



New Hampshire Department of Health and Human Services May 2012

Medicaid Care Management Frequently Asked Questions

What is a care management program?

Care management is a way to coordinate health benefits for people enrolled in New Hampshire's Medicaid Program. Under a care management approach, New Hampshire's Medicaid program will provide services through companies that will be paid a set rate for members. The managed care organizations (MCO) will be responsible for coordinating all health care services for members through a network of providers. This involves enrolling members into a medical home, which is typically a primary care physician (PCP) who will be responsible for providing regular preventative treatment and ensuring the continuity of care.

“Care management” is often used interchangeably with “managed care,” however; the Department believes that care management more accurately describes the program that is being put in place to coordinate Medicaid services

Why is New Hampshire transitioning from the current Medicaid Program to a Care Management Plan?

The goal of a Care Management Program is to improve access to care, quality of care and overall health status, while at the same time improving effectiveness and cost efficiencies. The new program will bring new resources and tools to meet the goal.

This change in how publicly funded health insurance works reflects changes that most people have experienced over the last 20 years. 98 percent of Americans who receive health insurance coverage through their employer are enrolled in some form of managed care, according to the Kaiser Family Foundation.

In 2011, the New Hampshire Department of Health and Human Services (DHHS) worked with Governor Lynch and NH Legislature to develop a bill that would establish a Care Management Program in New Hampshire. That bill, SB147, was signed into law and requires DHHS to contract with companies to provide care management services to the State's Medicaid population

I am currently enrolled in Medicaid; will I still receive the same benefits?

Your Medicaid benefits will stay the same in the Care Management Program. You may notice some differences in how you get those services. For example, you will need to choose a Primary Care Physician (PCP) if you do not already have one. Your PCP will refer you for some specialty services such as radiology or to see an allergist and may need to get approval from the care management company for those services. If you use the Emergency

Department when you should have seen your PCP instead, the care management company may contact you to assure that you receive the right care, at the right time in the right place.

How can I stay informed of the design and development of NH's Care Management Program?

DHHS has committed to keeping stakeholders informed throughout this process. There are presentation materials that you can review on the DHHS website at this link: <http://www.dhhs.nh.gov/ocom/care-management.htm>. The contracts with the MCOs also are posted on the website. Please visit the site often as new information will be added.

Who can enroll in New Hampshire's Care Management Program?

In the first step of the program, anyone currently enrolled in New Hampshire's Medicaid and Children's Health Insurance Programs as well as newly qualified individuals will be enrolled in the Care Management Program for their medical services. In the second step, long term care services, including specialty services and community based care, will become part of the program. Step 2 is expected to begin one year after the first step.

When will the Care Management Program begin in New Hampshire?

There are a number of approvals and activities that need to take place prior to the start of the program including approval from the federal Centers for Medicare and Medicaid. At this point, the Department's schedule is to begin to enroll members by October 1st and start the program by the end of 2012.

Will I still be able to see my current doctor? (If not what recourse do I have?)

Your current doctor needs to be an enrolled provider with the MCO that you choose to enroll with to provide and coordinate your health care. If your current doctor does not choose to belong to the MCO you wish to join then you have the choice of asking that MCO to assist in you in finding another doctor or joining another MCO.

When will information on plans be available?

Information on each of the plans will be available at least 30 days prior to the open enrollment period beginning. All of the information for Medicaid recipients must be approved by DHHS. As of now the timeline for release of the information is late summer. In the meantime DHHS is preparing letters and other communications to go out to Medicaid recipients and enrolled Medicaid providers.

How will I know which plan is best for me?

Each plan will provide information on how they work with members to coordinate care and what special programs they have that might be of particular interest to you. After reading the

information or at any time during the enrollment period DHHS Enrollment staff will be available to assist with decision-making.

Are all three plans available in all parts of the state?

Yes. All three plans are available in all parts of the state.

How do I sign up for a plan?

