Interview: MCM Provider Training Oct 9

(Chris): "Good morning. We're going to go ahead and get started. Thank you all for getting here and getting here promptly. Before I do a few housekeeping items and some opening remarks, we're going to have our new Deputy Commissioner Marilee Nihan say a few words to us, and she is very new as she'll tell us, was appointed formally just about a month ago. So I'll turn it over to Marilee for a few minutes."

(Marilee): "Good morning, everyone."

(Respondent): "Good morning."

(M): "As Chris said, my name is Marilee Nihan and I am the Deputy Commissioner of Health and Human Services. I'm very happy to be in this role because I get to do fun things like open up provider forums, provider trainings. Chris, today is the last day you're going to call me new Deputy Commissioner."

(C): "It is, okay."

(M): "A month has gone by."

(C): "[inaudible]

(M): "No. Absolutely not. Okay, so good morning and welcome to today's provider training. We've brought you here today to walk you through the processes that you can help us with in enrolling your clients in Medicaid care management. You know that we are going live on December 1. I'm not allowed to walk. I have to stay right here which is really hard for me, so just bear with me. I keep wanting to wander away. We are about halfway through our enrollment process. As of yesterday we had 20,000 voluntary enrollments occur. That's close to 20% which is, by national standards, about the average of voluntary enrollment. So we have another six weeks to go. We really want for our client to make their own choice about which care plan that they sign up with, so we have a lot of outreach activities that we are doing to encourage that, to make sure they understand the choices that they're making, the choices that they have in front of them, and they know how to execute those choices. So today is the last of four trainings to providers. We held two in September. We held one yesterday, and today is the last one. So Chris and her team will be walking you through some of the training. We also want you to know we have a dozen provider forums that we are facilitating throughout the state of New Hampshire. We've done two or three of them already. There's a provider forum in Concord over on Airport Road tomorrow night, and we'll be going throughout the state to many locations in the North Country, over on the seacoast, in southern parts of the, of the state. Those forums will be more of a Q&A session, rather than a walk-through a set of slides educational type. So if you get a chance to go to one of those forums, I have found them productive just for myself in learning what kinds of questions are out there, so you'll get a change to raise additional questions and learn from some of the discussion that goes on in the group. We also have client forums, a half a dozen client forums that are happening throughout the state where clients get to come in and similarly ask the questions, understand how do they execute their decision, how do they even make their decision on what criteria they should be thinking about. So all that outreach will be happening. In the next week, we will be sending out reminder letters to all the

enrolled individuals who have not yet signed up to remind them they have until the middle of November to make their decision. So with that, there's a lot of information that's flowing our way, flowing back out, and I would encourage you to check our care management website on a daily basis. We post new FAQs. We post new tools for you to use in response to some of the challenges that we are seeing. So again, every day there's new information, so keep checking in with the website. Maya's smiling because she gets to manage the website. So with that, I just want to acknowledge that this is the largest initiative this state, at least the Medicaid program has even engaged in and it is taking our entire village to pull it off. Our intent is to make it as successful as possible and we need and very much appreciate your help in doing that. So give it back to Chris."

(C): "So a few things before we get started this morning and the first thing is that, a housekeeping, two housekeeping items. If you don't know where the restrooms are located, there are two to my left in the hallway and then there's another one to my right around the corner from the reception desk, and please make note of your exits. We have two in the back and two in the front in case of an emergency and we have to evacuate the auditorium. So why are we here today? This training, as Marilee said, this is the fourth one on how to assist your clients. We developed this training in response to the many questions we got from providers last summer and in the months leading up to this training, and that was, 'Please let us know what our clients are getting in the mail. Can we see sample copies? Can we know the dates that they are being sent out?' So we developed this training in response to help providers. We also have, as Marilee mentioned, we have much information on our webpage and we encourage you to go to the webpage – excuse me – to go to the webpage frequently. That is your source for the most up-to-date, timely, accurate and detailed information. If you want to read more about open enrollment, if you go to our webpage under the 'Provider' tab regular communication, we have a series of publications called 'Regular Updates' and Regular Update #5 is all about open enrollment. And we just released Regular Update #6 yesterday and that is the schedule that gets us through December 1st, any other trainings – excuse me – and things like that. We also have posted on the website under the 'Client' section the way that you can get to a sample packet, and that's just what it is. It's a sample called the enrollment packet. That's what your clients receive and you will get a sense of what's within that packet, what they were asked to do, and we're going to talk about some of those things this morning. And finally, the reason we're here is that provider training is part of our overall provider communication strategy. As Marilee said, we also have provider community forums around the state. You can also find them in Regular Update #6 and they are posted on our website. We ask people to register for them so we know you're coming, and we still have ten more to go so plenty of time. Whatever community you live in, you might be able to make one. So, second item I wanted to point out to you this morning is evaluations. Now you can help us. We want to know if the training was valuable to you, if you're able to use it and more importantly what other suggestions do you have for us that we can make your life easier as providers. That evaluation will be sent out to you by email. It's a survey and we ask you to please get back to us on that. We really appreciate it. The slide deck for today, you got copies. Those of you who are both on the webinar and here in person, we will also post the slide deck up on our website. We also will have a recording of the webinar, so for those of you who have other staff or colleagues who are not able to make the training, even at the webinar site, you can go and do the webinar at your own convenience as well as capture the slides on the webpage. For questions today, we're going to ask you please to hold

your questions until the end of the presentation. There's a very good reason for that, and that is the folks on the webinar cannot hear you. Maya is going to rotate around the auditorium. She did it yesterday, pretty good job, and bring the microphone to you. We heard from participants at the September training that they had a hard time hearing the questions, so that's why we're asking that we hold questions till the end so that the webinar participants can hear us. And with the questions, what we're going to do, we have about equal numbers of registrants at the onsite and at the webinar, so we are going to alternate questions. I'll take one from the onsite and then Stacey will relay some questions coming in from the webinar for me so again, we have about equal participants and fairness to everybody. If your question is not answered today, if we run out of time, please write it down on the index card that you received when you walked in the door. The webinar participants can send it to the email address that will be one of the last slides in this presentation. And what we're doing is, we're posting the answers to the questions on our webpage. The second set of questions went up yesterday. I believe you got the link for those and there will be, no you didn't, they, the link is going to go out with the evaluation survey. Keep checking the webpage. We have many more questions that we're answering and they're going to be put up. So finally, before I get started with my section and introduce my colleagues, I do want to thank our partners at the University of New Hampshire, the Institute of Health Policy and Practice. We have Stacey Gabriel here today and Lynn Schramm who are helping us and supporting us putting these trainings on. We are also working on Institute on Disabilities. Kat jones is helping us through the provider community forums, so we want to thank them for their support, and their professionalism has been wonderful. Thank you. So my colleagues from the department who will be speaking to you today. I'll start with Betsy Hippensteel. Betsy is Administrator of Client Services. You'll hear a lot about what they're doing with the enrollment call center. Maya Glover, Maya is one of my colleagues in the Office of Medicaid Business and Policy. Maya, as you heard is managing the website, and I'm getting really good feedback on that, Maya, so good job. And then finally Joni Mullenmeister who is one of the trainers in Division of Family Assistance, is going to be presenting to you today on New Hampshire EASY. So get started. We've divided today up into these five sections. The first section on the managed care, Medicaid Care Management Program, I'm going to talk to you very briefly about what it means to your client and it's a very important piece. Then Maya will do sections two and three on the selection process itself and how to assist your client, and she's going to give you some tips on how a client can pick a plan, what, who has to pick a plan, who can have the option of picking a plan and who's exempt. And also what's in the enrollment packet and tips on using the provider directory. Then Betsy and Joni are going to alternate on the three ways – I held up four fingers, sorry – three ways that you can enroll and through the call center via phone, through the mail by using the selection form, and finally online with New Hampshire EASY. And then I will close the presentation with the question of, what next. What happens when a client is now a health plan member? And then we will open it up for questions. So what does it mean to our Medicaid clients? What's an important take-away for you today? The first thing is there is no change in Medicaid benefits. That is really important. If, and it's really important in particular for those clients who choose not to enroll in a health plan this time and they feel that the best choice for them was to opt out. There were some misunderstanding circulating about this. People were being told that if they opted out of care management they were losing their Medicaid; that is not true. For those clients Medicaid will remain as it is today. They will notice no difference. They will be in Fee-For-Service or traditional Medicaid, at least

