



Medicaid Care Management Provider Question and Answer

TOPICS

I.	THIRD PARTY LIABILITY	Page 1 - 3
II.	BENEFITS/COVERAGE	Page 3 - 4
III.	AUTHORIZED FOR RELEASE OF INFORMATION/CASE DISCUSSION	Page 4
IV.	PROVIDER DIRECTORIES/Primary Care Provider (PCP) CHOICE	Page 4 -6
V.	EXEMPT MEDICAID RECIPIENTS/SERVICES	Page 6
VI.	SERVICE/PRIOR AUTHORIZATIONS (PAS)	Page 6

I. THIRD PARTY LIABILITY

1. How will a Private Insurance plan related to the MCM Health Plan? Which company does a family defer to when choosing a provider?

Medicaid remains the secondary payer and that means that the Health Plan will assume the same position. Accordingly, the client's primary care provider (PCP) with their Private Insurance would remain the client's PCP. Ideally that PCP would participate with the client's desired Health Plan selection, so that continuity is guaranteed.

2. How will Private Insurance relate to the Health Plan?

In the event that a client's provider does not participate with the client's desired Health Plan (or any of the Health Plans) each Health Plan will work to encourage the client's PCP to join their network because it is in the client's best interest. If the Private Insurance PCP does not elect to participate with the Health Plan, it is possible that the Health Plan would assign the client a PCP from their Health Plan network. This will not negate the role of your Private Insurance PCP, but each Health Plan will manage those decisions and relationships differently. Clients are encouraged to discuss their options directly with the Health Plans.

3. Which company should a client defer to when choosing a provider?

When a client contemplates the selection of a new provider for a condition or concern, this determination should be based on whether the services will be covered by the primary insurance or by MCM.

- When the service is to be covered by both the Private Insurance or the Health Plan, the provider *should* be in both the Private Insurance and Health Plan networks.
- When the service is to be covered by only the Private Insurance, the provider does not need to be participating in the Health Plan provider network.
- When the service is to be covered by the Health Plan only, the provider *should* be in the Health Plan provider network.

4. Who does a family call for a referral when they have both Private Insurance and a Health Plan? Will all visits require two referrals?

Just as above, it will depend on whether the service is covered entirely by the Private Insurance, by both the Private Insurance and MCM, or by MCM entirely. If the Private Insurance will cover the entire service, only the Private Insurance policy regarding referral or prior authorization will apply. If the service will be paid in part by the Private Insurance and the remainder by MCM, then both plans must be considered. If the MCM Health Plan will cover the entire service, then only the policies of the MCM Health Plan need to be considered.

5. If the family has two private policies what happens since that makes Medicaid the third payer?

Same as above, but with another private health plan ahead of MCM.

6. If a person's Private Insurance plan denies a service that is a Medicaid service will a Health Plan cover it?

If the service is non-covered by the Private Insurance, but is a covered Medicaid service, Medicaid/Health Plan will pay. The MCM Health Plans cover most Medicaid services with the exception of Step 2 services (e.g., waiver services, long-term services and supports) and dental services that will remain in Fee-for-Service Medicaid at this time.

7. If a family wants to see a Health Plan provider who is not covered by their Private Insurance will the Health Plan cover them?

If it is a MCM covered service being rendered by a MCM networked provider, the MCM Health Plan should pay. However, details and context could impact the ultimate outcome of this question. Should this issue arise, it is recommended that clients discuss it with the MCM Health Plan directly.

8. If my provider covered by my Private Insurance is a Medicaid provider, but has not enrolled in my Health Plan, will they be a covered service?

It depends on whether the service is covered entirely by the Private Insurance. If so, then the Private Insurance will pay the provider for the service. If payment will be made in part by the Private Insurance but Medicaid needs to pay a remainder, the MCM Health Plan may not pay the remainder if the provider is outside their network. Clients are encouraged to discuss their specific situation with MCM Health Plan when such circumstances arise.

