Interview: MCM November 12, 2013

(Christine Shannon): "Before we get started this morning I have a few opening remarks and then my colleague Lisabritt Solsky, our Deputy Medicaid Director, many of you know Lisabritt, are going to run through some slides from the Department's perspective. So first of all, I want you all to know the schedule for today. There, each of our health plans will be doing their major presentation in this room. It runs for about fifty minutes. As we change plans, we will have ten minute breaks in between. We will be serving some coffee and refreshments later on this morning. I think we're looking at maybe getting something sooner, but at least as it shows you on your schedule we won't let you go home hungry. We have, we will adjourn this meeting at about 12:45. There will be no closing remarks or no re-assemblies, so for those of you who need to leave, please feel free to do so. What I'd like to point out about our break-out sessions in the Capitol Room and the Concord Room is it really is an opportunity for you folks to have some one-on-one time with the health plans to, you know, we're going to walk through the things that are in the quick reference guide and it's going to be rather a quick presentation, but you can go to the breakout rooms and have your questions answered, get more information, in other words get a little bit more details. So we really encourage you to do that. If you are not using the DHH webpage on Medicaid Care Management, I encourage you to go there and check it out. It really is your best source of timely and accurate information and in particular the next few weeks as we get ready to roll out, you should be going there frequently. We will also be sending you email blasts with breaking news but I know that sometimes it doesn't get distributed throughout an organization, so you as individuals go to the website. This webinar will be recorded and we will post it on our website post-training. In addition, the slide decks for the plans will be there as well as the Department and this is where we put the Q&A that comes from the webinar and the onsite presentation. The way we're going to handle questions today, I'm going to ask that all questions for all presentations be held to the end, and there's a very good reason for that. We have 150 sites on the webinar and when you ask a question from the back of the room or even the center of the room, they cannot hear you, and so we're going to hold all questions to the end. I will ask you to stand up and I will repeat the question so that the people on the webinar hear it. We will alternate between those of you onsite and those on the webinar, just as we did in our training sessions, and that is because we're about equally split. There's almost 200 of you here and about 150 folks on the webinar. Any questions that we can't answer today, we will take back to the Department. Same goes for the plans. If you, during one of the plan's presentations, there's a questions they need to get back to you on, we will supply with them their list of questions, ask them to return them to us with their answers. And again, we will post them on the training opportunities section of the webpage. Before we get started, I want to do two things. One is thank all of you for coming. Thank you for taking the time out of your day, for leaving your office. I know many of you are working under business or admin side of things, so thank you for coming. Clearly, this is very important to you. It certainly is to us. And it really feels good to see all of you here. And those who took the time to also do the webinar. I'd also like to thank our partners at the University of New Hampshire. Stacey Gabriel, who is managing the webinar, and she'll compile the webinar questions, Lynn Schrampf, who's at the back of the room. But they've also brought some colleagues with them Kate and Greg and Jean. Whom you met at the registration table, they have been a tremendous help to the department and we couldn't do it without them. I'd like to also introduce some of my colleagues who are here today and who you'll be seeing

through the rest of the day. Along that wall, to my left is, the woman standing is Mary Gay Gershwin, Mary Gay is the account manager for Well-Sense right now, she is also the overall chair management, what is Mary Gay, Bureau Chief. So Mary Gay will be in the breakout room so feel free to say hello if you have any questions for her. The gentleman seated just to the side is Patrick McAllen, Patrick is the account manager for New Hampshire Healthy Families, and finally Laura Ford who is the account manager for Meridian Health Plan. They again will be in the breakout when those plans are having their conversation with you. I also have, a couple of other colleagues who may be here to help me out, Valerie brown, Valerie King and Sue Lundberg wherever you are. Oh there she is. Ok so, Sue is from the Bureau of Adult and Elderly Services. So she's knows a lot of about those services. The two Vals as we refer to them, Val 1 and Val 2, are in ODP. So the presentation that the department is going to do this morning is a brief presentation that is going to get you to the point of watching or, understanding the health plans presentation, some of you, I think all of you, excuse me, received a copy of what we are referring to as the quick reference guide. That's the model for this day, each of us including the department will be addressing issues that are addressed in this document. We had a copy for each attendee today and if you want more copies you can obtain those on the web page, it's under the what's new column now, it's also available in color for those of you who have color printers and would like to see it that way. We are getting some really positive feedback on this and we want to make sure that anybody who needs a copy has access to it. So why are we here today and why did we do the quick reference guide? Just as we said during our training sessions in September and October, we decided to do the quick reference guide and match it with this training session because of the numerous questions we've been getting from providers and we started community forums last year, almost a year and half ago and we heard from you how some of this was confusing, how could you manage it? And what would it be like for some small providers who had only been used to dealing with the department? And you had been submitting claims and sending provider questions to one entity and now you would need to go to perhaps up to four different places. So we worked in collaboration, in partnership with the Health Plans to create this document and one of the thing that's really neat about it online is when you want to go and look up a particular topic and you click on that topic, there's a link that takes you directly to the page so you don't have to scroll through all 27 pages, it's a nice trick I learned a few days ago. And finally, in relation to the quick reference guide, we have noted on there that we have created it to help you, our providers, manage your business processes through the transition too care management. So we are very cautious to make you be aware that this has a date on it of October 31st, things can and do change, and you should always call provider relations and check your provider manual or go through your provider portal on the plan website when you want more details and you want to make sure it's up to date. So I can't emphasize that enough. So our, the department's agenda today, we're going to start with claims submissions. Talk a little about 3rd party liability, prior authorizations, and program start date. Claims submissions, I'm going to walk through these four bullets: Client Enrollment and MCM Participation, Business as usual – submitting claims to the MMIS, whose claims do I submit to Xerox Checking Eligibility and Enrollment Status, how do I do that when a client walks in and has an appointment and Submitting claims to the correct entity. So in terms of client reenrollment all MCM participants have 60 days to make a health plan selection before auto assignment. You'll hear a little bit about some dates related to what we refer to as the bubble, when we began sending out enrollment packets in September but this 60 days applies to all new Medicaid eligible. So if people who've applied

between September 11th and now become Medicaid eligible there's a new set, or number of people that then have 60 days. Mandatory participants have 90 days to switch, and that starts from the first day until planned coverage. So if we are looking at what we refer to as the bubble that group will have the 90 days to switch a plan from December 1st, but again that 90 days will be sort of a rolling number as the program matures. Voluntary clients, this is important, they can opt in or opt out. And many of them have made self-selections. They can also switch plans at any time in the 1st year of the program for any reason at all. Unlike the mandatory clients who just have that 90 day window. So our care management participants have or will enroll with the health plan and health plan coverage begins the 1st day of the 1st month after self-selection or auto assignment. We had a question when we did training about whether or not client enrollment was real time, it is not real time. It is Monday through Friday until 4 pm on each business day. So we created this slide to show you and it's [inaudible] right there it should say [inaudible] to select but this shows you that this client became Medicaid eligible on the 6th day of the month. On the 8th they picked a health plan, their enrollment, their first day excuse me, of health plan coverage would be the 1st day of the next month. So during, when we talk about the days in between here, those are the days that that client is still Medicaid [inaudible] service. And would submit claims for those days to Xerox or MMIS. So again this just repeats what I told you that if a selection is made after 4 pm on that business day, the last day of the month, their coverage won't start until the following month. So we've illustrated that here on the bottom, showing you that this client who made a plan selection on January 31st at 4:05 pm after the 4 pm deadline, their coverage with their health plan starts March 1st. In comparison, however this client made their selection at 3:55 on the same day so their health plan coverage begins on February 1st. Now submitting claims, there are a number of services and situations where providers will still submit claims to our MMIS. And those are for long term services that support static [inaudible] waiver services, services that are provided to individuals who have opted out, that means in the first year they've chosen not to select a plan, also those who are exempt from participation. Dental, all dental claims will be submitted to MMIS. Services provided to the first date of health plan coverage, so again, that person in the calendar that I showed you, who enrolled or selected a health plan early in the month, those dates between the date of selection and 1st day of health plan coverage would be submitted to our MMIS. And any retroactive service coverage, those claims are submitted to MMIS. Now we also got many questions during our training about how you could learn about Client Health Plan enrollment. How do I know what plan my client is enrolled in. Essentially you use the same methods that you use today, you can go online, though the Xerox MMIS Health Plan portal there will be a new field that's filled out that will indicate what health plan the client is in. You can do their electronic 270/271 enrollment transaction. The Automated Voice Response, or AVR, and finally another option is you can contact the Xerox New Hampshire Provider Relations unit, we provided you with a number. It is very important that despite the change to Medicaid care management, that New Hampshire Care Management remains a specific, eligibility is date specific, and you should always check eligibility prior to providing services and as I said that eligibility will, you not only see the client is eligible, will also see that they are involved in a health plan. Checking eligibility enrollment status, I mentioned claims, retrospective claims, we go to the MMIS, retrospective eligibility and health plan enrollment status information will be available, as I said, prospective eligibility or health plan ruling will not be available. We've had many questions from health care providers, well before December 1st I want to find out what health plan my client is enrolled in. That cannot be done in our system. You will be go in the

date the client appears in your office for an appointment or service, and be able to see that on that date they are eligible for Medicaid and enrolled in a particular health plan. If, this is a tip that one of our staff has been using for a long time, if checking on the online portal, take a screenshot to verify that you checked in, in advance of that appointment, that day you knew that client was eligibly, in case you run into any issues later. This is a schematic that one of our staff that's good at doing diagrams, prepared for you to help in a visual way see the things that I've just explained verbally and that is if this person is a health plan member then their medical claims are submitted to one of the three Medicare entities. If they are health plan member and they are receiving long term services or support for, or dental or waiver services, then those claims are submitted to the MMIS, just as they are today no change. This is submitting claims for a non-care management participant. All claims, your medical, your long term care services, your support waiver, they are all submitted to the New Hampshire Medicaid MMIS or Xerox. Now we're going to switch to Lisabritt, who will talk about third party liability, prior auth.

[Speaker Change]

(Lisabritt Solsky): "Thanks, good morning, thank you so much for coming. I apologize that we have such dry material on an early morning after a long weekend, but bear with us. I hope it will be worthwhile and it's funny to see so many familiar faces. I met a lot of you at the provider forums around the state. It's nice to see you. I'm glad you're here. So let's change the channel and talk a little bit about the complexities when you have locations of clients who, in addition to having Medicaid, also have third party insurance policies. We tend to call that CPL. I don't know if that's in your office, but that's what we call it. So, in the event that you have a Medicaid managed care participant who also has a third party payer, that member's MCO will be the de facto secondary payer just the way Medicaid is today. So they will step into the shoes of Medicaid and pay whatever balance, for instance, there may be after payment from the third party insurer. And so that's kind of what the second bullet is getting at, that if that third party payment for the service is less than what the MCO was paid, the MCO will pay the differential to the provider. But this would require the provider be in that health plan's network. Okay? Does that make sense? I see furrowed brows. Let me back up. So we talked a little bit about participating in a network with each of the plans, right, so if you have a third party insurer, you're going to bill them first. Let's say that their payment comes in less than what the member's MCO was paid. The MCO will pay the differential, but you have to be in their network. Okay, so if you've chosen not to be in their network, it's going to be a little trickier to get that differential. Okay? Does that make sense? Okay. Just as Medicaid fee for services does now, we will, the MCO will pay the copay if any on behalf of that member, so if that third party insurance policy requires a member copay, okay, that becomes the responsibility of the MCO. Okay, so as I said, the MCO are stepping in the shoes of the Medicaid program. And the MCO will cover in full any services that the third party coverage does not cover but is included in care management. But again, it requires that you be part of that MCO's network. Okay? That's a lot of digest from one slide. We like pictures. I'm a chart person. So this is a visual perspective of what we discussed in the forum and prior slide. So it's assuming that you have a Medicaid member who's a participant in care management. They're repeating the services covered by their third party payer. The claim will be submitted to that third party payer, and then again, if there's any differential in the medical claim, the MCOs come into play. But if it's something that is either not covered by the third party or perhaps not

