one of the most important one is the ability to be able to have access to health insurance, affordable health insurance. And that really is a key to achieving

a greater level of health. However, up until now, the ability the basically have access to health insurance was depending upon whether you were employed and with an employer that actually offered health insurance, or you were aged or you had some form of a disability that would allow you to be on the Medicaid program. The New Hampshire Health Protection Program changes all that. Our estimates are that over the next several years that we will see close to 50,000 of our friends, neighbors, colleagues, and others that will seek out the support of this program. It is a vitally important program for those folks and I'm pleased that as of last night we had over 7000 people who have actually been deemed eligible and have enrolled in the program. Now, we're getting to the details in terms of the timelines that will begin on August 15th for coverage and then through the Managed Care Organizations on September 1st. The services that will be provided will be a full array of services of essential health benefits that will include mental health and, for the first time for many of our state citizens, the ability to be able to provide a full array of substance use disorder services which is a very, very significant issue for, for the state and for the people that we serve. Along with a full array of services, there will be a number of, of services, really, around prevention and wellness to allow people to achieve a greater state of health. This program will be of significant economic benefit to the state on a number of different levels. Clearly, I believe that with the rates that we will pay on this program that will be benchmarked to the Medicare rates where we have the ability to basically benchmark against Medicare rates. We will be paid a higher rate for, for the services. This will help stabilize a number of the safety net-type of organizations and providers that we have within the system. Today's session, again, we're going to get into a whole lot more detail but we'll go through an overview of the program and then open it up for questions and answer as we, as we do that. There'll be additional training that will be highlighted in the presentation as well as dates, locations, in terms of where that will all take place. Again, this is a complex program and it is building on top of the Medicaid Care Management Program. It requires we develop additional systems, bring on additional staff, build new business processes from the ground up as well as basically contract with additional organizations in order to assist us. We went live with the Medicaid Care Management Program in December of last year and one

of the things that we're most proud about in that program was that we had 60% of the people who went into that program self-selected a plan, meaning they took the first step to taking responsibility for their health. We could not have done that without your help. And so as we move forward in this program, we once again will be asking for your help to be able to work with people to help, help them make the right types of decisions in terms of what they need to do, who they need to see, in order to be able to start this process and get coverage. Working together, we need to inform, to educate, to do the outreach, and again, we need your help in terms of doing that. I stand here as Commissioner of the Department leading, leading this effort. I must say, there are literally hundreds of people across the state and clearly a number of people here in the Department of Human, Health and Human Services that have put in an extraordinary effort in order to basically get us to the point where effective, we're at starting line of this effort. So I really want to thank them for the work that they have been doing up until now, and a down payment, thank you on the work that they will be doing moving forward. And likewise for all of you, again, thank you for taking the time to be here. You all have a number of things to do to be here in order to basically learn and to be able to help us as well as help the clients in terms of navigating this program and basically to allow us to achieve the results we're looking to achieve. So before, what I'm going to do, I have some other things I need to take care of upstairs, but I will leave you in good hands with a number of people who will facilitate and provide the information. And with that, I'm going to turn it over to Lisabritt Solsky, who is the Deputy Medicaid Director in the Department, who will begin the presentation and go from there. So again, Lisabritt. Again, thank you all. And again, for those folks who came in subsequent to this, we have restrooms out both of these doors, either direction as well as in the back. For the folks on the phone, you'll have your own direction. Thank you."

(Lisabritt Solsky, Deputy Medicaid Director): "Thank you, Commissioner. Good morning. Thank you so much for joining us. Alright, it's a different clicker."

(Female): "And it sticks a little."

(Lisabritt): "Oh."

(Female): "Try this. There you go."

(Lisabritt): "Okay, awesome. Thank you. So, as Nick said, I'm Lisabritt Solsky. I'm the Deputy Director of Medicare and part of a small but very eager and dynamic team that is implementing the Health Protection Program. So, what we hope to accomplish today – and forgive me, those of you behind me. I don't mean to give you my back. I'll try to move around if I can – so, we're going to go over just broadly what the Health Protection Program is, what its purpose is, who is eligible, the basic program features, program timeline, how to apply. We'll talk about some of the program options going forward into the future, education and outreach, as well as upcoming and ongoing training opportunities. So, you know, one thing that we recognize is that it's one thing to come here in July and hear about something that's coming; it's another thing entirely when the thing is actually here and you're in the weeds and you're trying to figure out, 'What did that lady say?' So we want to try to keep the conversation going, so consider this sort of your first installment, okay. But we don't want to be continually available particularly to the providers. As Nick said earlier, the high degree of self-selection when we rolled out Care Management last December, we really credit to the provider community being so incredibly engaged, okay. So we want to keep that up. So, what is it? The Health Protection Program is a federally funded, locally managed healthcare program that expands coverage for low income New Hampshire residents. There have been a number of estimates about how many people might qualify. It's somewhere on the order of 50,000 individuals based on our best estimates. So, here we are at, this is the one-month mark for having accepted and processed applications, and we're seeing more than 7000 of those folks already having applied and been determined eligible, so that's great progress. The purpose, multi-faceted, so I think primarily it's to provide health coverage for more New Hampshire, of New Hampshire's low income citizens. I think, you know, I'd be preaching to the choir if I started talking about the long-term economic and other consequences of people not being able to access the right care at the right time and the right place. We're also trying to provide options to utilize private health insurance rather than a reliance on the Medicaid program, but, so with us in the background making those options more

accessible. We want to try to improve population health with this endeavor and reduce uncompensated care costs in the healthcare system. So, the legislation that created the Health Protection Program is very long. Raise your hand if you've read it. There's a little line in there. It says to give me a raise. No, I'm joking. So, but there are some important components that make the New Hampshire Health Protection Program deviate from the cookie-cutter Medicaid expansions that were authorized in the Affordable Care Act in which have stood up around the country. So we're really going to try to focus on where we deviate from what the other states have done if they just did that cookie-cutter Medicaid expansion. So one thing that the legislature required is that we pay providers treating these individual's rates that will assure access to care. That is largely understood to mean pay them better than you would on the ordinary day. So we've built into the program, as Nick said, a more favorable rate structure that will be payable for treating these members but only in the Managed Care phase. We'll talk a little bit about, you know, the time in between when somebody's determined eligible before they go to Care Management. They're still getting coverage. We still have to pay the regular rates, but once they get into Care Management you can start getting paid those enhanced rates. There's also a requirement that the program foster personal responsibility among the folks who are newly covered. We'll talk about some of the things that we've tried to bake into the program that will help give these newly covered individuals a little more [inaudible]. And finally, the program is linked for its shelf life to the period during which it is 100% federally funded, at which time we need to reconfigure things, and we'll talk a little bit more about that as the presentation goes on. So, in terms of eligibility, this is where we are perfectly aligned with the Affordable Care Act. This is a program that benefits only adults from age 19 to 65, okay, and at the time of application they cannot be pregnant. They cannot be entitled to or enrolled in Medicaid Parts A or B. And they can't be otherwise eligible or enrolled in another category of Medicaid. So that's where the pregnancy thing comes in, so if somebody came in and applied and said, 'Yes, I'm pregnant', we're actually going to put them in our pregnant women's category, not in the Health Protection Program. That is not to say, though, that if somebody subsequently becomes pregnant that we would change their category. So just date of application you can't be pregnant because

we're going to put you in a different category of coverage. You're still going to get coverage but you're going to be in one of our traditional categories, not the Health Protection Program. Under the Health Protection Program, resources are excluded. So, in the Medicaid world we typically, it's a means tested program, right. You have to have income within certain limits, and typically you have to have resources, so what's in the bank, what do you own, within certain resources, or within certain limits. And for the Health Protection Program we don't care what's in the bank and we don't care what you own. We're only going to look at your income, okay. And then finally, in a move, I think, to increase access and increase coverage, most of the components of the eligibility determination can be based on self-attestation, okay. So, while we're going to be doing things behind the scenes to validate some of the information that folks self-attest to, unless there is a clear, a glaring mismatch – so, somebody says, 'I have no income' and somehow we tickle the Social Security Administration there is an indication that they do in fact have income, then we're going to ask the person to verify – but it's, you know, tell us first and we may ask questions later, kind of model. In the meantime, you're covered, okay. So, the income limits align to 133% of federal poverty, odd number, I know. So we've tried in almost all of our materials to put that into dollars and cents, both on a monthly and an annual basis. You'll notice that the numbers grow based on the number of individuals in the household, okay. So, here we go to a household of four. Some of our other materials will actually go up to, I think, a household of six or even eight. But there's a common additive, both on the monthly or the annuals if you start to exceed a household of eight, okay. Yeah? Question?"

(Male): "Gross or net?"