II. BENEFITS/COVERAGE

1. Clients understand that service coverage is the same, what they want to know is the how and the iterations that impact when and where they would get their services. For example, each of the Health Plans has varying approaches to how they fulfill the requirement to offer transportation. When will Health Plans have transportation member services available for client questions?

The DHHS is preparing a tool called the *Quick Reference Guide* for providers. Release date will be no later than October 31. This tool will have information on how to access non-emergent transportation services (via phone or e-mail) for each Health Plan. Non-emergent transportation services will be covered as they are in Fee-for-Service (FFS) Medicaid. The difference under is that Health Plan members will need to go to their Health Plan's transportation provider to request this service.

2. A family/client who does not see their specialist/provider represented in the network talks with the Health Plan and gets an assurance they will be in the network. Where can they get it in writing? Does the Health Plan offer written documentation?

If the question is whether the MCM Health Plan will commit in writing whether they are working through credentialing with a particular provider and anticipates inclusion in the provider directory, this request would need to be made directly to the MCM Health Plan with specifics.

3. If a clinic/billing organization and the providers that work there enroll with a Health Plan does that mean that all of the affiliated providers are enrolled as well? For example, a lot of times the labs are co-located but are not necessarily part of the organization.

There must be a clear affiliation, that is, the lab must be part of the same organization, not just co-located in the building with the provider organization, in order for the lab to automatically be in the network as part of the organization.

4. Is there going to be a capitated rate for medical care services in the same way that there is a capitated rate for mental health services?

The Department is paying a capitated rate on a per member per month (PMPM) basis to the Health Plans. An additional payment will be paid to MCOs to support the mental health services for clients in their network who are certified into one of the behavioral health categories by the CMHCs. The terms and method of payment for behavioral health services to the CMHCs is between the Health Plans and medical service providers.

5. Is there a change in cost for recipients?

No.

6. Can changes to selected Health Plans be made at any time after the 90-day period?

During Step 1, voluntary participants in MCM can change plans at any time for any reason or can opt out of MCM altogether if they are unsatisfied. Mandatory participants have limited ability to change Health Plans after the first 90 days of enrollment. With “good cause” a client can request to change their Health Plan after the 90-day period is up. Medicaid Client Services should be called for good cause waiver requests.

7. Are Adult Day Care services in Step 1 or in Step 2 - long-term care?

Adult Medical Day services are in Step 1.

III. AUTHORIZED FOR RELEASE OF INFORMATION/CASE DISCUSSION

What documentation does the Health Plan require to speak to someone other than the enrolled member, for example, a Guardian or an Authorized Representative? Will they accept the documentation on record with DHHS or do they have their own forms? How long are signed forms recognized by the Health Plans?

Best practice is to have the Health Plan's authorization form completed. An Authorized Representative who interfaces with DHHS on behalf of an individual is not conferred authority to discuss medical matters with the Health Plan from that document. Guardians over the person or medical proxies do have existing authority to discuss medical care with the MCO. Though it may seem cumbersome, the reason for this is to assure the confidentiality of the member's protected health information. The DHHS is working on this - please check the MCM webpage for any updates.

IV. PROVIDER DIRECTORIES/PRIMARY CARE PROVIDERS (PCPs)

1. Is DHHS able to display pending providers for each Health Plan?

DHHS' provider directory is updated daily with providers who have completed the credentialing process with the Health Plan(s). During this open enrollment period, DHHS will assist clients in determining the status of providers not appearing in the Provider Directory. Clients can call the Enrollment Call Center at 1-888-901-4999 and a representative will access a “In-Process Provider List” that has been provided to DHHS from the Health Plan. This list contains the names of those providers who have signed a contract but have not completed the credentialing process and therefore are not listed in the DHHS provider directory available publicly. DHHS fully expects that those providers, who are currently engaged in the credentialing process, will become Health Plan network providers in the near future.

2. How long is a provider obligated to stay with a Health Plan?

This is based on each individual contract.

3. How long are the Health Plans obligated to stay with DHHS?

The State contracts with the Health Plans are for five years. DHHS is currently in year two of the contract. The contract presently runs on state fiscal years (July 1-June 30).