for the first year. Eligibility for Medicaid and enrollment into the care management program will remain the responsibility of the Department, nothing changes there, so a client who wants to apply for Medicaid or has to do a redetermination will still go through the normal channels that we use today. In addition, we've added another step for the Department. As new clients enroll, we will also manage the enrollment into the health plan. And an important point that came up from questions in previous trainings is, make sure your clients understand when they get the redetermination letter from Medicaid, they still need to do their redeterminations for Medicaid, and failure to do so may cause them to lose, they would lose their Medicaid in that case. Most clients will have to select one of the three health plans. Maya's going to walk you through those who have an option and those who cannot. Important deadlines, 60 days to select a plan, so we are working from the initial mailing to all currently enrolled Medicaid clients that began September 11th. It's important for you to know that, as client enroll in Medicaid, during September, October, November, they will still have the 60 days but their deadline dates will be different. So you know, a client may come in to you with a letter and you'll say, well, this doesn't say December 1st as their start day. That's because of the normal process of clients enrolling monthly in Medicaid. And finally 90 days after the start of coverage, that is when a client has the opportunity to switch to another health plan. Once the mandatory clients reach the 91st day, they're limited into when, as to when or whether they can select another health plan. We'll talk a little bit about that. Again, three health plans. This gives you an idea of what the new cards will look like, so clients will have their Medicaid card and they may, will have a card for one of three health plans. The health plan will be paying for the medical services that your clients receive, so it is a change for all of us that, instead of sending our invoices or bills to New Hampshire Medicaid, there will be possibly up to three other entities depending on who your clients signed up with, that you will be dealing with in your business. Important to note, I think somebody asked a question, why weren't there any dentists here? That is because dental services are carved out of the care management program, so no dental service, and long-term care services and supports as well as waiver services are not part of Step One. Here's important dates that go along with the number of days that I just showed you. Again, enrollment packets for the first group, the major group, we call it the bubble were mailed out in early to mid-September. Reminder letters, that's why we did this training at this point in time because reminder letters start going out next week. Right Betsy? And this is sort of, I think you can anticipate that another surge of question from clients who have not yet enrolled, those letters are going to hit the mailboxes in the next week or so, and they may be coming into you saying, 'I got another letter. What does this mean?' Confirmation letters is another point of communication with the Department. These confirmation letters are generated as soon as the clients enroll, so if you have clients that have already picked a health plan, they've gotten their confirmation letter. Confirmation letters will also be mailed out to people who are auto-assigned. We're going to talk a little bit more about auto-assignment, but those will be generated in mid-November when those clients who did not choose a plan will be auto-assigned to a health plan. Notices went out both electronically and in hard copy. The hard copy went to, I would say, the majority of our clients. Electronic notices went out to people with New Hampshire EASY accounts. Some of New Hampshire EASY account holders also got a hard copy. Those who are what we call 'green', they want to get all their notices by email, they just got it electronically. So they went out two different ways. And now I'm going to turn it over to Maya for the selection process."

(M): "Thank you. Good morning. That was cool."

(P): "It is cool."

(M): "Right? So first I'm going to talk to you about the different participation statuses of our Medicaid clients, our recipients. So there are three: voluntary, exempt and mandatory. So voluntary means that it is optional for this recipient to participate in the Medicaid care management program. So these are a list of those types of assistance that would qual-, that would put them into that category. So you know, children in foster care, Katie Beckett, SSI, dually eligible and SMS. So these would, so if you have a client that falls into that category, they would be able to choose their participation. And basically, we're calling it, to opt out, so if you're opting in you're choosing a health plan. If you're opting out you're essentially saying that you want to stay on regular Medicaid. You don't lose Medicaid coverage. If just means that you're, for the first year, as you can see in the second bullet this is time-limited, that you'd rather just continue to receive your services as you do today. So we're calling that to opt out. So for those who are exempt, it's because of the type of assistance they receive, and they are not permitted to participate in the MCM program. So participation status basically dictates the types of choices that you have. So for those who are mandatory, they can self-select one of the three health plans within that 60-day window or be auto-assigned. So in not taking that action to select, they are in sense making a choice to be auto-assigned. And for those voluntaries, they can either self-select one of the three health plans or they can opt out within that 60-day time period. If they don't do one or the other then they are going to be auto-assigned. So if you don't opt in or opt out then we opt you in. We choose for you. So how to assist your clients. These are just a couple of tips that I imagine many of you – how many have already seen clients to help them make a selection? So a few of you. Did they bring in their letters? They did they brought in their letters. So I imagine that this is kind of intuitive to you to look at their letter, examine their situation, to guide them to whatever resources that you may have available to you, to remind them about deadlines to act and to facilitate in enrollment. So I think this is intuitive, but I think that you'll find that there's some helpful information that will maybe augment what you're already doing. So in examining the client's current situation, make a list of providers. Ask them, which providers are extremely important to you, that you really want to make sure that you're staying connected with because of perhaps a continuity of care or just a preference, relationship that's been built over years, and prioritize that. Look at the number of visits in a year. Consider other household members. Is there others to consider in your household who are making a selection and maybe it's ideal that you only have to consider one set of health plan policies instead of learning several others. So that may be a consideration they want to think about. And also just getting some input from their caregivers. That may impact their decision as well, so it's talking to the people that help them make decisions about their care. So guide them to information. As many of you raised your hands, there's that case-specific letter and a selection form that came to them either electronically or in the mail, and in that letter is going to be, it's going to include specifically who in the household has to select, what their status is and their due date, and each one is going to be distinct. Each letter from another is going to be distinct. It includes frequently asked questions and a side-by-side, and the frequently asked questions will have some tips for them to consider similar to what I'm talking to you about today. And then the, and then the Meet Your Health Plans is a side-by-side. On one side you'll see that there's a brief description of each of the

