# State of Nevada
# Office for Consumer Health Assistance
# Bureau for Hospital Patients


## Janise Wiggins, LSW, MPA, CPM
## Governor's Consumer Health Advocate



Agenda Item V A (FINANCIAL SECURITY)
Meeting Date: 03-21-2018

# AGENDA

- OCHA HISTORY
- SERVICES
- REFERRAL PROCESS
- PAPERWORK
- TYPES OF CASES TO REFER TO GOVCHA
- SOME COMMON HEALTHCARE BILLING TERMS
- AFFORDABLE CARE ACT UPDATE (PPACA, ACA, HEALTHCARE REFORM, “OBAMACARE”)

# OCHA HISTORY

**Established: 1999** – Workers Compensation privatization

**2001** – Bureau for Hospital Patients

**2003** – RxHelp4NV.org
– External Review

**2005** – Contact information on admission, discharge, and workers' compensation forms.
– Hospitals to Post discount policy for uninsured.

**2010** – ACA Consumer Assistance Program Grant

# OCHA SERVICES

# OCHA MISSION

To allow all Nevadans access to the information they need regarding their health care concerns. To assist consumers and injured workers in understanding their PATIENT rights and responsibilities under various health care plans, and policies of industrial insurance and to advocate on their behalf when necessary.

# REFERRAL PROCESS

**Intake** – Referrals should begin with OCHA's intake unit (702) 486-3587 or 1-888-333-1597.

**Forms** – Request for Assistance, HIPAA Consent, Appointment of GovCHA as Authorized Representative

**Case Assignment** – Cases are generally assigned by ombudsman specialty.

**Documentation** – Consumer should be made aware to provide GovCHA with copies of documents pertinent to their case: bills, EOBs, medical records, determination letters, any other correspondence.

**Case Duration** – Every attempt is made to resolve and close cases within 60 days but, may take longer because of complexity of consumer's issues.

# TYPES OF CASES

# TYPES OF CASES REFEERED TO OCHA

- **Access to Care**
  - Uninsured and Underinsured, Affordable Care Act Enrollment
- **Appeals and Grievances**
  - Benefit Denials, Termination of Benefits
  - Quality of Care concerns
- **Hospital and Ancillary medical billing disputes**
  - Affordability, Accuracy, Adequacy, Balance Billing (OON-Out of Network)
- **Prescription Drugs**
  - Access, Benefits, Cost issue, Formulary issue

# PAPERWORK

STATE OF NEVADA
**GOVERNOR'S CONSUMER HEALTH ADVOCATE**
OFFICE FOR CONSUMER HEALTH ASSISTANCE
BUREAU FOR HOSPITAL PATIENTS
OFFICE OF MINORITY HEALTH
555 E. Washington Avenue, Suite 4800, Las Vegas, Nevada 89101
(702) 486-3587 – Toll Free (888) 333-1597 – Fax (702) 486-3586
www.GovCHA.nv.gov E-mail: cha@govcha.nv.gov

FOR OFFICE USE ONLY
GovCHA CASE # _____
CCHO CASE # _____
SCANNED: ☐ BY: _____ QAS: _____

# REQUEST FOR ASSISTANCE

**PLEASE NOTE - THIS OFFICE DOES NOT PROVIDE FINANCIAL ASSISTANCE**

PLEASE READ CAREFULLY - *Before you file a Request for Assistance with the State of Nevada Governor's Consumer Health Advocate, Office for Consumer Health Assistance, Bureau for Hospital Patients, Office of Minority Health ("GovCHA") you should first contact your health insurance company/hospital in an effort to resolve the issue(s) if you do for the on this that a*

IT IS THE POLICY OF GovCHA TO WITHDRAW FROM PROVIDING ADVOCACY SERVICES IF THE CONSUMER IS REPRESENTED BY AN ATTORNEY. WE MAY STILL BE ABLE TO PROVIDE INFORMATION/EDUCATION WITH RESPECT TO YOUR ISSUE BUT WE CANNOT PROVIDE ADVICE, OR ADVOCACY SERVICES.

