



*The New Hampshire Department of Health and Human Services, in partnership
with New Hampshire Healthy Families and the Well Sense Health Plan*

present

Choosing a Health Plan—What Providers and Their Clients Need to Know About Enrollment

August 2015

Presentation Outline

- Opening Remarks
- Overview by the Department of Health and Human Services:
 - Expanding Participation in Medicaid Care Management
 - How to Enroll in a Health Plan
 - Medical Services Covered by the Health Plans and the Transition of Care
- Meet your Health Plans: Presentations by
 - Well Sense Health Plan
 - New Hampshire Healthy Families
- Q&A Session:
 - Questions from Clients and Caregivers
 - Questions from Providers

New Hampshire Medicaid Care Management

- The program began on December 1, 2013, and included the enrollment of most of the Medicaid population into Care Management for medical services.
- DHHS currently contracts with two Managed Care Organizations: **New Hampshire Healthy Families** and **Well Sense Health Plan**

- Those who were voluntary (previously able to opt-out) will now be required to enroll in a health plan for their medical services. Over half of the voluntary population is already enrolled with a health plan.

Step 2 – Care Management Implementation

A Four Phase Approach

Phase 1--2015

Voluntary to Mandatory Enrollment: Medicaid recipients will now be required to enroll with a health plan for their medical services