included in care management, the claim would revert to Medicaid fee for services in the Xerox system. The same thing I just told you before, just a picture. Okay. Everybody good? I still see some furrowed brows, so I don't want to move on too quickly. Okay. So prior authorizations, sometimes we call them service authorizations. We use them interchangeably, so just understand if we say prior auth. or we say service auth., we're saying the exact same thing. So for the first 90 days after December 1st, the managed care plans will be honoring any state issued prior authorization, okay, so if we authorize a certain number of units of service or if we authorize a particular event, say, you know, a high definition radiological service or something like that, the plan will honor that. During that 90-day period, however, the plans will be doing their own assessment of medical necessity and see if that prior authorization is something that needs to continue beyond the period of the authorization of the state issued. And remember that, you know, the prior authorization issued by the state may not have a 90-day life cycle on its own. It may term at 30 days. So that's why we say up to 90 days, okay. But in any event, if a plan came in and did its own assessment of medical necessity before that 90 day window, that new authorization would replace the one issued by the state, okay. It's really a period of transition that allows for the plans to get, officially get to know who their members are and figure out that the right consolation services are in place or perhaps change the consolation of services that are in place. It could mean that more services are authorized; it could mean that a different level of services are authorized; really anything is possible in that assessment of medical necessity. One thing that we have stressed, though, throughout is that the plans have to use the same definition of medical necessities as the state itself uses. There are some instances where health plans will require prior authorization for services that the state did not initially offer authorization on. So a really classic example is in a home-health arena. These are services that the state has not historically authorized but which the plans will plan to authorize. Anybody who falls into that category as a home-health provider, we are offering a stand-alone training next week on Tuesday the 19th that focuses on how the process that we will use to make sure that you know in advance which of your patients are with what plans so that you can be assured for continuity of care and that you can bill for services on day on in the absence of prior authorization. So mental note, next week there's a stand-alone training for home-health and hospice providers who fall into this category of services that will require an authorization from the health plan but for which the state has not previously issued. So it sort of falls outside of that bucket of honoring up to 90 days because that requirement assumes that there is a service authorization in place and that the state has not done prior authorization. Okay, so prior authorization is beginning to take on a level of complexity if you have member who also has that third party payment, so this slide is an attempt to illustrate how those things come together if you have a service that requires prior authorization and you have a third party payer. So the service will be paid by that third party payer following policies regarding the referral's authorization. So that third party payer has their own policies in regarding to referrals and prior authorizations. If the service will be pain in part by the PPL plan and in part by care management, the health plan for Medicaid, consultation with both of the payers' policies is highly recommended because they are the only ones who can say in a particular situation how those two policies would come together and be applied. Okay? So if you've got a third party payer who's on the hook for part of the service and you've got a Medicaid health plan on the hook for a portion of that service, both who have different policies on whether service authorization is required, please consult with both of them to figure out how best to adhere to their policies. Okay? Okay, so changing gears a little bit just to more on

the logistics and the timeline. So the first day of coverage, as you know, is December 1st and that's for folks who have gone through the open enrollment period, people that we've been calling up during the transition. They will start, well, people who have been auto-assigned will have notifications in hand no later than the 19th informing them of what plan they have been assigned to. Anybody who self-selected a plan should already have that confirmation of the plan that they selected in hand. Okay? The 90-day window to switch health plans will start on December 1st, okay, and that applies to the mandatory participants. And particularly in that first 90 days, there may be some confusion about what MC is covering what services, so again, just in the same way that your custom is to check eligibility on the date that the service is rendered, it pays to confirm that they have not changed their health plan since the last time you spoke to that patient. Okay, so that information is available on the same screen where you already check the eligibility on the basis of service, so just confirm that it's the same plan as the last encounter that you had with that member. If you have somebody who is scheduled for a procedure on December 1st, and let me just remind all of you that is a Sunday, so hopefully there aren't a lot of things that are scheduled for that day, we've had concerns in advance about coverage. Again, there are, the portal is available that day, so just as you would be confirming eligibility, you can determine what plan that member belongs to. But if that, if waiting that long gives you a sense of anxiety, you can certainly contact your patient and ask them, have you picked a plan or have you been notified of what plan you've been assigned to? And again, on the date of service, just confirm that nothing has changed. Okay? Alright, so now we're going to open it up to questions. My understanding is that we're going to alternate between folks who are participating via the web and folks who are here in the room. Stacey, is there a preference as to how we start?"

(S): "Nope, either way is fine."

(L): "Okay, so we are going to ask that folks in the room use the microphone and that is for the benefit of our friends who are participating via the web. Alright, so it looks like we have a question right down here."

(R): "Hi, in checking eligibility online, [inaudible] look around, the patient can change every 30 days. So if I'm online looking at John Smith or Susie Smith and her Medicaid number there is, and you have recently that she picked Meridian, she could have changed that. And how, what I'm asking, how updated is your website going to be catching up with these patients that are going to be switching every single month they want to?"

(L): "Well, let me just say that they can't switch every single month. They can make, mandatory members can switch plans during the first 90 days, so if they made a switch, say, on the 10th of the month, the first day of coverage with their new plan is the first day of the following month. There won't be any switches mid-month because it's a full month of coverage with each plan."

(R): "So if they came in on February 1st, would their new health plan show up on your website, or would you still be showing the old one?"

(L): "Yes, nope, it'll show up."

(R): "It will?"

(L): "Yep, yep."

(R): "Okay, and my other question is, a new Medicaid patient, a patient that is just getting Medicaid right now, they don't have, they haven't even picked."

(L): "Correct."

(R): "Okay, so usually with the new Medicaid, they find out that the window 3-5 weeks to get the patient to get their Medicaid number. Now, they now have to take one of the three, how long is it going to take because technically I can't do anything with that Medicaid number. I have to bill against one of those three which they picked."

(L): "Well, it's important to remember that, and I'm not sure where the feedback is coming from, not sure if it's you or me. Okay, it's important to remember that somebody that's brand new to Medicaid will have a minimum 60 days to pick a plan. So during that 60 days, their care is reimbursed by fee for service, by the state, okay, so it's not that they have to forgo care or postpone care. They can have care as soon as they're determined to be eligible and those services are billed to the state. Then, once they have made a selection of a plan, their first day of coverage with that plan is the first day of the first month after their selection. So that's why 60 days to pick but you could see 75 or perhaps more days during which they're covered by fee for service. Does that answer your question? Okay, good. Alright, so going to the webinar question."

(R): "Alright, so the first question here, we are a fairly small family practice whose panel has been closed to new patients for several years. We will certainly accept the new Medicaid insurance of our current patients but do not have the capacity to accept new to the practice patients. Please have each of the three companies explain how I should handle this."

(L): "That's an excellent question. That's actually something that came up with one of your colleagues this morning. It's important to have that conversation with the plan. So what will ultimately happen, if you are a primary care practice, which it sounds like the questioner has, primary care practice, if you have made yourself available to doing the network for continuity of care of the patients who are already on your panel but you don't have capacity to be auto-assigned new patients, you must inform the plans. Okay? The plans have different policies about what it means to have a closed panel and how that will appear on that directory, okay, but if you don't have capacity to take new patients but you are simply participating to maintain the continuity of care of your current patients, you need to inform the plans of that. We can bring that question up again in the breakout and each of the plans will be doing their own presentation so you can hear more about how they manage closed panels. We've got somebody in the front here, purple blouse."

(R): "Follow-up from the previous person that asked the question about clients switching coverage from one plan to another, we're a DME provider that requires 100% prior approval for providing any kind of service. It is reasonable to assume that we could stop the request of what the status of that individual's

insurance was in one month but because of the documentation required and the ordering of parts for wheelchair or whatever, that it could be the following month or the month after that that we actually have a date of service that we would bill it in. So you know, we're going to be hopping all over the place trying to figure out what insurance does this person really have. So if your system isn't absolutely solid with how you're doing your updates, this is going to be chaos in the broadest sense."

(L): "I think I hear your question. I'm not 100% sure. You're asking if our system will be up to date on a daily basis and the answer is yes, as we said."

(R): "Even if your system is up to date on a daily basis, that would mean, from when the client calls us to when we actually provide and deliver the product, we need to continue to check who they're covered person is and it happens that they go to Northwood, which requires a prior approval before you even begin service. You know, let's say they start with Meridian and they call us up and they need something that's not a safety issue on their chair, new tires. So we verify their insurance when they call but it's the chair, the tires and the documentation that we need in order to provide those tires, we don't get it for 30 days. So now we're up into a new month. Then the tires come in, let's say, at the beginning of the next month, so now we're into month three. Their insurance could have changed three times since we started that transaction."

(L): "Okay, so I think I hear you saying a few different things. First as it applies to Northwood. They're a DME subcontractor with one of the plans, so what I would encourage you to hold your Northwood specific question to when that plan comes and does their presentation because I'm really not going to be able to speak to that from a position of strength. Okay? So taking your other question outside of those specifics, what I hear you saying, and please correct me, is that it's possible that you could have a prior authorization issued by one entity who does not ultimately retain that member at the time that the claim is submitted. Is that what I hear you saying?"

(R): "Yes."

(L): "Okay, in that instance, the contract requires that in the same way that we've said that the MCOs must honor a prior authorization issued by the state, the same is true when somebody flips from one plan to another. So if the service authorization was issued by one plan but on the day of service there was another plan, that needs to be honored. It's not the full 90-day window that we had at the commencement of the program. I believe that it's 30 days, but I would like one of my colleagues to take a note, so that we can confirm that it's 30 days."

(R): "Usually we have a 3 month, usually on a prior auth., how it currently is, if we get an authorization, it's good for 3 months. So we have that, the 3 month to actually deliver the product. Will they honor that?"

(L): "It's not clear to me because it really depends on how that 90 days falls on the calendar with the switch of the plan, so there's not a one size fits all answer there. It's really going to depend on the unique circumstances and the fact of how the calendar plays out between issuance of the PA, issuance of the claim, and the change of plans in between."

(R): "And so if I understand correctly, we would bill their new insurance but the new MCO would honor the prior authorization from the previous?"

(L): "For the first 30 days, I believe it's 30 and we're going to confirm that, after the switch. So that first coverage with the new plan, they would honor a PA issued by the prior plan."

(R): "And then if they don't honor it and we've already ordered the equipment, paid for a new power chair, which is many thousand dollars, and they only honor it for 30 days, we won't get paid? Or would we have to restart the authorization process again?"

(L): "I have a hard time believing you wouldn't be paid, but that second part of the question really needs to be directed to the plans themselves, okay, because you know, it's impossible for me to say. Each plan may look at the situation differently so I would encourage you to ask that very same question with each of the plans, either in one of the breakout sessions or as they do their formal presentations to the big group. But it's an important question and I don't mean to give you short shrift. But I can't really speak for them. I can speak hypothetically. I can tell you what the contract requires, but only the plans themselves can tell you how they would deal with that specific situation. Okay, so we need to take a question from the web."

(R): "What date will the information be available through Xerox for us to check which plans our families have selected?"

(L): "So plan selection information will be available on the 1st of December. Okay, so just in the same way that the current MMIS does not project future eligibility, it does not tell future plan selection. This is something that really only comes up for this period of the bubble as we called it, but again, if you are one of those providers that is giving a service that has not required a service authorization from the state but will require service authorization from the plan, we are working out a process to make sure that we can have the highest degree of confidence in letting you know the plan selection of the people who are receiving services on December 1st. Okay, I've been given the high sign that we are out of time for the state Q&A. I know that we didn't get to somebody here in the back. Do we have-"

(R): "Two things. For those on the webinar, we've compiled all the questions that we haven't had time to get to, and as I said before, we will answer those when we post the webinar and slidedecks post-training. For those of you in the audience, there's two ways you may handle your unanswered questions. As Lisabritt said, many times your questions are going to apply specifically to one of the health plans, so either during their presentation, or if you have more detailed questions, more of those intricacies – what if this happens and then what if that happens – I strongly encourage you to do a breakout session with them. We have 15 minutes for you to really get into detail with them and again, we will, any questions that come from this session that we can't answer even with the plans, they will be compiled and they will be posted post-training. So you have about 5 minutes now to get across the hall, for those of you who are attending a breakout session. I know many of you are here where you have one, two, three or two, three or more of your staff here, and I encourage you to sort of send one person to a breakout, have another person present so that you get all of the information. Meridian health plan

is first. We have Well Sense in the conference room, and New Hampshire Healthy Families in the Capital Room. So we'll take a few minutes for the Well Sense staff to come up here. Thank you."

[end of presentation]

[48:25] (Mohammed Ali): "If I can ask you to kindly take your seats so we can begin the first MCO presentation. So can you hear me in the back? Good morning everyone. Thank you for attending today. I know how challenging it is to take time away from the busy office, and I think this is time well spent. I appreciate your coming out to listen to us. My name is Dr. Mohammed Ali. I'm an intern in training and practice for many years, up until two years ago. And I'm the President and COO of Meridian Health Plan in New Hampshire. We're in Manchester, New Hampshire and I have several of my staff, my senior staff with me today, and I'd like to begin first by introducing them and then doing a very small amount of housekeeping items and then we're going to get started with our presentation. First of all, Mark Simpson, who you'll be hearing from during the presentation, is my Director of Contacting and Mark hails from two parts of the state, Lyme and Ossipee. Mark was with Dartmouth Hitchcock for many years before he came to us. Carol Dunddee worked with Katie Dunn to build New Hampshire Healthy Kids and remained with New Hampshire Healthy Kids for 12 years, and Carol is my Director of Operations and is the one that is constantly keeping me on track with what is the New Hampshire Medicaid benefits. Andrew, Carol comes from Londonderry. Andrew McClure, Andrew is my Director of Quality. Andrew is from Brentwood and Andrew started with Mathew Thornton Health Plan a long time ago and then went on to New Hampshire Hospital Association, in change of hospital quality and then onto and back in New Hampshire with Meridian. I also have not in this room but in either the breakout rooms or outside, I've got Emily Kitchanyen, who is our Fraud and Abuse Coordinator, and Emily is from Derry and if there's any UNH alums in the room, Emily has asked me to give a shout-out for UNH. Lisa Donalyn is my DD coordinator, and Lisa hails from Sandown. Andrew is my Special Needs Coordinator and Andrew hails from Sanbornton. And I guess I'm saying that just so that you have a sense of the team that I have put together. I actually have lived in Nashua for close to three decades, and so this is, this is the New Hampshire team of clinicians and staff who have worked in the field and have interacted with Medicaid, or either the administrative level or directly with patients or clients. And that's the flavor that we bring as you work with us and as we collaborate with you to provide care or to help you provide care to support you in taking care of your members. Now the housekeeping, there were packets for Meridian Health Plans placed on the chairs. I would like to think that everyone has been able to get a packet, but if you have not been able to find a packet, if someone take a few, took a few for their office and there was none on the chair that you sat on, we're going have extra packets either on table in the back or in the breakout session. In your, in your packets you should have a copy of the presentation. You should have a copy of our prior auth. grid. You should have a couple of posters that you could use for your office. They're all on preventative health. And if you should need more posters for your office and just go ahead and contact us and we'll be happy to ship them to you. The other thing you should find is a little piece of paper where you can fill out information and check off whether you need more information from Meridian to either access the portal, to sign up on the portal, or you'd like one of us to call on you. Please fill that out and we'll be collecting those on your way out of the session and we'll be collecting them out on our tables so you can leave them there or in the breakout room. And please plan on attending one of our breakout sessions. We will be going over our portal at those sessions. We'll be going over the website and the portal, and we will be walking you through signing up so that you can get on the portal at those sessions. So I encourage you to attend. And now, here's the moment you've all been waiting for. Here's Mark!"

