

NH Medicaid Care Management Frequently Asked Questions

www.dhhs.nh.gov/ombp/caremgmt/medicaid-recipients



Picking a Health Plan

Do I need to enroll in Care Management? Beginning November 2015, all individuals that receive medical services through Medicaid are required to enroll in a health plan except for a small group of people that are exempt. Mandatory includes include: Dually eligible (people supported through both Medicaid and Medicare) recipients of all ages, as well as children who receive Supplementary Security Income, children covered under Home Care for Children with Severe Disabilities (also known as “Katie Beckett”), children with foster care assistance, children involved with Special Medical Services and Partners in Health programs.

Nothing changes for you if you are in any of the exempt groups listed below. You will continue to receive your Medicaid benefits in the same way you always have.

- People who are on In and Out Medical Assistance.
- People who receive certain benefits from the US Department of Veteran’s Affairs.
- People who are Qualified Medicare Beneficiaries (also referred to as QMB) and Specified Low-Income Medicare Beneficiaries (also referred to as SLMB/SLMB135) and have no other kind of medical assistance.
- People who are in the Qualified Disabled Working Individual (QDWI) eligibility category and have no other kind of medical assistance.

What Types of VA benefits exempts an individual from Care Management?

- VA pension-Veteran only
- VA nursing facility pension- Veteran only
- VA disability- Veteran only
- Aid and Attendance Allowance- Veterans and Survivors
- VA frozen pension- Veteran and Survivor entitled to \$90 per month due to residing in a nursing facility

When do I enroll and pick a health plan? How long do I have to make a plan selection? The Department of Health and Human Services (DHHS) will shortly authorize the start of open enrollment for those who have previously opted out and will mail enrollment notifications and packages to all affected recipients. You will have 60 days to select a health plan. If you do not select a health plan by the due date in your enrollment packet, the Department assigns a plan for you. Please be proactive and choose the plan that best meets your needs!

What are my health plan choices? You can choose from the following Health Plans:

Health Plan Name	Health Plan Contact Information	Hours
New Hampshire Healthy Families	www.NHhealthyfamilies.com Member Services: 1-866-769-3085	M-F 8 a.m. to 5 p.m. Care Coordination Staff 5 p.m. to 8 a.m. NurseWise
Well Sense Health Plan	www.wellsense.org Member Services: 1-877-492-6965	M-W 8 a.m. to 8 p.m. TH-F 8 a.m. to 6 p.m.

What if I am not happy with my health plan selection? You may switch health plans during the first 90 days of coverage with a plan. Thereafter, you may only switch to another health plan during the annual enrollment period in the fall. If you believe good cause exists for changing a health plan at any time, you may call customer service at 1-844-275-3447.

Will I get more information on how to best select a plan? Which plan should I pick? Every person’s health status and needs are unique. You, and/or your representative, need to consider individual needs and health priorities when selecting a health plan. The following steps can inform your plan selection:

1. Make a list of the doctors, clinics, hospitals, and other providers you use now. Prioritize which providers are most important in supporting your health goals.

2. To determine if your providers are in the health plan networks, you may contact each toll free health plan member service center, visit the health plan web site to look up providers by name, or you may call the Medicaid Service Center toll free at 1-888-901-4999. You can also use NH EASY by visiting www.nheasy.nh.gov and selecting the Health Plan Provider Directory. You can ask your providers which Medicaid health plans they participate in.
3. If you want to continue to see your providers, you should select a health plan that your providers participate with.
4. If your providers work with more than one health plan, select the health plan that you like best.
5. Make a list of your medicines. Contact each health plan to inquire about coverage for the medicines and to learn more about the prior authorization process your doctor may need to follow to ensure that there is no disruption in your medication regimen. The health plans are required to provide “continuity of care” for medications or services you receive prior to enrollment. Continuity of care will last for 60 days or until a medical review is conducted; whichever happens first.
6. Each health plan has a member handbook that provides detailed information on general services, prior authorization requirements, and special programs. You should review these handbooks to determine if one particular plan better meets your needs.

The Well Sense Member Handbook is on line at:

<http://www.wellsense.org/~media/038381733b5f4d48980ee101138bffa3.pdf> and the

New Hampshire Healthy Families Member Handbook is on line at:

http://www.nhhealthyfamilies.com/files/2013/11/NHMF_Member_Handbook.pdf.

Do I have to pick a Primary Care Physician (PCP)? A Primary Care Physician (PCP) is an important part of your health care team. Your PCP is the healthcare provider that knows you best. If you already have a PCP, it is important that you tell your health plan who your PCP is. If you do not already have a PCP, it is important that you choose one and let your health plan know who it is. Your health plan can assist you to find a PCP in your community that meets your needs. If you do not select a PCP on your own, your health plan will automatically match you with one in your area. You can change your PCP at any time by contacting the health plan.