Are you currently represented by an attorney for this issue? YES_____ NO_____

Is a lawsuit currently on-going or pending? YES_____ NO_____

NAME _____ SOCIAL SECURITY # (LAST FOUR) XXX-XX-_____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PRIMARY PHONE # _____ ALTERNATE PHONE # _____

E-MAIL _____ DATE OF BIRTH _____

HOW DID YOU HEAR ABOUT THIS OFFICE? _____

IF YOU WERE REFERRED BY A STATE OR FEDERAL AGENCY, WHICH AGENCY? _____

**The questions below provide the Federal Government with information to improve services.**

AGE ____ GENDER ____ ETHNICITY _____ EDUCATION LEVEL _____ MARITAL STATUS _____

EMPLOYMENT STATUS _____ NAME OF EMPLOYER _____ SIZE OF EMPLOYER (SM, MED., LG) _____

SPOUSE'S EMPLOYMENT STATUS _____ SIZE OF SPOUSE'S EMPLOYER (SM, MED, LG) _____ SELF-EMPLOYED? YES____ NO ____

HEALTH CONDITION? ____ IF "YES", SPECIFY CONDITION _____

INCOME SOURCE _____ MONTHLY INCOME $_____ HAS THERE BEEN A CHANGE IN YOUR INCOME IN THE PAST YEAR?_____

HOW MANY PEOPLE DOES YOUR INCOME SUPPORT? _____ ARE YOU A VETERAN? _____



If a consumer is represented by an attorney, it is GoVCHA's policy to withdraw from any advocacy services. We can still provide information and education to the consumer.

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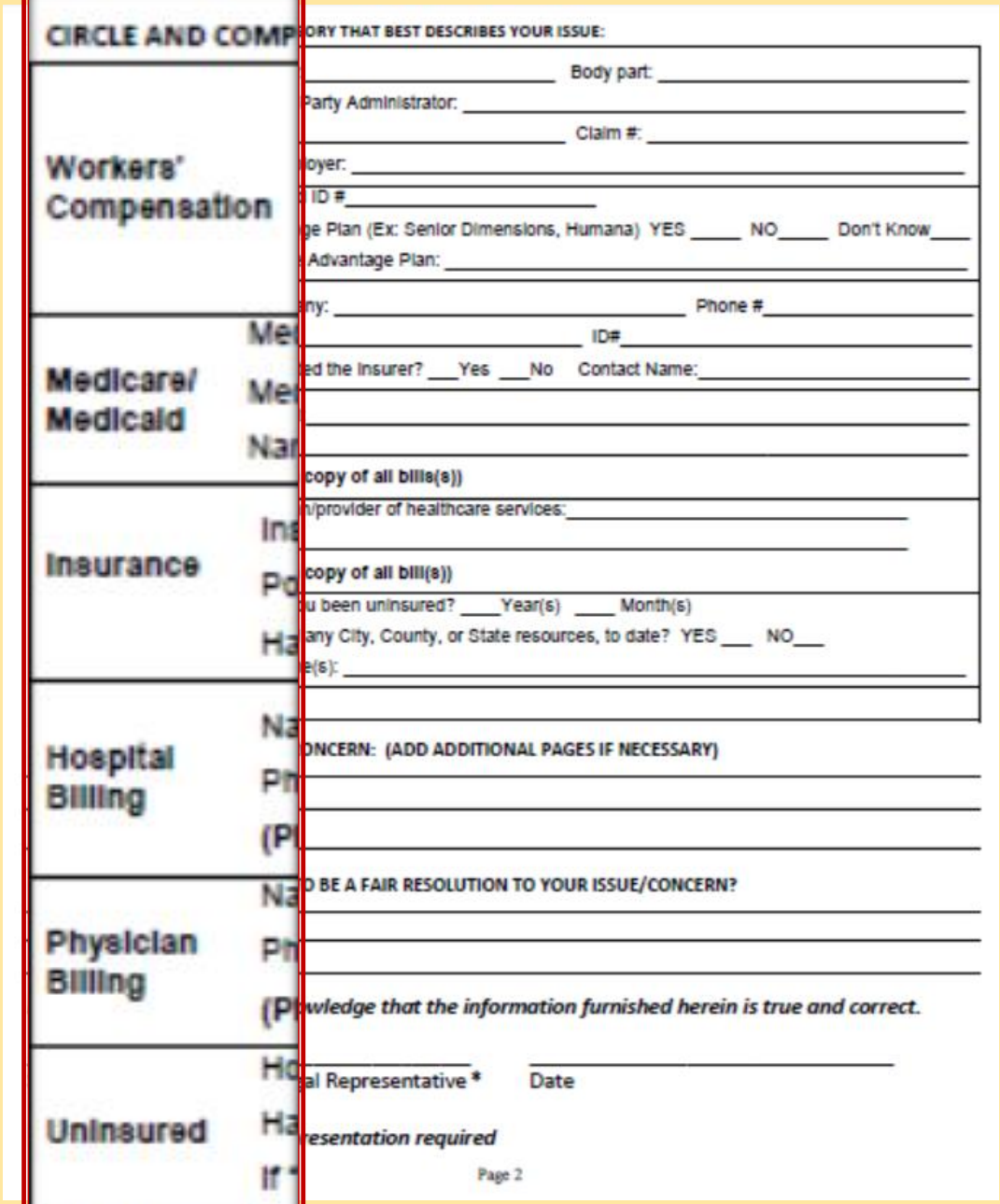
Demographic information is collected for reporting to the Federal Consumer Assistance Program administrator.