(Mark): "So I will start by, start by telling you that Dr. Ali and I flipped a coin this morning, so I get to give the presentation and he gets to answer all the vexing questions at the end. I won. Okay, so this morning we're going to walk through the agenda here, give a brief plan overview. We can talk a bit about care coordination, UM, home-care, pharmacy, authorization, claims and payment, network development and then most importantly how to contact us at Meridian. Meridian is a family owned and operated company run by a physician who started the company 16 years ago. Our mission is to continuously improve the quality of care in a low-resource environment, otherwise known as Medicaid. The reason we're in New Hampshire, despite the fact that most of our growth is in the Midwest is he does want to be number one in the country and in order to do that you have to play in New England. That's where the quality providers are; that's where the competition is. I love this graphic. We cover all of New Hampshire, all ten counties. We are URAC accredited and we are going for NCQA accreditation. Our care coordination slide, like most healthcare companies, we are patient centric and we use that approach to achieving the health goals of the patient who's in the center of all of our various groups that are in Meridian and that work to achieve that health. Immunization management, yes, we do prior auths. We do have the prior auth. list, one, in your packet, and two, like everything else, available on the provider portal for you to review. You can reach us for prior auths using fax, phone call or actually on the portal itself. For referral management, we do not require referrals for the patients to go see specialists in the state that are Medicaid, they're signed up for Medicaid through the state. We do obviously the inpatient review, concurrent review. It does say behavioral health here. That's referring to New Hampshire Hospital. Discharge planning, obviously it's important to connect the inpatient care with the discharge care. And then we work with our members for the follow-up appointments. We try to do this, obviously to bring down the readmission rate and make sure the patients are getting the proper care in the proper setting. The home-care services, we do want, if you want to prior auth. that just so we can get the appropriate services to the member in their homes. Referral management is the next piece. So I do know, having been on the provider side, it can take a while to get answers on prior auths. If a referral is submitted to us with complete and accurate information, we can usually render decision on that initial call. Again, we can be accessed via fax, on the web portal, or you can call us directly. Home-care services, this is referenced before. We do require referral and prior authorization. We understand Medicaid does not currently, but we do want to coordinate the care with the patient and that's why we are requesting it. For any weekend and holiday care that's rendered, obviously you can call us the next business day, get in touch with us, let us know what's happening. And we also will accept a hospice certificate as notification. When you're calling in for home-care services, here's some of the information that we'll need. I also want to point out that we do need prior auths for any DME that's over $500 and for home infusion. Meridian also owns its own PBM, Meridian Rx. We do have the formulary online. It's currently New Hampshire Medicaid. We ask for prior auths for specialty drugs and biologicals. And again, like the rest of Meridian, you can access us by phone call, the portal or a fax. We're available 24/7 and we currently have over 60,000 pharmacies contracted around the country. Authorizations, those forms can be found online also, along with our prior auth. request, which is the document on the far right. Okay, so as the members come aboard, these are the three MCOs that will issued a card. This is what the Meridian card looks like. Under member ID, the patient's member ID will be their Medicaid number. We do not assign a different number to them. Also listed obviously are the ways to get in touch with Meridian, and the back of the card is blank. All the information you need is on the front. Okay, so

for the primary care providers, we do have a quality bonus program, which we believe that trying to get the members into seeing the PCPs to get the care needed. Some of those include the physician does a diabetic panel for the member, they get an additional $200 for that, and that's above and beyond what we, regular Medicaid reimbursement. We also have well-child visits before 15 months, if they complete the six visits, it's worth an additional $100. And prenatal and postpartum visits, an additional $300. There is no minimum number of patients, so it's patient one, service one. For the specialist, as I mentioned before, we do not require referrals to see specialists. If possible for providers, when we're working with them to reduce readmissions. And our ancillary providers, actually, valued part of the team, we like to use them to keep the patient in their appropriate setting, so whether question before, what sort of wheelchair is most effective for that member. Alright, the fun stuff, how to submit claims. So in the breakout sessions, we'll be doing a walkthrough on our provider portal. You can actually submit claims on the portal. This is a partial screen shot of what we have. The bold colored squares are the required information for submission. You can also submit match claims on a FTC site. And if you're interested in doing that, see me at one of the breakout sessions and we can have our IT folks speak with yours. We also take snail mail, and I'm assuming the larger part of the crowd might be submitting through clearinghouses. We work with most major clearinghouses. We also work with a bunch of the smaller ones I've never heard of, and use the larger ones. If you have specific questions, we have information on the website, probably get you information on any of those. A couple highlights on this page, for clean claims that are submitted electronically, we obtain in 2-5 days. We have a check run every Monday. And then we also will reimbursed PCPs for well and sick child visits on the same date, for the same, during the same visit. The other piece I want to point out, this is a hallmark for Meridian is the bottom, the bottom thing there. It says, number of calls answered within 30 seconds, 99.9% of them. That's pretty good. That's actually, I like putting that up there. They're available from 8:00 to 8:00. This to me seems redundant, quality network development. Of course it's quality network. We're in the state of New Hampshire. So we have provider reps that will go out and visit in their territory with each PCP's office once a month, answer questions, ask if there is additional training needed, problems. Those reps are also available for any of the other specialties or groups in the, in their service area, for any additional trainings, any questions, how to use the portal, and they're happy to go out to meet with you individually or as a group. Some extra provider benefits, on our website, we do have the provider manual, member manuals, directories, FAQs, all that's available online. And you will have the ability to register people to get on the secure website. On the secure website, you have the ability to verify eligibility, and the site provides historical claims. You'll be able to see how many service counts towards the limit has occurred. And that's all available for your members that are signed up. You can also enter authorizations and print reports on your assigned members, review claims, if a claim has been pended for additional information you can actually upload and attach it to a claim on the website and hit 'resubmit' and print that. You have access to all of our other departments and live chat. You'll have somebody online in 30 seconds in asking a question, and hopefully we can answer that immediately. Also online, because we're so web-based, you have the ability to go and sign up for a webX training, and we have a whole list of dates, times available. We'll walk you through what we have, the functionality of various screens on the web. And we also have the ability to send one of the provider reps out to your office if you want to do a lunch time or first thing in the morning run-through the web for your staff. On the website also, this is kind of a neat function, for PCPs, we have the ability to help them achieve their

quality services, so you can get online and actually order postcards for [inaudible], cervical cancer, immunizations for your members that need those. We, Meridian, print the postcard, we mail it and it has your return address on there because obviously the members are more likely to respond to a provider than they are an insurance company. And we can help get those patients in for those services that are needed and get the PCPs and quality presented. And there's also the ability to ask for other training in some other areas located here and most importantly are the numbers on the last page on how you can reach us. Give us a phone call. You can, the website demonstration. You can actually ask questions online, that sort of thing, so there's a few other ways you can get in touch with Meridian. So I've done the easy part. I know there's a lot of questions, so why don't I open it up to questions."

(R): "This is about pharmacy prior auth. In the transition period, they're saying that we have 90 days, I think, you'll keep that prior auth. on file. How long are prior auth. for pharmacy good with your plan? Typically it could be like a year with Medicaid and so now am I going to be like prior authing pharmacy benefits constantly as patients switch plans?"

(P): "By and large, by and large, the goal really is definitely the first 90 days in and even beyond, since we have the same benefits as the state service Medicaid programs, we're trying to mimic that as much as possible. Pharmacy may be a little bit different, however, because I would bet that it's not every single drug that's requested, from the state pharmacies are required to prior auth., that one can get a 12 month approval on. I think of narcotics, for instance, and an oxy script may require a prior auth. every month, and that would be what the state would require now. I would say that certainly you shouldn't expect to see any change. We're required to follow the same Medicaid, the New Hampshire Medicaid preferred drug list and we try, we try to mimic everything the way the state's been doing it, and certainly what you'll notice in addition to that, because we have our own Meridian Rx, which is our pharmacy benefits manager, we're able to know within a half a second whether or not that prescription [inaudible] in the pharmacy and our staff are available 24/7 so that when the pharmacy calls they're calling us, we're aware where the request is, we can do the override instantly. So what you should find is not only are we implementing the same Medicaid drug benefits but the service level with which that is being implemented is much higher. Did that answer the question?"

(R): "Not really. So I need to know if the prior auth. is going to move, or so if my patient goes from Meridian to New Hampshire Healthy Families, you give me a prior auth. but then they have a new plan, am I just going to have 30 days or do I have to do the same pharmacy prior auth. [inaudible] drives are huge for kids that need prior auth. because they're not on the preferred and they have the couple and so we're constantly prior authing that particular medication."

(P): "I think that, if you're moving, if your patient is moving from one plan to another and it's outside of the 90-day period, and it's not a drug that's on the New Hampshire preferred drug list, it would probably have to follow the rules for the prior auth. for each of the plans and we'll have the same time frame. So it's currently, with Meridian, if you get a drug that the state approves for one year, when we get that request, we'll approve it for the same time period. But if your patient switches to another plan, then it's up to the other plan to weigh in on whether or not they'll honor that prior auth. from Meridian for more than 30 days. Because, as we heard from Lisabritt, we're going to honor each other's prior auth. for the 30-day period, but I can't guarantee what they're going to do beyond that."

(P): "We're going to move over to a webinar question now. We're going to switch every other question. We'll be in-person and then webinar. And the first webinar question is, currently MMIS does not require behavioral health authorizations for Medicare clients who have Medicaid as a secondary. Will Meridian require authorization for Medicare/Medicaid behavioral health clients non-facility?"

(P): "Do you have that individual's contact information, so in addition to my answer I would add that that individual feel free that they could contact us for a more detailed and accurate response. It appears that there are some nuances in there that I could get the question wrong and respond incorrectly. However, based on what I'm hearing, if your ME give me a, if the requestor is asking with respect to Medicaid function as a secondary payer as a instance and if they're asking that we are covering a gap that Medicare has already approved and there's an existing gap for payment, and that's a different question, then if it is that the Medicare payment is less than the Medicaid and we are assuming the primary responsibility, and then our auth. rules would apply. So I think that it is a complex question that we're happy to answer, but we need a little bit more detail and this is probably not the best forum. But I don't want to have that person not answered, so if you would have them contact us so that they could go to www.mhplan.com and click on 'contact us', it'll, and then click on 'email' and it'll create an email they can copy and paste message in there with their contact information. We'd be happy to respond."

(R): "Can you tell me what your timely plan is for claim submission? How long do we have to get a claim to you?"

(P): "I'm assuming this is a provider?"

(R): "Right."

(P): "We ask for as quickly as you can get it to us, so the contract will read 90 days. We'd like to have it before that simply because we want to know that something's happened with a member. That's how we coordinate the care. I believe the state rules have up to 365 days. I don't think anybody wants to wait that long to get paid."

(P): "So the answer is actually in the booklet for regional plan."

(R): "The question from the webinar, if we are an outpatient community-based pediatric therapy company that sometimes provides services in the home, is this considered home-care services, and will it require a prior authorization?"

(P): "So I know that for many in-home services, home-care, home-visiting, the state currently does require prior auth., and for us, our only opportunity to be able to coordinate that member's needs around everything that's going on is if we're aware that the service is being rendered. The mechanism that insurance companies have usually of getting information early enough that they can have their care coordination teams intervene as they prior auth profit, and so there are instances in which Meridian uses prior auth. process as a mechanism by which we can hear from you that you're providing services so that we can coordinate with you around other care coordination needs that are present. So for that reason, one of the changes with Meridian would be that you find that we need some form of notification in places where the state didn't issue a prior auth. before. I'll give you an example of hospice care instance. We won't ask you to give us a prior authorization for hospice, but because we need to know so we can be sure that the member, you know, or programs are not going to be calling the member up, for instance, and offering them disease management or healthcare assessment, etc., we'll

ask this provider to submit to us the service kit that they would normally submit to the state and we'll accept that in lieu of this prior auth. notification process. So the answer is, yes, we'll ask for a prior auth. if there's a submission referral. We ask you to let us know so that we can coordinate among the patient's caregivers to be sure that everyone is aware of what's going on in the care of that member."

(R): "I have a couple questions about hospice. Are you talking about the notice of election? Is that what you're looking for, for a prior auth.?"

(P): "That, that document is, that we'll accept that as the prior auth. documentation."

(R): "And the other question I have is in claims processing. I know there are, that hospice places can have T codes, F codes, Q codes. Are you going to show what you are going to report on your plan?"

