New Hampshire Department of Health and Human Services
129 Pleasant Street, Concord, NH 03301

Frequently Asked Questions: Meridian Health Plan Departure

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I. Transition Period

1. Can the Area Agencies get a list of the individuals they work with who are enrolled with Meridian so that they can reach out to families to offer assistance?

The Bureau of Developmental Services (BDS) will provide this to the Area Agencies. BDS will also supply the names of children in the Partners in Health Program.

2. Is everything with Meridian covered until July 31?

Meridian will continue to provide services **through July 31st**. During the transition, Meridian members will continue to receive services through the Health Plan they are enrolled with and Meridian will reimburse its providers for all services provided to its members through July 31st.

3. What happens to individuals between June 30th and July 31st?

See the answer to #2 above. In June, Meridian members received an enrollment packet from the NH DHHS advising them of the change and to choose one of the two Health Plans. Those who do not choose another Health Plan by July 10 will be auto-assigned to one. The member's services will be covered by Meridian Health Plan through July 31st unless they have enrolled with another Health Plan effective July 1st. All Meridian members will be transitioned to their new Health Plans (either New Hampshire Healthy Families or Well Sense) and receive their services from them starting August 1st.

4. Will the Department host a webinar or teleconference to provide guidance to individuals/families that are impacted by this change?

The Department is communicating with Meridian members and working closely with the three Health Plans, providers, Area Agencies and community partners. There are no plans to hold a webinar or teleconference.

II. Prior Authorizations

1. What about prior authorizations – will they be honored? What happens to prior authorizations that have been issued for procedures and specialty appointment scheduled for July?

Meridian will advise providers that prior authorizations previously issued by Meridian for services that extend after a member is enrolled in a new MCO must be confirmed by the member's new MCO. Meridian will also specifically advise providers with whom services for a Meridian member have been authorized for a period of time after July 31st, 2014. NH Healthy Families and Well Sense will honor prior authorizations issued by Meridian for 60 days from the time a member becomes enrolled with the new MCO or until completion of a medical necessity review, whichever occurs first. Disputes regarding prior authorizations will be resolved by the DHHS after the internal expedited appeal process of the new MCO has been exhausted.

2. If I have surgery scheduled between now and July 31 will I be all set for follow-up care? How do I make certain everything related to the surgery is covered after these shut down dates?

Member's services will be covered by Meridian Health Plan through July 31st unless they have enrolled with another Health Plan effective July 1st. All Meridian members will have been transitioned to their new Health Plans (either New Hampshire Healthy Families or Well Sense) and receive their services from them starting August 1st. Depending on when the surgery is scheduled, a member may receive some or all of their follow-up care from their new MCO.

3. If I have a prior authorization with Meridian for a prescription, transportation, etc., that goes past June 30th am I all set? Will the prior authorization transfer to my new Health Plan or do I need to get everything authorized – with my PCP – once again?

See the answer to #1 above. The member's services will be covered by Meridian Health Plan through July 31st unless they have enrolled with another Health Plan effective July 1st. All Meridian members will have been transitioned to their new Health Plans (either New Hampshire Healthy Families or Well Sense) and receive their services from them starting August 1st.

4. I have a 9 month authorization for skilled nursing in my home. Is this authorization transferred to the new Health Plan I select? If not, what do I do? Who do I contact?

See the answer to #1 above. The prior authorization from Meridian Health Plan will be honored by the other two MCOs for 60 days or until completion of a medical necessity review, whichever occurs first. In this case, the member should work with their provider (PCP) to ensure that either another prior authorization has been issued or the medical necessity review has been completed. The member can also contact Member Services at their new MCO to find out where they are in this process.

5. Meridian did not require prior authorizations for some services. How will I know if my new Health Plan requires prior authorizations for those services?

It is important that members consult the Member Handbook of Well Sense or New Hampshire Healthy Families to see if they require prior authorizations for services that Meridian did not.