(Lisabritt): "I'm looking at Robin. It's gross, though we do have, we do a couple of things administratively, but for purposes of the discussion consider it gross. Yes, and if you don't mind, can we hold the questions until the end? I should have said that at the beginning. We do find that, where we have folks on the line, that that makes it a little bit more organized. I typically tend to be more of a dialog kind of a person, so it makes challenging, but for this setting for the purpose of fair access to the folks on the phone we're going to hold questions till the end. Thanks. Okay,

so, there are two basic program components. First and foremost, we talk about what we call the Health Insurance Premium Payment Program or HIPPP. It is for this reason that we discourage you from calling the Health Protection Program the HPP because within the Health Protection Program, we have a HIPP already, and it's the Health Insurance Premium Payment Program. This is actually for individuals who either have access to or are already covered through employer sponsored coverage, okay. So, basically what we will do is we will pay the cost of that person's out-of-pocket so that they can access that employer sponsored coverage instead of utilizing straight up New Hampshire Health Protection or Medicaid, okay. And then the second component, for individuals who don't have access to employer sponsored coverage is what is referred to as the Bridge Program, and this allows individuals to receive comprehensive coverage through one of our two Medicaid Care Management companies, okay, our New Hampshire Healthy Families and the Well Sense Health Plan. You're probably all familiar with them, right? Okay. So, here is a little graphic that is intended to sort of illustrate how, from a high level, we determine whether you're going to be in the Health Protection Program or whether you're going to be in the Bridge Program. And I think what is of primary importance [inaudible side talk] if someone applies up here for Health Protection Program, friends on the phone at the blue box at the top, if they indicate that they have access to employer sponsored coverage, we're going to send them down to the left on the green chute here for assessment of the cost effectiveness of the HIPP Program. From the point that they've been determined eligible, while we're doing all of this work in the background, they are covered and they are covered on the fee-for-service platform, okay, so they don't need to forgo any treatment or engagement with cover, or with care. We'll continue to cover them on fee-for-service until we've made that HIPP determination. If the primary insurance is cost effective, they will remain in their employer sponsored coverage or they will enroll for the first time in their employer sponsored coverage, and we will just do wrap-around for things that aren't covered on the fee-for-service platform, okay. So it'll look a little bit like a PPL for you right now. The only difference is that they will not be in Care Management the way our current PPLs are. Okay. So, if the individual does not have access to employer sponsored coverage, or if that employer coverage turns

out to not be cost effective, they will be enrolled in the Bridge Program. They, just like their HIPP counterparts, while things are going on in the background administratively, they will be covered fee-for-service, so their first potential day of coverage is the day of their determination of eligibility which may or may not align with the date of application. They can self-identify as what is called medically frail. We'll talk a little bit more about that, which gives them the option of choosing the standard Medicaid benefit package or the alternative benefit plan. Either way, they are in Care Management, and until the first day, or the first day of the first month after they've selected a health plan, they remain in fee-for-service. It's all going to be crystal clear by the time I get to end of it, I promise.

Okay, so more about the HIPP Program. Again, if somebody has access to employer sponsored coverage, it will be mandatory that they participate through the HIPP Program. They don't have the option of going into the Bridge Program, okay. But that employer sponsored coverage must be cost effective. And what we will do through the HIPP Program is reimburse that individual for the cost of their premiums and basically all of their out-of-pocket associated with the access to that employer sponsored coverage. And we will also make sure that they don't forfeit access to important essential health benefits by utilizing their employer sponsored coverage. So if there are services that are identified in the essential health benefit which their employer sponsored coverage does not provide, we will provide that one the fee-for-service side as a wrap-around benefit. Classic example is transportation. Most commercial coverage doesn't allow transportation assistance. We do. We consider it essential. That's something that we would provide on the fee-for-service platform as a wrap-around benefit. Okay.

Medicaid providers will be reimbursed by the client's essential, or employer, employer sponsored coverage and cost sharing will work the same way it does now as if the individual was a PPL, okay. If you're not a Medicaid provider, the process for managing the copays is a little bit different, but of course the New Hampshire, the number of non-Medicaid providers is pretty small. Raise your hand if you're already enrolled in Medicaid. Come on, that's not it. I'm assuming that all you people that haven't raised your hand are not actual providers. You're maybe administrators, front-end, back-end. Is that fair to say? Phew! You guys need a coffee cup or something! My goodness. Alright. Okay, so once again,

during the time frame that we're determining the cost effectiveness of that employer sponsored coverage, the person is covered. They have access to fee-for-service. They'll have a Medicaid card. And they'll be coming through their provider's office just as [inaudible] individual. So, moving on to the discussion of the Bridge Program, I think this is the orange chute on our flowchart a few slides back. So again, this is for people who don't have access to employer sponsored coverage. They'll have a choice of one of our two Medicaid Care Management health plans. They are again New Hampshire Healthy Families and the Well Sense Health Plan. The benefit package that is going to be utilized by the vast majority is called the Alternative Benefit Plan or the ABP. It covers almost all of the same things that we currently cover on Medicaid with a couple of exceptions on both ends of the spectrum. But for the ABP, they get, again, most of the same services as current Medicaid but they get the addition of chiropractic and the substance use disorder services, and they're going to have different pharmacy copay starting in November, okay. So this is super high level. We're going to go a little bit deeper into the weeds. So, one of the programs, remember I said that the legislation requires some personal responsibilities [inaudible] for these newly covered individuals. Remember, they're able bodied, so there is a sense among the legislature that it's okay to ask them to do a little bit more to benefit from this program. So one of the things that is allowable is to have a different copay for pharmacy services for these individuals versus the currently Medicaid eligible population. You probably know currently eligible Medicaid folks have copays of \$1 or \$2 for pharmacy, \$1 for generic, \$2 for brand. For the Health Protection Program participants, those copays will be, again, \$1 for generic but \$4 for brand, okay. But because you might have heard we have a half an hour to pull this program off, and there are a lot of things on the backend with TMS that need to align and we just haven't had enough time to do all of that. So in order to not postpone the start of the program, we said that we're going to do a copay holiday across the board, okay. So nobody's paying copays today. That went into effect about three weeks ago on July 6th. Starting on November 1st, we will reinstate copays. However, there's one minor difference from how we did copays in the past, and that is to say that anybody, either currently eligible or newly eligible, whose income is lower than 100% of federal poverty will no longer pay copays at

all, okay. Folks who are over 100% of FPL, again, whether they're currently eligible or newly eligible, will either go back to the \$1 and \$2 or they'll pay their \$1 and \$4 based on which program they're in. Okay. So we're still working out how it is that you as a provider might know, is this somebody who does pay copays or doesn't pay copay? And if they do, what do they pay? That information is most important at point of sale, but we acknowledge and understand that that's an important thing for providers to know as well, so we're working on that. It's one of the things I said that was hard to pull off in a half an hour. Okay, so for the folks who we've ruled out with – am I okay?"

(F): "You're good."

(Lisabritt): "Okay. So the folks we've ruled out that are going to go into the Bridge Program and it's mandatory that they join up with one of our MCOs. They can't stay fee-for-service forever. So they have 60 days just like the currently eligible to choose one of our MCOs. If they don't make a choice within that 60 days, we will auto assign just as we have done for the currently eligible, okay. And just as now, while somebody is waiting to make their choice, they are covered on the fee-for-services plan, okay, so current, current rates will apply. Anytime that somebody's on a plan for fee-for-service coverage, New Hampshire will kick in once they are covered by Care Management. That actually, I think, you know, continues the incentive and the inducement for providers to assist people making that selection just like we did last year where we really partnered together. And again, we've credited the provider community for giving us, you know, really stellar selection rates, I mean, very note-worthy self-selection rates for the rollout of Care Management. Coverage with an MCO, same as current day. It's the first day of the first month after the person either makes their selection or is auto assigned, okay, so it's not date-specific. Same as current, if somebody's unhappy with the MCO they've chosen, they have 90 days to switch for any reason or no reason at all, okay. Once they hit day 91 with that health plan, the next opportunity that they will have to make a switch will be during the annual open enrollment period. So, anybody who's looking for more information about the two MCOs to help somebody maybe make that selection can go to our website. We try to post as much as we possibly can there in terms of resources that are available to anybody

out in the public either to satisfy curiosity or in to aid in the enrollment or selection process. So what you'll see there are client sample letters. So, I don't know how many times you have somebody come in and they're like, 'The State sent me a letter', and you're like, 'Well, what does it say?' 'I don't know.' 'Did you bring it?' 'No.' You can go to the web, say, 'Is it this one? Is it this one?' And really help somebody engage and digest what the content is. As much as we try and, you know, I'm looking at my colleague, Chris Shannon over here, but you know, we try so hard to make the content digestible and we try to write it at a 5th grade reading level, and inevitably we hit about 50% of the mark. 50% of the people understand it completely, 50% of the people don't, and that's just the people who read it. Right? So, but there's also a brochure that says, you know, how Care Management can help me, so you're really trying to, you know, up that sales pitch about why we're doing Care Management in the first place. What's in it for you as a member? Quick guide for enrollment, the client services contact information for both of the MCOs. This is not an exhaustive list. It's just examples of the things that are most commonly utilized by the provider community in working with their patients. So, once somebody has made their selection of an MCO, there, the MCO will contact them even if coverage hasn't started with the MCO yet, okay. But once the MCO knows that you're coming over, they're going to confirm or establish the person's PCP. Typically that is done through a welcome call where it'll be an explanation of, you know, how to work well with your MCO. Oftentimes they'll do a health-risk assessment. For this population that's so important. We have no history with these people, right. We don't know what we don't know about folks, so getting people to do that health-risk assessment is so important. Each member will receive their MCO card and a member handbook for quick reference the next time they have a question about, you know, 'What was my copay supposed to be?' And again, coverage begins first day of the first month after selection. Alright, so remember when we were in the flowchart and I said some people might raise their hand and say, 'I'm medically frail.' What does that mean? Well, there is a federal definition but basically we try and make it elegantly simple on the application, and again, it's a self-attestation. They're saying that they're frail. And the primary thing that that gives the individual is a choice between standard Medicaid benefit versus the new alternative benefit plan. Folks