(P): "Yes, and you can feel free to speak with us in more detail if that's not answered. We are trying to keep things as seamless as possible so whatever codes you were using before, submitting to the state, that's what we're asking you to continue to submit. And there are specific T codes, I believe, that the state let us know about. That information we'll be able to share with you if you want to know the actual detailed code after this session's over."

(R): "Okay, webinar question, our office is located in Maine but we are linked to New Hampshire hospitals. Many of our patients have Medicaid. Will there be anything different for our practice?"

(P): "No, we're contracting Massachusetts, Maine, Vermont."

(P): "And New Hampshire."

(P): "Oh, I'm missing New Hampshire."

(R): "Keeping with the authorization questions, what about the community mental health centers? [inaudible] prior authorizations we do not now?"

(P): "With the community mental health centers, we're currently working with CMHC in terms of detailing the processes by which we will share information with each other, the services being rendered. Because the process to date has been one of where a member's individual plan is determined and then put in to place and then looked back at retrospectively every quarter, it would be difficult to get into that with issue with requiring prior authorization because the prior authorization is really saying you have to ask before the plan is designed which services you intend to render. And for your patient, they're in the middle of a care plan. For that reason, we are, until we have been able to work with CMHC to find an alternate method, we are continuing to keep the fees for service program, the CMHCs as it is now, or method of managing the whole person if both the social needs, both the social needs and the mental need and the physical need, and so our staff are all integrated in the same place to address those needs. And so we will be asking or doing retrospective reviews like the state does now to audit the, the HE ends were met. However, for the, I think the first 90 days and maybe 90 days after that, we are continuing the same state because there's programs with the CMHCs that exist now."

(R): "Okay, webinar question, can you please clarify that Meridian will be using the client's Medicaid ID number as their subscriber number?"

(P): "Yes."

(P): "I promised I'd give him the easy, one-word answer."

(R): "Thank you. This is a question for a special education school, residential school. We have a submission as a staff. If we have a New Hampshire resident who , all her life, New Hampshire Medicaid who selected Meridian, home would be Berlin, New Hampshire; residential school, Green Field, New Hampshire. The student does not transport well. How would this student be able to see our residential physician? Is your prior authorization through the PCP? The child previously did not have a PCP. Typically PCPs will not provide authorization to another physician unless they've been seen by the PCP."

(P): "So just to make sure we're on the same terminology, in Meridian speak, authorizations are only provided by Meridian. Referrals may be provided by a PCP."

(R): "My mistake."

(P): "No worries, just want to be sure we're on the same page. And Meridian does not require a referral from a PCP in order for any of our members to see a New Hampshire Medicaid provider who might be a specialist. So the member wouldn't –"

(R): "Even a pediatrician?"

(P): "So the pediatrician could be the PCP or the specialist. Well, the pediatrician would, if the member is seeing a pediatrician, then more than likely, the member or caregivers would be inclined to choose the pediatrician as the PCP. They don't have to, but from the role of a PCP, then that may be the most logical the individual could take that responsibility."

(R): "But pediatricians enrolled with Meridian would be a pediatrician, not a PCP. Our understanding is the PCP has to be open to everybody. They would not have standard office hours because they are involved with the school only. Would that be a problem?"

(P): "I think that I'd like to have a little bit more detailed conversation with you because it appears that maybe some of the limitations you might be facing don't apply to Meridian. The PCP may be a physician who is assuming the responsibility as the primary care provider, and oftentimes in adults, that tends to be a family doc or an internal medicine doc, although it could be certain other specialties. And in kids it tends to be a family doc or a pediatrician who, who takes the role of the PCP. The credentialing on the physician is under their specialty and training, not under a role of PCP. So I'd like Mark to have a conversation with you a little bit more to be sure that we're helping you with understanding how Meridian works. Remember that Meridian was, 16 years ago, created by and still owned by Dr. David Cotton who is a gynecologist and an obstetrician and whose goal in the past 16 years has been to improve patient quality without, and by reducing barriers that get in the way of practicing clinicians under patients. So I would like to be sure that we're on the same understanding, I let Mark go over that with you."

(R): "Thank you so very much."

(R): "So webinar question, can you please clarify if providers can submit an 837 file directly through the provider portal?"

(P): "So I have plead ignorance about an 837 file. Is there anyone?"

(P): "A claim."

(P): "A claim file, oh yes. So a provider can directly on the portal submit a claim. They can do it one claim at a time, and so if they don't have a clearinghouse and they don't have an EDI, they can do that. If providers would like to submit a batch of claims to us, then we can arrange for that, too. That doesn't go in the same way through the portal as an individual claim goes. We would have our ITs work with provider office's IT to arrange for the [inaudible] transfers that need to occur."

(R): "I have a questions on [inaudible] for New Hampshire, and I have the sense that the five business day advance notice is required to schedule discharge transportation, which requires the prior auth. A great majority of our transports that we do daily are possible discharges to either rehab hospitals, nursing homes or even our patient's private residence. Who would be responsible for paying the prior auth. and are we held to that which would be for possible discharges?"

(P): "So I'm going to ask Carol if she can grab the mic and respond to that one."

(C): "For prior auth. for transportation, but members are required to call ahead when scheduling so that somebody can schedule the ride. As far as the discharge from the hospital, I think we'll have to get back to you for that answer because that's a really good question."

[inaudible]

(C): "So I think that's a great question because we have to, we certainly wouldn't require the members to schedule that, so we'll have to get a more detailed answer for you on that."

(R): "Hi. When you ask follow-up questions, would you please use the microphone? We cannot hear you at all here and then the people on the webinar can't hear you either. Thank you."

(R): "Okay, next webinar question, from a provider, does our Medicaid NH contract cover the Meridian plan?"

(P): "Would you repeat the question please?"

(R): "Does our Medicaid NH contract cover the Meridian plan?"

(P): "Meridian Health Plan in New Hampshire is contracting with New Hampshire Medicaid providers. I'm trying to understand exactly the question."

(R): "I'll ask them for more follow-up. Thank you."

(R): "I am a provider, and we have to identify different expenditures, right foot, left foot. My frustration over the years is Medicaid has never allowed us to use modifiers. Will Meridian use modifiers, for instance, right and left. We could be doing procedures on both heels for diabetic ulcers, for example, and if we submit just to regular managed Medicaid it comes out by itself with the code without the modifier, and we put two numbers, they'll deny the second saying it's a duplicate because they won't

accept right and left. And so also another modifier would be sometimes we perform services that are not covered Medicaid, routine foot care for example, but Medicaid does. We're required by other companies to use a GY modifier, which states the first one says no coverage but the second one could or at least will look at it. Will Meridian accept modifiers?"

(P): "So Carol, if you would contact Nancy with respect to this issue on modifiers and modifiers in general including left and right. We'll make every effort to give you the answer before the break time. I will tell you, though, that there are modifiers that we allow that aren't usually allowed. So for instance, if someone is doing a well-visit and a sick-visit in the same day and so using a modifier, to clarify what I think a modifier is, we'll pay for both because we recognize that our members are, you know, you get them in your office, it's an opportunity that we want you to maximize and provide as much care as you can at that time. So I would like to think that, following that logic, we would. I just need to confirm with our claims director to be sure that our system will allow those specific instances that you asked for."

(R): "Webinar question. This may be a question more for DHHS. Will the primary care provider be provided in the 270/271 eligibility transaction? If not, can it be added?"

(P): "It is a DHHS question and, Nancy?"

(N): "My understanding is it does not provide primary care provider. [inaudible] My big moment at the mic. Currently, our 270/271 eligibility transactions do not include any primary care physicians. I'm not sure if this is [inaudible] We will be returning the name of the care company and I believe the phone number but currently not the PCP. Thanks."

(R): "My question is, do you, because of the final being 90 days, are you going to be doing a pay [inaudible] for instance, an auto accident that's taking forever for auto insurance to pay, we would bill you and you would go after the auto insurance?"

(P): "Carol. This is PDL and I know Emily is outside. So maybe if we could come back to that question and Emily can respond directly. Thank you."

(R): "Webinar question, for mental health counseling, will Meridian authorize 24/7 initially as NH Medicaid does?"

(P): "I'll go back to my standard answer. Yes."

(R): "Hi. I attended the New Hampshire Hospital Association meeting for case managers, and correct me if I'm wrong, but during that session, there was discussion and I think it was Meridian, but discussion about the penalty for readmission rate, readmissions within 15 days. Could you explain all that, how that would play out for readmission and what that does for a hospital?"

(P): "I don't think that was Meridian."

(R): "Okay, webinar question, we are a community mental health center and many of our staff see clients in their homes or in the schools for individual or family therapy. Is this considered home-care and will we need prior authorization? This is related to the call earlier asking about home-care services and prior authorizations."

(P): "Did that questions start stating they are in DMHC?"

(R): "Yes, community mental health center."

(P): "So again, our arrangement with the community mental health centers is that they would provide the services required for our members' individual plan as they're doing now. We know that they're doing that, following the administrator rules and we would be auditing the degree to which those rules are met after the services is rendered, so we wouldn't be requiring them if it is a course that they've established plan to be picking out pieces for prior auth. at this time if it's coming under their plan, under that member's plan."

(R): "Hi. I have a quick question. Can you please clarify the timely filing limit because the book says one year, but I'm hearing 90 days."

(P): "It is up to a year. We do ask that you submit the claims as quickly as possible, so we do, if we can in 10 days I'd be really happy because then we could move forward. If the member's receiving care somewhere else, we would know about it. In our contracts, we do ask for 90 days, but we do realize that do have the ability to submit up to a year. We prefer not."

(R): "Okay, I have one other question. Will you at any point be accepting the 270/271 treat eligibility transactions directly so that we are not going through the Medicaid site for that?"

(P): "So you're talking like eligibility verification?"

(R): "Yes in that."

(P): "And I have, I have to get back to you on outside of your verifying on the state website or on our portal, whether or not you'll be submitting electronic verification that you provide, that you receive from the state. Again, this is our member. I would think logically, that might be a yes answer, but I just want to be sure that I'm correct. So don't quote me to saying that's a yes, but it seems like that might be."

(R): Okay, we have time for one more webinar question. And then when that question is answered, we have a ten minute break. Refreshments will be served outside the door. We will resume again at 10:55 with Wilson Health Plan in this room and I encourage all of you, as I've said before, to attend to breakout sessions that Meridian will be holding after they're done here. Okay, last webinar question."

(R): "Will Meridian be paying according to their own established fee schedule or paying based on the current NH Medicaid fee schedule."

(P): "I'll take that one. It's an easy one. On the current Medicaid schedule."

[end of Meridian Presentation]

[1:52:20] (L): "Good morning. I'm going to go ahead and get started. I know there are folks out in the hallway that are still gathering. I am Laura Picket [inaudible]. I am the regional manager with Well Sense Health Plan for provider relations. We also have our business partner Beacon Health Strategies are also here with us for behavioral health. Our director of provider relations, Gail Evans is with us, and our provider relations consultant, Diane Woodward is also with us. So I'm going to go ahead and get started and try and keep us somewhat on track today. So we're going to talk about Well Sense and working with Well Sense. So about Well Sense Health Plan, who is Well Sense Health Plan? Well Sense Health Plan is owned by Boston Medical Center. Boston Medical Center is the largest hospital in the Massachusetts market. They, what I like to say is they are our parent and they gave birth to Boston Medical Center HealthNet Plan in 1997, and they gave birth to us, Well Sense Health Plan, in 2012. In the New Hampshire market we are known as Well Sense Health Plan. We also have strategic business partners that we have been working with, that many of you have been in touch with as well, Harvard Pilgrim Health Care. Harvard Pilgrim Health Care is our partner for our contract. They are also managing our credentialing and demographic changes that you have. So your contracts are with Harvard Pilgrim. Your demographic changes go through Harvard Pilgrim. And after the finance contract with Harvard Pilgrim, everything comes to Well Sense Health Plan, so we'll manage the medical benefits, the care managements, member services, provider services, provider relations, anything else comes to us. So what does Well Sense Health Plan bring to the market? We have a core-integrated team approach working with the members and providers in assuring that each is aware of their coordination of care in an effort to improve the healthcare. We put the member in the middle and make sure the member has many touch points from their primary care physician, their clinician, inpatient, outpatient services that they need, behavioral health services. The member is the most important part. Working with Well Sense and our members, we do have a member outreach. Once we have received the enrollment and we understand that the member is enrolled with us, we will be making outreach calls to the members within the first 30 days. We will verify the members' primary care physician. We'll verify, we'll remind them that they have signed up with us. We'll do a health risk assessment form and through that we'll identify any of the members' needs, make sure that if needed we'll get the member turned over to the proper care management area, if needed. And the member services are of course trained to identify urgent needs if there are urgent needs that arise. Member eligibility, I think you heard first thing this morning through DHHS and through probably Meridian as well, your first contact should be through the MMIS system as you do today to identify whether the member is eligible for Medicaid, and it will also identify which of the three health plans the member could be on. If they are with Well Sense, you have the option to go in through the secure portal if you completed your provider web login form. You can go in through the secure portal. You can call the member services, or provider services line, which is also the member services line, at 857-957-1300. Or you can do it through your eligibility files 270 and 271. So a couple different options that you have. There is a snap shot of what our member eligibility portal will look like. You can verify eligibility through date of birth, name, and I think there's also an option to do it through your Medicaid number as well. This is what our member ID card will look like. On our member ID card, it will have an NH number which is our Well Sense number for that particular member. That is the number that we would want you to bill with. The card also displays their Medicaid number, so that will help you as well. Members should present those two cards. They should have one card which is their