health plans that they have as an option to choose and then on the other side it has what some of the incentives are related to that particular program, to that particular health plan, excuse me. And then there is, in your packets today, a provider directory tip sheet, and I'll talk about that a little bit more. So first, I want to show you guys the areas to look for, for those of you who haven't seen the selection letter where to look for the information that's most important. So here you have the names of those in the household who have to select in the first column. Then you have what their enrollment status is here and then, and the reasons, so the reasons that I showed you on those slides earlier will be indicated right here so you're not really guessing why they're being considered voluntary or, actually it's only voluntary. And then the due dates that an action has to be taken before auto-assignment begins. So what's important to note about the selection letters is that if you are exempt and you are part of a household where other people have to make a selection, you will not appear on the letter. Your name will not be in this column here. If you are the only person in your household with Medicaid and you fall into that type of assistance that makes you exempt, you will not receive a letter. So if you have any questions about that, you're going to want to call Betsy's people and, and talk to them about it because that may be a little bit confusing or concerning if they didn't get a letter while a lot of other people did or they didn't appear on the list. So you may want to give Betsy's team a call and the later, and the number will come later. As Christ had mentioned, the samples are available on our website. If you follow the MCM logo, it's always going to take you to the most up to date information. So the provider directory, so it's really important to keep in mind that the provider directory is changing all the time. It's not, and even beyond this open enrollment period, you're going to see it growing and changing. And it's not too dissimilar from any other network really, commercial or New Hampshire Medicaid currently. So the nature of the network is that they're going to contract with providers and then there's a subsequent prudential process, which means that, until that is complete, they will not appear on the health plan provider directory or the DHHS provider directory. So that's not to say that we didn't run into some system glitches, so we acknowledge that, and the fix is ongoing. So what we were seeing was some exclusions of providers that were appearing on the health plan websites, and we were also seeing some duplications of providers that were appearing more than once in a single health plan and on our DHHS provider directory. And so the fix is ongoing. We're always improving, but we're getting closer. And then we were also seeing some user error, like people were finding it difficult to navigate or maybe they were trying to fill in every single field and surprised they were getting no results or just searching generally and getting too many results. So I have some tips. So and this, there's a sheet that came in your packet, I believe, that has, yes. Stacey's nodding at me which is awesome. So you can see that it even expands upon this a little bit more than what I'm going to show you here today. So you can search by the doctor's name, and I love to use the laser pointer so I'm going to use it again. So right here, you can see that the providers first name, you know, so say it's Samuel. You can just type in 'Sam' and it's going to pull up a whole number, a whole bunch of results that you can see. If you want to narrow your search further you can maybe choose a city or town or you can put in a zip code to find, you know, your doctor Sam. You can search by the organization or search by the doctor. If you're looking for your specialist, you're going to want to be certain that you're looking and you click the 'all' button. Otherwise if you click the 'PCP' button only, you're really only going to get those who have indicated that they're primary care provider. You can also search by the phone number, so maybe you just, they have the office number of their doctor in the and they have it like I do labeled as my son's doctor, you know, so I have 'Eli's Doctor',

right. You know, I just go to that and I can type that in and pull up the organization or the doctor. That's a way, another way to narrow it or to just start your search. So here's just an example of, again, you know, in this ox here with the organization name, you don't have to write in the whole organization name, you know, like if it's Dartmouth, you're going to pull up a lot of them probably but you could just write Dart and you're probably going to get all your Dartmouth Hitch. Okay. And then the same narrowing applies and just note that if, if the person has a particular health plan in mind, they can search by that health plan to see what doctors are in it or narrow their search to see if their doctor is in that health plan. Okay. So one of the questions that we got or some of the feedback we got consistently from our last trainings last month was, 'If I'm voluntary, why should I opt in? You know, isn't it just easer to opt out?' And there's no one size fits all answer to that. So we can point you in the direction of some of the benefits, like care coordination and some of the other incentives for them to stay healthy. That is something that they're going to get as long as they opt in to the program and they select a health plan. They also have the opportunity to opt out if they don't like the way that the plan they're working with the plan. They could also choose another plan and try that one out, see if that one works a little bit better. Maybe it's a relationship thing with the care manager that they want to experience with another plan. And in that year, if they choose to opt in they can build that relationship because eventually it will be mandatory. So for some they may say, you know, I really want to try it out now. I want to get in front of it, and if it doesn't work, I know I can just opt out and that's okay. And others, they may say that, you know, I'm going to wait for things to settle. You know, I see that the provider directory is a new target right now and maybe it's more comfortable for me to just wait for things to settle, knowing that I can always opt in later or wait for it to become a mandatory piece for me. So for the mandatories who are required to participate, there's also another set of reasons to self-select, the extras that are provided. It's the incentives that I mentioned. Also, if they have complex healthcare needs, the care coordination, the optional wellness and prevention programs, but for those who are mandatory and maybe for those who are voluntary, if you make that self-selection and say, I am choosing this health plan, health plan A, then by doing that you're going to reduce the confusion when you walk into your doctor's office and you go, uh, I don't know which plan I'm in. I got this cared and that card. And it's going to reduce that confusion and it's taking an active role in making that selection. which is going to be empowering. So if you've gone through all of these steps and you still feel like you've got a lot of questions, there is help. So you can call the enrollment call center and like I said before, with the exempt folks if they're, if they're confused or if anyone's confused about why they haven't received their status, they can call the enrollment call center. They can call Betsy. And if you have specific questions about the individual health plans like, what is the policy on a particular type of service, we encourage you to call the members services call centers, and those numbers are available on our webpage and I believe there is a contact resources guide in your – Stacey's nodding at me again – so it's included in the packets that you have here in your hands today. So you want to remind them there is a due date. If you miss the due date, no, it's not the end of the world. They will have that 90 days to switch if they're not happy with their health plan, but by not making a selection they're going to get auto-assigned. And so we want to make sure that they have that opportunity to really consider to items that I already outlined for you and mostly their preferences. Auto-assignment can't consider that they just like Dr. Smith and that they prefer him over, you know, Dr. Ted. Who says Dr. Ted? That's a weird one. Usually John Doe, and you guys are a tough crowd. So it's important to remind to guide but not to direct. You want to reduce any likelihood

that somebody would come to you or come to any, any type of entity and say, you know, they told me to do this. No, no, no. They guided you. They helped you find the right resources. They reminded you that you had a due date and that self-selection is important. So that's just a little tip. Now, facilitate enrollment action whenever possible, so it's been mentioned and we mention it over and over and over again because we want it to really be clear that there are those three options. They can call. Maybe you have a phone right there on hand and you can sit with them as they make that call. They can mail in their selection form, so again, if you have a chance and you know someone's coming in and they want help, you can say, 'Can you bring in your letter?', and in that letter you would be able to help some perhaps, actually make their selection on that form and pop it in the mail. And then online. And, and Joni will talk a little bit more about how you can facilitate that through your organization, but also on that letter their PIN number is included so maybe they could just use your internet to launch their account and make that selection. So I think I said all of those things. So whenever possible to facilitate that enrollment action, please do so and make sure you have the client's permission to do that. Betsy."

(B): "Hi. Ask Chris said, I am in Medicaid Services. We're the group you, the clients call. Our number's on the back of the Medicaid card, and we've expanded our role to include the enrollments in the health plan. I want to emphasize that our enrollment call center is open 8:30-7:00, Monday through Friday for, to enroll this first large bubble so I encourage you to tell your clients the hours. And as Chris and Maya have said, we also, in your enrollment packet they got the mail-in, the enrollment form and then we will, Joni will talk about enrolling on, using New Hampshire EASY. This is the address if you mailed the enrollment form, and again, an envelope, self-addressed envelope was included in that enrollment packet so you don't need to, you know, worry about where it's going. So the call center, that's the number that you'll use to enroll. It's the number going forward that you will use to transfer plans or for newly eligible to enroll. We've trained the staff on what care management will mean for the client. They've been trained in the New Heights software which is the state software we use to enroll the person and note their PCP. And let's see. So, what do we do in the call center? There's actually two steps. When one calls, we, the 888 number, toll-free, we'll process their enrollments or if they want to opt out. We also ask them if they have a primary care physician or if they want to name one, and then if they want, we will search for other providers , specialists using our directory and tell them which plans they're enrolled in. We try to assist the client as much as possible with the providers. Often the conversations go into questions about their current Medicaid benefits or other concerns at which point the call is transferred to the more veteran staff, which is currently dealing with the regular Medicaid and knows how to address the other issues. So, I missed one. Let's, we get several calls now and I thank you, I think a lot of you have helped your clients because we have several calls what we term as easy calls where they know the plan and they know their PCP. So those calls are very quick and very easy for our staff. Then we get the people that are confused. They've received the letter. They really don't understand care management and they're not sure they want to participate. The call center staff, the CSF as we refer to them, will go over what care management means. It, they'll talk about the extra benefits. They'll ask if they want to go through the letter they've received. Some do, some don't. And then they'll also go through the side-by-side comparison, the two-sided sheet that was in your enrollment packet. Most of these calls result in enrollment but not all. Some clients want to call the health plans and ask specific questions about their coverage, and then we get the second call. The third