III. Health Plan Networks

1. Will I have access to Children's Hospital? Meridian had Children's in their network – do the other two Health Plans?

The other two Health Plans are in discussion with Children's Hospital.

2. My doctor is not with any Health Plan but Meridian. Will Well Sense or NH Healthy Families be signing up my doctor? When will this happen? I don't want to make a new plan selection until I know this.

The Department and the other two Health Plans will be doing provider outreach to encourage those providers who only signed a contract with Meridian to become a provider with all Health Plans. You may ask your doctor which health plan/s he or she is planning to enroll with.

3. Are the two remaining Health Plans equipped to take on all these new insured people?

Yes, the other two Health Plans are able to accommodate this increase in their enrollment.

4. What about network adequacy in the Nashua area given that the physician practices associated with SNHMC contracted only with Meridian?

As indicated in the answer to #2 above, the other two Health Plans are reaching out to these providers to join their networks. In addition, the NH DHHS will be doing a series of provider communications. Similar to the message the Department delivered during the implementation of the MCM program, providers will be encouraged to join all Health Plans.

5. How do I validate that my doctor is in the Health Plan network?

You will use the same process that you used during the MCM implementation and/or that you use now. First, you can use the Provider Directory to check to see if your doctor is with the Health Plan you would like to join by visiting: http://www.dhhs.nh.gov/ombp/caremgt/index.htm

The DHHS' Medicaid Service Center can also help you. They can be reached at:

1-888-901-4999.

Another way to check is to call the Health Plan's Member Services or check their provider Directories available on their website:

NH Healthy Families **1-866-769-3085** www.NHhealthyfamilies.com

Well Sense **1-877-957-1300** www.WellSense.org

You may also call your provider and ask which Health Plans he or she plans to enroll with.

IV. Changing Health Plans

1. Will an individual have a choice of a new Health Plan or will they be auto-assigned?

Every Meridian Health Plan member will be able to choose their new Health Plan. Starting in June, individuals received an enrollment packet from the DHHS so they can choose one of the other Health Plans. Those who do not choose another Health Plan by July 10th will be auto-assigned to one.

2. I want to select a new Health Plan now – how do I do this?

You can pick a new Health Plan by:

- Calling the DHHS Member Services Center at 1-888-901-4999.
- Picking a Health Plan online through NH EASY by going to www.nheasy.nh.gov

3. Can I switch my plan after I select it if I don't like it? How long do I have to change?

Yes. If you are voluntary for the MCM program (you can decide if you want to pick a Health Plan or opt out) you can change at any time. If you are mandatory (you have to pick a Health Plan) you have 90 days to pick a different plan if you choose. Once the 90-day change period is up for mandatory enrollees, you can change your health plan during the annual Open Enrollment period. (Some members may have a good cause to change and they should call the DHHS Member Services Center to see if they qualify).

4. How long will it take to get my Health Plan card? Last time it did not come until well after the start date. If I don't have a card, how do I prove to my doctor which Health Plan I have?

The Health Plans have 10 days to get the new card to their members. If you have not received the new card and have an appointment, your provider can check which Health Plan you are enrolled in when you go for care.

5. Will I have to do another "welcome call" and fill out more paperwork or will my information be transferred to the new Health Plan I select?

You will receive a welcome call and new Health Plan card. The Department is providing some information to your new Health Plan.

V. Other

1. Does this mean that the managed care system is collapsing and that Step 2 is not going forward?

No. DHHS is currently focusing on implementing the NH Health Protection Program (NH HPP), which will provide expanded Medicaid coverage to over 50,000 people in the state. The Department is committed to a planful and engaged process to design Step 2 MCM, which is the integration of long term services and supports, waiver services and developmental disabilities services into the Medicaid Care Management Program.

2. Will DHHS issue another RFP to select a third/new MCO?

The DHHS will make that decision sometime this fall.