DHHS eligibility card, as well as they, members should have one of the three MPO cards. For us, ours will have this information on it. There's also information on the back of the card, key information that the member can use, our member services number, our behavioral health number, other key information that the member can have including our Coordinated Transportation Solutions, which is our non-emergency transportation vendor. Prior authorization, prior authorizations are required for outpatient medical and surgical services, home-health services, inpatient admission. They are not required, or notification is required, I should say, for emergency services, observation services, and urgent care services. In your packets, there should be a prior authorization matrix. That prior authorization matrix is also available online. We can provide that for you to identify which services do require prior authorization. Specialists do not require a referral. And authorizations can be sent in via fax, phone or online, and our online capabilities will be up in January and we'll be back out to meet with all of you, talk about our online capabilities once that is up and we'll be communicating with you on that. Claims and provider appeals, our standard claims processing is to submit within 90 calendar days from the date of service. Coordination of benefits and third-party liability do apply. And for appeals, our standard is that appeals should be filed within 90 calendar days from the original date of service, 180 days from the date of services, so a total of 180 days from the date of service. Who are our partners? I've already talked about Harvard Pilgrim Health Care. We also use Envision Rx as our partner for our pharmacy. If you have a pharmacy within your facilities, you want to make sure that you've gone out to EnvisionRx.com, signed up and make sure that you are working with them so your claims can get paid. We do have our formulary, is available currently online and it will also identify if there is a prior auth. needed. It is currently in a PDF format. It will be an interactive format shortly, at the end of the month, when our webpage changes and gets updates with our portal. That will also change at that time. The formulary will not change, but you will be able to have an interactive approach to it. Coordinated Transportation Solutions, as I'm sure you've heard from the others, we do want to work with members and ensure they get to their appointments. We have contracted and partnered with Coordinated Transportation Solutions, or CTS. They are a vendor based out of Connecticut. They have been around since 1997 working primarily with the Medicaid population. They are also in Maine and they've been in New Hampshire for almost a year working with us. They have contracted with a number of different volunteer vendors with friends and family in the communities that do have public transportation or taxis. They have contracted with them as well. In, and they have contracted with ambulance companies that have non-emergent transportation or assistance. So the member can call and request for services. You can also call with the member with you and have, there can be a three-way call if needed and coordinate that transfer. Once the member has contacted Coordinated Transportation Solutions and has set up the appointment, CTS will call the member prior to service, remind them that they have a medical appoint. Then they'll follow up after the appointment with the driver to ensure that services have taken place, and then forms can be sent in. Beacon Health Services is also our behavioral health partner. If you haven't contact Beacon Health, we do have them here with us today happy to answer questions. They will be managing all of our behavior health services. They will manage you contracting, your claims and credentialing will go through Beacon Health Services for behavioral health services. Northwood is our DME, prosthetic and orthotic provider. They are the management company. They have contracted with over 100 DME vendors in the state of New Hampshire and nationwide for services. When you are just charging a member with a prescription, that member can take that prescription to the local DME

provider and that provider will contact Northwood to get that prior authorization. Okay? Med Solutions is our out-patient radiology center for high-end radiology. So similar in your commercial world, we also require authorization for our high-end radiology for CT tests, MRIs, MRAs, all of those services. There's a number of options you can go through to get the prior authorizations, either phone, fax or their website. VSP is our vision source provider. Members are entitled to one pair of frames and lenses on an annual basis if their prescription changes, biannually if their prescription does not change. We do no cover contact lenses if not medically necessary. So what resources do we have for you? We have our website and currently on our websites, we have lots of different options for, our provider manual is available online. That can be downloaded easily. Then there's a point and click option so if you're looking for a specific section or topic, you just click on it and it brings you right to that topic. The provider directory is also available online. Once we have our web login completed, you can sign up to get your web login if you haven't done so, or I think there's also forms in your packets if you'd like to submit those. Once you have gotten your secure password, you can go and check claims eligibility or claim status, member eligibility, remittance history. So if you're reporting for someone through your offices, specific reports you can, are interested in, you can pull those reports down. Our quick reference guide, which is already in your packets, will be posted online. The members' benefits are already available online. You can go out and click in the members section and pull up the member handbook, and you can see what the members' benefits are. News and updates, we have just sent out this week our first newsletter. That will be posted on our website shortly. And then of course, our website is wellsense.org. Training opportunities, if you haven't had the opportunity, Diane and I have been out across the state since the end of September doing multiple orientations. We'll finish those up this week for the larger forums, and then we're also doing individual sessions so we're going to have to come out and visit you, I've hired two new provider relations consultants who will be starting next week. So we'll have much of our coverage get out and visit your offices, who can come back out anytime. You can request materials from us. Our general plan policies, our payment policies, medical policies will be available online. We're also available online to provide those for you and we'll be doing re-education, as I mentioned. This isn't the first or last time that you'll see us. We're here to help you and support you. And lastly, we do have our community outreach team. They're Daniel and Katelyn, are actually here in the back of the room. They've been at our table. Our community outreach team works with you as the providers with school systems, the Y's, anything that's health related. We can work with you to sponsor and team up one people with you so if you have questions about what we can do in the community, you can definitely contact Katelyn and Daniel, can help you out with some of those questions. And at this point, I am going to open it up to questions. And I think we'll do the same as we've done, one in the room and then one of them on the computer. So, you want to start over here?"

(P): "Hi. We were wondering, we're concerned about the 90 day about claim filing, usually a company that is covered in 90 days, especially with all the eligibility issues and the fact that Well Sense is the only one with a specific ID number for the company. Are you going to be giving any consideration to that, for providers?"

(L): "So we're certainly going to work with providers. We're not here to put you out of business. We are going to hold, this is what the contract said. So this is our standard, but we are going to work with you."

(P): "I have one more question. We do all our eligibility electronically through 270s and so we're debating how to set that up because we need to use the Medicaid number to check the eligibility, and then how would you suggest we register our patients to make sure we have the Well Sense ID number on our claim?"

(L): "So in your packets, there's a one-page piece of information that says EDI on the top of it. At the very bottom of that piece is our EDI Department and what I would recommend is that you need to contact our EDI Department with any of those types of questions. And Sam and his team can help you do testing and whatever information that you have regarding EDI. Sam's our, one of our great resources. He's at our corporate offices and can help you with that."

(P): "Okay, webinar question: if we are an out-patient community-based pediatric therapy company that sometimes provides services in-home, is this considered home care services and will it require a prior authorization for Well Sense?"

(L): "So out-patient services do, home services do require prior authorization. So one of the things that I didn't mention, although Lisabritt did mention it in the earlier session was the 90 days, so if it's a service that does require prior authorization today, we will be carrying that forward for 90 days. So you should be set if your preexisting prior authorization. Question in the room?"

(P): "And if you could repeat the question just to make sure we can hear it through the webinar people, that would be great."

(L): "Sure."

(P): "Hi, I am a DME provider and we have a very, very large incontinence supply client base. Currently, with New Hampshire, with Medicaid, we have to purchase incontinent supplies from one provider, and I'd like to know how that's going to be handled through Well Sense."

(L): "So through, the question was, incontinent supplies with the DME vendor and do you need to go through one particular vendor and the answer to that is no. Again, if you check our provider directory, there are a number of different DME vendors and incontinent supply vendors on that list and you can check in with them. So we don't require you go through one specific incontinent supplier."

(P): "There is currently a maximum time frame of 12 week intervals that MMIS will cover for prior authorization requests. Will this stay the same for Well Sense or will there be a new maximum time frame that prior authorization requests will cover?"

(L): "Prior authorizations will be dependent on what is submitted to us for specific services. There are limits on certain services, specifically around your outpatient functional therapy services. There are limits on those. But again, it depends on what is sent in to the prior authorization department and what will be submitted back to you. We have questions up here in the front. There's one over here and then-"

(P): "My question is, are we going to get a list of who has picked up the primary care physician?"

(L): "So the question is, will you get a list of has chosen you if you're a primary care physician? We are working to gather that information in advance. As you know, open enrollment closed today and we'll

start to do auto-assignments. I can work with you offline and see what I can do to provide you something prior to that. We are working to get that up though."

(P): "Transportation question for Well Sense are ambulance providers required to be enrolled in your network or CPS to be reimbursed? What about emergency transport?"

(L): "So the question is about ambulance providers and whether they need to be participating for emergent and non-emergent services. For emergent services, they should have signed a contract already if they're working with New Hampshire Public Healthcare. If not, they need to contact us and we can work with them. For emergent services, for non-emergent services, yes, they do need to be signed up with Coordinated Transportation Solutions, and again, if they have not done that already they can contact us and we'll get them signed up. NHProviderInfo@Wellsense.org, NHProviderInfo@Wellsense.org is our email address. That email is answered daily so if you do have questions, we can certainly get that out. Folks at the back with the microphone, we did have a question up here with this gentleman, I'm sorry."

(P): "Hi. My question is about modifiers and first company and we are an ankle provider so we do both feet often times, procedures on both feet, correct Medicaid will not accept modifiers and they deny the second as a duplicate. Will Well Sense allow right and left, which every other insurance in the world allows modifiers, the second time question."

(L): "So the question is, will Well Sense accept modifiers, specifically on the right and left? The answer is yes, we do accept modifiers."

(P): "And follow-up, we also as providers, we do services sometimes not covered by Medicare, like routine foot care, and we're required to use the GY modifier to send to other carriers. Say, Medicaid didn't but you might. Will you accept GY or do they have to go through with the paper process so they can get a denial and so forth?"

(L): "So similar to what you do today for third party liability, the MCO as a pair is a last resort so you do need to get the denial on the primary and then submit to us as the secondary."

(P): "Can you please clarify if providers can submit an 837 file directly through your provider portal?"

(L): "The question is, can a provider submit directly through Well Sense Health Plan? The answer is yes, if they go through, again, they need to contact our EDI Department. On our website, you can also get information about our EDI Department. If you call the 800-957-1300 number, you also, our provider service center, they can connect you with our EDI Department as well."

(P): "Hi. On the specialty pharmacy side of your plan, will you both be honoring prior authorizations when the patient is placed on your plans if the provider does not have a contract with you, but will you do that for 30, 60, or 90 days to ensure their consistency of care and assist in the transition of their care?"

(L): "The question is around specialty pharmacies and if a member is currently on service, will we honor that prior authorization, and the answer is no. We will honor all prior authorization, existing prior authorizations for up to 90 days."

(P): "Are prior authorizations by unit or by visits?"

(L): "Are prior authorizations by unit or by visits, and it depends on the type of service. There's questions everywhere."

(P): "I have a question regarding emergency transportation from home to a hospital, ER, all covered correct?"

(L): "All services, all things that come through Well Sense Health Plan, not through their contract with New Hampshire Program all of the claims come to Well Sense Health Plan with the exception of behavioral health services."

(P): "Okay, which takes me to question, which is, if the, if the patient went into the emergency room and were later called back to take meds or medication in a patient psychiatric hospital, so psychiatric emergency, would that be going through CTS or through Beacon?"

(L): "I'm going to ask, I'm going to ask my partners Jen and Margie to come up and help me on that one. They're the in-house providers and I don't want to mislead you."

(P): "And could you repeat the question for the folks on the webinar please?"

(P): "If we transport a patient by ambulance, if they are called to a ER or hospital in general to transport a patient, a psychiatric patient to psychiatric hospital, would that particular non-emergent transport be billed to CTS or to Beacon?"

(R): "It would be billed to the ambulance company. It goes through Well Sense, if that makes any sense whatsoever. So it's not a pri-, itself, right. So it doesn't get billed through Beacon. It gets billed through Well Sense and not CTS. That's an easier way to answer the question. Because it's an emergent transport, it's not a non-emergent transport, it's an emergent transport, so you're going from facility to facility, in this case because the patient is leaving the ER and going, and going for admission into another hospital setting –"

(P): "Right, that is traditionally a non-emergent transport [inaudible]. If the patient's stabilized through [inaudible].

(R): "Oh, I'm sorry. I misunderstood. I thought it was emergent, emergent care so it's, yeah, it would go through CTS. Yep. So CT, for emergent transport, non-emergent transportation, CTS can do the transfer within two hours so they just need two hours' notice. They can do it shorter sometimes. It depends on how quickly they can get an ambulance up and ready or a driver there, but two hours is usually the standard."

(P): "And they, would be ordering personnel contact us or would we at CTS providers?"

(R): "It can be either."

(P): "I would like a little clarification then. If the hospital discharges me or full for our provider, would we be contacting you or would you like them to contact you? And that's going to be a big issue in our dispatch center."

(R): "So if it's the, if it's the hospital calling the ambulance to say that they want the transfer –"

(R): "And if it's, if it's behavioral health and, are they going to another facility? Are they going home? Or what?"

(R): "We have lots of different scenarios. Possibly sending their patient to another facility, possibly discharging to a medical facility, or our patient may be even starting to private residence. Some are non-emergent, and our biggest concern as the ambulance dispatcher is, who actually calls you folks? The discharge planner? The ER personnel? Or do we as the provider? And we may not be able to bill it if we end up paying or contacting you about allowing the transport."

(R): "So the discharge planner should be calling CTS to arrange for that non-emergent transport. That's the way that should work."

(R): "Whoever it is, whether it's the emergency room."

(R): "The emergency room and they're made aware of that, is that correct? Because we're contacting the medical organizations and we're getting different opinions in regards to who would be making those phone calls."