type of call we get really focuses on the eligibility. Why, why are some of my family members mandatory and my one daughter's voluntary? And so we will, again, review why some are mandatory, why some are exempt and go through that and then spend time on each of the case members their primary, their current primary care physician if they have one and go, again, go through the specialist if they request it. There, all calls, at the end we ask if they'll participate in a survey. Currently about 50% do. They surveys have been helpful for us to refine our script and, you know, make the services better for the client. Some people, and currently we have just over 3000 paper enrollment forms that have been mailed in, and my message to you on this is two things. We can't, the form is case specific, so we can have a pile at our client forums but those that do send them in, if you notice the barcode at the bottom, they're scanned in, and not that this really matters but some people have asked us, 'Why are the directions so detailed?' They're detailed and specific because they're scanned into the system. However, my message to you today is don't worry about it. Don't get hung up on the directions. Check the box and if your client has a provider, a primary care physician they want to keep and you have the MPI number, fill that in. We are, if they're not scannable, we're processing them manually. So I really don't want anyone hung up on reading the paragraph about the correct way to do it. The most important thing is, is we can, we know the plan you select. And those, we'll skip that because, you know, that's saying, use black ink, make sure you fill in the hole, but it really, it's nice if you do that, but please, the clients, if they want to fill it in, just check the box. So again, the MPI number is confusing to some. As you all know, it's what I call the social security number for the provider, and I will say that on some of the paper forms, numbers are transposed or the number is incomplete. We do our best to figure out which provider they wanted and if we can't, we will call the client because if they've made an effort to fill out that MPI number, that's telling us that they do have a primary care physician that they prefer. And again, that's the address. And now Joni will talk about the online option of enrollment."

(J): "Good morning. So the online option is through New Hampshire EASY which does mean New Hampshire Electronic Application Systems, and what we have is the website will take us here so that any individual that has access to the internet has the opportunity to apply and submit online an application for our DFA assistance programs such as cash and Medicaid and childcare and FoodStamps but not our long-term care program. That's still done through the district office. New applicants that do not have a New Hampshire EASY account can do a basic quick anonymous check to see whether or not they're eligible - ooh, sorry – eligible for FoodStamps by going to the 'Do I Qualify?' column there and go ahead clicking the 'Check Now' orange button. And existing or returning clients, they can go ahead and click on the 'Create Account' button. It's a little kind of misnomer, so it's literally for the existing or returning clients. The ones that want, that are brand new and they're going to go ahead and apply, they're on the third column that says 'New Client' and 'Apply Now' so that'd be the third one over here. Our existing and returning clients, they normally have a PIN letter for the ones that had already created their New Hampshire EASY account but they might not remember it, so when they go ahead and log in, it's just going to ask them what their PIN is and if they don't remember it, they'll be able to answer some security questions and get it that way. But the ones that are coming in and they're returning because they have an account with the, well, with the State in terms of a case number, they'll be able to start to create this account but they won't have a PIN yet. So they're going to get a question that says, you know, do you have a PIN? They're going to say, no, and they're going to get a letter, and once they get

that letter, it will have the PIN number on it and they can then go back into the site and put that in and finish up the process here. So, organizations enrolling as a New Hampshire EASY provider, there's a two-part step to this. The organization has to complete a 777, a New Hampshire EASY provider enrollment authorization form, and when they do that, it's going to be coming back to the state and then the New Heights Security Administrator is going to take that form and then create a provider an account and set up a password for the administrator for your organization. So it's normally just one person that's going to get that information and then they in turn are going to be able to decide who in your organization is going to have access for their clients with the New Hampshire EASY account, and they'll set you up with your name as a, and a password, and they'll oversee the individual people in your organization for that. But receiving that as an organization, that says you want to be able to do this for your clients is just the first step of it. We still need to have from each individual client a 776 and that is what's going authorize you to act on their behalf for them. So, acting on their behalf, what you're going to be able to do is, of course, file the application for them. You'll be able to access their case information, their letters and notices that went out to them. You'll be able to perform changes for them, add a program, reapply, do their redeterminations online if they've gone ahead and asked for you to do that, and to go 'green' as well as select their health plan for them. And have any of seen the form 777 or 776 for your clients yet? The clients are giving up the right to do this when they're signing it your organization. It doesn't mean that they won't be able to go into the district office though and still report changes or even turn around and say they don't want you to do that any longer, but when they do give that in, they are saying, I'm going to let you do that for me. And they'll just get mailed information instead of online info. Now, in New Hampshire EASY, those who already have an account will be able –oops, yeah – will be able to enroll for a health plan through their account, so what you'll see is there's a bunch of tabs across the top and the first one says 'Home' and there's three boxes across the middle and it's, on the last box it says 'Care Management' and 'Go Now'. So that's going to be displayed whenever there's at least one client that has a valid enrollment window, so that would be the 60-day period to enroll, a 90-day change period or perhaps the annual enrollment period where they can go in and change their health plan. So as, I think it was Maya was saying, that the excluded people, if it's a household of one, they're not getting any letter. So that excluded person of one wouldn't see that 'Care Management' box. It wouldn't display. So, by selecting the 'Care Management' box, the clients are going to be able to research a health plan, enroll in one, change their plan, or even view their health plan history. So, by clicking on that box, it gives us three new sub-tabs. It'll say 'Selection' 'History' and 'Research'. Oops, I keep pressing the wrong buttons. Maya's the best with this. Right here, 'Selection' 'History' and 'Research'. So, on the 'Selection' one, they will be able to go ahead and they're going to see who is in their household that's being offered this information. So we have a 'Name' column. That's just going to show the name and the date of birth here, and it'll also show their status, whether they're mandatory or voluntary. They opt in or out will show if somebody is voluntary. That opt in is actually the default, so they have to be proactive and decide to opt out or choose their health plan, or if they don't be proactive and they leave the opt in that's when they get auto-assigned. And then, if they've chosen a health plan or want t, oh my goodness gracious, it will show up right here and then we have the PCP which is optional, so if they wanted to go ahead and pick out a PCP they can at this point as well. So on the 'History' tab, this is where you can go in and you can see when each person and their name at this point is only going to display with their first name and their middle initial if we had one and then a suffix, if they were like a Jr. or a Sr. So what we

have is the mom here, and she has New Hampshire Medicaid, and it began for her in July so it'll tell us the begin date and an end date, so we don't have one in here. It's ongoing. Her status, she was voluntary, excuse me, mandatory. And for the opt in and out, because she's mandatory, that was not applicable for her. As well as the, oh my goodness, the voluntary exempt reason, so since she didn't fall into either one of those categories, it's also not applicable. And as Maya said earlier, when we're asking and telling you that somebody actually is voluntary, it'll give you the reason, like this says SSI child. And then the last sub-tab under 'Research', this is where they can go through and if they wanted to research the three health plans, when they click on these buttons, it will actually take them to a separate browser and go onto that health plan's website. And, thank you very much."

