FAQ About the Changes in the Program's Manner of Processing Claims

1. What is changing about the manner in which the Birth-Injury Program processes claims?

All claims first must be submitted to the admitted claimant's private health insurer; and the Program or the Program's Third Party Administrator (the "TPA"), depending upon the nature of the claim; before any claim is submitted to Medicaid. In other words, the order of responsibility for payment of medical costs covered by the Birth Injury Act will be: 1. Private insurance; 2. The Program; 3. Medicaid (if eligible).

2. My child receives Medicaid or a Medicaid Waiver, what do I need to do?

✓First, you will need to obtain a private health insurance policy for your child. (Information about how to obtain a policy is below.)

✓Then, be sure to inform all of your child's healthcare providers that they should send bills for all items prescribed, and all services performed, on or after August 15, 2017, to the health insurance company that provides your child's private insurance coverage. If no private insurance policy is effective at that time, you should ask your child's healthcare provider to send bills to the Program's TPA, Benefit Plan Administrators. Please be sure to give each healthcare provider a copy of your child's new Program card and a copy of your child's new insurance card as soon as you obtain the new policy.

✓If any portion of a claim remains unpaid after the claim has been processed by your child's private health insurance, you may send the claim to the Program's Third Party Administrator ("TPA") or to the Program directly, depending upon the nature of the claim. (Below you will find a list of the types of claims to submit to the TPA and a list of the types of claims to submit to the Program.)

✓If your child continues to meet the eligibility requirements for Medicaid, then a claim can be submitted to Medicaid as follows:

> For expenses covered by the Birth-Injury Act: A claim can be submitted to Medicaid if any portion of the claim remains unpaid after the claim has been processed by your child's private health insurance and by the Birth-Injury Program, and if all other sources of payment have been applied.

For expenses NOT covered by the Birth-Injury Act: A claim can be submitted to Medicaid for secondary coverage after the claim has been processed by your child's private health insurance, and if all other sources of payment have been applied.

This means that all claims must be submitted to the private health insurer; and the Program or the Program's Third Party Administrator, depending upon the nature of the claim and as described above; before any claim is submitted to Medicaid.

3. How do I obtain private insurance for my child?

The Program will provide guidance, however, as the parent/guardian you will have to make the arrangements. The Program has hired a Facilitator to answer questions and provide information that may be helpful to you in selecting a policy. The Program's Facilitator is Ms. Mercades Cooks. She can be reached at (804) 330-2471, extension 3110, or at 1-800-260-5352. Ms. Cooks will provide you with a letter that you may give to those answering phones for the federal marketplace or to insurance agents when you ask them for an insurance policy for your child.

4. Who will pay for my child's health insurance?

From July 1, 2017 forward, the Program will reimburse you for the premiums you pay for your child's private health insurance coverage after he or she has been admitted into the Program. This applies to all admitted claimants whether or not they have had Medicaid coverage.

5. What type of insurance should I buy?

In most cases, policies that are equivalent to the gold or silver level policies that are available under the Affordable Care Act's federal marketplace will provide appropriate coverage for your child. Most insurance agents will be familiar with these policies and policies similar to them. You may want to ask the agent that is helping you to select a policy to provide you with information about policies that provide coverage for the kind of care your child needs and coverage for your child's current healthcare providers. You should request that the policy take effect no later than September 1, 2017, and you should not request any federal subsidy for your child's insurance premiums because the Program will provide reimbursement. If you need help, however, please contact **Ms. Cooks, the Program's Facilitator, at (804) 330-2471, extension 3110, or at 1-800-260-5352**.

6. How do I request reimbursement for my child's private health insurance premiums?

You may send your request for reimbursement and the documents to support your request to the Program's Third Party Administrator (the "TPA"), Benefit Plan Administrators, each month. In the near future, you will receive specific instructions from the TPA.

If you prefer to have the Program pay the premiums for your child's policy directly to the insurance company, you must ask your insurance agent to send the bills directly to the Program's TPA. Benefit Plan Administrators, Inc., must receive the invoices on a timely basis in order to avoid any lapse in your child's insurance coverage.

7. What do I need to show or send in for reimbursement?

Initially, the Program's TPA will need proof of insurance coverage, a copy of the coverage summary that shows the amount charged for the premium for your child's coverage, and proof of your payment of the premiums. Afterwards you will only need to submit proof of payment to the TPA each month.

8. If my child's health insurance is part of a family plan, how much of the premium will the Program reimburse?

There are different ways this can be determined:

A. The insurer may charge a specific amount for each person even if it is a "family" plan. You may want to ask your insurance agent whether or not this is the case for your policy. If you have health insurance through your employer, you may want to ask your employer's administrator or Human Resources Department for this information. OR

B. If the coverage is "parent and one child" the amount generally can be determined by simply comparing the cost for "employee only" coverage to the cost for "parent and one child" coverage. OR

C. If neither of those methods applies, the amount can be determined by dividing the total amount paid by the number of individuals covered. For example, if a family of four pays $400 per month for health insurance, then the amount would be $100 per person. In this example, the amount that the Program would reimburse, therefore, is $100.