(R): "Let me, we're going to be in the Capitol Room. It's the room that's at the furthest end of this hallway, afterwards, and let me get some direct contact with you, okay?"

(R): "Okay, thank you."

(L): "We want to go to the web?"

(P): "Are the DME claims set directly to Northwoods for processing or are they sent to Well Sense Directly?"

(L): "DME claims will go to Northwoods to be processed."

(P): "I have a question regarding vision care. Frames, you said, would be provided through Well Sense through VFC. Is there a select group or a dollar amount on the frames standard or plastic?"

(L): "There are some restrictions and I do have a pamphlet that I can provide to you at the end of this session. The question was around VFC and vision and is there a limit. There, they did recommend, VFC does recommend that if you're, for your hardware there is a $30 limit on your hardware and there are some requirements around vision lenses. Again, I can provide you that information after this session. I can get you your specific information."

(P): "In New Hampshire, New Hampshire Medicaid allows non-licensed masters, masters level clinicians to see and be reimbursed for therapy in a community mental health center setting. Will Well Sense plus Beacon be the same? If so, do you see this changing in the future?"

(L): "So the question is, okay, and correct me if I have it wrong is, at the mental health centers there are providers who are non-licensed providing services."

(P): "Masters level, non-license."

(L): "Masters level, non-license individuals who are providing services. At this point in time, we will continue to reimburse for that, and that's, I need to say we are reviewing that for the future but there is no change in that."

(P): "If we have an inpatient that's currently on Medicaid and they continue to be inpatient as of December 1st, they maybe came eligible with Well Sense, how are you, how are we transitioning that?"

(L): "Is this, this inpatient requires – hold on one second. I'm going to get you that answer. The question was around inpatient services and whether it requires, what do we require prior authorization on 12-1 if the person is still in services or not and Mary Gay Gershwin is going to answer for us."

(MG): "Hi, I'm with the Department of Health and Human Services and we have come to agreement with all three health plans that inpatient stays November 30th into 12-1 will be covered by the state of New Hampshire until discharged and then they will be covered by the health plans that they, the member has enrolled with."

(P): "Okay, webinar question: Are speech, OT and PT considered combined services in allowing for authorization or visits?"

(L): "The question is, are PT, OT and ST combined visits? And the answer is yes, they are combined visits. And I think we have one question over here, and then we'll come back to you. Yep."

(P): "Can I get clarification on the notification required for emergency services? Is that in your pamphlet? In the quick reference it says notification is required for emergency inpatient admission. So where it says notification required for emergency services, that's not somebody coming into the emergency department, is anything discharged?"

(L): "Correct."

(P): "Okay thank you."

(L): "Okay, thank you. We'll get that clarified. The question was around notification in the emergency room and how we clarify that, so notification for admission in the emergency room. Web question?"

(P): "We're from a long-term care facility. Many residents require wheelchair transport to outside specialist offices, out-patient testing, etc. How do we handle this transportation?"

(L): "The long-term care facility will need to understand which health plan the member has enrolled with and arrange for transportation via that health plan's transportation agent. So if the member is enrolled with Well Sense, the facility would contact CTS, and if the member was in the other two health plans they would contact Access to Care. Question here first."

(P): "Behavioral health, we're, speaking in covering a behavioral health aspect. Is everything necessary to proceed to the same Welfare website or do we have a separate website?"

(L): "We have a separate website."

(R): "You can go to the Welfare website and there will be a link to the Beacon website on top of Well Sense"

(R): "Can you just repeat the question?"

(L): "Sure, the question was, behavioral health benefits through Well Sense the provider would need to go directly to Beacon's website to bill or procure additional information."

(P): "Web question: for clients who are Medicare Primary, there are many services that are not covered by Medicare such as PT. Medicaid allows us to skip billing the primary for the denial if they are already aware of what services are not covered. Will we be able to do the same thing with Well Sense, or will we be required to bill the primary before the denial?"

(L): "So the question is on the Medicare dual population, do we require to bill the primary first and Medicaid the second or in this case Well Sense secondary? You will be required to obtain that denial from Medicare. They are primary first and then send to Well Sense as the secondary. And then we have a question in the back of the room here."

(P): "Question regarding transportation, and this is with the state as well as Well Sense. A lot of the facilities, and we have a different law than other communities, we have contracts with facilities, how do we guarantee that CTS knows that we have a contract and we get that person, that call, that transport because we rely on that contract."

(L): "So the question is around transportation and CTS, specifically, and will this particular ambulance company know that you have contract with particular facilities. You need to be outreaching to Coordinated Transportation Solutions on that and working with them on that. You should have signed a contract with Coordinated Transportation Solutions."

(P): "We already have one in place."

(L): "So you would work with them on that."

(P): "Okay, and the other question that I have is, we've reached out to our facilities in New Hampshire, hospitals and nursing homes and they have no clue what's going on. They said that they, they're opting out for a year. We're heard that they don't know what to do. And we're trying to educate them so we can have a smooth transition."

(L): "Mary Gay, Mary Gay can you respond to that question."

(MG): "Okay, I first want to clarify that a nursing facility is not eligible to opt in or opt out. Members, individuals have to opt out. So within a facility, there are members who may be in-care management or may be out of care management, and it will be up to the facility to understand which members have different arrangements so that they can properly advise those providers on how to bill. The nursing facility itself will not bill for transportation, will not bill for podiatry, pharmacy. It is the member and the sole individual providers who are doing the billing."

(P): "Right, but you got to understand that they have steered all their clients in their facilities to opt out, or many have, not all."

(MG): "Right, and we consider the opting out activity as being a personal choice and appropriate in some situations. So if a nursing home member has opted out, then those claims for the medical and the non-long-term care services continue to go through there."

(P): "Thank you."

(P): "What is the notification process for urgent care centers and emergency rooms?"

(L): "What is the notification process for emergency rooms and urgent care centers? You can check online in our provider manual. In Section 9, it does tell you what the requirements are, and the requirements are that you need to notify us within 48 hours or two business days. You need to call the prior authorization department, saying that you will do notifications through the same prior authorization number that you would submit for a prior authorization. I don't know where we are in the room. There's lots of questions. Over here. Okay."

(P): "We have a hospice house which would be inpatient admission. Do we need prior auth. for that?"

(L): "So the question is that we have a hospice house that requires inpatient admission, so I'm going to answer this in two ways. First of all, DHHS is holding a meeting with all the homecare and hospice center next Tuesday, 1:00 in the Brown Building. It's 1:00 to 3:00 the Brown Building in the auditorium. So collectively, the three manage care organizations have met and we have collectively agreed that for hospice provider, members we're going to accept the existing authorization form that you submit currently to the state and that we'll cover for the first 60 days and then we'll work with each of you following that. There's lots more information around homecare and hospice services and DHHS, we met last weekend. They'll be sending something out to you within the next two business days around this meeting. But there is Tuesday the 19th, 1:00-3:00, the Brown Building Auditorium."

(P): "Will DSP who use Medicaid ID for Well Sense member to look up PTs? I'll ask them to clarify."

(L): "Apparently that wasn't very clear. There's a question up here that, I know this woman in the black has been raising her hands multiple times. I'm sorry."

(P): "Hi. I just want to clarify one of the webinar questions that was asked previously about the Medicare-Medicaid dual. Her question was about PCM, which was targeting case management, she made it about community health center. Currently, we do not bill Medicare if it's a denial. Okay? So if it's a community mental health center, I'll defer to my business partners on claims questions."

(L): "So the question is, at mental health centers, who currently do not bill through Medicare for targeted case management."

(P): "For non-covered services."

(L): "For non-covered services. So it would still be the same as the claim center."

(P): "Okay, thank you."

(L): "Sure. I apologize. So no more web questions. Do we have more questions in the room? We have five minutes, so somebody has a mic? Somebody's got the mic?"

(P): "If one plan is secondary to another insurance, do you require prior authorization for radiology?"

(L): "Not on the secondary."

(P): "Okay, thank you."

(P): "I come from a long-term care home, long-term care nursing facility, in response to the gentleman over there, and you are right about opting out, but there are many facilities who have not opted out, they have chosen plans and we have run into a lot of barriers and one of my concerns is that, we have a lot of residents that come into our facility on a daily basis, whether it be an inpatient or an outpatient, back and forth to specialists and what have you. How are we supposed to, when sitting with families trying to figure out which plan's appropriate, there are some plans cover what members need and there are some plans that don't, kind of a 50/50. So we're kind of at a loss because we're not really sure what to tell these people. And again, it doesn't really make us look very well-educated. But one of my biggest concerns is that, a majority of my residents, we have not received any information from them, either to them directly or to their families about opting out or choosing plans. Families, I have a hundred, I have a resident who is 102 years old who has no family. She's out-lived her entire family and trying to tell a 102-year-old that she needs to pick a new insurance plan, it's not flying. What do we do?"

(L): "So I'm going to defer to my friend Lisabritt and Mary Gay because they have sent out notices."

(MG): "I walked in on the back-end of your question, but let me make sure I understand what you're asking. You have a resident of a long-term care facility. She is over a hundred years old, and the question is how is she to pick a plan?"

(P): "No, not how is she to pick a plan. She hasn't received any information about opting out or choosing a plan. How do you tell a 102-year-old that’s set in her ways, that she and I are going to sit down and play on the computer and try and choose a new health insurance for her?"

(MG): "Well, okay, two things that, the two things that I am hearing are that she hasn't gotten an enrollment packet, but that's a problem on our end and we'll need to address that. And then the second thing I'm hearing you ask about is, how do you council somebody in that situation? Dollars to donuts, she a dual eligible, is that correct?"

(P): "She is."

(MG): "Okay, so she has the opportunity to opt out for year on."

(P): "Right, but how do you assess? We fought it out with a lot of our residents. We've met with families. We met with our residents. This person in particular, and my guess is that and I hate to refer to her as the old age, but she is so stuck in her way that we can't express to her the new age. Like, this is what she needs to do. How do we go about? I mean, we obviously can't just say, okay, walk away. We'll do it for

you. I don't know how, how to get it across to her that she needs to pick a plan. And if you tell her to opt out, that's another thing. She doesn't have any insurance."

(MG): "Okay. I guess, what I'm hearing is two things because there are a lot of questions but I don't know if this is the best use of everybody in the room's time, but I would like to give you some one-on-one attention to try to walk through what to navigate, sort of the best way to manage somebody like that who presents challenges in making their way through the enrollment process."

(P): "And I think today makes the deadline, right? So if she's not enrolled and they automatically enroll her, I guess, do we wait and see if it's something suitable for her and at that point try and move her again?"

(MG): "That's a possibility to opt out but I feel like we should, we should really just, in the best interests of everybody in the room and to give Well Sense their deal but I would love to talk with you offline."

(L): "Lisabritt, thank you. Mary Gay, thank you very much for helping. Jen and Margie, thank you very much for helping. My time is up, as I mentioned to you, in fifteen minutes we will be located in the Capitol Room and we will answer your questions. I'm sure it will be a little crowded but we will get your questions answered. So give us fifteen minutes, right. Use the facilities. We'll get our stuff cleaned up out of here and we'll meet you in the Capitol Room. Thank you very much for having us today."

[Break to next group]

[2:52:13] (R): "-portion of the agenda. I have a very soft voice and I try to speak loudly. Welcome everybody. Welcome to the New Hampshire Healthy Families Presentation. My name is Beth Dillon and I'm the Director of Medical Management for New Hampshire Health Families. My colleague is Maria Scott. Maria is the Manager of Provider Relations. We have a number of colleagues in the audience that would be happy to help us with the questions that you might have at the end of the presentation. But I thought I'd kick us off with a little bit of background information about New Hampshire Healthy Families. New Hampshire Healthy Families is a product under our state name of Granite State Health Plans. Many of you may have heard about the Granite State Health Plans in the early days of the Medicaid Management Care Program, but the product name for the Medicaid product is New Hampshire Healthy Families. Granite State Health Plans and New Hampshire Healthy Families is a subsidiary of Centene Corporation, and Centene Corporation is a national managed care company. We have a Medicaid contract in 19 states across the country, so New Hampshire is the 19th state in which Centene will be managing Medicaid, a Medicaid contract, managed care contract. In our local office, which is based in Bedford New Hampshire, we'll have a number of local people here to support all of you. We'll have a local Chief Executive Officer and our call center, our provider relations call center and member relations call center will be based here in New Hampshire. My team is the medical management team. I'm a Registered Nurse, and I've been living and working in New Hampshire for the last 25 years in managed care, and I'll have a team of 20 clinicians, more or less, that will be working with all of you to help coordinate the care for our Medicaid members. And we use a model of case management that's called an integrated care team and looks at the behavioral health aspects of every person enrolled with us as well as the physical health aspect. We'll have local provider relations and contracting staff and we're working with a state-wide health plan, so we'll have providers contracted and members enrolled with us in every county of New Hampshire. We have a number of specialty companies that we work with. We have a pharmacy management company. It's US Script that will be administering the pharmacy benefit for the New Hampshire, for New Hampshire Health Families. This slide gives you a little bit of information about how to bill for pharmacy services and the phone number to use if you have questions about pharmacy services. For vision services, we're working with a company called Total Vision, and we have also some information here. I'm going to talk about our vendors sort of at a high level, sort of move through these slides quickly so we can get to the root of the questions, which I think are probably primarily around billing and prior authorization. For high-tech radiology evaluation and medical necessity radiation, we use National Imaging Associates, NIA, and there are some high-tech imaging services that do require authorization that are listed on this slide and they're also provided in your, in the packet of information we provided, on a prior authorization list. Something I'll point out about the prior auth. list that is in your packet is that it's a high level list. It doesn't list everything for which we require prior authorization. So it's really important for you to know that on our website, we have what we call a code checker, and if you have a question about a service and whether or not a service requires prior authorization, you can go onto our website. You don't even need to be in a secure provider portal to do that. But you enter a code, a CPT code, and it will tell you if that particular service requires prior authorization or not. So we've provided you with, you know, some details today, but we encourage you to always check because the list that we've given you is not an exhaustive list of what requires prior auth. I'm going to now introduce it to my colleagues to talk about Cenpatico."