(C): "So now you've heard from us on who must enroll, who's voluntary and who's exempt, as well as the ways clients can enroll. So now we're at the point where our members have joined a health plan or been auto-assigned and what happens next? The first couple of things and startup activity are that our members will get a welcome call from their health plan and the health plans are obligated to do this within 30 days of their enrollment and they have to try three times to reach a client. We have heard from the health plans that some of them are already making contact with our clients. One of them has, Meridian Health Plan has already started making calls. The others were going to start mid to late November but I did hear yesterday that they're considering, one of them is considering starting earlier, so in case your clients say to you, 'Why did the health plan call me? You know, what's up?', that's why. They're obligated to do this in their contract with us. They will also get a letter in the mail and they will get their ID card from the health plan. I skipped one there, mailing the member handbook, that is also going to happen. What we know at this time on that is that the plans are not planning on sending material to much closer to that December 1 start date, and that's because they want to alleviate any confusion of clients if they were to get something from the plan prior to that and clients would thing maybe their coverage has started, and they need to work with the health plan. It's still December 1 as program start date. Other startup activity, the plan will ask your client to confirm or select a PCP. Remember, it is not required that you select a PCP when you enroll, but the health plan will follow up with your clients and ask them to select a PCP if they have not done so already. The brief health risk assessment, it's a questionnaire that will be administered by the health plan representative. We've gotten questions, 'Do my clients have to fill this out? Is it required?' It is not. We encourage our clients, we encourage you to work with your clients to do the health risk assessment because it's in their best interest. That gives the health plan some idea about their medical needs and what kinds of services the plan might target to them. They will also screen our clients for special needs or services that they might need. They health risk assessment helps them get there and as your client's time in the health plan matures we will have claims history. Prior authorizations may be a hint to a health plan or certain services the client needs. And referrals that the client may have received. But again, that's going to take a few months to get into the health plan, where services are administered and covered before those kinds of things like claims history and PAs and referrals begin to appear. They will also determine whether a client needs any special communication needs such as assistive technology, preferred language. Other startup or operations, points that we want to make with you today are that, clients have 90 days to switch to another health plan and today we're talking from that December 1 start date, but again, remember that clients will be enrolling all through this process. They will still have that 90-day

period; it'll just be a different date. Health plan membership information is also available to you as providers in our MMIS. It really just says it is, today there will be a new field that will appear that will tell you what health plan the client is enrolled in. And the health plans also have the ability to check the MMIS for health plan enrollment as well. And we've also encourage our clients to keep both cards with them, their regular Medicaid card as well as their new health plan card, and that is because there are circumstances in which a client will still be Fee-For-Service Medicaid. Those are exempt. Those who are waiting for the health plan enrollment date, that is the first of the month, so for example if a client enrolled today, October 9th, they would remain Medicaid Fee-For-Service through October 31st before their health plan enrollment kicks in on the first of the month. And then there are some services that are not included in what we call Step One for this first year, waiver services, long-term care services, and support, so clients receiving those services need to present with their Medicaid card. We've prepared the next two slides with some helpful hints for you to determine whether you or your client needs to call the Department or the health plan, and there are certain things that the health plan will do. For example, the, if a client wants to change their primary care physician, they've lost their health care, they need a new one, it the health plan has sent them a communication that's confusing to them, they need to call the health plan for that. If they're waiting to hear about a prior authorization, and they haven't heard anything yet, they need to go to the health plan, questions about their coverage now that they're a member of the health plan. And if they want more information on the optional services that are available, they need to go directly the health plan. And grievances and appeals, this is a little different. The client must start with the grievance and appeals process at the health plan level before coming to the Department. And I'll say a little bit more about that in a minute. And information on care coordination. When to call the Department, if you want to switch health plans. Remember I said that the Department will maintain the responsibility for eligibility enrollment and enrollment into a health plan. So if a client says, 'I don't like the health plan I'm in', they need to call the Department. The fee, the services that remain Fee-For-Services, if you or your clients have any confusion about that, you should call the Department. Anything to do with Medicaid eligibility, including redetermination. If your client needs a new Medicaid card, come to the Department for that. Any questions related to dental, again, dental is not included in care management. The request for fair hearing and I just mentioned in the previous slide, that is after the member has exhausted the grievance and appeals process at the health plan level and wants to come to the Department for that next level of appeal. If your client has questions on the Medicaid provider network, that would probably be most important to those who are still on Fee-For-Service or receiving those services Fee-For-Service. And then finally, and questions about Medicaid care management, how do I enroll, what is the other phases of the program, are we going to be – getting a common question – what happens to waiver services and long-term services and supports and what we refer to as Stage Two, that would be a question you refer to the Department. So, important dates again, open enrollment began mid-September and it continues to November 11th. After that point, we begin on November 12th with the auto-assignment process, and letters begin being mailed to clients around November 18th, Betsy? So that clients have an opportunity in these next four weeks and we encourage you to do the best you can to remind them to help guide them that, if they are not, if they have not chosen a health plan by November 11th, as you've heard before, we will pick a plan for them. So in summary, next couple of slides is just a brief repeat of what you've heard already this morning. How to assist your clients, four important points here. One is, as Maya walked you through,

examine your client's current situation. What is their participation status? Are they mandatory, voluntary or exempt? And some questions that you can ask them. Second, guide your clients to available resources. We have given you a number of resources this morning and two in particular that should be helpful is the quick guide to enrolling and the 'How Care Management Helps Me'. One gives the client the important direction of how to enroll and where, and the second one explains care management to a client if they don't really understand the concept. And all of these are available on the webpage. We gave you samples today. You can go to the webpage and obtain them and print out copies as you need them. We also gave you that poster that we'd like you to use and perhaps post in your waiting room, in your office where you see clients, on the back door of the exam room, any way that you could get that message out that now's the time to pick a health plan. And you, we're asking you to remind your clients about the due date and that auto-assignment is really a default position; it's not an informed choice. Whenever you can, we ask that you help facilitate enrollment and if possible provide some more aid to your client if they request it. Enrollment, three points of contact the Department has or will have made with your client as well as three ways to enroll that you've heard about. The enrollment packet went out last month. The reminder letter is coming out shortly, and the confirmation letters will be issued. Three ways to enroll, the call center, mail in or online. As far as what the health plans will do, as I've said, they will contact their new members. They will confirm or establish the primary care provider, and they will send each member a card and a member handbook. Member handbooks, by the way, will also be available on each of the health plan's websites and I understand that some of them are already up so if you want to have a sneak peak, or it also may be a way that your client can get some more information. The member handbooks are up on the website. Just a pictorial representation of the webpage, and the webpage is constantly being updated and we've made some revisions and probably make some additional revisions based on feedback we receive from providers like yourself, so there are multiple ways to find information and probably be a good thing to just go and work your way and navigate through the webpage. In terms of questions after today, we have an email box that we've established just for providers, so you can send your questions to that address that you see at the top of the slide. We also have the ability to answer client questions. As Betsy suggested, the enrollment call center is appropriate for some client calls and other client calls, perhaps those are more complicated or the client has lost their letter and needs a new one, that's when you call Medicaid client services. And finally, clients can also email questions to that mail box that we've established just for this purpose that's at the bottom of the slide. We do have at least one more training coming up. I think Marilee said, well, this would be the last one. This is the last training that we have on how to assist your clients to enroll, but we have another training coming up on November 12th. Registration information went up on the website yesterday, and you can go there to click on that link and register for this training. This one has a slightly different audience in mind. We suggest that you look at your billing staff, your, those who specialize in reimbursement, and those who administer your facility or organization. This is really about business practices, and we will ask people to limit the number of staff they send to the onsite. We do have it at the [inaudible] Center which gives us more room and we can have more people come at one time, and if we hit that number then people will be referred to the webinar. And by the way, I've talked to people and I've looked at our numbers, the webinar has been proven to be extremely popular. I think that the first training in September, we had about 300 people attend via webinar. We had 100 yesterday and we have close to that today, so we think we've reached in this training over 700 providers and the