Additional details requested which will expedite the Ombudsman's ability to assist the consumer.



CIRCLE AND COMP

Workers' Compensation

Medicare/ Medicaid

Insurance

Hospital Billing

Physician Billing

Uninsured

Other (please spe

ORY THAT BEST DESCRIBES YOUR ISSUE:

Body part:

Party Administrator:

Claim #:

oyer:

ID #

ge Plan (Ex: Senior Dimensions, Humana) YES ____ NO____ Don't Know____

Advantage Plan:

ny: Phone #

ID#

ed the Insurer? ___Yes ___No Contact Name:

copy of all bills(s))

/provider of healthcare services:

copy of all bill(s))

u been uninsured? ____Year(s) ____ Month(s)

any City, County, or State resources, to date? YES ___ NO___

e(s):

ONCERN: (ADD ADDITIONAL PAGES IF NECESSARY)

O BE A FAIR RESOLUTION TO YOUR ISSUE/CONCERN?

*wledge that the information furnished herein is true and correct.*

al Representative * Date

*esentation required*

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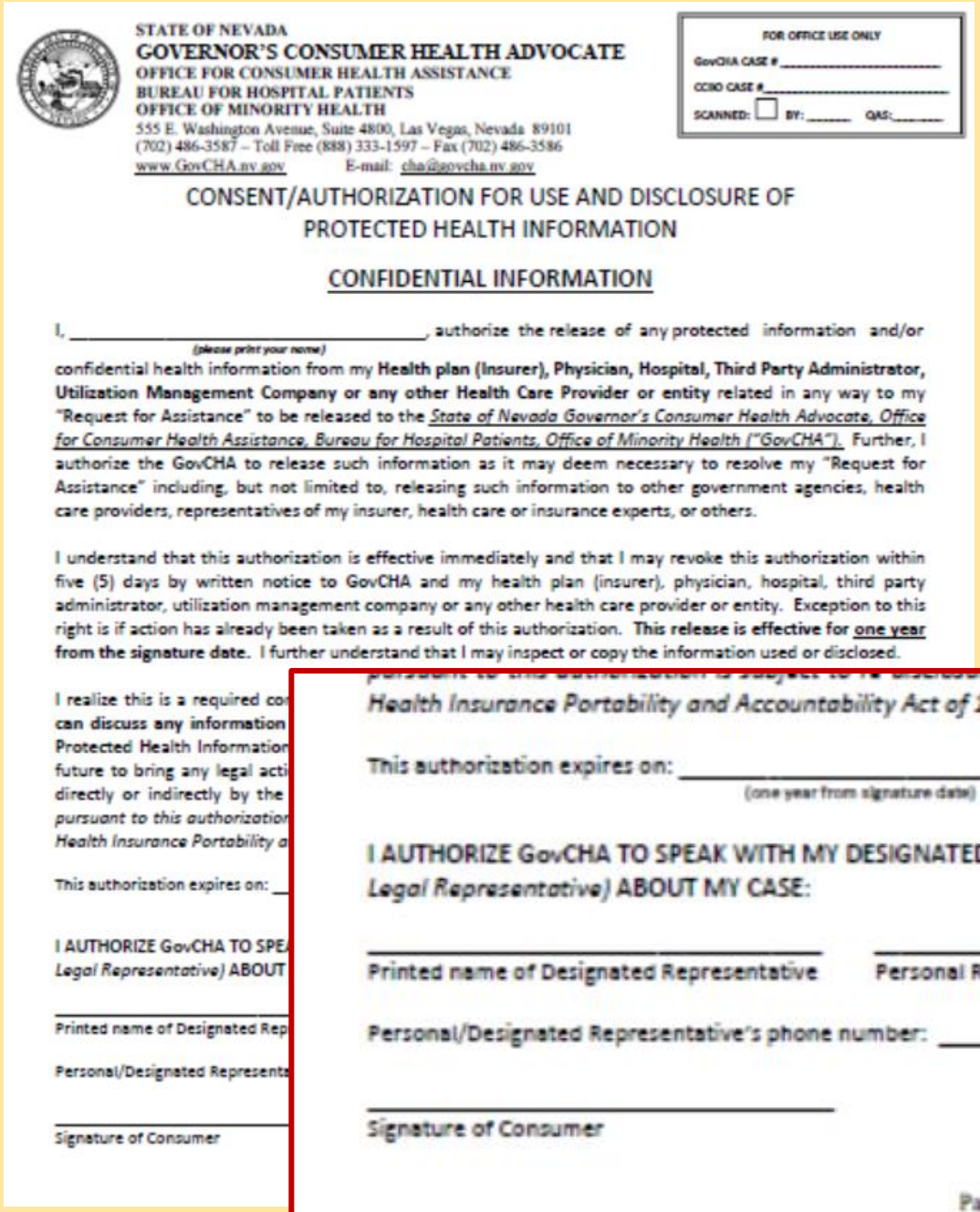

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SCANNED: ☐ BY:_____ QAS:_____

CONSENT/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

CONFIDENTIAL INFORMATION

I, _____, authorize the release of any protected information and/or
(please print your name)
confidential health information from my **Health plan (Insurer), Physician, Hospital, Third Party Administrator, Utilization Management Company or any other Health Care Provider or entity** related in any way to my "Request for Assistance" to be released to the *State of Nevada Governor's Consumer Health Advocate, Office for Consumer Health Assistance, Bureau for Hospital Patients, Office of Minority Health ("GovCHA").* Further, I authorize the GovCHA to release such information as it may deem necessary to resolve my "Request for Assistance" including, but not limited to, releasing such information to other government agencies, health care providers, representatives of my insurer, health care or insurance experts, or others.

