DEPARTMENT OF HEALTH AND HUMAN SERVICES
Medicaid Care Management – Frequently Asked Questions

HEALTH PLAN ENROLLMENT AND SELECTION
Do I have to enroll in a health plan?
With limited exceptions, those eligible for Medicaid Care Management coverage must select a health plan contracted with the NH Department of Health and Human Services within sixty (60) days of initial eligibility. Until you are enrolled in a health plan, you must use your Medicaid ID card for all covered services.

The following individuals are exempt from health plan enrollment:

- People who receive In and Out Medical Assistance
- People who receive certain benefits from the U.S. Department of Veterans Affairs (VA), including:
  - VA pension (Veteran only)
  - VA nursing facility pension (Veteran only)
  - VA disability (Veteran only)
  - Aid and Attendance Allowance (Veteran and Survivor)
  - VA frozen pension (Veteran and Survivor entitled to a monthly stipend due to nursing facility residence)
- People who are Qualified Medicare Beneficiaries (also referred to as QMB) and Specified Low-Income Medicare Beneficiaries (also referred to as SLMB/SLMB135) and receive no other medical assistance
- People who are in the Qualified Disabled Working Individual (QDWI) eligibility category and receive no other medical assistance

If you need help with health plan enrollment contact Medicaid Service Center toll-free at 1-888-901-4999 (TTY: 1-800-735-2964, ext. 711), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET. You can also call or visit a ServiceLink Resource Center at 1-866-634-9412 or www.servicelink.nh.gov.

What are my health plan choices?
Individuals eligible for coverage choose from the following health plans:

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<th>New Hampshire Healthy Families</th>
<th>Well Sense Health Plan</th>
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<td><strong>1-866-769-3085</strong> (TTY/TDD: 1-855-742-0123)</td>
<td><strong>1-877-957-1300</strong> (TTY/TDD: 711)</td>
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<td>Monday through Wednesday 8:00 a.m. to 8:00 p.m. Thursday and Friday 8:00 a.m. to 5:00 p.m. ET (excluding holidays) <a href="http://www.nhhealthyfamilies.com">www.nhhealthyfamilies.com</a></td>
<td>Monday through Wednesday 8:00 a.m. to 8:00 p.m. Thursday and Friday 8:00 a.m. to 6:00 p.m. ET (excluding holidays) <a href="http://www.wellsense.org">www.wellsense.org</a></td>
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Which health plan should I choose?
Everyone’s health needs are unique. For many individuals, provider network and drug coverage are the most important features to consider for plan selection. The following steps can help inform your plan selection:

- **Check health plan provider network(s).** Make a list of the doctors, clinics, hospitals, and other providers most important to you. Then contact the plan or check health plan provider directories available on plan websites to see if providers on your list are in the plan network.

- **Check coverage for your medications.** Make a list of your medications and check each health plan’s prescription drug list or drug formulary to learn whether your medications are covered, including any...
special rules for coverage. Even if your current medications are not covered by the health plans, there may be other drug options available to you. Contact each health plan for more information.

- **Check health plan Member Handbooks.** Member Handbooks include information about plan benefits, special programs, prior authorization and other plan rules. Member Handbooks can help you determine if one particular plan better meets your needs. They are available on plan websites and upon request from the health plans.

- **Learn about special health plan programs and services.** Contact the health plans or visit plan websites (see table above) to learn about value-added or extra services and programs available from the plan at no cost. Extra services vary by health plan.

**Am I required to select a health plan network Primary Care Physician (PCP)?**
Yes. If you do not notify the plan of your PCP selection, the plan will assign one for you. You can change your PCP at any time by contacting the health plan. If you prefer, your health plan can help you find a PCP in your community that meets your needs. Contact your health plan for more information.

**What happens after I sign-up with a health plan?**
After enrollment you will receive a welcome packet from the health plan with important information about your coverage. You will also receive a health plan Member ID card. Present your Member ID card, Medicaid ID card and any other insurance ID cards at time of service. Your health plan will contact you to explain how your plan works. If you have special needs you may self-refer to your plan’s care management program at any time.

**May I change my health plan?**
You are limited to when you can change your health plan. You can change: a) within 90 days of your coverage effective date after initial health plan selection or auto-assignment, b) during open enrollment each year (usually November 1 through December 31 or the last business day of the month), and c) with or without cause as explained in your health plan Member Handbook. For more information, contact the Medicaid Service Center at 1-888-901-4999 (TTY: 1-800-735-2964, ext. 711), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.

**PRIOR AUTHORIZATION**

**What services, equipment and supplies require prior authorization by the health plan?**
Your Member Handbook lists services, equipment and supplies that require prior authorization. Your provider must request prior authorization from the health plan and provide supporting information to demonstrate medical necessity for services before treatment. Contact your health plan for more information.