webinar was really instrumental in hitting that number. So there's a little bit more information. We, all three will be there with us and we will be launching a tool on how to manage your business processes that is called the 'Quick Reference Guide'. That tool should be available on our website by October 31st and the plans will speak to that tool, each individual plan, as to the processes that they have for things like grievances and appeals for both clients and providers, how to file a claim, what they consider timely claim submission, even if I want to submit a paper claim. There is a number of things that we also heard from providers, particularly small providers who, this is a big change, that they did not anticipate that they would have to file claims, for example, with up to four different entities, that is if they contract with all three health plans and they also maintain their Fee-For-Services. So we're going to do this training to kind of help you get through this transition period of beginning to work with the health plans. So, this is the end of our slide presentation, and we're going to open it up for questions. Again, we're going to alternate between those on the webinar and those onsite and in order to make it easy for those on the webinar to hear the question, Maya will come to you with the microphone. I ask you to state your name and the organization that you're with. We'll start with the onsite."

(P): "Sharron Granite [inaudible] formulas for the different health plans just to know if there's differences in the [inaudible] formulas for the three plans. Prior authorization [inaudible] so that's my question.

(C): "The, each of the health plans must follow the Medicaid PDL, our preferred drug list. Then, within the different classes of drugs, they can, they may be able to offer something in addition, but at a minimum they have to follow our PDL. And prior authorizations, I think you'll find that the process will of course be different, but the prior authorizations, if the, for those services you need one and how to do it will be in the quick reference guide that we give you so that you can, at a glance, especially during this transition, just quickly look it up.'

(P): "How will these plans accommodate out-of-state providers?"

(C): "I was asked that question at one of the provider forums. Can I still see my doctor – was in Keene – can I still see my doctor in Vermont? Of course you can. The caveat there is, the out-of-state provider must be enrolled in that health plan so it's no different than it is today. For those who live on the Maine border like I do or live on the Vermont border and you have a provider over on the other side, as long as they're enrolled in that health plan you are able to continue seeing them."

(P): "Hi, Lisa Spencer from [inaudible] Mountain. We have several clients that are in programs also receiving Quimby for their Medicaid Part B and have questions about whether those folks are voluntary or mandatory."

(C): "Yes, and you know, that's a good question. It came up several times yesterday. I have a friend and colleague at [inaudible] Mountain who raised it the first time. They're, if a client is what we call straight Quimby and Medicaid only covers their copays and deductibles, they are exempt. However, there is another set of Quimbies who, some people refer to them as, CMS calls them Quimby Plus. Those are the Quimbies that not only get that assistance but they get Medicaid services from us. Those are the Quimies that are voluntary."

(P): “I don't have any other questions. Just getting one in. Do we have to get authorization for out-of-state providers?"

(C): “Again, that will depend on the health plan and it will depend their network, so I encourage you to look at the Quick Reference Guide, find out where you go to make that request as well as contact the plans individually when we're up and running to find out what, if anything, is available to out of state. Again, it shouldn't be, if you go and look at the provider's directory now, which I did, just like town after town in Massachusetts, Vermont and Maine is listed. There were even some ones that were other parts of the country, so again, there is out-of-state coverage but it has to be through the health plan."

(P): “Deb from VNA. Does provider directory have only physicians or does it also have a social worker within MPI?"

(C): “The question was, does the provider directory only have physicians or does it have social workers within MPI? It has all providers that enrolled with Medicaid, so there are advance practice nurses listed, there are LCSWs, there are psychologists. I've seen other social workers. If your organization or yourself has signed a contract, you will appear in the provider directory."

(P): “Deb from Northern Human Services. My question, how are people going to be auto-assigned? How is that going to work?"

(C): “Four steps. The question was, how are people going to be auto-assigned? How is that going to work? There are four steps to auto-assignment. The first one is, we will look at the preponderates of claims, where did the client go most often. First we'll look for primary care or we'll then go to a specialist. That, we've used this before in doing some studies in where our clients go for primary care, and it is amazing. I think we came up with like 80% matches on primary care. The second thing is, if that doesn't pan out, we will go to looking at if that client has other family members and what health plan they've joined. They will be auto-assigned to the plan with their family member. The third thing is not immediate but it would take a while is that we will look at their membership in the plan and where, if they have a previous relationship. So let's say it's a client who didn't do their reading, they didn't get back with it within 30 days so now they have to pick another health plan, and if they don't tell us what plan they want we'll look and see what plan they were in and we'll assign them to that. And then the fourth step is an algorhythm that we use and it is based on a formula where the plan that received the highest technical score in the RSP process and that is Well Sense's, they will get two auto-assigned members to every one member that Meridian health plan and New Hampshire Healthy Family gets so four, say four people have the auto-assign, two go to Well Sense, one goes to Meridian and one goes to New Hampshire Healthy Families."

(R): “I heard you say that agencies could enroll in New Hampshire EASY to help people will redetermination and things like that. What about individuals that have family members to help them or DPESs or reps, are they also able to enroll on behalf of that person?"

(P): “The question is, New Hampshire EASY, organizations can use to help their clients do enrollment into a health plan or eligibility or reenrollment. Can individuals do that? Can a rep do it? Can a family member who's assisting a client? I'm going to let Joni answer that."

(J): "If they've actually assigned the organization to do it, that's the only one that's going to be able to do it online. But if they don't, if they want to do it themselves, they can have anybody they want assist them. If they want to assign a rep payee, they're going to need to do that with a form 778 so that person can go ahead and go in and they can make the calls if they needed to and get the information they needed. But anybody can have anybody they want without officially assigning an authorized rep form assist them but they would have to provide them with their PIN number or their password if they already have it established. So that's with the client and between them and whoever they want to have help them. So normally, they're there at the same time, so that we wouldn't know. If they're giving out their password, we don't know that. So I mean, yes, it's entirely possible as long as they haven't given up the right to an organization already to go ahead and do that, because then then can't do any of the online information. Alright?"

(R): “Deb from UNA, can the PCP, the primary care provider be a nurse practitioner or does it have to be a physician?"

(P): “Can the PCP be a nurse practitioner or does it have to be a physician? Nurse practitioners are listed as PCPs in the provider directory."

(R): “[inaudible] Commission, and we get a lot of calls thinking that they're calling Medicaid for some reason and in sitting here, I'm not a provider obviously, but I'm kind of confused at how do you pick what plan is best for the client? It seems to be a lot about, are you just picking which plan your provider is in? Or do you pick the plan that best suits the needs? Or are all three plans the same?"

(P): “The question is, how do you pick the plan that is best for your client? Do you, are all three plans the same? I'm going to let Betsy answer that. How are you advising?"

(B): "What, what we tell clients when we talk to them, we do first start with the providers, ask them if they have a primary care physician. Some say no. We say, 'Who do you see that's important to keep?' And then if that particular specialist is with all three or two, then they say, 'Well, how do we pick?' And we'll go over some of the extras, but then we advise them to call the individual call centers of the three health plans because customer service and just, you get a feel when you ask specific questions. So most are very receptive to that and have called the three individual health plans. Some go even further and research the individual websites. So I would say, you know, the primary care physician first; their other providers; and then customer services and reviewing materials on their websites."