Instructions on how to sign up with a plan will be sent to you thus it is important that if your address changes that you inform your local district office of your new address.

What happens if I don't sign up for one?

If an MCO is not selected DHHS will automatically assign a plan to you. There will be a period of time after this auto-assignment to change plans should you wish to do so.

What is the process for utilizing specialists? Are specialists outside NH included in the plans? (If the one I use is not included in any plan, what recourse do I have?)

All care including utilizing specialists will need to be coordinated through your primary care provider/medical home. DHHS anticipates that there will be specialists outside of NH included in the plans. The list of providers in each plan will be available to you as part of the enrollment information. If your current specialist is not in any of the MCO plans then the MCO will assist you in finding another specialist as well as assist in the transfer of medical records.

How will I pick a "medical home?" Or will one be assigned to me?

Members will be able to pick their own medical home, provided that the medical provider meets the requirements for being a medical home.

Can my Area Agency or Community Mental Health Center be my medical home?

Any medical provider wanting to be a medical home must meet the requirements for being a medical home.

Can I change plans if I don't like the one I picked?

Yes. You will be able to change plans during the annual open enrollment period. If you have been automatically assigned to an MCO (when the care management program first starts or after losing and reestablishing Medicaid eligibility) and you would like to change, you must do so within 60 days. If your primary care doctor is not a part of the MCO that you have been

automatically assigned to, you may change to an MCO that has your primary care doctor in their network within the first 12 months of the care management program.

**What limits (caps) are placed on covered medical services for each person?
Are there lifetime caps? Will there be any deductibles or co-pays I have to pay?**

Each managed care plan will determine the management of medical services for their plan. One plan may continue a prior authorization already in place under the current fee-for-service program or may decide to not continue a pre-existing prior authorization process. Federal law 42 CFR 438.210 states that the managed care plans can be no more restrictive than the state's Medicaid fee for service program. MCOs may continue to require a pharmacy co-pay as is already in place in the fee-for-service program. Generics have a \$1 co-pay and brand name drugs a \$2 co-pay. There are certain populations and some drugs that are exempt from co-pays again as is the case in the current fee-for-service program.

What if the prescription medication I depend on is not covered by any of the plans and I've had bad experiences with less expensive alternatives?

Each managed care plan will have an appeals procedure to address any disagreements about benefits and services coverage. If after going through the MCO appeal process you are still not satisfied, an appeal may be filed with DHHS. There is also a DHHS Ombudsman's office available to assist. DHHS will be monitoring MCO appeals as part of its oversight responsibility for the NH Medicaid program.

What if my doctor recommends a treatment that the insurance company says it won't pay for?

Each managed care plan will have an appeals procedure to address any disagreements about benefits and services coverage. If after going through the MCO appeal process you are still not satisfied, an appeal may be filed with DHHS. There is a DHHS Ombudsman's office available to assist. DHHS will be monitoring MCO appeals as part of its oversight responsibility for the NH Medicaid program.

Will medical providers refuse to see me because I'm insured by a Medicaid plan? (What recourse do I have if they do?)

If a provider is a member of the MCO provider network they cannot refuse to see you and provide care. Should this occur you should immediately call the MCO Member Services call center. All of the call center contact information will be made available to each Medicaid recipient as the implementation date draws closer.

Will the insurance company determine my eligibility or (recertify me) for Medicaid or will DHHS still do it?

DHHS will continue to determine Medicaid eligibility.

Will transportation assistance still be available?

Yes, transportation assistance will be available. When enrolled with an MCO, the transportation will be coordinated by the MCO. Otherwise DHHS will provide the assistance as it does now.

What recourse will I have if I am having trouble with my insurance company? If I've been denied a service, gone through appeals and am not satisfied? Is there an outside oversight group or ombudsman at DHHS to ask for help?

If after going through the MCO appeal process you are still not satisfied, an appeal may be filed with DHHS. There is a DHHS Ombudsman's office available to assist. The Ombudsman's office telephone number is 603-271-6941.