



*Empowering and informing families and professionals caring for children with special health care needs and disabilities from birth to adulthood.*

## **NH Medicaid Managed Care Supplemental Issue**

In 2011 the NH legislature signed into law (SB147), a requirement for the NH Department of Health and Human Services (DHHS) to transition all of NH Medicaid to a managed care type of service. That legislation has led to many changes for families who use NH Medicaid as a way to pay for health care for themselves and their children. The process of implementing SB147 will continue to impact us as DHHS follows through with the requirements of the law.

Over the next three to four months many families who have previously been voluntary or allowed to "opt-out" will be receiving letters from DHHS informing them that they must now enter the managed care system. These are the categories for children under age 19 who will now be brought under Medicaid Managed Care - Children eligible for Supplemental Security Income (SSI); Children having Home Care for Children with Severe Disabilities (also known as "Katie Beckett"); Children in foster care or other out of home placement; Children receiving foster care or adoption assistance; Children receiving services through Special Medical Services or Partners in Health and Children and Adults who are eligible for both Medicare and Medicaid (also known as "dual eligible").

There will no longer be an optional /voluntary category. Knowing that many within this category are families with children who have significant medical needs, NH Family Voices has put together this supplement in an effort to help you better understand NH Medicaid Managed Care. If, after reading this information, you find yourself continuing to struggle with the system please give us a call. As always, NH Family Voices is here to answer any questions and help you learn how to access services through NH Medicaid Managed Care.

### **What is Managed Care?**

Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and other services through contracted arrangements between NH Medicaid and managed care organizations (MCOs). The MCO accepts an established per member per month (capitation) payment for services. This means that the company receives the same amount of money every month, for each type of member, regardless of what type of service is delivered to the individual. Once you choose a MCO you become a "member" of the plan. You will be issued a member card and must present it **with** your Medicaid card when receiving care. As of this writing NH has a contract with two managed care organizations, Well Sense Health Plan and New Hampshire Healthy Families.





## ***What's the role of my Regular Doctor in Managed Care?***

Within the MCO you must choose a primary care physician (PCP). The PCP is very important as you will usually need to see them prior to receiving any other medical services. If you need to see a specialist the PCP will provide a referral to allow this to happen. The PCP is the one who is supposed to be able to tell you if a prior authorization is necessary. However, keep in mind that requirements change and at times a physician will need to check with the MCO. There may also be times that it is in your best interest to verify this information with the MCO so that you don't find yourself with an unexpected bill.

## ***What is an MCO network?***

The MCO network refers to the primary care doctors, specialists, hospitals, pharmacies and other providers that managed care companies contract with to deliver services to their members. The providers has a contract with the MCO that specifies things such as what they will be paid by the MCO for providing care to a plan member, what services are covered, and how providers meet specific quality of care standards. The MCO looks to contract with providers according to their expertise as well as where they are located to enable members' access to services. The networks are designed by the MCOs in an effort to provide for all the care a member may need. Members very often choose which managed care company to join based on whether or not their provider is part of the MCO network. Offering a variety of appropriate service providers within network is part of what makes managed care a cost effective way to deliver quality health care.

## ***What does "Out of Network" mean?***

Out of network means a service that is obtained from someone who *does not* have a contract with the managed care company to provide services to managed care members. In order to have a service paid for by an "Out of Network" provider you must first seek authorization from the managed care organization. Out of network care is paid by your MCO if you are receiving emergency services when you are traveling out of the network area and need care, however you (or a family member) must notify the MCO within 48 hours of the emergency to let them know of the emergency.

## ***How do you request payment for "Out of Network" care?***

Requesting out of network care requires proving that the care you require is not available within the MCO's network. The request would be based on the service not the service provider. This means that if you have been getting services from Doctor X but Doctor X is not in the network and Doctor Z, provides the same service you will have to change providers. Check with the MCO to find out what policies they have in place to facilitate a smooth transfer of care for the patient. If you are unable to find the specific medical service that you need in network you must notify the MCO and ask for their assistance in locating a provider. This may be the time to request help from a care coordinator within the MCO.

## ***The Member Handbook.. Why is it important?***

Each MCO has a member handbook that will be mailed to you when you sign up with their organization. The handbook can also be found on-line at their web-site. The handbook is a great place to have many of your questions answered about how to receive services through their organization. They provide specific direction as to whom to call and what should happen when you do call, as well as tell you of things that require prior authorization. Making yourself familiar with the handbook can make it much easier to work with your MCO.