who choose one or the other and then they regret the choice that they made, they can switch back at any time. If they're in Managed Care, it's going to be the first day of the first next month before that switch will actually take hold. But fundamentally, there are a few reasons why somebody might choose one over the other. So in the ABP, you can get substance use disorder coverage and chiropractic services, but you do have a higher copay. It's only a \$2 differential so maybe that's not enough to sway somebody one way or the other. But there are a couple more pretty valuable services available in the ABP versus current Medicaid. But at this time, the ABP is not going to provide access to long-term care services. So you know, that really distills the choice. Are you somebody who might need home community based care? Or are you somebody who really wants to deal with your substance use problem? I think that, I think that's going to be the essential question. Of the north of 7000 folks who have applied and been determined eligible, there are, I don't know, a few hundred at this point are getting the actual, who have identified as medically frail but only 50 have chosen standard Medicaid. Most of them are more than happy, at least at this point, with the alternative benefit package. And again, they can switch. Okay, so we're going to move into the discussion of the substance use disorders benefit now. I'm pleased to introduce for this section of the presentation, Jamie Power, who's an Administrator in the Bureau of Alcohol and Drug Services. She is one of the principle architects of the benefit. And let me just say as a footnote how delighted all of us are at the Department to be able to roll out a substance use disorder benefit, and I will throw myself on my floor to say it also really bothers us that we can't make it available to everyone yet. It is part of our strategy for the state fiscal year '16-'17 budget to request state funding to draw out the match to make these services available to all Medicaid enrollees. I think we all understand the value and the importance of doing that, so the next time you're thinking about, 'What do I want to talk to my State Rep about?', you might want to put this on your list because we're not going to be able to get the funding without just a rally of support from the tip top of the state to the bottom, east, west, north, south. Everybody needs to support it if we're going to pull it off. So with that, I'm going to hand it over to Jamie for discussion of the benefit."

(Jamie Powers): "Good morning. I want to start by saying how excited I am to be talking about this benefit. I have a fairly long history of trying to help people find substance use disorder services in the state of New Hampshire and dealing with the inevitable challenges of both a lack of services and when there are services, inability to get those services paid for in an effective manner. So it's really exciting for me to be talking about this very broad array of services that we're able to make available. Services include outpatient and crisis intervention services, both for individuals, groups and their families. Opioid treatment programs, which are certified by Substance Abuse and Mental Health Service Administration, the Bureau of Drug and Alcohol Services, support of pharmacies and the DEA, where both methadone and morphine services can be provided. Prenatal services; screening, brief intervention and referral to treatment services, which are typically provided in emergency departments, physician offices and other medical settings; withdrawal management both medically managed withdrawal management and acute care settings as well as medically monitored withdrawal management and more community-based care settings. Medication – excuse me – assisted treatment services, this is providers who are prescribing medications to assist with treatment and recovery in their offices and usually, ideally are provided in coordination with clinical [inaudible] treatment through quasi talk therapy type services and partial hospitalization outpatient services. Residential treatment services, everything from the low intensity, transitional living programs on up to the more high intensity, what we typically used to call 28-day programs, as well as some specialty care services for pregnant and parenting women and their children, as well as recovery support services, both [inaudible] services which are designed to help people address barriers to recovery. One of the things that we know is recovering from a substance use disorder is not just about getting the disorder treated but also working around those other barriers to recovery. And finally, case management or continuous recovery monitoring, which is regular check-ins with folks. How are you doing? What do you need to sustain your recovery? If they've had a relapse, what do you need to get back into recovery? Those are a pretty exciting array. It's also a very heavy one, and because of that, in order to assure that we have adequate capacity for all of these services as well as to sort of ease the startup process and hopefully smooth it out

a little bit, we have created a phase-in structure. So beginning August 15th, outpatient and crisis intervention services will be available. Those can be provided by outpatient and comprehensive substance use disorder programs which will provide the Bureau of Drug and Alcohol services. All of these are Medicaid enrolled folks working in the practice and [inaudible] community mental health centers, psychotherapy providers, community health centers, physicians and APRNs, as well as within the opioid treatment programs. So it's a pretty wide range with folks who can provide those, as well as methadone services specifically within the opioid treatment programs and medically managed withdrawal management services and acute hospital setting. At six months, we're looking at rolling out prenatal services as for medical assisted treatment, intensive and partial hospitalization outpatient services. Partial hospitalization services will really be specific to individuals with co-occurring substance use and mental health disorders as well as residential treatment services. And then around one year, we'll be adding withdrawal management; both medically monitored both ambulatory and inpatient, as well as recovery support services and continuous recover monitoring. So that's where we're going. What we're really actively involved in right now today is enrolling our SUD specialty providers. These are LADUP licensed by the New Hampshire Board of Licensing for alcohol and other drug use professionals. I hope I got that right, as well as outpatient and comprehensive substance use disorder programs. And then also getting those folks contracted with the MCOs, so enrollment, which I think is going to be talked about more. It's a two-step process so one with Xerox and then contracting with the MCOs. We're also working with a number of state agencies as well as private groups to really develop the capacity for the services that are being phased and in and further refining quality measures and review processes based on American Society for Medicine standards and criteria as well as Substance Abuse and Mental Health Services Administration criteria."

(Betsy Hippensteel): "Good morning. I'm Betsy Hippensteel. I'm the State Medicaid Provider Relations Manager. As you all know, we started accepting applications July 1st. The actual coverage for those found eligible begins August 15th and as Lisabritt stated earlier, they will be in the fee-for-service from August

15th until September 1st when, if they chose the health plan from the time their eligible on, before the 1st of September, they will go into one of the two health plans. So, there are four ways to apply. I'm sure many of you have used New Hampshire Easy online. I'll keep going and ignore that. You can also call in. You can phone the call center and they will assist you with your questions when you're filling out the application, or they will answer any other questions that you have about this program or the eligibility. You can still fill out a paper application. You can either download it or go in a district office. And your fourth choice would be to go through the marketplace, the Affordable Care Act. But we encourage you to use New Hampshire Easy, ours, you do have option for. Okay, am I safe to change it? Alright, this is a look into the future. We just want to remind you that program options may change, that the New Hampshire legislature did limit by time this program. They eventually hope that those found eligible for this program will transition to the health insurance marketplace or employer sponsored insurance. But obviously the intent is to keep the people covered and when the changes are known they will be announced by the Department. And again, this is referring to transitioning to the premium assistance program if CMS approves the Department waiver, but details will be announced well in advance and you could be back here for another training. So what are we doing? This is, this program is different than the past. We're used to New Hampshire citizens finding us or you the providers helping the clients apply for Medicaid. Now it's a different challenge to find those uninsured and educate them about this program. So the first task of the Department was to identify who would be eligible. And with the help of Valerie Brown, who's in the audience, and other staff within the Department, they did statewide surveys and focus groups, specified, looking at the uninsured and who they are. What they found in this research, as you can see, I won't read every bullet point but 63% were male; 34% were between the ages of 18 and 29; 36% have a high school education or less; and most are hourly workers. There's pretty much a split between where they live in the state. So in the literature that you will see that we are doing for the eligible, we're trying to be consistent with our message, make it simple, straightforward and hopefully encourage any that think they may apply, be eligible to apply. We're using different types of media to get the message out, press releases, and radio

announcements. We've caught up, Facebook, Twitter. And by in reach, we mean those people who are known to the Department, so they've either applied for SNAP or they've been denied for ATDB, Disability or whatever. So they're people that are in our system. And the first set of letters, I think there are 8800, went out this week to those that we know of and think would be eligible for this program. So we start with in-reach and then we try to go to out-reach where we're sending several direct mail pieces to people we think would be likely eligible but are unknown to the Department at this time. So now I'm pushing our provider trainings. Obviously you're here at the July 30th one. Next week, the training on August 4th and August 7th, they are targeted to business administrators within the provider groups. We will be talking in more detail about the benefits, the rates, and the two health plans will be here and they will also speak about what's the same under the New Hampshire Health Protection Program and what's different so providers will know. We have plenty of space at the Littleton forum so if you'd like to take a nice drive up to North Country, I encourage you to do that. And then again, we'll be back here in the Brown Auditorium August 7th. On August 12th, we have a session just for chiropractors because this is, we've added chiropractic back into the alternative benefits plan. So we are meeting with chiropractors not only to talk about how they enroll with the health plans and Medicaid but also what the benefit covers, how they bill, et cetera. So if you know any chiropractors, encourage them to come to that session. And then on the 14th, it'll be the same but it'll be for the substance use disorder providers. And they, at both the 12th and the 14th, they'll have an opportunity to meet individually with the health plans. So, if you have any, if you want to know what's about future trainings, go to the DHHS website. As you can see, the logo for the New Hampshire Health Protection Program is on the first page of the DHHS website. If you click on that, that will eventually lead you to the provider trainings. This session and others will be recorded and will be on our website for those whose staff couldn't come today. Now, before we start, I just want to explain how our questions will work and introduce the subject matter experts. Joining us today is Robin McGee. She's Regional Manager for the Division of Client Services, so she can answer anything you want to know about eligibility or how to apply. Chris Shannon is Medicaid Senior Analyst and she has helped me write the training. And

then Lisabritt and Jamie. We are going to alternate between the audience and those on the webinar and, but we will start with the audience. And Lisabritt will repeat the questions for the benefit of those on the webinar."