**How does prior authorization work if I have primary insurance coverage through Medicare or a commercial insurer like Anthem?**
Generally, health plans do not require prior authorization for services covered by Medicare or other primary insurer. Some Medicaid-only covered services not covered by Medicare or other insurers, however, require prior authorization coordinated through your provider. If you are not sure whether a service is a Medicaid-only covered service requiring prior authorization, contact your health plan in advance of seeking treatment.

**What do I do if I want to see an out-of-network provider?**
If Medicaid is your primary insurance coverage your health plan generally requires that you see providers in their plan network. For out-of-network services, your network provider must request and receive prior authorization from the health plan and provide supporting information to demonstrate medical necessity for the out-of-network service. Contact your health plan for more information.
What if the health plan denies my prior authorization request?

If the health plan denies your request for services, you have the right to file an appeal within 30 days of written notice from the plan. If medically necessary, your provider may request an expedited appeal if your health condition cannot wait 30 days for standard service determination review. After all appeal rights have been exhausted with the health plan, you may request a State Fair Hearing. If the denial is for services you currently receive, you may request continuation of benefits. However, you may be liable for the cost of continued benefits if the plan’s denial is upheld by the State Fair Hearing. For more information contact your health plan.

What if I am dissatisfied with the results of my appeal or grievance filed with the health plan?
If you are dissatisfied with the health plan’s ruling on your appeal or grievance you may contact the Department of Health and Human Services at 1-844-275-3447, Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.

PRESCRIPTION DRUGS
I am enrolled in Medicare, Medicaid, and have pharmacy insurance. Which cards do I bring to my doctor visit and who pays for what services?
Bring all of your insurance cards to your provider visits and the pharmacy. Medicaid health plans will always pay last after your other coverage. Contact your health plan for more information.

What Medicare Part D medications are covered by Medicaid?
If you have Medicare Part D, your Medicare prescription drug plan will provide coverage for most of your medications. With limited exceptions, you pay all Medicare Part D drug co-payments. You generally have $0 co-payments if you receive coverage under the Home and Community Based Waiver (HCBC) (also known as Choices for Independence (CFI)) or reside in a nursing facility. The health plan prescription drug list or drug formulary may include medications excluded from coverage under Medicare Part D.

What medications require prior authorization by the health plan?
The prescription drug list or drug formulary is available on each health plan’s website. The drug list outlines covered medications that require prior authorization. Your prescribing provider must request and receive prior authorization from the health plan when required, and provide supporting information to demonstrate medical necessity for the medication. Contact your health plan for more information.

How does the health plan manage compounded medications and off-label use of medications?
In most cases, the health plan will require your prescribing provider to request prior authorization and provide information to demonstrate medical necessity for compounded medications and off-label use of medication. Contact your health plan for more information.

Are specialty formulas covered by the health plan?
Both health plans use durable medical equipment (DME) providers to dispense specialty formula and generally require prior authorization. Your prescribing provider will work with the plan to get prior authorization for specialty formula. In an emergency, a limited supply of specialty formula can be obtained at a pharmacy. Contact your health plan for more information.

CARE MANAGEMENT AND CONTINUITY OF CARE
What special care management programs are available through the health plan?
If you have a complex or chronic condition or special needs you may benefit from participating in a care management program available through the health plan. A care coordinator can help manage your care and assist in making connections with providers and other resources. Contact your health plan for more information.
Are there special continuity of care provisions for new members?
When transferring from Medicaid to a health plan your coverage may include continuity of Medicaid covered services and medications you receive currently. This means that Medicaid covered services and medications you currently receive are generally covered up to 60 days after initial enrollment with the health plan, or until the plan reviews and approves your treatment plan. Contact the health plan for more information.

COVERED SERVICES
How can I find out what benefits are covered under my health plan?
You should have received a Member Handbook when you enrolled with the health plan. They are also available on plan websites and upon request. The Member Handbook includes information about plan benefits, your member rights, special programs, prior authorization and other plan rules. You can also contact your health plan to learn more about plan benefits.

Are licensed nursing assistant (LNA) services covered by the health plan?
Generally, LNA services require prior authorization from the health plan. Contact your health plan for more information.

Are dental services covered by the health plans?
No. For Medicaid covered dental services, please use your Medicaid ID card when seeking treatment from NH Medicaid dentists.

Does my Medicaid health plan arrange transportation services?
Yes. Each health plan provides transportation assistance for covered service appointments. Assistance can be in the form of mileage reimbursement for you, your family or a friend. If no family or friends are available to drive you, arrangements can be made for bus, taxi, or other modes of transit as appropriate. Contact your health plan for more information.

AUTHORIZED REPRESENTATIVE AND GUARDIANSHIP
I am guardian for my adult child. (I am an authorized representative for a friend.) How can I work with the health plan?
As guardian or authorized representative, make sure both the health plan and DHHS have documentation authorizing you to represent the member. Contact the health plan for more information.