## **What does an MCO Care Coordinator do?**

MCO's may call these people different things but they pretty much do the same things. Care Coordinators are usually nurses and/or social workers. Most of the time coordinators work with people who have complex medical or behavioral health issues. Together with you and your doctor they will help navigate the system to meet your medical needs. They will do things like help locate providers, get prior authorizations, and provide education about managing special health care needs.

## **What is a Referral and why do I need one?**

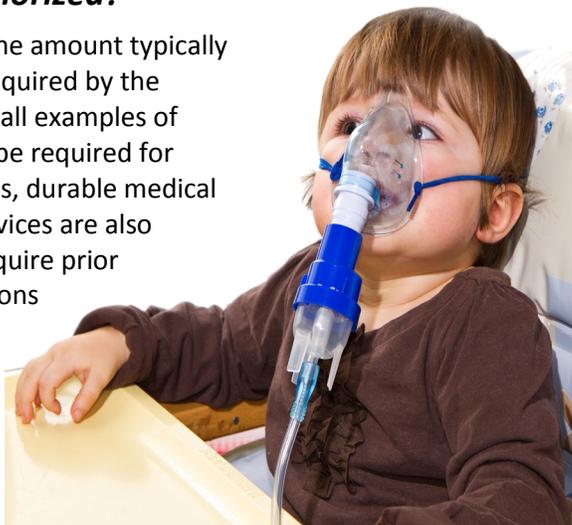
If you need to see a specialist you may need to get a referral from your PCP. The referral will say who you are to see and for what period of time the referral is in effect. For instance, if you were seeing a physical therapist the referral may specify who you are to see, how many visits are approved and between what dates the visits must occur. Knowing what all of these things are will keep you from scheduling an appointment only to find that when you get to the visit the referral is no longer in effect. Without a current referral you may be responsible for payment of the service. There are some things that will not require a referral. To know what they are please check your MCO's member handbook or call the MCO.

## **What is "Prior Authorization"?**

Needing a "prior authorization" means you will need permission from the MCO to receive the service/medication, before it happens, in order for them to pay for it. Prior authorizations are done through the MCO or by a company with whom they subcontract. Your physician should be able to tell you if a service needs to be prior authorized as the provider is the one who submits the prior authorization paperwork, however you may also contact your MCO and ask if something needs prior authorization. We would suggest getting the answer in writing as a written denial can be appealed and a written confirmation will put your mind at ease as you go forward with accessing the procedure.

## **What has to be prior authorized?**

Drug prescriptions that exceed the amount typically prescribed, brand name drugs required by the physician or a specialty drug are all examples of when a prior authorization may be required for medications. Surgical procedures, durable medical equipment and home health services are also examples of things that often require prior authorizations. Prior authorizations will have a time limit attached to them so you may need to routinely request new authorizations. If you are receiving a service on a regular basis that requires prior authorization.



**Pass It On** is a free quarterly newsletter for parents of children with special health care needs and the professionals that support them.

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## **Pharmacy**

Each MCO has what is called a formulary within their health plan. A formulary is a preferred list of medications, both generic and brand name drugs. The MCO may only pay for the drugs that are on this list. If you need a drug that is not on the list you may need to get a prior authorization by proving medical necessity.

When you are getting a prescription filled you must go to a pharmacy that is a provider within your MCO. The pharmacy can also tell you if a drug needs a prior authorization and they can work with your doctor to go through that process. If the pharmacist tells you your medication is not covered and is not able to help you, your next step would be to call the MCO and ask for a care/case manager.

Some MCO's also offer a mail order prescription service through companies with whom they have a sub contract. This is an additional service but you are not required to use the mail order service.

*Medicaid 30 day supply limit:* It's important to remember that you can refill prescriptions up to 3 days in advance, which also helps when months are 31 days. In addition, emergency preparedness advice for natural disasters recommends having an extra week's supply. For children on Medicaid, parents can refill several months in a row using the "3 day ahead" rule so they have a safety net.