(Lisabritt): "Alright, so let's start in the room. You can go first. Yeah."

(F): "For those people who are projected to start Medicare in November or December but don't have it right now and are applying to this program, what happens when the Medicare kicks in?"

(Lisabritt): "So, friends on the phone, the question is, what about people who expect to have Medicare coverage sometime later in the year, say, November, what will happen if they are first covered by the Health Protection Program but then subsequently become eligible for Medicare A and/or B? Robin, have you an answer to that one?"

(Robin): "I don't have a definitive answer on that but my assumption is, once we are informed by Social Security the individual has Medicare, we will approach HHP program medical staff and explore other if they may be eligible for other medical assistance and reach out to that client and ask them if they want to see if they may be eligible for another form of Medicaid."

(F): "That's what I would have answered."

(Lisabritt): "So friends on the phone, were you able to hear that answer? Are we getting any responses?"

(F): "Yes, can we just say that one more time?"

(Lisabritt): "Sure, sure. So, for the benefit of people on the phone, our, our DSA representative, Robin McGee, has indicated that in all likelihood we would get a cross-match from the Social Security Administration that indicates that that health protection coverage person now has Medicare and that will trigger a closure of the Health Protection medical segment. But before doing that we're going to explore whether that person may actually now be eligible for a different Medicaid category so that they could potentially be a dual-eligible. Did I get that right?"

(F): "Yes, you did."

(Lisabritt): "Thank you. So we're going to take a question from the web."

(F): "If a person is pending Medicaid and received a notice that they are eligible for NHHPP on August 15th, 2014 does that mean they were denied?"

(Lisabritt): "Can you repeat the question?"

(F): "Yes. If a person is pending Medicaid and received a notice that they are eligible for NHHPP on August 15, 2014 does that mean that they were denied?"

(Lisabritt): "Let's go to Robin. Maybe it makes more sense to her than it does to me."

(Robin): "No, that does not mean they're denied the ATPD MA. It means that they're getting the option of having the NHHPP program medical until an ATPD medical decision is approved or denied."

(F): "Alright, another question in the room here. Yeah, go."

(F): "Could I just get a mic?"

(Lisabritt): "So if she uses the mic do I not have to repeat it? Okay."

(F): "Could I just get a clarification. They said this was based on gross income. It's my understanding it was based on magi."

(Lisabritt): "Well, remember I said to the gentleman in the back that there's something that we do administratively in the back. So modified adjusted, G magi gross income. So yes, you're both correct. I wasn't going to go too deep into the IRS weeds, but you're absolutely correct. This is a magi category and it is a modified adjusted gross income. We do not marry perfectly to the IRS definition. There are a couple of things. I want to say child support we might do differently. There are a couple of things we do slightly differently, but it is still considered a magi category. So next one from the web."

(F): "Will we be able to see which MCO plan a member has assigned to or chosen when they are covered under fee-for-service?"

(Lisabritt): "Possibly. It all depends on timing."

(F): "Yes, can you iterate?"

(F): "So, sure, so the question was whether we would be able to see what health plan somebody has decided before their MCO coverage begins. And the answer is no, in the MMIS system will not see the health plan listed until the 1st of the month or when it begins. So if you went into the MMI system prior to the 1st of the month, it'll say, you know, state Medicaid."

(Lisabritt): "So recall that, just the way the MMIS does not project future eligibility as point in time specific, that same rule follows as I gather from Betsy's comment. So the only way that you would really know that somebody has made a selection but has not yet had their first day of MCO coverage is to ask them. Alright, are we live in the room again? Okay."

(F): "[inaudible] person's been covered?"

(Lisabritt): "Are you asking how long between the eligibility determination does it show up in the MMIS, or are you asking how long between just submitting the app?"

(F): "For instance, with the ATPD."

(Lisabritt): "Yep, yep."

(F): "[inaudible]"

(Lisabritt): "Right, okay. I see where you're going."

(F): "How many days until?"

(Lisabritt): "Sure, so all of the magi categories are supposed to be determined eligible in what is called real time. There is not an operating definition of real

time. It is, however, we don't need 90 days to determine eligibility for the Health Protection Program. How quickly do they turn around, Robin?"

(Robin): "Right now, currently, within a couple of days."

(Lisabritt): "Okay, so just for the benefit of friends on the phone, right now applications for the Health Protection Program are turning around in a couple of days. So it's not a category where we would be looking to that 90 day window as is allowed under aid for the permanently and totally disabled."

(Robin): "You noticed I said 'right now'."

(Lisabritt): "Yeah."

(Robin): "I have a feeling I'm going to get [inaudible]."

(Lisabritt): "Right, so you know, here, as we've been saying, there are multiple ways to apply, right. So you know, New Hampshire Easy can process a little bit more quickly than when we get a paper app and we have to scan it in, and then a worker actually has to sort of press the buttons, right. And right now, with just north of 7000 individuals who have come through the door who have been approved, it's more like 9000, right, because we do have some denials, most for being over income. But the volume has been manageable because people have been diverse enough in the ways they have applied, so we haven't taxed either our human capital or our IT capital. But it's possible that that two day turnaround could become more of a four day turnaround if we suddenly see an on slot, particularly in the paper apps. To the web? I'm losing track."

(F): "The Bridge Program has a prenatal SUD benefit?"

(Lisabritt): "Correct."

(F): "Does this mean if a pregnant beneficiary has an established SUD Dx can they stay in the Bridge Program?"

(Lisabritt): "Yes. So remember that I said, so, did everybody get? I'm going to repeat the question. So the question sort of identifies that in the description of substance of use disorder services is a prenatal targeted benefit, so somebody

who's pregnant but who has a substance use disorder problem. And they're sort of harkening back to the description of who's eligible for the Health Protection Program where it said you can't be pregnant. So I want to return to that comment and remind everybody that you can't be pregnant on the date of application if you want to be in the Health Protection Program. You can subsequently become pregnant and stay in the Health Protection Program. So the Health Protection Program will have and is required to have a full consolation of maternity services. We also have the prenatal services in the substance use category because we know that just because you're not pregnant on the day you apply doesn't mean you'll never be pregnant. So we have a full consolation of maternity services available for people who are in the Bridge Program and subsequently become pregnant. We're live in the room for the next one, right? I feel bad that the person we had running has a bad foot and is wearing a boot."

(F): "I just need a little clarification on patients who are going to go through the HIPP program for the basic fee-for-service. Things like emergency [inaudible] people who are like [inaudible]. I just want a little clarification."

(Lisabritt): "Nope, sure. So the question for our friends on the phone is to sort of revisit the – are we able to go back to that slide with the flowchart maybe? But to revisit the question of, who gets HIPP and who gets standard Medicaid and who's in the Bridge and all of that. So friends on the phone, we have, I hope you can see we've gone back to slide #9 which is our flowchart. So the Health Insurance Premium Payment Program is for people who have access to employer sponsored coverage, okay. So we at the Medicaid Program behind the scenes, through HIPP will pay that person's out-of-pocket costs for participating in their employer sponsored coverage including premiums, copays, deductibles, co-insurance and the like. The only time that they will rely on Medicaid is for wrap-around services, so something that we determine to be an essential benefit but which their employer doesn't cover. So only those services will be billed to the Medicaid Program on the fee-for-service side, okay. They're going to look like any other PPL person in your practice. So they've got a primary insurance and they have Medicaid as their secondary. It doesn't matter whether they're, you know, medically frail. The same is going to be true. On the Bridge Program side, the

medically frail people have, they don't meet a disability determination. We're not going to test how frail you are. It is just a self-attestation. And so, you know, this idea that somebody is disabled, which was part of your inquiry, is unlikely to be common in the Health Protection Program. The only way I would expect to see some disabled people in this program is if their income exceeds the limit for ATPD and they don't have Medicare. So medically frail people get the choice of which benefit package they want to access, whether it's the ABP or whether it's the standard Medicaid package. But either way, if you're in the Bridge Program and you're medically frail, you are in Care Management, okay. Is it a follow-up or should we go to the web?"

(F): "It's a brief follow-up."

(Lisabritt): "Okay."

(F): "Is there ability to spend down to get into the HIPP program?"

(Lisabritt): "You wouldn't spend down to go to HIPP. Are you saying HIPP as in the Health Insurance Premium Program? Please tell me you're not using HIPP for the Health Protection Program because we already said that's not allowed. [laughter] So which was it?"

(F): "I was thinking Health Protection Program."