9. Do I still use the Birth-Injury Program card I received?

You may use the one you have until you receive the replacement card within the next few weeks. The Third Party Administrator (the "TPA"), Benefit Plan Administrators, Inc., will send you the new one which will show the Birth-Injury Program's name on it, plus information for filing claims through the TPA. Please be sure to provide the new card to all of your child's healthcare providers.

10. Who do I call if I have problems with my new insurance?

Generally, you will contact the insurer such as Anthem, Optima, Cigna, etc.

11. I was receiving insurance payment reimbursement under the HIPP program. Is the Program's insurance reimbursement the same as the reimbursement under that program?

HIPP and the Program are not identical programs. The Program only affords reimbursement for the post-admission premiums for admitted claimants' insurance coverage. You must contact the Department of Medical Assistance Services ("DMAS"), the agency that administers the HIPP and Medicaid programs, for answers to any questions you have about HIPP or Medicaid.

12. Previously, Medicaid paid for some of my child's hours of attendant care and the Program paid for some of my child's hours of attendant care. What happens now?

The Program will provide reimbursement for the number of hours of care that are prescribed as medically necessary for the admitted claimant by his or her treating physician in accordance with the Birth-Injury Act and the Program's regulations. You must contact the Department of Medical Assistance Services ("DMAS"), the agency that administers the Medicaid program, for answers to any questions you have about Medicaid.

13. Under Medicaid we have been receiving "respite" hours, will the Program provide respite hours?

The Birth-Injury Act does not afford "respite hours." You must contact the Department of Medical Assistance Services ("DMAS"), the agency that administers the Medicaid program, for answers to any questions you have about Medicaid.

14. Will we need to utilize different medical care providers?

It is not anticipated that substantial changes in providers will be necessary; however, whether changes are necessary will depend largely upon which insurance policy you obtain for your child. You may want to ask the agent that is helping you to help you choose a policy that provides coverage for the kind of care your child needs and coverage for your child's current healthcare providers.

Generally speaking, most providers will accept most private insurance plans that provide the type of coverage your child needs. In fact, most providers will prefer the reimbursement rates of private insurance plans over those offered by Medicaid because Medicaid reimbursement rates generally are lower.

If one of your providers does not accept your private insurance plan, please ask the provider to join that insurer's network. Finally, if you need help, please contact **Ms. Cooks, the Program's Facilitator, at (804) 330-2471, extension 3110, or at 1-800-260-5352**.

15. Why has the Program hired a Third Party Administrator?

The Third Party Administrator ("TPA") has been hired to make claims processing more efficient and more cost-effective. Additionally they will process claims that are not eligible for reimbursement or payment by private or other public insurers.

16. Will I have to change providers of medical equipment and supplies?

Whether changes are necessary will depend largely upon which insurance policy you obtain for your child because providers of medical equipment and supplies are usually determined by the primary insurer's network. Many insurers include the same providers in their respective networks.

You may want to ask the agent that is helping you to help you choose a policy that provides coverage for the kind of medical equipment and supplies your child needs and coverage for your child's current providers.

17. Which requests for reimbursement should be sent to the TPA and which should be sent to the Program at this point?
The Program and its TPA will work together to ensure that all claims are processed as efficiently as possible.

Generally speaking, you should submit claims for all items prescribed, and all services performed, on or after August 15, 2017, to the TPA for reimbursement if the following is also true:

✓**Medical expenses not covered by insurer:**
If the request is for payment of an expense for medical care or therapy that is not covered by the admitted claimant's private health insurance policy, you should submit it to the TPA. Expenses for some doctor's visits, hospital care, therapy, dental care, or previously approved experimental therapies are some examples.

✓**Medical supplies not covered by insurer:**
If the request is for payment of an expense for medical supplies that are not covered by your child's private health insurance policy, you should submit it to the TPA. Expenses for some prescriptions, initial requests for durable medical equipment not covered by insurance, diapers, and prescribed over-the-counter supplies, such as formulas, probiotics, or supplements are some examples.

✓**Co-pays and Co-Insurance:**
If the request is for payment of your child's co-pays or co-insurance amounts, you should submit it to the TPA.

✓**Health Insurance Premiums:**
If the request is for reimbursement of post-admission private health insurance premiums for your child's individual policy, you should submit it to the TPA. Alternatively, if you want the Program to pay such premiums directly to the insurer, you must have the insurer send the invoices directly to the Program's TPA in a timely fashion.

Claims to be submitted to the Program include the following:

Requests for reimbursement for nursing and attendant care
Requests for reimbursement for family care
Requests for housing benefits
Requests for vans
Requests for reimbursement for medically necessary mileage, certain taxes, and attorneys' fees
Requests for reimbursement for postage, cell phone use, and therapeutic toys
Requests for augmentative communication technology
Requests for reimbursement of funeral expenses
Any request not specifically described here