



Department of Health and Human Services  
Office of Medicaid Business and Policy  
129 Pleasant Street, Concord NH 03301  
mcmprovidercontact@dhhs.state.nh.us

## How to Assist Your Clients: Navigating Open Enrollment *Post-Training Question and Answer*

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### I. **BENEFITS/COVERAGE**

#### **1. If a client chooses to opt out of a Health Plan (MCM) do they lose Medicaid?**

When a client opts out of participating with an MCM Health Plan they are *not* opting out of Medicaid. They continue to be enrolled in Medicaid with the same benefit package long as they maintain Medicaid eligibility. However, this only applies to voluntary participants.

#### **2. Does the Health Plan someone picks effect the services they receive?**

The Health Plans must provide the same services recipients get today. All Medicaid recipients – regardless of whether they are in a Health Plan or Fee-for-Service Medicaid – will receive the same Medicaid benefit package. Health plans, may at their option, offer different benefits on a case-by-case basis or offer optional services or incentives for healthy behaviors. These additional benefits will be different from plan to plan. Please refer to the document *Meet the Health Plans* that is contained in Enrollment Packets available on the MCM website.

#### **3. What is Health Plan “care coordination”?**

The Health Plans will coordinate care across all need areas (physical and mental health, social) and across all providers (ensure that providers communicate/collaborate with each other). In addition, care coordination will:

- facilitate access to services and achievement of outcomes;
- link people with other state/local/community programs that provide/assist with related health and social services;
- help individuals acquire self-care skills; and
- support care-giving families.

**4. If someone enrolls in a Plan on the 3rd day of the month, their new coverage will not begin until the 1st day of the following month. Is that correct?**

Yes. Health Plan coverage begins on the 1<sup>st</sup> of the month following the date of enrollment in a Plan.

**5. When a client selects a Health Plan, how long does it take before it is registered into the MMIS system? Is it real time or delayed?**

The effective enrollment date is not real time. A client must enroll by 4 PM Monday – Friday (a *business* day not a weekend or holiday) in order for their enrollment into a Health Plan to be registered into the MMIS the next business day. Health Plan coverage begins on the 1<sup>st</sup> of the month following the date of enrollment in a Plan.

**6. Can clients switch their Health Plan after Open Enrollment ends?**

Yes, they have 90 days to change their Health Plan.

**7. When the client brings 2 cards, which Plan do we use – NH Medicaid or the Health Plan?**

DHHS recommends that clients bring both cards to their providers since there are instances where Fee-for-Service Medicaid will still cover their care. For example, clients who receive waiver services and clients waiting for the 1<sup>st</sup> of the month Health Plan effective date will still need their Medicaid cards. It will depend on whether the client is enrolled in a Health Plan, what the effective enrollment date is and the type of service delivered.

**8. If a client goes to the hospital in an emergency situation and the hospital is not enrolled with the client's Health Plan network, what does this mean for the client?**

The hospital cannot refuse treatment in an emergency under federal law. The situation described is unlikely in NH (unless the client is traveling out-of-state) since all 26 hospitals are enrolled and many border hospitals are as well. If this situation did occur, the client would have to notify their Health Plan and PCP (refer to the Member Handbook for the timeframe and contact information).

**9. Are Fee-for-Services rates payable by an MCM? Will MCM reimbursement be the same as Medicaid?**

The MCM Health Plans will cover the Medicaid benefit package. The rates they pay are between the Health Plan and the provider who has signed a contract with them. They may not be the same as the current Medicaid fee schedule.

**10. Do any plans cover prescriptions? If so, does that mean they no longer use Medicare D plans? Or is it just clients who have Medicare for their prescriptions and not Medicaid?**

All 3 Health Plans cover the full Medicaid benefit package, including prescription drugs. If a client is a dual eligible (they have both Medicare and Medicaid) and they choose to join a Health Plan, they will continue to receive their prescription drug coverage through their Medicare Part D plan just as they do today in Medicaid Fee-for-Service.

**11. Are the prescription drug formularies the same for all 3 Health Plans?**

Each Health Plan must follow the NH Medicaid Preferred Drug List (PDL). They can, however, allow additional drugs and can manage other drug classes as they see fit.

**12. After December 1, do they still have to bring Medicaid cards and Health Plan cards to their providers?**

Yes. DHHS recommends that clients bring both cards to their providers since there are instances where Fee-for-Service Medicaid will still cover their care. For example, clients who receive waiver services and clients waiting for the 1<sup>st</sup> of the month Health Plan effective date will still need their Medicaid cards.