(Lisabritt): "Okay, where's my cattle prod? [Laughter] That breeds so much confusion and we need to arrest that collectively because when you talk to somebody from the Department and you say the HIPP program, that means to us the Health Insurance Premium Payment Program. Okay, everybody got that? Take a note, right. Okay, to the web. The real HIPP?"

(F): "Yeah."

(Lisabritt): "Friends on the phone, I'm just going to ask you to hang on because we have another follow-up question from the last one, and just in the interest of flow we're going to, we're going to deviate from our practice."

(F): "This individual is already receiving health insurance through their employer but they qualify in the HIPP guidelines. Do they still qualify for HIPP program?"

(Lisabritt): "Yes, yes. So you don't have to be un-enrolled in your employer sponsored coverage in order to participate. You can be enrolled in your employer sponsored coverage, apply for the Health Protection Program. You check the box 'Yes, I have employer sponsored coverage'. We're going to send you down the green chute and we're going to figure out if it's more cost effective to keep you in your employer sponsored coverage with us paying your out-of-pocket. If we determine that it's not more cost effective, then you have the choice to say, 'I don't care. I'm going to stay with my employer sponsored coverage. Thank you but no thank you.' Or you can go into the Bridge Program and cease your coverage from your employer. Okay, now we're going to go to the web."

(F): "Will they ever get rid of Medicaid spend downs?"

(Lisabritt): "No."

[Laughter]

(Lisabritt): "I'm sure there's a follow-up to that. And let me see. Let me see if I can channel the follow-up question. It's a federal mandate, okay. We have no choice but to allow people to spend down for the other categories of coverage. I won't bore you with all of the details, though I have it committed to memory. It's one of my only party tricks. You don't need to know it. It's a federal mandate. We're never going to get out of it. It is a plague on you. It is a plague on us. However, it is a very meaningful way to make sure that many people get some coverage some of the time, and it assures that a lot of providers aren't left holding the bag. Some are, I know, because if you're not able to meet the spend down, you don't always get paid, but for the providers who come into the mix after that [inaudible] spend down, it assures that they're able to be paid. So it is inelegant. It is a challenge to administer. It is painful. But it is nonetheless required and a meaningful safety net for a lot of folks. Oh boy, okay."

(F): "If a client has, currently has ATPD in a spend down but they're under the 133 can they, they can change to the NHHPP?"

(Lisabritt): "Right, so for friends on the phone, the question was, what if we have somebody who is currently ATPD with a spend down, so they're over income for regular ATPD, could they though go into the Health Protection Program? Answer is yes, and gosh darn it, they should."

(F): "Robin wants to clarify."

(F): "Now she wants to correct me."

(Robin): "Now, it's okay as long as they don't have Medicare."

(F): "Right."

(Lisabritt): "No, and you guys are channeling each other. So friends on the phone, the only caveat to that comment is that that ATPD spend down person will not be able to be in the Health Protection Program – notice, I didn't call it HIPP – they can't be in the Health Protection Program if they also have Medicare. So the one caveat to that important point. And I'm sure that this is a related question in the back."

(Male): "[inaudible]"

(F): "Third party liability. Are we in the room or on the web? I'm losing track. We're on the web, sorry."

(F): "Do employees have to meet eligibility requirements of their employer plan or just have access through an employer for the program to pay client's share of insurance costs?"

(Lisabritt): "I'm not sure if I understand what an eligibility requirement on the part of the employer would be. It's only that they work fulltime. Okay, so yes, it can't be theoretical access to employer sponsored coverage because the goal of the Health Insurance Premium Payment Program is that we're going to put you in that coverage if it's cost effective, but if you don't work enough hours for your employer to offer you that coverage it's not going to work. Does that make sense? So if you never have enough hours to access the employer sponsored coverage, I do not recommend checking the box that says, 'Do you have access to employer

sponsored coverage?' There has to be real access, not potential access. Okay, we're in the room. How are you?"

(F): "Good, how are you?"

(Lisabritt): "Good, thank you."

(F): "I just had a question on the HIPP program. If you are paying the client's premium for the health insurance, I assume you'll send them a monthly check."

(Lisabritt): "Yep."

(F): "How are you going to assure that they're not taking that and it's paying for their health insurance premium? Is there going to be a routine check? Are they going to have to send you proof?"

(Lisabritt): "So excellent question. So for the benefit for our friends on the phone, it was, how do we troubleshoot when we have an individual who is in the HIPP program? They are covered by their employer sponsored coverage. And you're correct that we're going to reimburse them for the amount of their premium payment that's deducted from their paycheck by either direct deposit or we'll send them a check. So how are we assured that they stay covered instead of dropping it and pocketing the happy, happy state money? We have hired a very experienced vendor to manage the HIPP program, and part of what they do is to make sure that things like that don't happen. If we were to later discover it, I mean, that is a fraud, and we would manage it the way we would manage any other kind of client fraud. Excellent question. To the web."

(F): "Will the application process stay the same since resources are excluded for NHHIP?"

(Lisabritt): "There's no 'I'. So the question was about application process given that the Health Protection Program does not have a resource test, and the answer is yes and no. All of our magi categories - so we have three other magi categories. They are children, pregnant women and parent-caretaker-relatives – don't have a resource test. So the Health Protection Program application process will model the other magi categories. Where it is a non-magi category, we follow the

traditional process and we look for resource information. Robin, do I have it right? Thumbs up or thumbs down. Thank you. Friends on the phone, I got a thumbs up. I think we're going to the back here."

(F): "How are providers going to follow along with a client to try to figure out where to appropriately bill?"

(Lisabritt): "Good question. So friends on the phone, it was, how do we know who to bill? Did I distill it correctly there? Yeah. So basically what's going to happen is two things at sort of your front end check-in when somebody comes to receive a service. So, beginning of the day, you're going to ping Xerox and say, 'Is this person eligible today?' And it's going to say yes, person is eligible. It's going to tell you category, if it's a Health Protection Program or not, and it's going to tell you which health plan they are in. Then somebody comes, when they come in, say, 'Show me all your cards. Show me your Medicaid card. Show me your Care Management card.' The cards that are being issued by the MCOs will have the New Hampshire Health Protection Program logo on them, is my understanding. Correct me, friends from the MCOs. Okay. So that'll be a clear indicator that you've got a Health Protection Program person in your list, and at that point, you're going to bill the MCOs just the way you would today unless it's a service that's outside of Care Management. So let's say you have a 19 year old and you're a dental office. Then you're going to bill fee-for-service Medicaid. Does that make sense? It really is going to come down to, 'Show me your card' because if it's somebody who's in the Health Insurance Premium Program, you're honor bound to bill that ESI first the same way you would today with somebody who has Medicaid as a secondary."

(F): "And I was just going to say, the next, next week's session will show you the Medicaid card is the same as New Hampshire Health Protection Program card. It doesn't change, but we will show you what the two health plans cards look like. We'll also show you what eligibility looks like in the MMIS and then in the health plan system. So we'll get you some more details."

(F): "We're going to get to look at them really well. Or, I think we have to go to the web. Oh, oh, sorry, people behind me. Yes, Laura."

(Laura): "So I just want a clarification on the FTL because the document from [inaudible] folks on the [inaudible] says that it's 138 but you keep saying 133."

(Lisabritt): "Yep, good question."

(Laura): "I need clarification."

(Lisabritt): "Sure. So the question was, why does it sometimes say 133, which I've been saying all day, versus 138. And this is where it gets sort of bureaucratic. So the federal law, the federal law that created the opportunity to do this coverage says 133% of federal poverty. That is in the statute. That is what we follow. And my friends over in the eligibility part of the house got out the same cattle prod every time I said 138. It is a defacto 138. Why? I know that's your next question. Because in the old days, we had all kinds of income deductions that we calculated, that whole question, is it net or is it gross. So we had to do this whole equivalency exercise to say, because we never calculated eligibility based on a percent of the FLD before. We just had a hard number. So we had to do this whole equivalency exercise that would adjust for the fact that we used to have deductions from income and we don't anymore, and we had to express our magi categories of eligibility as a percent of federal poverty which we didn't used to do. So in all of that mishmash, it becomes a defacto 138 because we're not doing those income deductions anymore. So federal law holds up to the 133 but it is a defacto 138. It's the same number at the end of the day."

(F): "Where is the training on that?"

[Laughter]

(Lisabritt): "I'm so much fun at a party."

(F): "Is there a resolution to getting Meridian to pay claims where the patient has Medicaid?"

(F): "Medicare Part B."

(F): "Okay."

(F): "Yep."

(F): "But chose not to exceed the Part B current – do you want me to continue?"

(Lisabritt): "No."

[Laughter]

(F): "We all want to know that answer."

(Lisabritt): "I know. So friends on the phone, this has to do with a long-standing issue that was primarily with Meridian Health Plan which was previously one of our Care Management MCOs where they were holding claims for individuals who have Medicare Part B and the service could have been covered by Part B if the person was enrolled. So they access to Part B. They hadn't signed up. And so they received that service and the health plan was saying, 'We think Part B should be paying this', but the person was never enrolled in Part B. So the short answer is, yes, there's a resolution. It is coming. It is on a glacial pace. I am embarrassed that it has taken this long. Another opportunity for me to throw myself on my sword. I, you know, it is me and my direct [inaudible] who are hearing from all of you and hearing from patients who are being down-billed by providers who haven't been paid. So I am extremely sensitive to this and unfortunately, this matter is in the hands of the lawyers, and [inaudible] by training for this particular reason I'm going to distance myself from the profession. It's coming. It's just extremely slow. And please accept my acknowledgement of its tardiness and my apology. Was that an in the room or on the web?"