Each PCP has a special number called a National Provider Identification (NPI). When you select your health plan and identify your PCP, you can also provide the NPI number to the plan. You may get the NPI number by calling the Medicaid Service Center toll free at 1-888-901-4999, by going to www.nheasy.gov for the provider directory, or contacting your health plan.

I have to select a health plan. Who can help me? If you need a better understanding for the enrollment process you can contact the Medicaid Service Center at the toll free 1-888-901-4999 or ServiceLink at 1-866-634-9412 or www.servicelink.org. The ServiceLink Resource Centers consist of local and accessible community based offices, so clients can also call or walk into the ServiceLink office. If requested, ServiceLink staff can help you complete on line enrollment in their office, help fill out the paper enrollment form, and answer phone inquiries.

The individual receives Medicare and Medicaid. The PCP that the individual currently sees is not an enrolled provider with either MCO but the individual is able to continue seeing their Medicare PCP because Medicare will cover the cost. Why must this individual select a PCP with one of the MCOs if he/she is going to continue seeing his/her current Medicare PCP?

If an individual is eligible for Medicare and has a PCP within the Medicare Network, then the expense will be paid up to the allowable amount by Medicare. However, if the individual also wants to use Medicaid to pay for expenses not covered by Medicare, they will need to select a Managed Care Health Plan. Well Sense or NH Healthy Families was well as a PCP that is enrolled in the Health Plan’s Network.

Prior Authorization Processes and Your Rights

My child sees specialists, including those in Boston, who are not listed with either health plan. What do I do?

The health plans will require that you see providers in their network. Special permission called “prior authorization” will be required to see a provider that is “out of network.” Both health plans require a prior authorization to go “out-of-network” *if Medicaid is your primary insurer*. Prior authorization is requested by the provider who is referring you to the specialist; such as your primary care provider. The provider must explain why it is medically necessary to go “out of network.” Your provider will file the necessary paperwork with the plan.

In the Care Management program, it is much more likely that you will need to request prior authorization/prior approval in order to receive certain services or care from certain providers. It is best to check with your health plan about prior authorization requirements before you need a service or schedule an appointment.

What if my doctor and I disagree with a health plans prior authorization determination? What are my rights? You and your doctor have the right to request a peer-to-peer review of the determination empowering your provider to speak to the medical necessity of the request. In addition, you have the right to file an appeal if you disagree with a coverage decision. It is important that you take action within 30 days of being notified by the health plan. Your provider may also request an expedited appeal if the situation cannot wait for 30 days. After all appeal rights have been exhausted with a plan, you may request a Fair Hearing with the State Administrative Appeals Unit.

What happens if I also have primary insurance coverage either with Medicare or a commercial insurance like Anthem? How does in-network and out-of-network get applied? How does prior authorization work? The health plans do not require prior authorization for services for out-of-network care if you have primary insurance coverage, through Medicare or another private insurer if the third party covers the service and/or the provider.

I understand that health plans require prior authorizations for certain covered medical services. How do I find out what services require a prior authorization with each plan? Does my doctor know what services require an authorization? Each member handbook outlines what services require a prior authorization. You or your provider can also look up what services require prior authorization on the health plan web sites. You can also call member services for each plan to learn about prior authorization requirements.

If a prior authorization is needed, your provider will complete a prior authorization request form with the necessary clinical information and send it to the health plan. The health plan will then determine if the information in the request form meets the criteria for the requested service. You and your provider will be notified of the outcome of the prior authorization request. For emergency situations, the health plans do not require prior authorization.

Medications and Transportation

Right now, some of my prescriptions are covered by Medicare Part D. How does health plan coverage work with Medicare Part D? Will the health plans pick up balances and do I need to do anything to make sure this happens? Do I have a co-pay? How does the prescription plan integrate with the current requirement to enroll in one of the several Part D plans? People with Medicaid coverage under the Home and Community Based Waiver (HCBC), also known as Choice for Independence (CFI), and those residing in nursing facilities should have zero co-pays for their Medicare Part D prescription drugs. Health plans do not pay these co-pays.

Well Sense: The only products Well Sense would cover are Part D **excluded** drugs, which we have listed on our website. For those drugs we do cover, there may be a co-pay depending on the member's income and eligibility category. Well Sense does not pay your Part D co-pays, they remain your responsibility. The link is: <http://www.wellsense.org/~media/4b8a2210e91d4dfc8536b32d3ffa72d1.pdf?#>

My child relies upon "off-label" prescriptions, how will the health plans manage this? Continuity of care will ensure that there is no gap when your child transitions to a health plan. Continuity of care will last for 60 days after enrollment or until the plans complete an assessment of medical necessity. Both health plans require providers to complete a prior authorization that demonstrates the medical necessity of the off-label use of the medicine.

