



TO: NH Medicaid Providers
FROM: Kathleen Dunn, RN, MPH - Associate Commissioner, Medicaid Director
RE: Regular Update #3: The Medicaid Recipient’s Transition to Health Plan Membership

Background NH Medicaid is undergoing a transition from the current fee-for-service model to a managed care model. This initiative is called Medicaid Care Management (MCM).

The transition to a managed care model means that most Medicaid recipients will enroll with one of three managed care organizations (MCO). Fee-for-Service Medicaid will be maintained and Medicaid recipients will not lose coverage or their Medicaid level of benefits. Medicaid services, with some exceptions, will be provided by the member’s Health Plan provider network. While the member’s coverage will include the Medicaid covered services, Health Plans will also offer additional programs and services. The program start date is **December 1, 2013** – this is the date Medicaid recipients begin receiving coverage from the Health Plans.

MCM Participation Status & Health Plan Selection Each Medicaid recipient will be assigned a participation status in the program. The Medicaid recipient’s participation status is **Voluntary, Mandatory, or Exempt/Excluded**. Their status is assigned based on the type of assistance received, and it identifies whether the recipient is required to, has a choice to, or is not permitted to participate in the program. **Mandatory or Voluntary Medicaid recipients will have at least a 60-day period to self-select before DHHS will autoassign the recipient to a Health Plan.**

Medicaid recipients will be notified of their participation status at the start of the open enrollment period, the period of time in which Medicaid recipients can make a Health Plan selection. Notification will include information on each of the Health Plans with instructions on how to select a Health Plan.

Mandatory – participation in the Medicaid program requires these recipients to self-select one of the three Health Plans or be autoassigned to a Health Plan.

Voluntary – recipient has the option to NOT participate in the MCM program or to “opt out”, for example, Katie Beckett recipients are voluntary participants in the MCM program. Not selecting to “opt out” or choose a Health Plan, the voluntary recipient would be autoassigned.

Exempt/Excluded – recipients are NOT permitted to participate in the MCM program.

For more detailed information on participation status, view the *Recipient Participation Guide* enclosed and also available on the MCM webpage under the “Resources.”

Coverage Under NH Medicaid for Fee-for Service (FFS)

There are two circumstances in which the Medicaid recipient, who is enrolled in a Health Plan will continue to be covered under the NH Medicaid FFS program:

- (1) Prior to the start date of coverage under the Health Plan. Health Plan coverage begins on the first day of the first month after a Medicaid recipient self-selects or is autoassigned to a Health Plan.
- (2) When a recipient receives dental services, long-term care supports and services including waiver services or NH Division of Children, Youth and Families (DCYF) specialized services. **Please note:** The long term care supports and services described above does not include behavioral health services, this includes community mental health services. Behavioral health services are covered through the members' Health Plan.

Additionally, when a Voluntary recipient has elected to "opt out" of MCM program participation their services will continue to be covered under the Medicaid FFS program.

Most Medicaid clients will present at appointments with a NH Medicaid card and a Health Plan card. Regardless of the number or type of cards your client presents with, check eligibility to ensure they are currently eligible for Medicaid and, as applicable, to confirm Health Plan coverage.

The Member Experience

The MCM program is designed to enrich the recipients Medicaid experience by offering a choice of Health Plan membership. There are several factors for Medicaid recipients to consider in making his or her Health Plan selection. The Health Plan member experience is made up of three main components:

(1) Health Plan Network

Members will receive services from providers who have contracted with an MCO. For Medicaid recipients concerned with the continuity of their care, they may select a Health Plan because this network includes a particular provider.

(2) Additional Programs and Services (e.g., Wellness and Prevention)

Health Plan members will have access to programs for wellness and prevention through their respective Health Plans. These services will be in addition to the current Medicaid benefits and will be coordinated to meet the needs of the Health Plan member.

(3) Care Coordination and Health Home

Health Plan members will have the opportunity to select a primary care provider. The member will count on this provider to ensure their care is coordinated, comprehensive and inclusive of their specific needs. The recipient and the recipient's family will play a prominent role in health care decision-making.

For members with more complex medical needs, the Health Plan will provide a health home. One aspect of this model includes the assistance of a care manager to develop and secure the appropriate community supports for the member.

Upcoming Event: Assisting Medicaid Clients

DHHS acknowledges that your clients often use you and your staff as a resource for information about their benefits. In order to support and strengthen that relationship, DHHS will offer training sessions for you to attend either in-person or via webinar.

These trainings will offer tips for talking with your clients about their participation status and their Health Plan selection. These trainings will demonstrate your client's enrollment and self-selection experience, offer answers to frequently asked questions and will outline the contacts and resources available to clients for self-select decisions, including directions for online access to the Health Plan network provider directories.