(F): "On the web."

(Lisabritt): "Okay. Who's next in the room? Okay."

(F): "I was wondering in regards to the HIPPA."

(Lisabritt): "Which one?"

(F): "HIPPA, that one."

(Lisabritt): "Green one, good."

(F): "The green one. In regards, the count, the companies that are now, like you have two of them coming up [inaudible]."

(Lisabritt): "Yep, yep."

(F): "And they'll be a lot of people probably who will fall under this category. So I'm wondering, is this the employer's responsibility to bring this to their attention, or is it their responsibility to?"

(Lisabritt): "Sure, excellent question. So for the benefit of friends on the phone, it was, you know, what's the sort of behind the scenes both employer outreach and open enrollment opportunity for people who may be Health Protection eligible but do have access to employer sponsored coverage? So I hear that as a two-part question. I'm going to answer it in two parts. First, I want to point out that, for the Health Insurance Payment Program, the piece of legislation that created the whole Health Protection Program says that if you have access to your employer sponsored coverage, having been determined eligible for the Health Protection Program is a qualifying even so you can enroll with your employer sponsored coverage off cycle. You don't have to wait for the annual open enrollment period for that. For the second part of question was, how will employers know that this might be available? I would think that a lot of employers who value coverage but know that it's a large financial list for some of their staff might want to help them and say, 'Have you heard about this program?' We're not doing as much as we should. We're developing more of a plan. It will not coincide nicely with the July 1 starting of applications and the 8/15 start of coverage. It is on the work plan. We had like a half an hour to pull this off. So it is important. Tell all your friends. Help me out. But it's not something we've really been able to do in a robust way as yet."

(F): "And folks could opt out of that?"

(Lisabritt): "Opt out of?"

(F): "Taking the employer health?"

(Lisabritt): "No."

(F): "No, okay."

(Lisabritt): "No. Unfortunately, the way the law was written, if you have employer sponsored coverage and we determine it to be cost effective, you must go that way. If you don't, so let's say you've brought us all the materials to determine the cost effectiveness and we've said, yep, cost effective, you have this much time to enroll with your employer. If you don't, you have just forfeited all of your coverage, so the consequences are serious. So you know, the law really has a preference for wherever possible commercial coverage. You know, our Medicaid coverage is sort of a last resort, okay. That's the architecture of the program. So it's not to say that that person who didn't enroll timely and who forfeited their Medicaid coverage can't come in and reapply the very next day because they can. There is no lockout period. But anytime there's a gap in coverage, there are typically gaps in care. And that drives up not only costs but it also compromises people physically. So we really want to avoid that. But you know, it's something I really didn't hit earlier and I'm really glad you brought it up. To the web."

(F): "Will all HIPP beneficiaries have fee-for-service as secondary with the card?"

(Lisabritt): "Yes. Everybody's surprised I had a one word answer."

(F): "We're waiting."

(F): "You said that we have to, so when we get eligibility and we're checking off to see if they're eligible, are we billing the MCOs to, do they have their own site or are we paper billing?"

(Lisabritt): "Good question. So the question from the room was, if we have somebody who's enrolled in Care Management, so they're Health Protection Program eligible, they've gone into the Bridge Program, they have selected an MCO and now they are a card carrying member, you will bill the MCO for those services. There are a couple of services that are not included in Care Management. It's an extremely short list. It's available on the web. Where, where do you work?"

(F): "Serenity Clinic."

(Lisabritt): "Okay. So your services are going to be covered in Care Management. You will bill the MCO that that member has selected. Okay. To the web."

(F): "Beneficiary is in the HIPP Program. Are these considered Medicaid eligible days for purposes of Medicaid/Medicare Department care statement?"

(Lisabritt): "Friends on the phone, I just winced and shuttered. I have no idea what they're asking so I want to put a pin and that socialize it around to see if it make sense to people smarter than me. Back to the room, yes."

(F): "Yes, I have a question about eligibility based on income. If there is a person who, let's say for example, with low income last month, had a job change. Now based on their current salary meets these guidelines. Can they be deemed eligible based on their income today? I guess what I'm looking to find out is how does it work when someone's income becomes eligible and then they have a job change. Now they meet the guidelines. Maybe in six months they'll get a better job and now not be eligible again. How does that person decide whether they even have a chance to be in this program today? How does that work?"

(Lisabritt): "Yep, yep. So when the application is essentially put in time – oh, for friends on the phone, question was, what if I got denied last month for being over-income but, you know, I've had this life upheaval and my income has gone down? And the answer is reapply because we're going to look at what your circumstances are today. For the reverse, though, somebody who's already in the Health Protection Program but they got a better job and their income has gone up, essentially the same rules that apply in the Medicaid world today apply there, which is to say, when you have a change in circumstances you have ten days to report it. And sometimes those changes affect your eligibility and sometimes they don't. But you do have a responsibility as a recipient of public assistance to report those changes. Robin, should I add anything?"

(Robin): "If they're over income, if they, you know, tell us that they have a new job and now [inaudible] over income for the program, we'll refer them to the marketplace to pick another insurance there or if they have an opportunity through their employer."

(F): "That is not true for people that were formally, didn't even apply, were denied because they didn't apply, and now they are at a lower level day. Last week they wouldn't have."

(Lisabritt): "Yeah, reapply. Yes. I mean, if your, if circumstances have changed and particularly if it's in the negative direction, reapply. Yeah. I think we have to go to the web though, right?"

(F): "How will Medicaid providers be reimbursed for deductibles and copays for HIPP?"

(Lisabritt): "Betsy?"

(Betsy): "Now, I'm green and they're green. It depends, and again, next week at our presentation Tasha Blanchard, who's the Administrator for the State HIPP Program, will be here to give. We will go into the weeds on this program. But for now, how providers will be reimbursed, it depends. A Medicaid provider will be reimbursed just like they are today under the TPL Program, under Third Party Liability. No change. If a HIPP, the green, eligible goes to a non-Medicaid provider, it's different and we, because obviously –"

(F): "If they can't bill it, they can't bill it."

(F): "If they're not a Medicaid."

(F): "So it has to be different."

(Betsy): "Is it a follow-up?"

(F): "So I am new to Medicaid, so I don't know how TPL today for Medicaid works."

(Lisabritt): "Okay. So I'm going to give you sort of the 50,000 foot and encourage you strongly to come to the next training. And let me also say that, as somebody new to New Hampshire Medicaid, there are a lot of provider resources available through Xerox to help you just sort of get your feet wet in how things work in the normal course. So please avail yourself of that. If you think it would be helpful to come to the upcoming training. But in the ordinary course, you bill, for services

you bill the TPL first and then you bill us as the secondary. If you are Medicaid enrolled and you have somebody with TPL, you would basically bill us through the MMIS for the patient liability for that service. But there's, and again, that's a 50,000 foot view to the probably 20 caveats to what I just said. I think I have to go to the web and then we'll go to you."

(F): "What about SLIMBY patients?"

(Lisabritt): "SLIMB. There's no 'Y' on SLIMB, FYI, and I'm not sure I understand the question because SLIMB stands for Special Low Income Medicare Beneficiary, notice again, no 'Y'. So because by virtue of the fact they are Medicare, they are not New Hampshire Health Protection Program eligible."

(F): "Just a clarification, if somebody qualifies for the HIPP, on the green side, they have insurance as primary through their employer through Cigna, are we going to be billing Cigna as primary for their covered services?"

(Lisabritt): "Yep."

(F): "And anything Medicaid only covered would be through Medicaid?"

(Lisabritt): "By George, you've got it! You don't even come, you don't even need to come back this week! No, you can. Follow-up?"

(F): "So if someone has the green HIPP and they have the Cigna, and Cigna doesn't cover essential services, will they get the dental services?"

(Lisabritt): "Only if they are under the age of 21. So the follow-up question was the availability of dental services in the Health Protection Program. So Health Protection coverage starts potentially at age 19, but the Medicaid program must allow individuals under 21 to have access to oral healthcare. So a Health Protection Program person who is under the age of 21 can access dental services. They will be reimbursed on the fee-for-service side. Dental is carved out of Care Management."

(F): "Okay, and then no extractions for adults that have HIPP?"

(Lisabritt): "Possibly. The question was coverage for extractions. That's really going to depend on what their ESI gives them. Yeah. I think we have to go to the web and then I'll get you."

(F): "What product is the bulk of the population going to use--- traditional Medicaid, Xerox, or MCOs?"

(Lisabritt): "MCOs. They will all have a fee-for-service spell, either while we are determining their HIPPA eligibility or while they are selecting an MCO. But the principle coverage model will be Care Management. In the back."

(F): "If we go back to the green part, if we start providing services, for an example, we then go all the way to the bottom and we actually don't accept the insurance that they're employer [inaudible] the end services or [inaudible]?"