My child requires specialty formula, what is the process for obtaining it? Both health plans use a Durable Medical Equipment (DME) provider, and not a pharmacy, for customer access to specialty formula. Authorization is required for specialty formula. If you already have an authorization on file with DHHS, that authorization will be sent to the health plan for continuity of care not to exceed 60 days. The health plan will assess medical necessity and enter a new authorization before the conclusion of the 60 days if medical necessity is demonstrated. A 5-day emergency supply of specialty formula can be obtained at a pharmacy if needed; member services staff can assist in finding a supplier for ongoing use.

My child currently is taking compound prescriptions. Does my doctor need to do anything different now that we are enrolled in a health plan? Both health plans are likely to require a prior authorization for compounded medications. If you have an authorization from DHHS under the current fee for service program, that authorization will be sent to your health plan to assure continuity of care not to exceed 60 days. The health plan will assess medical necessity and enter a new authorization before the conclusion of the 60 days if medical necessity is demonstrated.

I am enrolled in Medicare, Medicaid, and have pharmacy insurance. Which cards do I bring to my doctor visit and who pays what? Bring all of your cards to your doctor's visit and the pharmacy. New Hampshire Healthy Families and Well Sense will always pay last after your other coverage.

Do health plans offer mail order for pharmacy?

New Hampshire Healthy Families: We offer the option to obtain 90-day supplies at the pharmacy for certain maintenance medications which can help you reduce the frequency of pharmacy visits. New Hampshire Healthy Families does not offer mail order for pharmacy.

Well Sense: Our pharmacy benefit manager, Envision, offers mail order for some medications. Contact Member Services to see if your medication is available by mail.

How will enrollment in a health plan impact my LNA services? LNA Services will require prior authorization.

Please clarify dental coverage for children and adults. What do the health plans cover and what prior authorizations are needed? There is no change in dental coverage for children and adults. Please use your NH Medicaid card for dental services.

I need to get to doctor appointments and don't drive anymore. Can the health plans help?

Well Sense: Both health plans offer transportation assistance to covered services. Assistance can be in the form of mileage reimbursement for the member or the member's family or friend who drives the member to an appointment. If no family or friends are available to drive the member, arrangements can be made for bus, taxi, or other modes as appropriate. A prior authorization is necessary for 100+ miles. We want people to maintain relationships with their in-network providers.

New Hampshire Healthy Families: To schedule transportation contact Member Services or visit the web site for information about transportation. You must call before your visit to receive mileage reimbursement. We do not have a mileage limit for transportation.

Continuing Care and Care Management Programs

My adult child, that I am the guardian for, has a lot going on medically. Who can I speak with at the health plan about her medical complexity and ensure that she gets continued care? This member may benefit from participating in either health plan Care Management Program. A care coordinator can help manage complexities and assist in making connections with providers and other resources as needed. Once your daughter is enrolled in a health plan, you can self-refer to the Care Management Program, so be proactive and request assistance.

Do the plans offer support for members with complex conditions and special needs? Do the plans offer any programs or supports for people with autism?

New Hampshire Healthy Families: Our Complex Care Management Program is designed to meet the needs of individuals with complex conditions and special needs. In our integrated care management program, we work across multiple domains while maintaining a single point of contact. Our goal is to support the member, family, and providers to help the member to achieve optimum health. Each individual in our Complex Care Management program has access to professional disciplines including, but not limited to: Registered Nurses (RNs), Social Workers, Behavioral Health Clinicians, and Program Coordinators. Our Integrated Care Teams have the support of our Developmental Disabilities Coordinator who formerly worked for an Area Agency and is experienced in working with individuals with autism.

Well Sense: Well Sense offers many care coordination and disease management programs for its members. The first step is to enroll with Care Management so we can understand your needs and goals. Care Management is not just about medical concerns. Our approach is based on the "whole person" and is integrated across domains, medical, behavioral, long term care, etc. Our care managers work closely with your team of providers to coordinate your care in an integrated way.

What to Expect After Enrollment

I heard that for the first 60 days everything will remain the same. Is this true?

There is a 60 day "Continuity of Care" policy in place for everyone coming to managed care from fee-for-service. This ensures that your current services and prescriptions will be honored by your health plan until they have had a chance to assess the medical necessity of your services and medicines.

What happens after I sign up? What can I expect from the health plan?

You will receive a welcome packet from the health plan with important information about your coverage. You will also receive your member ID cards. Do not throw your Medicaid card away. You will still need it. You will need to use both your Medicaid card and your new health plan card when you get medical services. The health plan will call you to ask you questions and answer any you might have. Be proactive and self-refer to the health plan's Care Management Program to assist you with any medical complexities once enrolled.

I have heard that sometimes the plans do not know that a parent is a guardian or representative for an adult child. What if my child's plan doesn't recognize me?

You can call the DHHS Customer Service Center at 1-844-ASK-DHHS or 603-271-4344 and they can assist you and your health plan to show the appropriate relationships and authorized parties. You can also complete a form on the health plan's web site that authorizes you to speak with the health plan. Both plans have this form on the web sites.