I understand that this authorization is effective immediately and that I may revoke this authorization within five (5) days by written notice to GovCHA and my health plan (insurer), physician, hospital, third party administrator, utilization management company or any other health care provider or entity. Exception to this right is if action has already been taken as a result of this authorization. **This release is effective for one year from the signature date.** I further understand that I may inspect or copy the information used or disclosed.

I realize this is a required co
**can discuss any information**
Protected Health Information
future to bring any legal acti
directly or indirectly by the
*pursuant to this authorizatio*
*Health Insurance Portability a*

This authorization expires on: _

I AUTHORIZE GovCHA TO SPE
*Legal Representative)* ABOUT

_____
Printed name of Designated Rep

Personal/Designated Represent

_____
Signature of Consumer

*Health Insurance Portability and Accountability Act of 1996.*

This authorization expires on: _____
(one year from signature date)

I AUTHORIZE GovCHA TO SPEAK WITH MY DESIGNATED REPRESENTATIVE BELOW *(Family Member, Friend, Legal Representative)* ABOUT MY CASE:

_____ _____ _____
Printed name of Designated Representative Personal Representative's Signature Relationship

Personal/Designated Representative's phone number: _____

_____ _____
Signature of Consumer Date

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If a consumer would like GovCHA to speak with a representative/designee about their issue, the representative **must** complete and sign this portion of the HIPAA form.