(Steve): "Hi everyone. I'm Steve Stefanick. I'm the relations provider contact for Cenpatico Behavioral Health. I'm sorry. Provider Relations contact for Cenpatico Behavioral Health here in New Hampshire. I'm just going to go over a few slides just so you know who we are. We are going to have a breakout session if you've got a few additional questions. You can also, my, [side conversation] Just so you know,

slide 15 is my contact information. I know I'm jumping ahead just a little bit but that's, if you need to reach out to me after this, you can do it with my information there. Real Quick –"

(R): "I'm going to help you out here. There you go. How's that?"

(S): "We're just committed, you know, to the philosophy of appropriate treatment to our members. We're not going to get into a whole lot of detail here. If you want more specific behavioral health related training, we can come into your office and do that as well. On the next slide is just a little bit about our customer service. You can contact us via the web portal. You can contact us via the phone to check eligibility, to request authorizations and claims and such. We have our web portal. We're doing a web portal training on the 20th and 21st of this month if anybody's interested. I can get you the contact information to call in. Please just see me before you leave and give me your email address, and I'll send all that contact information. Again, I'm pretty sure it's the 20th and 21st, WeDMEsday, Thursday. Just a run through how you can bill us, how you can check authorizations online and eligibility, all that good stuff. And I'm going to turn it over to our STRS folks."

(Daniel): "Sure, thank you. Hello. My name is Daniel Hernandez and I'm a speech pathologist and also the Clinical Provider Trainer for STRS. And STRS is our specialty therapy and rehab services. So we review the OT, PT, ST. I'm going to get into just a little bit about who we are, what we do as far as STRS goes. STRS requires prior authorization for your initial eval., re-eval out of your network. If you're in network, it will not require prior authorization for those services. What we do is we have three components that make up the STRS department. We have the UM, or Utilization Management and that's referral specialists who are admin people. They do the intake portion and they set up the requests, so they send them over to the Utilization Managers. Those are our therapist, and so you have peer on peer review with OTs, PTs, STs actually reviewing the requests for those therapy services. Then basically the therapist will either approve the request or they'll send it on to medical review or a physician will review if they're not able to approve. We also have a clinical provider trainer, which is what I do, and in your market, Julie Stover is also a provider trainer and what we do is kind of go out to the different providers and we give services such like, such as this but more in depth on what you need to do to submit for prior authorization, and we also help you guys if you're having difficulties with submitting for prior auth. We help you find out what's going wrong and to fix that problem, so we kind of guide you through the process. If you are a provider of rehab and you're going to need to submit for prior auth., you can see me after this and I can give you some contact information, some packets about what we do and also we can set up and on-site or telephonic training. The other component of our STRS is we have care coordinators and they're our social workers internally, and they help our patients navigate the system and they help the members to get their services they need. They coordinate with behavioral health if needed or transportation or anything that would help the patients be successful. We already passed it to Steven."

(S): "Just mention Julie's name in there as a contact."

(D): "And Julie at the bottom here. Julie Stover is your clinical provider trainer for your market. That's her contact information. Alright."

(Maria): "I love this. I have the laser. I love that! Hello everybody. My name is Maria Scott. I'm glad to be here. Quite a group, huh? Questions and answers are not up there, yes before lunch, right? Need a nap. I'm going to talk to you a little about provider relations and what my team does. We hired three provider relations. Can you hear me over there? Alright. We've hired three provider relations specialists

throughout all the counties, so each provider relations rep will have multi counties that we will work with, yourselves, hospitals, public providers, to schedule subsequent visits with you to train you, also tell you about policy and procedures, changes to the plan, clinical questions, and to form a partnership with you and your team. Okay, there's that. Most of you have a welcome packet in front of you, right? If you haven't, we have some out on the tables that you could take with you before you leave. And a welcome packet is, is a packet of how you do business with us. How do you do business with us? It has quick reference guides in there. It has provider information about medical services. It has the provider portal information and how to get into the portal, how to navigate through that system, as well as prior authorization forms that are required, notification of pregnancy forms and member connection, which we'll talk about in a little bit, as well as PCP changes, PaySpan, as well as HEDI portal guidelines. Yeah, my, what do my teams do? Our team services partner with you and your team and we are the liaison between the plan and the health plan. I'm sorry, the plan and the provider. What we'd like to do is educate, update you with any changes that we might have as well as demographic changes, credentialing information that you might have, as well as any administrative policy and procedures they might have changes on, monitoring performance patterns. We look at your claims' history, see if there are any trends there, as well as contract and if you have any questions regarding contracts, member and provider roster questions that you may have, as well as assist you through the portal. Any questions? I know, questions until the end, right? I can't, you can't ask any questions right now till the end. No, I normally say do not ask now. Okay. Just want to share with you, we are going to have provider summit calls, which are every Thursday for the month of November, and in the month of December they're going to occur Tuesdays and Thursdays, and this is an open mic forum that, if you have any questions, if you could come to this forum and you could ask a question and if you have cross functional work teams that attend these meetings with us. So you'll have medical management and you'll have claims experts, you'll have a specialty, companies can be and it's a Q&A. If we don’t answer a question for you, we'll jot down a question and get back to you. The plan post all the speaker asked questions in our website within a couple of weeks, so any question we're getting throughout these forums, we are documenting and will be putting that on the website. We're also going to be scheduling webinars, and go right into our website and there's dates that you can RSVP and once you RSVP we'll respond back to you and invite you to the selected date that you picked and we can do webinars. So for members, or for teams, members that are not able to attend some of these forums or some of the orientations that we've already went out there, to conduct, they can go ahead to our website and RSVP and we'll provide you a webinar. And those start November 13th through December 18th, from 10:00 to 11:00 and 2:00 to 3:00. Of course, all this information is online. Okay, now for the fun stuff, the web, the portal. These are some of the tools we have on our web portal. We have the provider manual and provider billing guide. That's already posted in the public site. We also have medical services information. The prior authorization co-check, and you've been hearing this throughout, this is a really neat feature that the procedure put in that you're billing for and it will tell you whether or not you need a prior authorization for that service. We encourage you to use that because you can also go online where we have a list, but we encourage you to go online and use this function. We also have prior authorization, any form that you're required to fill out, we also have those online. We have clinical practice guidelines. We also will have provided newsletters and announcements, which we're working on right now, that we'll publicize very shortly. We have plan news and also find a doctor. And of course, once you've established that relationship with your provider liaison and you're finding that there might be some answers that you'd like to see on the website that, we'll take that to our corporate team and if there's any answers that would benefit you to do business easier with us, we'll take those ideas and bring that to our IT folks. And here's our provider secure portal and some of the things you will see in it, the member eligibility. You'll also see the authorization requests. You'll see the patient list and the care gap. Submit and adjust claims online as

well as view history, claims history. And it’s registration free starting November 1st. Has anybody signed up for it yet? How do you like it?"

(R): "We're only used it a couple of times. I like it."

(M): "Good, good. We try to make it as easy as possible for you to navigate through it. If you have issues with it, go give us a call and we'll help you navigate through that. So I encourage everybody to sign up right after you leave this meeting, okay? Member eligibility, here's our ID card and it has all the key information, key member information, medical claims, where we're located. Actually, that's wrong. We just moved. That's wrong address don’t mail there. And just key information about the Medicaid. There's a lot of questions regarding, will New Hampshire Healthy Families carry the New Hampshire Medicaid number and we will, so that will be, we will carry that number over. And here's our online eligibility verification screen. But we are encouraging, for the first 90 days, to please, please go through state websites to validate eligibility because, as you know, there might be some movement through the first 90 days, so we encourage you to go through corporate first and please, before you render services that you do that. Claims, fill out claims at the end of the day if you want to get paid, just make sure when you make claims they are standard coding guidelines and they are made up of all the elements that are required so they don't get rejected. We have, for claims submissions, we have 180 days. We encourage members to do 180 days. We have 365 days to make a claim in their plan. Also for your standard requests for reconsideration claims received or correction claims, you have up to 180 days from the original notification of payment or denial. Okay. If you happen to have a dropped claim, to pay for it and this is the address that you may bill. However, for claims disputes, you'll have to drop that to paper. We do not currently submit that electronically or through web. However, if you need to drop it by paper, we encourage you to go into our web portal and submit and actually enter those claims, like an EDI claim will get submitted to our claims department. And here's our EDI information, payer ID for medical and behavioral health as well as some of the clearinghouses, just some of them, this is not a total of the all of them, and should you have any questions, whether you want to test with us for EDI, you can contact our EDI as well as contacting provider relations rep. Any questions on this? PayScan is our electronic fund transfer, EFT, as well as ERA so we encourage you to submit with us electronically. If you have any questions, you can right into the web, to the website to register. And they also have a training, additional training if you should need it. You cannot balance bill a member, no-shows unless they sign a waiver. Then you can bill, balance bill them. Waste, fraud, abuse, we have an investigation unit in corporate that manages this, this process and we run reports based on provider transit education inquired will reach out to you and do that. And please, for more details, reference to your provider manual. And Beth is back."

(Beth): "Thanks Maria. Okay, so I'm going to talk about med management, medical management. Our medical management program is fairly traditional in the sense that we do require prior authorization for certain procedures. We do conduct concurrent review of our patients that are hospitalized, and we have a case management program or a care management program, which I mentioned earlier where we follow an integrated care team approach and the way we, the way we describe that is that we work hard to make sure we're recognizing the person, that full entire person. And a lot of times when you're dealing with an insurance company you dial one number to get to the behavioral health company and another number to get to the physical health company. Well, you'll be calling one number and my team will have, as I mentioned earlier, behavioral health clinicians, nurses, social workers. We'll have a full complement of folks really looking at the whole person. We'll have a couple of social workers. One of our social workers is a special needs' coordinator, and the other is a developmental disability coordinator, and they each have special training in those populations. We'll have a foster, we do have a

foster care liaison, who's one individual on our team that will know of all of our foster care children and know where that child and their family is in the course of the program with DCYF. I've already mentioned behavioral health and we will have a particular focus on OB-GYN, especially supporting our mothers who are expecting to deliver a full-term baby to the extent that that can happen. We have a disease management program similar to the other insurance companies that you work with in New Hampshire, and our disease management program is focused on specific chronic illnesses where, with some intervention and education a patient and their family. There, there health status can greatly improve and, and those diseases are listed here on this particular slide. Our medical management hours will be 8:00 to 5:00 every day and our phone number is listed there, and at 5:00, after 5:00 you'll still be able to call our department and our phone will be answered by a company called NurseWise that will have nurses available 24/7 to all of you and to our members. And our NurseWise team afterhours can verify eligibility, so you know, don't hesitate to call us after 5:00. They should be able to verify eligibility and take an authorization request as needed. We try to make the authorization process as easy as possible. I think Maria mentioned or even mentioned in the breakout session, just to be clear, we do not require a referral from a PCP to a specialist, so that's not required. But there are certain circumstances and services and procedures where we do require the health plan prior approve. We ask that you submit a prior authorization request 5 days prior to a scheduled elected procedure, and if you have to do an emergency procedure or refer someone for an emergency service that typically requires prior auth., we ask that you let us know within one business day of that service being provided. We always say prior authorization is given in advance of the service is not a guarantee of payment because we want to, we don't know for sure if on that day of service that the member will be eligible, and as we said today a number of times, it's always best to, especially in the first 90 days, to check eligibility before providing service, even if you have an authorization. So the way you can receive authorization from us is one of three ways. You can ask for an authorization approval online. You can call us. Or you can fax us. But what I've been telling folks is that, if clinical information is required, which it usually is, that information needs to come over by fax to us so it's probably most efficient if you have to call the clinical information to submit the prior auth. over the fax, over fax. And we've provided the fax number here for you. We've also provided the phone number for our hospitals to use when notifying us of an inpatient stay or when they're notifying us about ongoing concurrent review for somebody who's hospitalized. We use InterQual Criteria at Healthy New Hampshire Families to determine medical necessity, and if you have an urgent or an expedited authorization, we will process those within 72 hours but if you, there is a place on the prior auth. form to check 'urgent' so be sure to check that so that we know that, to expedite that request. And we asked to be, that you provide the NPI number with your prior authorization request. We have a transition plan for new members which has been mentioned throughout the day, and New Hampshire Healthy Families will be honoring medically necessary open authorizations on December 1st, and the way that that will work is the state is giving us a file of authorizations in place just before December 1st. Those authorizations will be loaded into our system and we would expect around the 1st of January to start applying medical necessity criteria to any authorizations that are still open at that point. Any new authorization request after December 1st, just follow the procedure I was just mentioning, which would be most likely a fax request but also online and by telephone. Out-of-network services do require prior approval, so if you have a patient going out of network, you need to notify us and we will evaluate if that service could safely be provided within our network. We'll work with the patient and the family to redirect them back into the network. We know that on, in the first few months of the program, we have a lot of, we'll have a lot of members getting services out of network, and we are committed to looking at every patient individually and their set of circumstances including how long they've been going out of network, why they're going out of network, if they have special needs, for example if they're developmentally disabled or something like that. So we will look at all of the facts associated with that and make a determination with our Medical Director

