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Medicaid Care Management Provider Question and Answer

TOPICS

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I. PROVIDER ENROLLMENT IN HEALTH PLANS

1. How can I enroll in all 3 plans?

Contact Provider Relations at each of the Health Plans; the link to that information on the MCM webpage is below:

<http://www.dhhs.nh.gov/ombp/caremg/documents/provider-contact-resource-guide.pdf>

2. Are other providers in my group enrolled?

The Provider Directory will have that information but the most efficient way for you to get that information would be to contact the contract manager for your organization or practice.

3. I sent all enrollment paperwork into the 3 MCM companies in August but I am still not listed as a provider.

There are two issues; one is whether a contract has been signed with the Health Plans. The other is that once a contract has been signed, providers must then go through the credentialing process. DHHS cannot publish a list of providers who are pending credentialing. A provider can find out where they are in the process by contacting Provider Relations at each of the Health Plans; the link to that information on the MCM webpage is below:

<http://www.dhhs.nh.gov/ombp/caremg/documents/provider-contact-resource-guide.pdf>

4. I am a psychotherapist in Belknap County having trouble signing up for all 3 of the companies that will be providing MCM. I am concerned about my work with some of my clients being interrupted if I cannot get them to

respond and add me to their networks. I am also one of only two therapists in the county that works with young children, so client access to services will be affected. How can I resolve this issue?

The best course of action is to call the individual Health Plans. The link to that contact information is below:

<http://www.dhhs.nh.gov/ombp/caremgmt/documents/provider-contact-resource-guide.pdf>

5. Why was a provider who tried to enroll in Centene (called 1-866-769-3085) sent back to DHHS to enroll?

In order to be enrolled as a provider in each of the Health Plan networks, a provider must first be enrolled in NH Medicaid. In this case, it is likely that was the initial step that had to be completed before the provider could enroll with a Health Plan.

II. PROVIDER DIRECTORIES / PRIMARY CARE PROVIDERS (PCPS)

1. Currently there are no labs listed under the NH Easy provider network in Concord. Where would these people need to have labs drawn?

It is best to check with the Health Plan to find out which labs are in their network.

2. Why aren't community mental health centers listed?

As of this writing, the CMHCs are in the process of credentialing with all 3 Health Plans. In addition to frequently checking the Provider Directory, a provider can find out where they are in the process by contacting Provider Relations at each of the Health Plans; the link to that information on the MCM webpage is below:

3. Are DME providers loaded into the directory yet?

DHHS has asked the MCOs to include DME providers in their directories.

4. I had a patient call me yesterday to say that she was unable to pick her PCP, which is a nurse practitioner. She states she was told that she would have to pick the physician that oversees the nurse practitioner. Our understanding during our training was that a patient can pick a nurse practitioner or a physician's assistant as they would also be in the system. is correct that patients have to pick the physician over the nurse practitioner? Is this correct?

Each Health Plan allows nurse practitioners to be listed as a PCP as long as they are the billing provider. If they are not, the client has to choose the physician (billing provider) that oversees their work as their PCP. However, they can still continue to see that nurse practitioner.

5. Providers are showing up on the provider directory on NH Easy, as signed up with just one plan, yet on the individual plan websites I noted that some are signed up with more than one plan, will this be updated?

The Provider Directory is being updated on a daily basis. It is best to check it frequently.

III. SERVICE / PRIOR AUTHORIZATIONS

1. Does the recipient need a referral for other providers?

That will depend on the Health Plan. The DHHS is preparing a tool called the *Quick Reference Guide* for providers for release by October 31 that will be used in conjunction with the November 12 training on managing business processes under MCM. This tool will have information on what, if any, services require a referral for each plan. The Provider Manuals and the Health Plan websites also have that information for providers.

2. Which services will require prior authorization?

That will depend on the Health Plan. The DHHS is preparing a tool called the *Quick Reference Guide* for providers for release by October 31 that will be used in conjunction with the November 12 training on managing business processes under MCM. This tool will have information on what services require a PA for each plan. The Provider Manuals and the Health Plan websites also have that information for providers.

3. After the 90-day transition period (in which the Health Plans are contractually obligated to honor existing PAs at the December 1 Program Start Date) do we need to start the PA process all over again? Can we do it before the 90 days?

It is highly advisable to request PAs in advance of the 90-day transition period. That period of time is to allow providers to work with plans without disrupting care of patients.

It is best to contact Provider Relations at the Health Plan to find out what, if any, advance requirements they have for PAs. That information can be found at:

<http://www.dhhs.nh.gov/ombp/caremgmt/documents/provider-contact-resource-guide.pdf>

3. Will the NH Medicaid service limits still apply in MCM?

While the Health Plans cannot apply service limits that are stricter than NH Medicaid Fee-for-Service (FFS), they do have the option of allowing more than the Medicaid FFS limit if they choose. Provider Manuals (and Member Handbooks) provide more information about each Health Plan's approach to service limits and service authorization.

IV. CLIENT ASSISTANCE

1. Will there be a "Service Link" type of organization that can go through all the client's providers with them and then help them to choose the best plan, like we do with Medicare Part D plans?

The Enrollment Call Center (1-888-901-4999) will be able to assist clients in locating their providers in order to make a decision on which Health Plan to join.

2. Will Service Link be able to assist clients with these choices and enrolling folks?

Service Link can assist only their existing clients and others that are part of the population they serve. (See above re: Enrollment Call Center assistance.)

<http://www.dhhs.nh.gov/ombp/caremgmt/documents/provider-contact-resource-guide.pdf>

V. BENEFITS/COVERAGE

1. Will Medicaid continue to provide waivers?

Yes. Waiver services are not included in MCM at this time (Step 1) and will continue to be covered under Medicaid Fee-for-Service.

2. When clients have a redetermination are they automatically sent a new enrollment package?

Redetermination is independent of MCM enrollment. Clients need to make sure they complete their redetermination so they do not lose Medicaid eligibility. If they lose eligibility they are disenrolled from their Health Plan. They will be sent an Enrollment Packet at the time of their Annual Health Plan renewal, which may not coincide with their redetermination date.

VI. CLARIFICATION OF PREVIOUSLY POSTED Q&A

In reference to exempt status what is meant by VA benefits? Is it a pension? VA health care?

Previously, this question was answered that it referred to VA health care. However, after further investigation, it was revealed that it is broader than that.

Recipients of VA benefits who are exempt from MCM means those that receive:

- VA pension
- VA nursing facility pension
- VA disability
- Aid and Attendance Allowance
- VA frozen pension