Phase 2--2016

Choices for Independence Waiver

Phase 3--2016

Nursing Facility Services

Phase 4--TBD

Developmental Disabilities, Acquired Brain Disorder and In-Home Supports Waivers



Voluntary Groups Now Mandatory in 2015

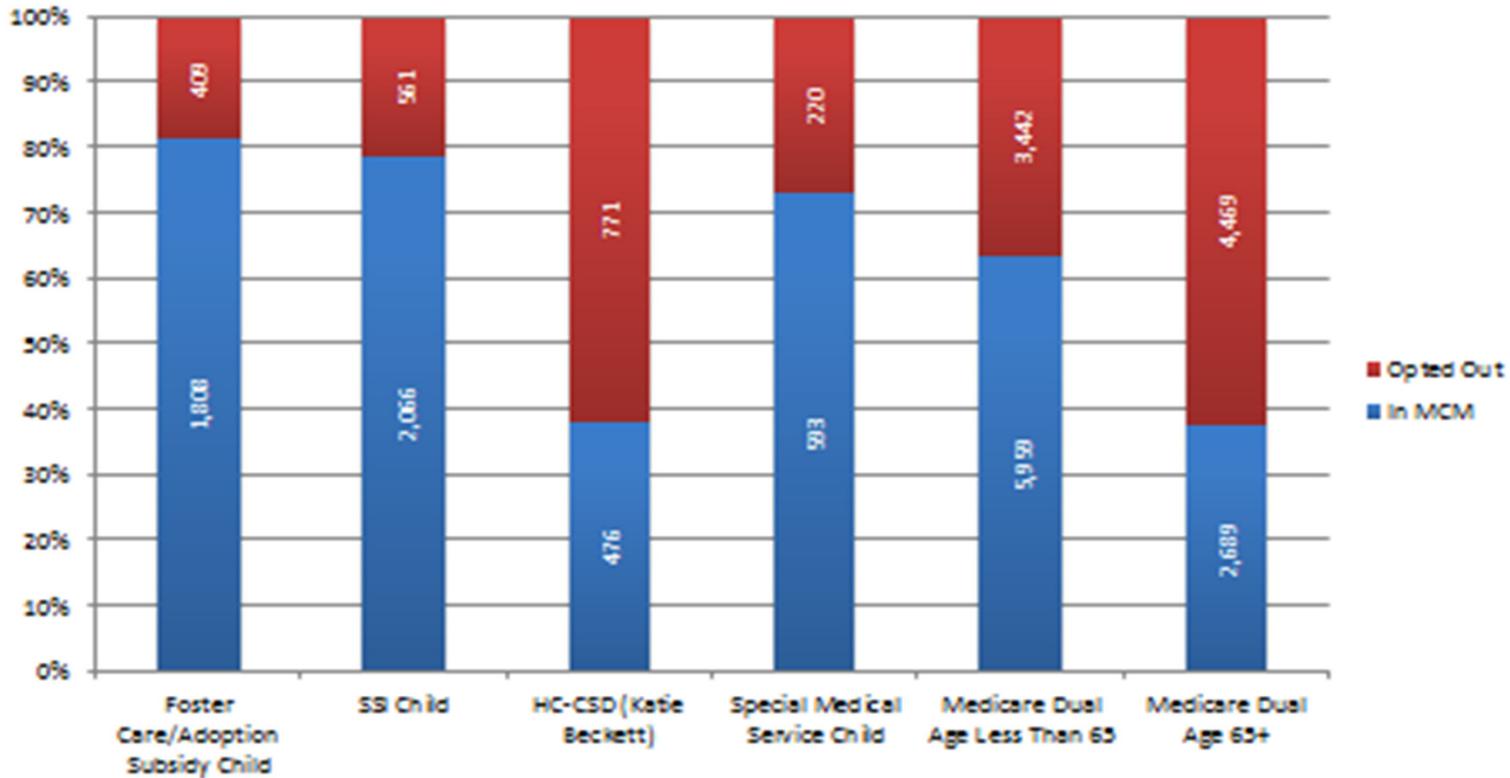
Children under 19

- With Supplemental Security Income (SSI)
- In the eligibility category *Home Care for Children with Severe Disabilities*—also known as *Katie Beckett*
- In Foster Care or other out-of-home placement, or receiving foster care or adoption assistance
- Receiving services through *Special Medical Services* or *Partners in Health*

Recipients of any age

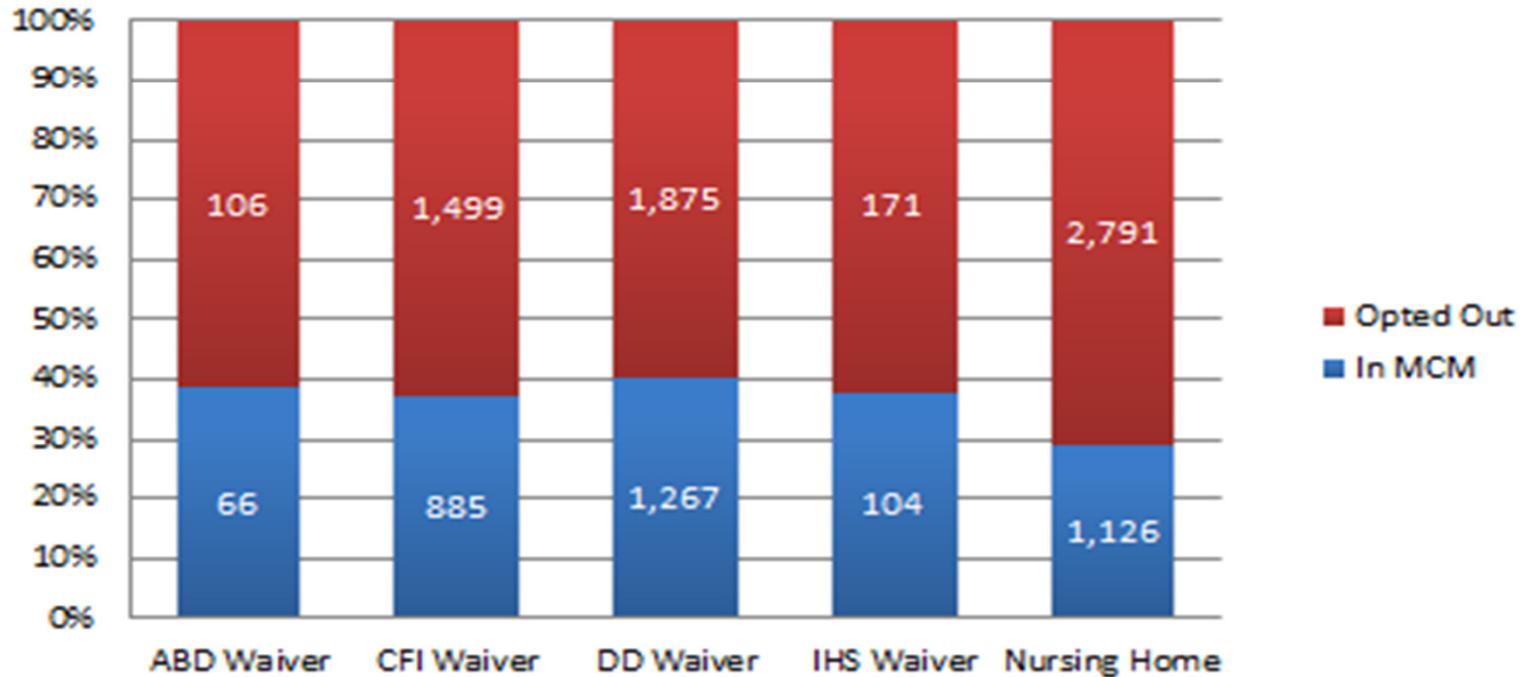
- Who are eligible for both Medicare and Medicaid, also known as *dually eligible* or *duals*.

Individuals who previously were allowed to “opt out” will now be required to enroll in a managed care plan for their Medical Care: N= 9872



N=23,463. Data source: MMIS as of 6/4/2015

MCM Waiver and Nursing Home Population currently voluntary, but will be required to enroll with a Managed Care Plan for Medical Care in Step 2, Phase 1 Shown in Red at top of bar. Already enrolled shown in Blue at bottom of bar.