(Lisabritt): "That's not where I thought you were going. I was so ready with an answer to a different question. So friends on the phone, the question is being posed by a substance use disorder provider, I believe. So we have somebody who's been referred to HIPPA on the green boxes on our flowchart, and while we're working our magic to determine if their employer sponsored coverage is cost effective, they are receiving services from this new provider to treat their substance use disorder, and we're paying for that on the fee-for-service side while we do our work in the backroom trying to figure out cost effectiveness. The question I thought you were going to ask is, what if the employer sponsored coverage doesn't offer substance use disorder services. In that situation, you would bill fee-for-service and it would be a wrap-around covered benefit because we're covering it, just the employer isn't. But your real question was, what if we don't take their employer sponsored coverage? And honestly, I need, I need to marinate that one a little bit more because in a perfect world I would say sign up with them. But I'm hearing the groans in the room so we need to take that one back. I don't mean to punt but it's one off from, you know, the thousand riddles that we've come up with in this program. So do we have a running Q&A on the web? Yep. So I think this is a good one for us to take into the Q&A that we have on the web for providers. Okay. Yeah, thank you."

(F): "Will there be a webinar on billing?"

(F): "Yes. There, for new providers how to bill with the MMIS system, that will be done at Xerox and those sessions will be in early September, and providers will receive announcements. And both health plans will have orientations including billing that will be announced shortly."

(Lisabritt): "So we're back in the room, right? Okay, go."

(F): "We're a community mental health center, and we have [inaudible] level play backs."

(Lisabritt): "Great."

(F): "We've been told not to enroll in the SUD program because we're providing mental health."

(Lisabritt): "You can't enroll in the program. You're a provider already."

(F): "Right."

(Lisabritt): "But Jamie, I want you to field the question."

(Jamie): "Community mental health centers and community health centers are sort of have been deemed to be the same as the SUD outpatient programs. You don't need to re-enroll to be able to do all the same services as a SUD outpatient program can do."

(F): "Because what looks like on this chart here that the rate is higher on the SUD services."

(F): "You, you will still bill for the same services. So what'll happen is, rather than, so our current SUD outpatient programs need to enroll with Xerox as SUD outpatient program. For you guys, you don't need to re-enroll but those rates, the SUD service rates will open up to you so you'll be able to bill them."

(Lisabritt): "You'll see those codes and you'll be paid those rates without having to do a re-enrollment as an SUD provider."

(F): "So instead of billing 90837 an hour for individual therapy, we bill the H004 modify."

(F): "Yes. If it's SUD treatment."

(F): "Right."

(F): "Yes."

(F): "Lisabritt, can I add something."

(Lisabritt): "Yeah, additional information on that."

(F): "I just wanted to let the community mental health centers know that Joe Harding will be speaking to you executive directors on August 20th. We set aside some time at a regular meeting they have in Concord. So if you have some specific questions, would you send them to your director because we're collecting questions, too."

(F): "Great, thanks. I didn't even know that. Alright, I think we go to the web."

(F): "When will we see all programs on Xerox? Example, spend downs, is there anywhere we can see them?"

(Lisabritt): "That's not on my script today. [Laughter] I'm not sure. We'll have to bring that back. I don't know if any of my colleagues have a sense but –"

(F): "Yeah, we did not, on the MMIS system, you just see when someone's eligible, when someone's eligible. So if their spend down and not open in our system's mind, they are not eligible for Medicaid so you are never going to see them in the MMIS system."

(F): "Although, the Xerox people, when they first rolled out [inaudible]."

(F): "[inaudible] Alright, you know, and here's the thing with the MMIS, I mean, it's everybody's favorite dog to kick, right. I do it sometimes, too. But you know, we need to assume some of that responsibility because we're fixing and riding the bike at the same time. Every single time that they're within an inch of having

something fully functional, we don't need to do it that way anymore. Now we want you to do it this way. Hocus Pocus. So I understand and I appreciate your frustration but I want to absorb some of that on myself rather than on the people at Xerox and the state team on the MMIS side because they're dancing as fast as they can on the head of the pole. And it really is, you know, us on a program side who are constantly changing our minds that makes it so difficult for them to really fulfill the obligations that they make in good faith."

(F): "Is that requires still on the plate?"

(Lisabritt): "What's that?"

(F): "Is that request still on the plate?"

(Lisabritt): "Sure."

(F): "Okay."

[Laughter]

(Lisabritt): "But I don't know when it's really going to become a reality. I mean, we continue to change their priorities for them. [Inaudible] Do I have to go to the web? Okay."

(F): "I just want to do a follow-up with regard to the CMHCs that they already enrolled in Medicaid."

(Lisabritt): "Yeah."

(F): "And other providers contracted with the MCOs. Does this mean that the providers, the LADAC or anybody who's eligible for my SUD services still needs to be credentialed with the MCOs?"

(Lisabritt): "Yes."

(F): "Or is it facility credentialing?"

(Lisabritt): "Well, I'm going to say yes but maybe I'm incorrect."

(Jamie): "For the outpatient and comprehensive program it's facility credentialing. For the individual and group and LADAC, it is the individual credentialing."

(F): "Can you please repeat that for the folks on the phone?"

(Lisabritt): "Sure. So it was a credentialing question specific to community mental health centers that have MLADACs on staff and it was, do the, as an already enrolled Medicaid provider who has a contract, or an agreement right now, with the MCOs, do those MLADACs need to be individually credentialed by the MCO. And what I heard Jamie say is –"

(Jamie): "The SUD outpatient and comprehensive program is the facility enrollment. Everyone else is individual credentialing. So if you're a psychotherapy group, you would need to credential those MLADACs."

(Lisabritt): "Good thing you're here. Anything on the web? No, okay."

(F): "I'm curious about the determining whether someone is on cost effective for the HIPPP. So is that on like an algorithm?"

(F): "Yes."

(F): "Or do they do that on a case-by-case?"

(Lisabritt): "So the question was, how do we determine cost effectiveness for participation in the Health Insurance Premium Payment Program? Yes, it is an algorithm but it is applied on an individual basis. So the, we look at the policy that the person has potential access to or is covered by in some circumstances. And we look at all of the costs that we would essentially absorb on behalf of that person and we compare it to what we think their costs to the Bridge Program would be. If the costs of paying all of their out-of-pockets for their ESI plus whatever wrap-around's might be indicated is less than what it would cost to put them in the Bridge Program, we're going to put them in the green bucket. If the cost is more, they go orange. Sure. Other questions. Hi."

(F): "So if we have, a client is open under the Bridge Program medically frail and they have, they chose the standard Medicare or Medicaid because they need in-

home [inaudible] support, would they still get the limited SUD services that are currently covered for Medicaid clients or is that absolutely out?"

(Lisabritt): "They would have standard Medicaid, the today benefit package, no add-ons, no subtractions. So the question, for people on the phone is, if we have a Bridge person medically frail who has selected the standard Medicaid benefit package, do they have any access to substance use disorder treatment? And the short answer is they have what is currently available in the standard Medicaid package. They will not have access to the now, you know, formal substance use disorders benefit that are only available in the ABP at this time. Any other questions? Hi."

(F): "I'm just wondering, sounds like a side here regarding the whole purpose of this is that it is time limited program while the 100% covered benefits."

(F): "Yep."

(F): "And will need to be reauthorized."

(F): "Yep."

(F): "Is there a specific time where it will be determined for how long?"

(F): "So the question is about the sunset provision in the state statute that authorizes a program, so it's linked to the availability of 100% federal funding. That is actually set in federal law in the Affordable Care Act, so the 100% federal funding will term December of '15. So our state legislation as currently written sunsets the Bridge and the HIPP. Well, the Bridge Program for sure in December of '15. There are a couple of options available to the state legislature at that point. The one that they have instructed us to pursue is to get special permission from CMS to do something innovative and interesting in the form of a premium assistance program that would look a lot like HIPP but it would allow us to buy people commercial coverage on the marketplace. We don't know that CMS will approve that. In the event that CMS doesn't approve that, the New Hampshire legislature could chose to reauthorize the current, the program that we're rolling out right now understanding that the state will have the obligation of

contributing, I think, 2 or 3% of the total costs of the program. And they would need to appropriate for that. The other alternative, and I certainly would not promote this was that they sunset the entire thing and it was this grand 16-month experiment. Other questions?"

(F): "Just one more."

(Lisabritt): "It's okay. That's why we're here."

(F): "For all of the clients who, before the start of receiving applications in July 1, where they had application transfers from the marketplace for this program where they were denied because it wasn't available, is any outreach going out to those folks?"

(Lisabritt): "Yes, yes. So the question was, what about all the folks who started applying in the marketplace starting last October who, had we started this program in January the way that many states did, would have said, would have had a place to land, and who instead were told, 'You're not eligible for anything?' Some of them may have purchased much higher cost coverage through the marketplace and drawn a tax subsidy. Some of them might have gone without coverage at all. So the question is what kind of outreach are we going to do to those folks to, you know, point out that they now have a different option? We have needed to know who those people are and where they are in order to do that targeted level of outreach. CMS has that information. I don't know the status of the data transfer. I know they gave us something and we were trying to figure out if we could read it. I'm going to Robin. Do you have any update on that? No. So we do plan outreach but it is data-dependent and we have needed the feds to tell us who all these people are and where they are so that we can do that targeted outreach to them. Yeah? Go."