Families should make sure all of their insurance is billed to reduce costs and should not agree to pay if other insurance is responsible for the copay. Sometimes there are billing errors and pharmacies may tell families that they must agree to the co-pay (for expensive medications the co-pay can be hundreds of dollars) before they can obtain medicine. A provider cannot bill Medicaid and then bill the balance to a family. This type of "balance billing" is not allowed.

If you are told by the pharmacist that your prescription has been denied you should receive a 3 day supply and immediately call your MCO to determine why and, if necessary, file an appeal. The number can be found on your health plan card. By ordering medication 3 days in advance it gives you medication to use while you appeal the decision.

## **Medically Necessary**

This is a term used by MCOs to identify services that are covered. The definitions may not be the same in every Managed Care Organization, however because we are talking about "NH Medicaid Managed Care" we would direct you to the description in the NH Department of Health and Human Services Administrative Rules HE-W530.01 (e) which reads:

"Medically necessary" means health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

- (1) Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;
- (2) Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;
- (3) No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and
- (4) Not experimental, investigative, cosmetic, or duplicative in nature.

For adults over the age of 21 the medical services must also be part of the listed benefits provided by the managed care company. While this definition is important you should also ask how the company makes its decisions. On what are they basing their information? And remember if you disagree with the decision made you have the right to appeal.

### ***What is EPSDT and why should it matter?***

EPSDT (Early Periodic Screening Diagnostic and Treatment) is a category of services within the federal Medicaid regulations. This regulation requires that children under the age of 21 be screened and if any problems are identified the child is eligible to receive any of the services that are available through the federal list of Medicaid services. This may include services that are not part of the “covered services” within your managed care plan but are part of the Federal Medicaid service requirements.

### ***What happens if I don't agree with a decision made by the Managed Care Company?***

Managed care companies have something called Peer to Peer review which can occur if a denial has been made by the MCO. A Peer to Peer review happens when your provider asks (via the MCO) to speak with a provider from the same field of knowledge to discuss why the request for a specific service has been made. If the conversation results in the peer agreeing with your provider's request the MCO will very likely reconsider their denial. This is a much less involved process than a formal appeal and choosing to request a peer to peer review will not stop you from filing a formal grievance and/or appeal of a decision.

Every member of a managed care company has a right to appeal. You must file your appeal with the MCO. The process of appealing is a very specific process and is explained in detail in your MCO member handbook. Once you have completed the appeals process, if you continue to disagree with the decision of the MCO you also have the right to request a “Fair Hearing” through the NH Administrative Appeals Unit.

While it is possible to file an appeal with just a phone call to the MCO, NH Family Voices always recommends a written paper trail as best practice. This may mean simply documenting with a follow up letter that you called in a request for appeal. If you need further assistance with how to document your appeals process, call NH Family Voices for assistance.

### ***Considerations after you pick an MCO***

Managed Care is by definition set up to save money and improve healthcare access and outcomes. One of the ways this is done is by review of services. As high users of health care services families of children with special needs and disabilities should be aware that managed care companies will monitor the health expenses of our family members. This is done by utilization/service reviews, prior authorizations and closely monitoring services to be sure they are being delivered appropriately and in a fiscally appropriate manner.

A service review may result in your having to use a different provider. You may also have to request prior authorizations more often, or you may no longer be able to receive a service. Each of these things will happen by a defined set of rules and procedures so it is important that you ask questions to clarify why and how decisions were made and what your options are to appeal decisions with which you disagree. Service reviews can be done at any point so you may find yourself periodically working with the MCO to explain why your child is receiving services, medications or seeing specific providers.





### ***Medical Transportation Reimbursement***

If you have been getting transportation reimbursement from NH Medicaid , once you become a member of a MCO you will have to register with them to continue receiving transportation reimbursement . You should contact the MCO and ask for the necessary forms to sign up.

### ***Changing plans***

When you choose your MCO don't worry that this is a decision you are stuck with forever because that just isn't true. You can change your MCO for any reason during the first 90-days you are covered by the MCO. After the 90 day period you can change MCO's during the annual open enrollment period.

You may also be able to change your MCO if you have "good cause". If you think you have good cause, and want to change your health plan you should call Client Services at 800-852-3345, ext. 4344 or (603) 271-4344.

### ***What if Medicaid is not my only insurance plan?***

The "coordination of benefits" is very important and can be difficult. Having both insurance plans often means you can get services from one that the other doesn't cover so it can be a bonus, however it also means more planning and understanding is needed to know how each one works and how they will work together.