about whether we feel those services should be redirected in network. If a service is not available in network, we will approve that out of network. And I'm just going to talk about a couple of additional programs, and I'll try to be quick because I know it's the end of a long morning and, and we're in between lunch. We're the only thing standing in the way of lunch for all of you guys. So, but I will talk about a couple of programs that we offer that we're very proud of. One of them is our Member Connections program, and this program is unique to New Hampshire Healthy Families. We have a couple of folks that will be on my team, on the Medical Management Team, that are community educators, and they're available to hold open houses, educational open houses across New Hampshire, in communities across New Hampshire, and we'll be doing that where we invite our Medicaid members to come to learn about just some basics of managed care, why it's important that they select a PCP, why it's important to keep appointments, helping go over with them what their benefit coverage is. We also, these particular folks, these Member Connection representatives are available to visit our members at home, and oftentimes our nurse case manager, our behavioral health clinicians will as a Member Connection rep to go out and visit a family. We'll also do that for all of you, so if you have a family, a particular family, for example, that is a no-show all the time and you want to engage our help and our support in encouraging that member to understand what the importance is to keeping an appointment, you can let us know. And there's actually a form in the packet if you want to make a referral to us and have one of our Member Connection reps visit with a family, we will do that. We've talked a couple times already today about the Start Smart program for your baby, which is a program that all of our pregnant mothers are entered into. We ask if you are a provider office and you know or are aware of a New Hampshire Healthy Family member who's expecting, to notify us by using the Notification of Pregnancy form, which is also in the materials we gave you, but it's online as well. And we will engage all of our moms the minute we get a notification from you, we send the mother a package of information about taking good care of herself during the pregnancy, you know, with the intent of the baby being born to term and healthy and the mom having a healthy pregnancy. If a mom is determined to be at high risk for early delivery or premature delivery, if they delivered prematurely in the past, we will engage a case manager to work very closely with that member, probably weekly contact with that member. We have a program called the CentAccount program where we actually give our members a financial reward for doing certain things, taking good care of themselves. So for example, if a pregnant mom goes to the doctor at least once in each of her trimesters of her pregnancy, or if you're an adult over the age of 21 and you have your annual checkup, or if you're a child under the age of 18 and you, I should say over the age of 18, and under the age of 18, we will reward our members with a credit card/debit card, actually more like a debit card but looks like a credit card, and there'll be money available to them on that card that they can use like a flexible spending account. They can use the money that we bonus them to be used towards things in the drugstore, such as over-the-counter meds, diapers, formula, that sort of thing. We do provide non-emergency medical transportation, and we work with a vendor by the name of Access to Care, who I believe Meridian is also working with. If you have a patient and you know they need transportation to an appointment, for example, you can call our 800 number and if you're calling about transportation, they'll tell you to press, you know, number 3. You'll get transferred to Access to Care and you can, I encourage members to do this themselves, actually, but the member can tell Access to Care when their appointment is, where they need to be picked up and where they need to be brought. And we ask for three days' notice for non-emergency transportation and 3 hour notice for urgent, an urgent situation like an urgent care visit. All of our staff are trained in cultural competency. We know that the Medicaid population in New Hampshire is a diverse population. We also have translation services available, so if we have a person on the phone of in your office that doesn't speak English, they can call our office and we will conference call in a translator so that we can help interpret for you in your office, and we will be able to converse with that person in their native language. We're also, our staff are trained in disability sensitivity. We know a lot of folks in the Medicaid population in New Hampshire

have disabilities, and we're trained in, you know, the issues related to that. And I mentioned we have, you know, specific staff dedicated, including our developmental disability coordinator who's a social worker with many years' experience dealing with the disabled population, and she'll be able to help us with social issues, you know, surrounding that population. And that's the presentation. I know we're going to open it up for questions, and I think we're going to follow the same format that we followed earlier where we'll take one question from here and then alternate with a question from the web or the webX. We'll start here in the room. Our first question."

(P): "Hi. Are fee schedules going to be the same as Medicaid now?"

(B): "Yes, with New Hampshire Healthy Families, our fee schedule is the Medicaid fee schedule. And now, on the, on the presentation, web presentation."

(P): "Please repeat the name of the gentleman from Cenpatico and the information on the training dates of 11/20 and 11/21 for those us who are not in the audience."

(B): "Steven Stephanick and he's a Provider Relations Specialist at Cenpatico and his number is provided in the presentation. He's also, he doesn't mind accepting emails, if you want to email him as well, and his email is – would you prefer that? Okay, he'd prefer email overall, and his email address is in the presentation. Question in the room?"

(P): "Currently, we're a DME provider with a very large incontinence supplies base and we have, we do not have to have a prior auth. for people under the age of 21, or we do for people over the age of 21. I'd like to know how that's going to be handled by New Hampshire Healthy Families. We also with Medicaid are required to purchase our incontinence supplies through one supplier, and I'd like to know if that's also the same. And currently we do not have to go to a primary insurance for denial prior, or before going to Medicaid for the incontinence supplies."

(B): "Well, New Hampshire Healthy Families does not require prior authorization of incontinence supplies."

(P): "Even over 21?"

(B): "Even over 21. I don't think we're restricting incontinence supplies to one provider, but I'll look to my provider team in the back of the room. I think as long as the provider participates with us, is that right, Margo?"

(M): "Yes, that's correct. When I was looking, or when I was looking at the memo from one specific provider, as long as that provider's contracted with us as a supplier, then we should be good to go."

(R): "I'm sorry, could the presenter also repeat the question. Thank you."

(B): "Sure, okay. That question was specific to DME and is a DME provider, and she was asking if incontinence supplies will require prior authorization and if we require those services or those products to be ordered through one vendor. And as long as the vendor is participating, we're, we don't need to get prior authorization. You can just order it through a participating provider."

(R): "Do we have to go to, sort of the third part of that was, do we have to bill Medicare and or their private insurance before going to New Hampshire Healthy Families? Currently we do not."

(B): "The question is if the person has other insurance primary, do the, does the incontinence supplier have to bill the primary insurance first, and then answer would be yes to that, that we would need to know that it wasn't covered by the primary carrier before we would pay secondary carrier. Question on the web?"

(R): "We currently us MD Online as our clearinghouse. Does NHHF accept electronic claims from them?"

(B): "Yes. Yes, we do."

(R): "For your Medicare claims that cross over, will they cross over automatically or do we have to submit them to you?"

(B): "They will not. The question, did everybody hear the question? It's Medicare crossover claims, do they have to submit them to New Hampshire Healthy Families, and the answer is yes, you will have to submit to New Hampshire Healthy Families. Right, Maria?"

(M): "That's correct."

(B): "Question on the presentation."

(R): "There is currently a maximum limit of 12-week intervals that MMIS will cover for prior authorization requests. Will this stay the same for NHHS or will there be a new maximum time frame that prior authorization requests will cover?"

(B): "There could be a unique time frame authorized for each request, depending on what their request is for. So I would say, when you're requesting authorization, feel free to request for, you know, the amount of services, the number of units that you'd like to request. It'll be uniquely reviewed and determined by our nurses and our medical director as to how these services will be authorized. It won't be like a cookie cutter approach. It'll be unique to the patient and the circumstances. In the room, a question?"

(P): "Hi, good afternoon. Question regarding behavioral health, will it still be the allotted 24 visits that they currently have, and how does group therapy work in that? Is that part of the 24 visits, or does it become a separate authorization?"

(B): "I'm going to defer to Steven. He's coming up. You needed the walk."

(S): "Who asked the question? Where was that? So for outpatient visits, the 24 visits, we are not going to require authorization for outpatient services moving forward. And we'll be looking, you know, on the other, on the back end, so you're not going to have to request authorizations for outpatient services. It's like testing will. And was there another portion to your question?"

(P): "Regarding group therapy, if there was another standard of preauthorization that you needed."

(S): "I do not believe so, but connect with me before you leave and then we'll get you contact with the clinical folks and make sure."

(P): "Thank you."

(S): "You're welcome."

(B): "A question from the web presentation."

(R): "Please describe the requirements for ambulance providers. Are ambulance providers required to be enrolled in your network to be reimbursed? What about emergency transports?"

(P): "Well, emergency, if it's an emergency, the patient should be transferred without obtaining any prior authorization. It can be billed retrospectively. I would look to the provider contracting team in terms of ambulance providers and the status of our contracting with ambulance providers. I think Marco was going to take this one."

(M): "I would say, if it's an emergency, it's an emergency. We're going to cover regardless of authorization if the provider is in network with us. If whoever it is, is not on the list, you know, the name, if they want to give me call, reach out we can answer that."

(R): "Thanks Marco. A question in the room?"

(P): "Hi. Segue to the last question about modifiers, not modifying but transferring from Medicare to yours, as podiatrists, we do right and left often times we'll see the same time. Right now Medicaid has denied the second as a duplicate, well, mostly modify it. My two part question is, will you allow right and left modifiers, number one, and number two, when it's a non-covered service like routine foot care through Medicare, and we often have to submit a GY which means it's not covered by Medicare or by others that cover it. Will you accept GY?"

(R): "So the question is, does New Hampshire Healthy Families accept modifiers, specifically right and left modifiers, and I believe the answer is yes, we do. And I'm getting confirmation in the back of the room that we do. And the second question is the GY modifier. I'm looking to see. Do you know, Miranda?

(M): If it's a valid PCP. If it's a valid PCP modifier, it will be accepted."

(R): "And you can bill them."

(P): "Thank you."

(R): "You're welcome."

(P): "Last week I spoke with Steve and we were unable to be recognized with our tax ID because we were not really a provider until 12/01/13. Has this problem been corrected?"

(R): "That's going to be, I think we're going to need a little more information in regards to where. I'm going to go based on this question is being asked in regards to our web portal, login to our web portal,

and I don't know if they can respond and say yes or no. If it is regards to the web portal, then you can now re-enroll into the Cenpatico web portal and we have a work around in place and you will be accepted. And like I said, we have the web portal training coming up in the future and email me for the call-in number for that."

(P): "Okay, another question in the room."

(R): "I have a question from a prior question that came up in one of the, one of the other providers also. In the case of Medicare with incontinence products, they won't even acknowledge the claim. In other words, you can send it to Medicare, but they're not going to give you a denial because they won't even accept the claim because it's not a covered service period."

(P): "So your question is, do we really need to have you submit first to Medicare? Okay, the question is, with incontinence products, if the DME providers submit the claim to Medicare, Medicare doesn't recognize it as a claim so they're not going to respond to that claim submission. So the question is, and I'm going to look to Miranda in the back of the room, would we require submission to Medicare first or would we just accept incontinence supplies for members with dual coverage directly to New Hampshire Healthy Families?"

(M): "I think we're going to get back on this answer, but what it sounds like is if they are one of the exceptions, like you have an exception especially for like OB services, that you may not have to have ... before we process. But I think it’s best for OB team to see if these incontinence services can be on that exception list."

(B): "So if you could, before you leave, see Miranda and give her your card, your contact information, she'll get back to you. Thanks."

(R): "The second, the second question I had was, presently there seems to be a lag time in regards to providers getting, DME providers getting listed on websites. Is this something that's going to get caught up, or is that your problem, or Medicare's problem, or just our problem?"

(P): "Okay, the question is, there seems to be a delay, at least with DME providers and I think sometimes with other providers as well, in getting you onto the website in our 'find a provider' section of our website, even though you've already signed a contract and are considered participating. I'm going to let our contracting team specifically speak to us, but I do know, I don't know if this is true for DME providers, but with physician providers, they have to go through a credentialing process so many of our physician providers have signed contracts but they're still in the credentialing pipeline. And every day we post, you know, we have more and more providers getting through that credentialing process, and as more and more providers get through every day we update the 'find a provider' website. I'm not sure that, if there's a credentialing process for DME providers. But Marco will address it."

(M): "Yeah there is credentialing process for DME providers as well. Usually, sometimes there can be, I’m sorry, there can be a lag. Hopefully that their credentials are up to date, whether it be if they're missing, you know, a certain license or a certain certificate. That's usually is what the hold up. But we are providing the state with, you know, a list with the contracting providers as well. You know, they're getting the same information we are. Our credentialing process can take anywhere, there's really no time frame, could be anywhere from 30 to 60 days. But again, it kind of depends on the provider and making sure that all of your credentials are up to date."

(R): "Okay, we have about two minutes left. I'm going to take a last question from the webinar, and I'm sure my colleagues from New Hampshire Healthy Families would be happy to answer some last minute questions as you're going to leave today. Thank you."

(P): "Regarding ERAs, if we submit 837 claims through a clearinghouse and our case Caprerrio doesn't HIPPA require a Caprerrio to return the 835 ERA via the same channel, and not necessarily via PayScan?"

(R): "I don't know the answer to that question. Does anybody from New Hampshire Healthy Families know? Why don't we take that one as a take-away to follow up. Okay, well, thank you very much for hanging around to hear our presentation. Feel free to ask any of us questions after. Thank you."

[end of presentation]