(F): "Will providers need to re-enroll with the MCO if they are already contracted with the MCO for the additional?"

(Lisabritt): "Nope. So the question was, do I need to re-enroll with the MCOs as a provider if I'm already in their network? And the answer is no."

(F): "[inaudible]"

(Lisabritt): "Yep. So for the Wealth and Health Plan, there will be an amendment coming to your provider agreement. It is intending to accomplish two things. One, to alert you to the fact that you get paid better, but also to say just because you get paid better for serving Health Protection or Bridge folks doesn't mean that you can sort of cherry-pick and serve only them to the disadvantage of your current Medicaid patients. Okay. The New Hampshire Healthy Families folks are accomplishing the same level of communication and surveillance, not through an addendum to the current provider agreement, but the same expectations and information will be available. I don't know, Amy, do you want to add anything to that?"

(Amy): "Letters will be mailed to all the providers with the same information."

(Lisabritt): "Yeah?"

(F): "Do letters go out to providers listing what the fee schedule is?"

(Lisabritt): "There should be, in respect of how you get notified, you know, because I'm going to assume because I was the 1988 Regional High School Class Optimist, that you are enrolled in both MCOs. You haven't just picked one. So you're going to get notified and what you'll see is a URL that will link, that will bring you to the fee schedule. That URL is hosted by us through Xerox. Even though you're not billing them or us, that was just the most elegant way to post the fee schedule so that – I'm looking at my friends again, confirming my understanding that those communications have the URL in it and you'll probably want to bookmark it, I'm guessing."

(F): "Perfect."

(F): "And next week's training session."

(Lisabritt): "And next week's training session. Anything on the web? Okay, radio silence out there. Any other questions in the room?"

(F): "I have a question."

(Lisabritt): "Okay."

(F): "And I may not know the full terminology so bear with me."

(Lisabritt): "Okay, I'll put my prod away."

(F): "I'm with [inaudible] community mental health service and it is my understanding that currently the [inaudible] level depending on [inaudible]. Is this also tied into that type of category? Are they linked?"

(Lisabritt): "I'm not sure I understand your question. Are you asking about the different fee schedules and the provider rates based on currently eligible versus Health Protection eligible?"

(F): "Yeah. I'm asking about the current rates being established for SMI and SCMI, and will it be linked into how we get reimbursed, or where state MCO fee-for-services? Or is that all being changed with this new program? I assume so but we'll find out next week."

(Lisabritt): "You are hired! I'm not sure. I think I understand your question, but I'm not confident. So what I might suggest –"

(F): "[inaudible]"

(Lisabritt): "- what I might suggest is, you know, why don't we sidebar rather than trying to work through it. If it is something that we think has sort of value for the group, we'll put it on our Q&A log."

(F): "Okay."

(Lisabritt): "Okay? But let's sidebar it when we conclude the session if that's okay."

(F): "Maybe that's a question for next week."

(Lisabritt): "Perfect, perfect. I think I saw a hand over here."

(F): "Just a comment with regards to her question, in attending of the [inaudible] the CFOs and the administrators, and I think where she was going with it is, where

we're looking at per member per month, we're talking about different rates for different categories, SMI, SCMI, CPD. And the plans made it very clear to us that this is different book of business and we're billing fee-for-service according to the fee schedule that you've provided. So it's not the same. It's not like rolling it in, and I see her nodding her head as well."

(Lisabritt): "Yeah, so, so but I think, and this is another plug for next week's training where we're going to have our MCO partners available, that this is sort of a three-pronged question. And I am not confident in trying to wrestle an answer as just the DHHS representative. But I do think that next week is going to be an excellent opportunity to, to dig into that. Okay, sorry. I don't mean to punt. Oh, I have something on the web."

(F): "Yes. For spend down clients with no Medicare that can apply for NHHPP, will they be notified?"

(Lisabritt): "Repeat that."

(F): "For spend down clients with no Medicare that can apply for NHHPP, will they be notified?"

(Lisabritt): "We're not going to invite them to apply for NHHPP. You know, we did, as Betsy said, in reach to 8800 or so people whose income we knew to be within the eligibility span. They are primarily Food Stamp or SNAP recipients or people who were denied ATPD in the last however many months for not being disabled enough and some parents of children who are currently covered. I am not aware that we included in that group spend down people because they're eligible now sort of. So I think we need to explore that one a little bit more because I just don't remember it, that description being included in the 8800 that we did in reach for. It's not to say we couldn't. It just means that we might not have done it yet. But it was a good question, good suggestion. Alright, so, we're getting on ten to noon. I know I got a grumbly in my tummy."

(F): "I have a quick follow-up on that. If I remember correctly, last time we were at a session meeting a month ago or something, they said that Human Services was going to be reviewing some of the current spend down clients and that they

would be automatically putting them on NHHPP if they qualified for it. So can we get that put up on the Q&A piece?"

(Lisabritt): "Sure. Sure, yeah. And I, you know, I don't know what session you were at. I know that a lot of the seventy, 700, or 7000, sorry, folks that have gone into the Health Protection Program so far are people who are coming through [inaudible] and maybe were no longer eligible for the Category they were in but now they're eligible here. So this is a new step in the cascade as we try to build eligibility for somebody. So I don't know if that's what they were talking about or if there was something specific about counting the records for the spend down people and trying to reprocess them. And Robin's wrinkling her brow, so we'll take that back and try to get to the bottom of it."

(F): "My whole [inaudible] the supervisor there systemically told me that they are, when they look at whether or not the spend down [inaudible] they're automatically looking at whether or not they qualify for NHHPP, already, already has a [inaudible]."

(F): "Well, and that's great. And that sort of assumes, though, that you have somebody who's meeting a spend down every month, and it's important to remember that there are lots of people who are open for a week out of the year. They're not coming in every month with a shoebox full of receipts to have us calculate eligibility. So there are sort of two groups here. I mean, in spend downs, we have people who need it every single month. Those are the people, you know, that I think are easy to capture and it sounds like they're doing an excellent job at it. For the people who, you know, are very sporadically in and out is the harder, it's more a list. I'm going to go to Robin."

(Robin): "And don't forget the caveat is, a lot of these spend down clients have Medicare so that could be another, that never meet their spend down and have Medicare, so they can't look at NHHPP provider."

(F): "I have about 200 on my spend down list and only about 5 who don't have Medicare."

(Lisabritt): "But you know, it's one of the frustrating things about, and that's a federal requirement, you can't put somebody in this category if they have Medicare, and we very early on identified that this would [inaudible] the potential opportunity particularly at the community mental health centers to offset this complicated care."

(F): "And Medicare [inaudible] Correct? [Inaudible]"

(Lisabritt): "Yep, yep. Anything else before we wind up? Sounds like we've got somebody on the web."

(F): "Will people pending ATPD right now stay on NHHPP if they qualified if their income is above MCD limits?"

(Lisabritt): "MCD?"

(F): "Medicaid."

(Lisabritt): "Oh, that's not how I abbreviate it. I know you've all lost complete confidence in everything you've hear this morning. MCD?"

(F): "Yeah, I was right there with you."

(Lisabritt): "I'm sorry. Can you repeat the question?"

(F): "Will people pending ATPD right now stay on the NHHPP if they qualified if their income is above MCD limits?"

(Lisabritt): "So I think the question distills to, while they're pending ATPD they're covered New Hampshire Health Protection Program because it doesn't have that extra hurdle of demonstrating disability. As a client's determination comes in for ATPD and let's say it's favorable, they basically have a choice of programs because you have both mandatory coverage groups."

(F): "Yeah, we would put them into the ATPD category because they've tell us they're disabled and we're going to cascade them back into ATPD."

(Lisabritt): "What if they want substance use?"

(F): "I don't know if we've come across that discussion yet."

(Lisabritt): "Sounds like the architecture is to favor the ATPD category over Health Protection but there may be some other things that we need to explore because the benefits package is different. So good question and we'll follow up with a complete answer on the web."

(F): "But if they're over, if they qualify for the ATPD but income-wise they don't, but they're still under the Health Protection Program would they stay with the Health Protection? Or will they go with the ATPD with the spend down?"

(Lisabritt): "No. Correct, Robin? If they're only way to do ATPD is with the spend down, they will stay Health Protection. Would they not?"

(F): "I believe so."

(Lisabritt): "Friends on the phone, if they ultimately are determined to be disabled but their income is too high for the ATPD category, that person would stay New Hampshire Health Protection Program. Alright, anything else before we wind up, wind down? Alright, well, thank you everyone for coming out this morning for all of your excellent questions. I do hope that we will see you again next week. I don't think I'm doing that one, am I?"

(F): "Not sure"

(F): "I'm not sure."

(Lisabritt): "Maybe I'll see you and maybe I won't. But thank you again. We are so appreciative of your interest and your involvement. Stay in touch and, you know, looking forward to April, or August 15th. Thank you! Should I hang up the phone?"

[End of recording]