When choosing an MCO you should consider the benefits offered by your private insurance and how the two will work together. When you have multiple payers there is a hierarchy that you must go through to be sure all billing is done appropriately. If you have difficulty or questions about how billing will occur you should call the member services department of the MCO. It's best to do this PRIOR to receiving a service. For instance is there a provider who is not an MCO provider but is a provider with your private insurance? If so when you see this person will the MCO be willing to cover any remaining balance? Having a conversation with your MCO prior to the service will clarify if the MCO would pay any of the costs. All private insurance rules must be followed before an MCO will become engaged in the process. This means you cannot use an MCO provider if they are not a provider with your private insurance company. Families should make sure all of their insurance is billed to reduce costs and should not agree to pay if other insurance is responsible for the copay. Sometimes there are billing errors however, a provider cannot bill Medicaid and then bill the balance to a family. This type of "balance billing" is not legal.

***YOU CAN NEVER BE DENIED MEDICALLY NECESSARY COVERED SERVICES  
BECAUSE OF ISSUES OR CONFUSION DUE TO MULTIPLE PAYORS***

### ***In the Future***

There are also periodic opportunities for other managed care organizations to enter the NH Medicaid system. By staying involved with NH Family Voices you will hear of changes and new companies that become available through NH's Medicaid Managed Care.

## **FINAL TIPS:**

The following are some tips for working with your MCO. They are not listed in any particular order nor are they guaranteed to always work, they can help to make the system less difficult to work within.

- ♥ **Use a friendly approach.** Everyone knows that you get further when you are pleasant and it's really important to remember that the person on the other end of the phone may not be the person who actually made the decision that has you frustrated. If you have a hard time handling your emotions when talking with the MCO employee, be honest that you are upset and that you are trying to remain calm. You may want to consider using humor as that often puts people at ease. No matter what, do not yell, swear and/or be rude to someone whom you are trying to convince to help you.
- ♥ **Be persistent.** It can take time to get through any system and a Managed Care Organization and NH Medicaid are systems. Ask for decisions, promises made and or denials in writing. You can also always offer to send a letter explaining your understanding of what was said. Keep a copy of your letter and be sure to ask when you can expect any specific decision or actions to be completed.
- ♥ **Follow the process.** Be sure that you understand the process and follow it accurately. Don't try to skip steps in the process to save time as that will only delay things when it is discovered you have not gone through all of the appropriate stages of a process. Getting pushed back to the beginning when you thought you were making headway will only cause you further frustration. Ask for the process in writing to be sure you are following the correct process. Use the appeals process and remember that appeals follow strict lines so you should be aware of them from the time you are given a denial.
- ♥ **Ask questions, seek clarification.** Make sure that you understand what you are being told. Ask all questions you need to ask in order to proceed. If someone has difficulty explaining what you need then ask for them to recommend who else may be able to help you.
- ♥ **If you need accommodation** or if English is not your first language ask for interpreters or more a accessible format of information to meet your needs.
- ♥ **Ask for coordination.** If you are struggling with accessing care, or getting through the process you may want to consider asking for a coordinator or case manager. Call the MCO and ask about their care coordination service.
- ♥ **Get it in writing.** In order to appeal or question a decision you must have it in writing. Getting as much information and assistance as possible in writing will make it easier to move ahead within the process.
- ♥ **Keep accurate records.** This includes who you spoke with, when, and what was said. Keep copies of any written information you receive. Having written information/decisions to fall back on will make it much easier to work with people within the systems.
- ♥ **Explain your need in medical terms.** Medicaid managed care is a medical system, paying for medical services. For services to be paid for they must be medical needs – use those terms.
- ♥ **Emphasize cost savings.** Medicaid Managed Care has been implemented in NH to save money. Remember to emphasize any costs savings that will occur because of your request.
- ♥ **Recognize and thank everyone who is helpful.** People who feel appreciated will go the extra mile for you. Be sure to thank and recognize individuals, organizations, or anyone who helps you to get through the process. You may need to go back to these people in the future for additional assistance.
- ♥ **Speak up with specific information to help improve the system.** Providing concrete ideas for ways to improve the system will help to improve things for everyone. Share your stories, both the positive and the negative as they both have a benefit to the overall workings of NH Medicaid Managed Care.

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