This page of the Request for Assistance packet should be completed by the consumer ONLY if they have health coverage and are looking for assistance with an appeal or any other issue with their health plan.

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## APPOINTMENT OF GovCHA AS AUTHORIZED REPRESENTATIVE

(Complete this form **ONLY** if you are insured.)

NAME _____ GovCHA CASE # _____

ADDRESS _____ CITY _____ STATE ____ ZIP CODE _____

PRIMARY PHONE # _____ ALTERNATE PHONE # _____

NAME OF HEALTH PLAN _____ PHONE # _____ CLAIM # _____

POLICY/GROUP ID # _____ MEMBER ID# _____

*I, hereby, appoint the **State of Nevada Governor's Consumer Health Advocate, Office for Consumer Health Assistance, Bureau for Hospital Patients, Office of Minority Health ("GovCHA")** to act as my representative in requesting a reconsideration of a coverage/claim denial made by the aforementioned health plan. I authorize GovCHA to make the appeal request, present or elicit evidence, to obtain appeals information, and to receive any notice in connection with my appeal. I understand that personal medical information related to my appeal may be disclosed to this person. NRS223.500*

_____ _____
**Signature of Consumer** **Date**

FOR OFFICE USE ONLY

_____ **Above appointment accepted by GovCHA? YES NO**
**Appointed Representative**

_____ _____
**Signature of Appointed GovCHA Representative** **Date**

# SOME COMMON HEALTHCARE BILLING TERMS

- Certification of Coverage
- Prior Authorization
- In/Out of Network
- Explanation of Benefits
- Advance Beneficiary Notice (ABN)
- Observation vs. Inpatient
- Self-Administered Drugs

# THE AFFORDABLE CARE ACT

# Key Provisions of the ACA Affecting Consumers

- No denials or for children with pre-existing conditions, expanding to adults in 2014
- Coverage for dependent children through age 26
- Establishment of the Pre-existing Condition Insurance Plan (PCIP) *[ENROLLMENT SUSPENDED 2/16/2013]*
- No lifetime dollar limits
- Restriction on annual dollar limits
- Prohibition on rescissions
- Internal and external appeals
- No cost-sharing for certain preventive services
- Insurance plans must cover essential health benefits

# Nevada Health Link

- On-line marketplace to purchase health insurance:
  - Individuals, families, and small employers
  - Enables consumers to review benefits, compare plans, and enroll in coverage
- Eligible consumers can also apply for publicly subsidized health coverage through Nevada Health Link:
  - Medicaid
  - Nevada Check Up (CHIP)
  - New subsidies for commercial insurance
- **OPEN ENROLLMENT BEGAN NOVEMBER 1, 2017 AND ENDED THROUGH DECEMBER 15, 2017.**
- **WE ARE NOW IN THE SPECIAL ENROLLMENT PERIOD FOR THOSE WHO EXPERIENCE QUALIFYING LIFE EVENTS, WHICH WILL ALLOW THEM TO ENROLL WITHIN A 60 DAY WINDOW**

# Essential Health Benefits

1. Ambulatory patient services (outpatient, non-admission)
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management.

# Helpful Websites

**http://dhhs.nv.gov/Programs/CHA/**

www.healthcare.gov

www.medicaid.gov

www.exchange.nv.gov

www.dhhs.nv.gov

www.dwss.nv.gov

www.kff.org

# THANK YOU!


**State of Nevada**
**OFFICE OF CONSUMER HEALTH ASSISTANCE**
**GRANT SAWYER BUILDING**
**555 E. WASHINGTON AVE., SUITE 4800**
**LAS VEGAS, NEVADA 89101**
**702-486-3587**
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