(R): “[inaudible] River Bend Mental Health. Another nurse question, under the current Medicaid system, nursing services are covered, but private insurance companies do not pay for nursing services. River Bend has contacted all three of the manage care companies. Does that mean nursing services are covered under those, the umbrellas of the different plans?"

(P): "The question is, I'm from a behavioral health organization and I provide nursing services. Will my services be covered under care management as commercial insurance usually does not cover these services? How did I do? Your service is covered currently under New Hampshire Medicaid, correct? There will be no change. The Medicaid benefit package remains the same. There is no change in your benefit package when we go to care management. That service is covered now; it will be covered later."

(R): "I've just got one more. I'm Deb Booten from Northern Human Services. I'm just wondering about, with the rollout plan, once the person enrolls for the network or the health care plan, you said they have 30 days that they'll make the phone call to the person. Is that a recording just to thank them with that phone call? Or is it a person calling and talking to the person?"

(P): "Question is, once a client's enrolled and the health plan has 30 days to make the welcome call, is that a recording or is it a live individual speaking to the person? It is a live individual. It's a live call."

(R): "[inaudible] and Community Bridges. And my question is, and I think I know the answer but I figured I'd ask it anyway, Medicaid benefit package such as Medicaid transportation reimbursement and HIPP program and things like that will still be in place?"

(P): "That is correct. The question was, does the Medicaid transportation and the HIPP program, will they still be in place? And the answer is yes. As a matter of fact, I don't know if you heard the news this morning, but the Medicaid Commission voted 8-1 to extend Medicaid. I don't know where we go next, but part of that expansion concerns using the HIPP program to a greater degree than it is today, and the HIPP program is where Medicaid will cover the premium for an individual as long as it is still cost effective. So the HIPP program will probably be, if this goes through, it will probably be larger than it is today."

(R): "I have a question. For the first year, if you make a selection, do you still have the Medicaid coverage, for example, dental?"

(P): "Okay, so for the first year, if you make a selection, do you still have Medicaid coverage, oh, for dental, so it wasn't for example. Dental coverage under Medicaid, as I think all of you are well aware, is almost entirely for children. That dental coverage does not change, and that is why I said to you, make sure your clients hang onto their Fee-For-Service Medicaid card. They will need that. The children will need that to access their dental services. As you know, it's extremely limited to emergency situations for adults."

(R): "So you're wondering what's going on. I brought down, I had a friend of mine upstairs bring down the poster because it wasn't actually in the packets, and in doing so she grabbed whatever was around my desk. And so you guys can get more copies of everything. So take as many as you like, more than one poster and quick sheet or 'How to Help You Clients'. It's just a little extra. No one else got that. You guys are special."

(R): "I have a question over here. So for the River Bend coverage, my understanding was that case managers have, it's up to their discretion whether to off-write a service or not. So couldn't they actually

say that somebody can't even though they have more services that could be covered from River Band nurses? Could that case manager say, not authorize those service because they feel like they're being over-utilized, are not medically necessary?"

(P): "The, I'm trying to capture what the question was, so you're asking if the health plan would not authorize a service, they would make a determination that a service was over-utilized, for example. Is that what you're saying?"

(R): "Not necessary."

(P): "Or not necessary. Again, the benefit package remains the same. The health plan must work with whatever limits we have in place now. They cannot go lower. They can offer more of a service if they want, but they cannot give fewer services. So again, benefit package remains the same and the plan cannot decrease the number of services, for example, but they can if they want to offer more."

(R): "Of course, my concern is that they're providing services at the same level that they have been under straight Medicaid, but what happens after a year or two? That's my, you know, concern of all of us providers is that they're going to start rationing parts of the treatments."

(P): "So the comment was that there is concern that Medicaid services stay the same now, but what happens two years down the road. Will the plans start rationing services? The plans can't make that determination on their own. That's going to be up to the Department, and I think all of you as providers will be active in the conversation. The plans cannot unilaterally decide they don't want to offer a service. They need to have permission from the Department. They're under contract with us and they're under contract to deliver a certain number of services."

(R): "I'm just following up on what you said, they're contracted with you."

(P): "With the Department."

(R): "With the Department. So they pull out?"

(P): "The contract that the plans have with the Department is for 5 years. They are in year two right now of the contract, and if things go well, we like them, they like us, we will up their contracts. We have the ability to amend them and add additional years. The Department always has a clause in our contracts that, depending on certain circumstances, that we can cease and desist with that contract, so we have protections in place and the plans are protected as well. Hard to say. We hope that we're successful, that the plans enroll our clients and services are delivered successfully, but we have a number of things in the contract, like the whole quality improvement plan that is, in fact it's up on the website now. I couldn't even begin to tell you all the parts of it, but I do know that one of the federal officials commented on the number of measures that we have that we're going to be tracking, and they said they hadn't seen any states do that many before."

(R): "What do children do for dental care once the year is up?"

(P): “Again, children, when we talk about the year being up, we were referring to the services that are carved out now and going from Step One to Step Two. Children dental services are not going away. I want to let Betsy say a few words about the client forums that we have."

(B): "I want to go back quickly on your question about transportation. Medicaid transportation does continue. However, it will be for those enrolled in health plans as handled by the health plans. So it will be different for transportation, as in my unit, with the current program we will, in the transition we will assist clients with where they call, what is different. We'll hold their hand through the process, but it continues, but it is a little different. And now, finally, I just wanted to tell you that we are starting client forums next week. The first will be held at Families First in Portsmouth on the 17th from 9:00-11:00. There are several scheduled and more to be scheduled and they will posted on the website The difference in the format for the client forums in October, we will have all three health plans at most of them, and we will, at the end, there will be a few of us who will assist clients with enrollment if they have time to stay. So the health plans will be there to answer their questions. We will be there to answer, the Department, questions addressed to us. And finally, we'll be able to help them with enrollment."

(C): "The regular update that I mentioned at the beginning of this presentation, that includes the dates, times and locations of the client forums that have already been scheduled as well as the provider forums. And again, we have Concord coming up Thursday night, 5:30-7:00, and everybody's welcome. It is not a training. There will a very short presentation, probably reiterating some of the points we made here today. And then we open it up for questions, answers, comments, concerns. It is a time for dialog with us."

(R): “Understanding of services that are not covered under the health plan. However, when children are received in the operating room for major restorative work and then they have a primary insurance, does managed care, or if they have a primary insurance carrier, New Hampshire Medicaid manage care also [inaudible]for the child? Do we have to get preauthorization just to be [inaudible]?"

(P): “Okay, the question is, what happens during care management if a child is seen, say, in a hospital for major restorative work? How is that covered? Does the care management plan cover it after Medicaid? Is that what your question was?"

(P): "So the child's in the hospital in the operating room, has general anesthesia, so what will happen is, New Hampshire dental program, just as it does today, will pay, they'll work out with the primary those fees that are involved with the hospitalization. At this point, those cases will, so if they're, have a primary and then they have Medicaid, they're mandatory for care management and then they have dental services which remain as they are today. The dental program will work with the health plan if there are any charges remaining. But, so there's no definitive answer. I can just assure you that the patient will not be billed anything. Does that help? It is, it is very complicated. I've seen those cases now. We know it and we'll handle it, but it'll be on an individual basis."

(R): “[inaudible]

(P): “I'm sorry, refer them back to their case worker?"

(R): “[inaudible]

(P): “Yeah, by case worker, which type of case worker do you mean? I'm sorry."

(R): “Meaning care coordinator."