**13. Will all physicians and specialists involved with START be billable under all 3 Health Plans?**

**START** - Systematic Therapeutic Assessment Respite and Treatment - is administered through the Institute on Disability (IOD) at UNH. The clinicians that provide services under the START program are funded through the Bureau of Developmental Services (BDS) Waivers exclusively and are not included in Step 1 of the MCM initiative, therefore, these services will not be reimbursed by any of the Health Plans.

**14. Will the Health Plans pay for Choices for Independence (CFI) services?**

No, CFI waiver services are not included in Step 1 of MCM.

**15. If a client was spend down and now is part of the CFI program, what is the client's participation status?**

If they are dually eligible, they are voluntary under Step 1 of MCM. If they are not a dual, they would be mandatory. (The CFI services the client receives *are not* part of Step 1.) People on a spend down are exempt from MCM.

**16. What happens if Medicaid goes down? Does the Health Plan need to be re-selected when Medicaid goes back up or is that automatic?**

It depends on the length of time the client lost Medicaid eligibility. If it is within 30 days, they will automatically be re-enrolled in the Health Plan they were in at the time eligibility ended. If it is more than 30 days, they will receive a new Enrollment Packet and need to select a Health Plan.

**17. Are there any changes in dental coverage?**

No. Dental services are not part of the MCM program and will remain Fee-For-Service.

## II. EXEMPT MEDICAID RECIPIENTS/SERVICES

### **1. Clients with spend-down are exempt. Will they be receiving any letters regarding Health Plan selections or changes in Medicaid?**

Not if they are the only Medicaid recipient in the household. If they live with other Medicaid recipients, they will be listed on the enrollment form as 'exempt' and will not have the option of selecting a Health Plan

### **2. If an individual has cost of care where do they fall?**

Cost of care liability applies primarily to Nursing Home and CFI recipients. Cost of care liability applies to *services* that are exempt from Step 1, which does not mean the *person* is exempt in Step 1.

### **3. In reference to exempt status, what exactly is meant by VA benefits? Is it a pension? VA health care?**

The exempt status of someone with VA health/medical benefits is because they are receiving health care through the VA system.

### **4. Will CFI clients have dual prescription plans? Or will they still use Part D plans if they have Medicare?**

Dually eligible CFI clients who opt in to MCM will maintain their Medicare Part D prescription coverage. The Health Plans will not provide their prescription coverage.

### **5. Are Medicaid clients with dual eligibility (Medicare and Medicaid) and MEAD required to select a Health Plan?**

Dual eligibles are voluntary for MCM (they can choose to participate or opt out). A client who is a dual and MEAD is voluntary and can opt out if they choose.

### III. NH EASY ACCOUNTS

**1. If someone has a NH EASY account do they only receive notices via the Internet or do they also get a hard copy?**

If the client is “green,” they will receive all their notices online. Other EASY account holders - those who do not have a “green” account - will receive both an on-line notice and a hard copy in the mail.

**2. If an organization has a NH EASY account for a client do they have to have specific accounts for each and every client?**

No. If the organization has set up an EASY account and they represent several clients, they will see all the clients listed for their organization in that organization’s dashboard. It is the *organization* that has the account and they can manage a number of their clients.

**3. If a provider is established as an authorized representative in NH EASY, does that mean that the client would no longer receive letters/notices by mail?**

A provider must complete Form 777 (*NH EASY Provider Enrollment*) and Form 776 (*Client Consent to Grant Access to NH EASY*), in addition to Form 778 (to become an Authorized Representative). Once these forms are completed, then yes, the client’s case will now be connected to the organization’s NH EASY account. Notice and letters, e.g., redeterminations, will be sent to that organization and will appear on your dashboard.

## **IV. PROVIDER DIRECTORIES/Primary Care Provider (PCP) CHOICE**

### **1. Are providers currently signed up for a plan? Why doesn't my client's preferred PCP show up in the DHHS Provider Directory?**

Many providers are currently signed up with the Health Plans but that is changing daily. Please refer to the provider directories available via the MCM webpage or on the Health Plan websites to stay up-to-date on the Health Plan networks.

### **2. What is the enrollment percentage of providers in the entire network?**

Unable to determine at this time - see answer above. However, in order to begin Open Enrollment, each Health Plan had to have "substantial network development." This meant that they had to assure the DHHS that they met the network adequacy standards in their contracts, which are to serve 80% of the projected Medicaid membership in each county.