N=9,890. Data source: MMIS as of 6/4/2015

Groups Exempt from Care Management

- Medicaid recipients on In and Out Medical Assistance (Spendedown)
- Medicaid recipients who receive income benefits from the US Dept. of Veteran's Affairs
- Qualified Medicare Beneficiaries (QMB) or Specified Low-income Medicare Beneficiaries (SLMB 120) with no Medicaid coverage
- Recipients in the Qualified Disabled Working Individual eligibility category (QDWI)
- Medicaid recipients in the Health Insurance Premium Payment (HIPP) Program

Step 2- Phase 1

Voluntary Groups' Enrollment Schedule

- The *Heads Up* letter was mailed at the end of May, telling clients about the upcoming change.
- Enrollment packets will be mailed (once we have CMS approval). Clients will have 60 days to select one of the two health plans. The letter in the enrollment packet will give the due date for plan selection.
- If an individual in this group is already enrolled with a Health Plan, they will not receive an enrollment packet---they are already enrolled. S/he will have the opportunity to make a plan change at the annual open enrollment period in the Fall.

How to Enroll in a Health Plan

Enrollment can happen in one of three ways:

1. NH EASY on-line enrollment at www.nheasy.nh.gov

1. Paper enrollment form included with the enrollment packet



2. Telephone enrollment via the Medicaid Service Center at **1-888-901-4999**

Clients can also call or walk into a ServiceLink office.



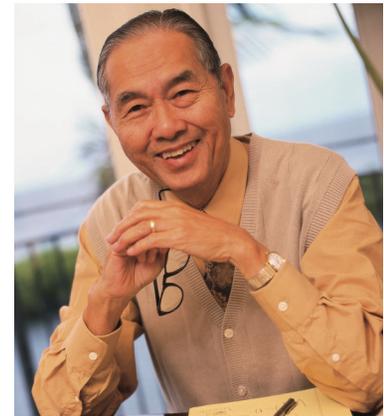
1-866-634-9412

www.servicelink.org

The ServiceLink Resource Centers consist of local and accessible community based offices.

If requested, ServiceLink staff will assist you with enrollment:

- Complete on-line enrollment in their office
- Help fill out the paper enrollment form
- Answer phone inquiries



Medical Services Covered by Your Health Plans

- Doctor visits
- In-patient and out-patient hospital visits
- Prescriptions
- Mental health services
- Family planning
- Home health services
- Speech therapy
- Physical therapy
- Occupational therapy
- Audiology services
- Durable Medical Equipment
- Personal care services
- Private Duty nursing
- Hospice
- Adult medical daycare
- Ambulance services
- Wheelchair van services
- Optometric services, including eye glasses
- Nonmedical Services: Transportation

Prior Authorizations Important Considerations

- In the current Medicaid program, also referred to as the fee-for-service program or standard Medicaid, some services require Prior Authorization, but most do not.
- In the Care Management program, it is much more likely that you will need to request Prior Authorization/Prior Approval in order to receive certain services or care from certain providers.
- It is best to check with the MCO/Health Plan about Prior Authorization requirements before you need a service or schedule an appointment.

How does this change affect the services I receive in a nursing facility or under the CFI waiver?

What if I live in a Nursing Facility?

- Eligibility for nursing facility care will continue to be done by DHHS.
- Nursing Facilities will continue to bill the per diem rates for daily care in the same manner they bill now.
- Services you receive by providers that are billed separately, like the hospital, will be paid through the MCO you choose.

What if I receive Choices for Independence (CFI) waiver services?

- Eligibility for CFI services will continue to be done by DHHS.
- CFI waiver providers will continue to bill for all waiver services in the same manner that they bill now.
 - This includes providers of residential care/assisted living services as well as home care providers.
 - DHHS will continue to approve service requests and issue authorizations for CFI services.

Transition of Care

- DHHS staff will work with each Health Plan to:
 - Identify individual member's Care Management needs
 - Discuss In-Network vs. Out-of-Network providers for these members
 - Review member's services that don't require Prior Authorizations under NH Medicaid fee-for-service and formalize the process to assure continuity of care
- Once a health plan has been chosen, the current waiver Case Managers and other Care Coordinators (ex: SMS, DCYF, etc.) will collaborate with health plan staff to avoid disruptions in care.

Individual Assistance During the Transition

- Individuals receiving Waiver services will be assisted by their Case Managers during the transition.
- Children and their families who are a part of Special Medical Services, Partners in Health, DCYF, or other supporting agencies will also be assisted by their Case Managers/Care Coordinators.



**If you have additional questions
after this Session,**

Email: mcmstep2phase1@dhhs.state.nh.us