(P): “For, for dental work, major dental work for a child, what one should do is call Medicaid client services first. We'll work with the dental director or the other two dentists on staff for that particular case and help coordinate it."

(R): “[inaudible] from Special Medical Services. For individuals who have another form of insurance that currently would be considered their primary insurance and Medicaid was secondary, where is the best way for those individuals to get their questions answered for how that relationship will be managed so that they can choose the plan that will work best for them?"

(P): “We're working on that and we will, at a minimum, put that up on the website under Q&A but we are working internally. We should have something shortly."

(R): “Question."

(P): “I'm sorry. What was the question? I can't even remember it. Can you repeat the question/'

(R): “For people that have another form of insurance that under the current would be considered primary with Medicaid being secondary, where is the best place for them to get information about how that will be handled once they're enrolled."

(P): “So the question that I answered was that for people who have another form of insurance, so for those who have, say, commercial insurance as their primary and Medicaid as their secondary, where is the best place they can go to get some place on how to-?"

(R): “Questions like their primary care provider is in one plan but not the other plan, how do they make the decisions?"

(P): “So to get their questions answered about the different plans and how they negotiate that with, if a provider's in one network but not in another, and we are working on that at a more systematic way to answer that and handle that internally and we should be up and going shortly."

(R): “I know this is just started out but I was just wondering what are some of the problems you're running into? Or have there been any? Are there any problems?"

(P): “No, no problems. [laughter] The question was, you know, I know we're just starting out but have, are there problems that you've run into? Well, Maya, you can answer part of that. The directory was, of course I was."

(M): "Well, I'm going to go to the front. So as I mentioned as part of my part of the presentation, the, the provider directory has posed some challenges to us since open enrollment, mostly with what I was mentioning about how some providers were being excluded from our DHHS provider directory. Sometimes there was duplicates and so we had to start really scrubbing those files that we were getting from the health plans in order to make sure that they were appearing correctly in our provider directory. And so we found that we really have come up to date with most of that. There of course is going to be some ongoing fixes. There's tweaks here and there, so we're still working on it, but I would say that's probably been our biggest challenge since the, since the start. Otherwise, you know, we've had a couple days where our computer system that, that – what?"

(C): "I'm saying, yes."

(M): "Oh, our computer system where people select and where our call center people log into to their selections if they're going online, that went down a couple of times. One day it was for a short period of time, like a couple of hours and there was almost a full day that it had gone down like last week. And that's very unusual for us. You know, I feel like I sound a little bit like what you guys are hearing about ACA, you know, please wait a moment. We'll be right back with you. There's a lot of, there's a lot of people logging in right now. I could say something similar to that. I don't know. But it's, it's just the, the you know, the system has to get used to what we're trying to accomplish here. So there's a lot of change happening. So I would say those are the biggest challenges but otherwise we're seeing people are enrolling, they're choosing. Yeah, so."

(C): "And I think, related to what Maya just said, what because the contracting process as a plan, as a provider contracts with a plan and then they're, they have like a hospital system has 350 providers that – and this is a true story- that are not appearing in the directory. You know, we've had to counsel our providers to say, we know in this particular community the contracts were assigned and they're going through the credentialing process. That takes four to six weeks, but all 350 providers in that community are signed up with all three plans. So it's okay to tell your clients that they can pick their health plan and then wait until they get the welcome call and pick their PCP. It's just a matter of time, but we do stand by NCQA standards and national commission for quality insurance and that is a requirement that we cannot put providers up who have not completed the credentialing process. So you know, we're changing our messaging at our client center, Q&As. The Quimby thing, that must have come up four or five times as a question yesterday, but because we had already been made aware of it, we started off by saying, if you're a Quimby you're exempt. And then, we started getting the questions from providers like yourself that made us change that message. So I think it's, when we find a glitch or a, we've made a mistake, we acknowledge it, we move forward and then best place is to look on the website.'

(P): "Would you repeat what you said about Well Sense and why it's preferred in the auto enrollment/'

(R): "That is, the question is why is Well Sense preferred in the auto enrollment? I wouldn't call it preferred. I would call it an algorhythm that was part of the RFP process and it's in the contract. That is why Well Sense is receiving the preponderates in the auto-assignment is because Well Sense received the highest technical score in the RFP process."

(P): "What's the RFP?"

(R): "Requests for Proposal, the bidding process. They came out on top in terms of technical score. It's a pretty routine way to do it. Other states do it this way as well. So they got, they'll get two for every two that the other plans get."

(P): "What is the technical score? [inaudible] from Northern Human Services."

(R): "The best way – the question was what is the technical score? I think the best way to explain that was that was the, we had two parts of the proposal. One was the financial or the cost part and the other was the technical part. So the proposals were not just rated on what cost they came in on; it was customer service - the I'm trying to, Betsy did you do any of the other? I can't remember the other things – quality of care. There was a good dozen or fifteen people on that. So the technical scores really the hands-on delivery of care more than, it wasn't just based on cost."

(P): "What if a client's PCP is in a particular plan but not the specialist he or she has been seeing regularly?"

(R): "Couple of things, the first thing we encourage our clients to do, or someone who's helping them is to call that health plan and ask them if that specialist is going to be in their health plan. If they say no, we encourage you to ask them to please consider enrolling that specialist. You know, this question goes all the way to the good news that the health plan is in the credentialing process to perhaps that client not seeing that specialist in that health plan. What we're doing now is we're working diligently to make sure that they are, our clients are well served, and we are discussing this. Again, this is another one that we're dealing with internally as to what we might do if that situation does come to pass. We hope it doesn't."

(P): "My name is[inaudible]. I'm Executive Director [inaudible] Greater National Region 6. Seeing that it is the support centers to support consumers in this endeavor and my question is more for New Hampshire EASY, to use the online process. How would we go about registering to be this program and would we submit the 777 as well as the 776 in our case being a non-billable program?"

(R): "A non-billable one? When you say non-billable, do you mean you're not an enrolled Medicaid provider?"

(P): "Right."

(J): "I don't know. I don't actually know the answer to that question either. Alright, so the question is whether or not the organization, where they can get their forms for the 777 to enroll with New Hampshire EASY, as well as the 776 for their clients and whether or not the organization, if they are non-billable via Medicaid, if they can still do that. That one particular aspect of it about not being a Medicaid billable entity, I am not certain of that qualifier. But in terms of where you can get the forms, they're not up on our website yet, but if you were to call the New Hampshire help desk, the provider number, there's actually a, it's 271-6111, or if you were to call actually Trisha LeValley who actually runs that help desk, she also will just send you out the forms. Whether it's fax or mail, I'm not certain but we can get

the forms to you. I'm not certain that it matters whether or not you're really a billable client if you're enrolling the person."

(C): "Let me make a suggestion. Can you leave your phone number for Joni and she can call you back."

(J): "Yeah, I'll try and find that out for you. It's not ever come up."

(C): "Yeah, it hasn't ever come up before."

(R): "[inaudible] and we did some training [inaudible] which is Medicaid billable but our center as a resource center, and we went to the training to support people with DHHS service but that was a [inaudible]."

(J): "Do you have a regular clientele?"

(R): "Yes, we serve, I serve about 30 to 50 people a day."

(J): "Alright, yeah, if you would leave your name and number so I can find out the specific answer. I really don't know it."

(R): "Every public help center in every ten regions, we have a [inaudible] center. So I'll leave you my number."

(J): "Thank you."

(C): "Got a little over five minutes. Any other questions? Okay. Thank you very much for coming. Be sure to check the website. We'll post more Q&A and any further updates. Thank you."

[end of recording]