### **3. What happens if a client does not choose a PCP?**

While DHHS encourages Medicaid recipients to choose their PCP at time of enrollment into a Health Plan, it is not required. Their Health Plan will contact them to either confirm their PCP or have them select a PCP. Those who do not select a PCP will be autoassigned one by their Health Plan. The client can then contact their Health Plan if they want to switch their PCP.

### **4. If clients do not designate a PCP after 90 days, will they be assigned a PCP?**

The 90-day period referred to in the training and provider and client communications is the timeframe clients have to switch Health Plans. See answer above.

### **5. What is the drop-dead date for all provider information to be on the website (one Health Plan has no Provider Directory listed)?**

The provider directory offered on the Department's MCM Member website (<http://www.dhhs.nh.gov/ombp/caremgmt/index.htm>) includes information from all three Health Plans. Additionally, all three Health Plans will have provider directories on their respective member websites by October 1.

### **6. How can an existing patient sign up with his doctor if the doctor is not listed on the provider list because he is not accepting new Medicaid patients?**

If you are already the patient of a particular doctor, it is highly likely you can choose that doctor as your Primary Care Provider (PCP) even if the physician is not accepting new patients. You may indicate your preference at the time of enrollment in a Health Plan. If for some reason, the Health Plan is unable to process your initial request, contact the Health Plan directly to make this selection.

### **7. Who will cover the costs of transferring client medical records if someone has to choose a new PCP because their current doctor is not in their Health Plan?**

This is up to the provider and is the cost of doing business. There could be some providers who charge for this service.

### **8. How can a client that has limited computer skills or who does not have access to the Internet look up each and every doctor in order to choose a Health Plan?**

Clients who need assistance choosing a Health Plan and looking up which Plan their doctor is in should call the Enrollment Call Center at: **1-888-901-4999**

**9. Is there a deadline for Medicaid Providers to enroll in one or all of the Health Plans?**

No - but for continuity of care and choice of Plans for Medicaid clients, DHHS is encouraging providers to not only enroll with all 3 Health Plans but to do so before/during Open Enrollment, which began September 11<sup>th</sup>.

**10. What happens if a client does not choose a PCP and sees a PCP provider – will that provider be paid?**

In the event a client has a PCP visit before they have been contacted by the Health Plan to select their PCP (because they did not do so at time of enrollment into the Health Plan), that visit would be covered as long as the provider was in the network of the client's Health Plan.

## V. OPT OUT AND AUTOASSIGNMENT

### 1. How does autoassignment work?

For beneficiaries who have not selected an MCO, the following, in order of priority, will be considered to assign them: 1) evidence (from claims) connecting their inferred primary care provider (failing that specialty care) to a provider in the MCO network; 2) prior selection of a Health Plan by family/case member; 3) prior membership in the MCO (applies to post-implementation); and 4) random assignment with the MCO with the highest technical score (Wellsense) receiving 50% of the membership, and the other two MCOs each receiving 25%.

### 2. What is the benefit to the client to choose an MCM Health Plan versus opting out and staying in the Fee-for-Service Medicaid program?

Clients will need to educate themselves in order to make a knowing and informed decision based on their own needs and their families' needs. Personal preference and tolerance for change will help voluntary clients in Step 1 to make their decision. For example, someone who does not need immediate critical services may be willing to try a Health Plan, learn how MCM works and let the Plan get to know them. The care coordination and customer service offered under this model and the greater flexibility the Health Plans have might also be appealing to some clients. This is not a one-size-fits-all and some clients will not see the advantage in such things and choose to opt out in Step 1.

### 3. What happens to clients who opt out? If they opt out will they be forced down the line to choose a Health Plan?

A client who opts out of MCM does not opt out of Medicaid in Step 1. They continue to receive the same Medicaid benefits they receive today. The DHHS is planning for Step 2 of the MCM program. When Step 2 begins, those who currently can opt out of MCM will have to choose a Health Plan.

### 4. A voluntary participant can opt in or opt out? Please explain.

A voluntary participant who decides that one of the MCM Health Plans meets their health care needs can make an active choice and pick a Health Plan – that is “opting in.” Another voluntary participant may decide MCM does not work for them and choose not to participate – that is “opting out.” It is important, however, for clients to take action. Voluntary clients who do not notify the DHHS that they wish to “opt out” will be autoassigned a Health Plan. They will then have to notify the DHHS that they either wish to “opt out” or pick a different Health Plan.

## VI. TRAINING AND FORUMS

**Could you please e-mail the link for the October 29<sup>th</sup> and 31<sup>st</sup> trainings?**

Registration for this training is not yet open. Please check the MCM website for the training announcement and/or Regular Update #6 or #7 that will be posted on the website soon.