Upcoming Event: Assisting Medicaid Clients – contd' DHHS is partnering with the University of New Hampshire to offer a series of MCM trainings. The first of the training sessions, titled “How to Assist Your Clients: Navigating MCM Open Enrollment” is scheduled to occur twice before MCM Open Enrollment and offered again approximately one week after MCM Open Enrollment begins.

This training is scheduled for **Wednesday, September 11, 2013 and Thursday September 12, 2013 from 9:30am to 11:30am** at the Auditorium in the State Office Complex, Brown Building in Concord NH. The two additional trainings will be offered October 8 and 9.

Training space is limited so please share this information with your front line staff and visit https://www.events.unh.edu/RegistrationForm.pm?event_id=15461 to make your reservation.

Medicaid Recipient Communications

DHHS sent a letter to Medicaid recipients, known as the “Heads Up” letter, which informed recipients that the MCM program will begin in a few short months and they should watch for more information in the mail or on their online NH (Electronic Application System) EASY account.

Information will be available on the DHHS MCM webpage – just follow the MCM logo from the home page. DHHS is also sharing key messages about the transition through social media mediums, Facebook and Twitter. If your client is looking for more information and uses social media, please direct them to find DHHS on Facebook at:

www.facebook/DepartmentOfHealthAndHumanServices.com

Or to follow us on Twitter at:

[@NHMedicaidCM](https://twitter.com/NHMedicaidCM)

Recipients with internet access can also go to the MCM webpage for further information by clicking on the MCM logo on the DHHS website.

New Resources Available

Please visit the MCM webpage – just follow the MCM logo from the home page - for up-to-date resources.

Resources include *The MCM Program Contact and Resource Guide*, first released on August 19, 2013, this guide contained Health Plan contacts and information. This week, this guide has been updated to include both Health Plan and DHHS member call center information as well as the addition of DHHS Medicaid Management Information Systems contact information. Additionally, *The Recipient Participation Guide* has been released and can be found on the MCM webpage under “Resources.”

Upcoming News

The next Regular Update is scheduled to be released on August 28th.

The next communication will focus on the Provider's participation in the MCM Program.



NH Medicaid Care Management Program

The Recipient Participation Guide

MCM Participation	Recipient's Type of Assistance	Health Plan Selection Process	Coverage*
Voluntary** – Not required	<ul style="list-style-type: none"> Children in Foster Care Home Care for Children with Severe Disabilities (also known as the Katie Beckett benefit) Children with Supplemental Security Income Dually Eligible for Medicare and Medicaid Special Medical Services and Partners In Health enrollees 	<p>Recipient is provided notice and 60-65 days to “opt in” to MCM coverage. If the recipient does not self-select a Health Plan or to “opt out” they will be autoassigned to a Health Plan.</p> <p>The recipient can “opt” in and out of participation in the program at any time. For those who “opt out” of participation, they will NOT lose Medicaid coverage.</p> <p>Individuals will be covered Medicaid Fee-for-Service.</p>	<p>Recipients who self-select or who are autoassigned will begin coverage under their respective Health Plan on the first day of the first month after they have enrolled with a Health Plan until such time that:</p> <ul style="list-style-type: none"> The recipient’s participation status changes, The recipient “opts out,” or The recipient loses eligibility.
Exempt/Excluded – Not permitted	<ul style="list-style-type: none"> Spend-down Clients Recipients of benefits from the Veterans Administration Qualified Medicare Beneficiaries (QMB) Special Low-Income Medicare Beneficiaries (SLMB) Qualified Disabled Working Individual (QDWI) 	<p>Recipient is informed that because of a type of assistance they receive that are unable to participate in the MCM program. These individuals will not lose Medicaid coverage. Medicaid will cover these individuals Medicaid Fee-for-Service.</p>	<p>Coverage is maintained under the NH Medicaid’s fee for service model of administration until such time as the recipient’s participation status changes to either Voluntary or Mandatory.</p>
Mandatory – Required	<ul style="list-style-type: none"> All other Medicaid recipients (including children) 	<p>Recipient offered notice and 60 -65 days to select a Health Plan. Not selecting a Health Plan means the recipient will be autoassigned to one.</p>	<p>Coverage begins on the first day of the first month after the recipient enrolled with a Health Plan and continues until such time as:</p> <ul style="list-style-type: none"> The recipient’s participation status changes or The recipient Loses eligibility.

*The first day of coverage under the MCM program will begin on 12/1/13, this is an exception to the standard start for coverage, as mentioned in the chart to be the first day of the first month after enrollment.

** Long term care supports and services including waiver services will continue to be covered under Medicaid Fee-for-Service regardless of whether the participant “opts out” of participation in the MCM program. **Please note:** Behavioral Health services are services covered by the members’ Health Plan.