

04/28/09

Questions:

- 1. Routine Hearing:** Coverage is represented as including an examination by a hearing specialist for ages 18 and under only with coverage in full for ages 0-18 and copay for age 19+? Does the NHID want the benefit to deny or apply a different cost sharing for age 19+?
Answer: The co-pay is applied for 19+ members. Other than that, there is no difference in cost sharing for the service.
- 2. PT, OT, Speech:** The NHID Benefit Summary says there is a \$50 Copay. If this service occurs on an inpatient or outpatient hospital setting, what does the NHID want charged: the facility T1 or T2 deductible, the \$50 copay, or both?
Answer: The \$50.00 copay is the only amount that should be charged unless the services are performed on an inpatient basis. If the services are performed on an inpatient basis, the services may be subject to the deductible.
- 3.** The 11/25/08 FAQ states, "All non-hospital facility charges will be applied to the deductible at the Tier 1 rate." This is interpreted to mean that **Professional Services** outside of an office location to apply to a Tier 1 Deductible. It is also interpreted to mean that **Ambulance** and **Durable Medical Equipment** take the tier 1 deductible.
Answer: All deductible costs incurred by the member related to services provided at a facility or by a provider that has not been identified as a Tier 2 facility shall be subject to the Tier 1 deductible.
- 4.** What are the **Home Health and/or Home Infusion** benefits, if any? If covered, what's the member cost-sharing? These benefits are not mentioned in the NHID HealthFirst Benefit Summary, but are standard covered services.
Answer: All standard covered services are included in the HealthFirst plan. Home health care includes all services that are provided as an alternative to otherwise covered services in a hospital or other related institution.
- 5. Retail/Minute Clinics** were not mentioned. Will they be addressed/included in this Product?
Answer: Visits to retail clinics that are in the carrier's network will be subject to the same benefit structure as visits to primary care physicians.
- 6. Standard, Mandated or Supplemental Benefits:** If a benefit is not specified on the NHID Benefit Summary, does that mean it is not covered? Are state mandated benefits covered? Some supplemental benefits on the Schedule of Benefits are annual eye exams, voluntary sterilization and voluntary termination of pregnancy. Are these benefits covered?
Answer: All state mandated benefits are covered. Similarly, all benefits that are generally provided in comparable products are covered by the HealthFirst product.

7. Telehealth: The NHID HealthFirst Benefit Summary states that “Telemedicine” is a covered benefit and the telemedicine description gives criteria for the “originating site” (where the patient is located) and the “distant site” (where the provider is located). In some instances, the billing does not identify the originating or distant sites. Therefore, any provider would be paid who billed with the “Q code” supplied in the Telehealth document. **Answer:** Due to pending legislation on this issue, the department will issue further guidance issue after the close of the legislative session. “Q Codes” are acceptable for the short term.

Network Tiering

8. What methodology may a carrier use to establish tiering that differs from the department’s tiering? **Answer:** To use tiering that is different from that established by the department, a carrier is required to submit a formal request for its own tiering. The formal request must be supported by data that is comparable to that used by the department in its tiering. If a different methodology is used to support the tiering, the carrier must provide the department with the reason for the difference in methodology and must justify any changes.

9. Please reconsider the date by which a health plan has to adopt the state revised hospital tiering. HealthFirst will be built on a plan year, and tiering can change mid-contract for an employer. With this said, forcing the tiering change to happen in January does not seem necessary. Can you consider allowing a plan to pick the date that they want to adopt the revised tiering as long as they only update it once/year? **Answer:** The department will give consideration to proposals submitted by the carriers to address systems challenges presented by hospital tiering. The department will establish its default tiering based upon a calendar year beginning on January 1st of each year. The reason for this is that the department uses the hospital discharge data set and the commercial claims data to establish the tiering. The discharge data set is generally available in November. For that reason, establishing tiers on a calendar year basis beginning in January reflects the most recent data that is available to the department. Application of tiering based on the renewal date of the policy will be allowed.