4. What if the other providers within my group do appear to be enrolled with the same plan? Can I still see other doctors within that practice?

Best practice would be to confirm the status of the provider you want to see. DHHS can assist with this.

5. What happens if you don't choose a PCP?

The plans will assign one to you. You can change the PCP if you are dissatisfied, though each Plan has different policies about changing PCPs.

6. Will out-of-state providers such Boston Children's Hospital be covered under specialty services?

It is unlikely that Boston Children's Hospital will be considered broadly as a 'specialty service'. Coverage will depend on many factors, including but not limited to, the status of Boston Children's Hospital with the Health Plans, as well as whether the service can be provided in state or in the MCM network.

7. For recipients with complex health care needs and multiple providers (as many as 8-9 doctors), what is the best way to ensure that they will have access to all the necessary providers? Some providers are only signed up with one Health Plan, another provider may be signed up with a different Health Plan. For many specialty doctors there is only one or two in the local area, leaving a client to choose between which specialists they need the most.

Each of the Health Plans has experience with complex Medicaid members and anticipates that there are members with many different providers. It is recommended that clients contact the Health Plans and inquire on the status of a particular provider. Typically, the first step if you select a Health Plan that does not include one of your providers is that the Health Plan will encourage that provider to join its network and continue serving you in a coordinated way. The networks are still taking shape and DHHS remains optimistic that such instances will be the exception, not the rule. If you choose to continue to see that provider in an out-of-network capacity, you can consult the Health Plans as to how they manage out-of-network relationships.

8. According to the NH Easy Provider Directory, my local hospital is ONLY signed up with one of the three Health Plans. Does that mean that clients who could possibly have an emergency can only choose the Health Plan that is contracted with that hospital?

Federal law requires emergency departments to stabilize anyone who arrives, irrespective of how the hospital is ultimately paid. Selection of a Health Plan will not lock a member in or out of emergency departments within the state. (The networks are still taking shape; clients are encouraged to keep checking the Provider Directory.)

9. If the client does not choose a PCP with the Health Plan and a provider sees them, will the provider get paid or will it deny for no PCP chosen? How can picking a PCP be optional? Without a PCP they cannot get the service.

Payment to ancillary providers will not deny because the member failed to select a PCP as long as that provider is part of the Health Plan's network. Picking a PCP at enrollment is optional; once enrolled the Health Plan will assist with selection of a PCP or assign one to you.

10. If a provider does not enroll with any Health Plan, can that provider still see Medicaid patients?

In this case, providers would only be able to see those who are excluded from MCM, those who chose to opt out in Step 1 and those who are waiting for their 1st of the month Health Plan effective date. If they treat an MCM recipient, they will need to negotiate an out-of-network arrangement with the Health Plans for payment (with the possibility of not being reimbursed at all).

11. If the recipient chooses a provider in their office as a PCP and that PCP is not available can they see another provider in the office? Does the recipient need a referral for other providers?

Yes, as long as that provider is in the Health Plan's network. Members should consult their Member Handbook to check on what, if any services, require referrals. The DHHS is preparing a tool called the *Quick Reference Guide* for providers. This tool will have information on what services, if any, require referral and, if so, how to obtain that referral.

V. EXEMPT MEDICAID RECIPIENTS/SERVICES

1. Individuals with Medicare only should not be receiving letters at all. Individuals with Medicare and Medicaid (dually eligibles) are voluntary (stated in their letter). Does that mean that they can opt out and still receive the same services that they have been receiving all along?

Voluntary members can opt out and remain Fee-for-Service (FFS) Medicaid with no changes to their current experience during Step 1.

2. Are MEAD recipients, voluntary or mandatory?

Mandatory.

VI. SERVICE/PRIOR AUTHORIZATIONS (PAS)

Which services will require prior authorization (PAs)?

Each Health Plan will have their own approach to service authorization/prior authorization. If there is a particular service you are curious about, the Health Plan's customer service line (members) or provider relations (providers) can assist. The DHHS is preparing a tool called the *Quick Reference Guide* for providers, which will include information on what services require a PA and how to obtain one.