

Meet the Medicaid Care Management Health Providers
October 23, 2013 Frequently Asked Questions
Step 1 Health Plan Enrollment

- What if my family member on Medicaid has a prescription that requires a prior authorization now; will it require a new prior authorization from the MCO?
 - Processes vary at each Plan. Consult them with questions on specific Rx protocols.
- If I opt out now will I be able to opt in any time?
 - If you are voluntary, you may opt in or opt out at any time during the first year.
- If I do not opt out in the first 90 days, can I opt out after the 90 days?
 - If you are voluntary, you may opt out at any time during the first year.
- How much will it cost me monthly if I join your MCO?
 - There is no premium cost for Medicaid clients to enroll with a Health Plan.
- Can I see the same specialist if they are with your health plan?
 - Yes
- Can I see the same specialist if they are not with your health plan?
 - Within the first 90 days of the program start (beginning December 1st), Health Plans will honor existing specialist relationships, if they exist outside of the Health Plan's network, during which time all Plans will encourage those providers to join the network. After the first 90-day transition period, Health Plans will work with clients to find comparable services within their network. If those services do not exist, consideration of out of network services will be made.
- Can I see a specialist out of state? Can I see a specialist out of state if is within your health plan provider listing? Can I see a specialist out of state if it is not within your provider network?
 - Any specialist within the Health Plan's network may be seen, regardless of location. Specialists outside of the Health Plan's network would require special consideration by the Health Plan. Consult the Member Handbook.
- Will my orthotics, that I have now, which required special permission, be covered next time?
 - All medically necessary Medicaid benefits continue under the Care Management program. Prior Authorizations may need to be re-issued, please consult the Member Handbook.
- How do I know if my prescription is covered?
 - Prescription coverage continues under the Care Management program. The Plans must honor current PDL.
- I can't find my Provider on your directory; does this mean they have not contracted with Well Sense? Meridian? NH Healthy Families?
 - The Provider Directory is updated every day, and will continue to be. The only providers appearing on the directory are those that are fully contracted and credentialed by the Health Plan. There are many providers that are "in process" of completing all requirements, and consequently are not listed on the directory at this time.
 - Consult Health Plans or the Enrollment Call Center for the status of providers not appearing on the directory.
- Will my Medicaid benefits change?
 - No. Health Plans must offer at least the same benefits.
- Do the three plans differ - if so, how? How is your – Meridian, NH Healthy Families, and Well Sense -- plan different from the other MCOs?

- All Health Plans must offer the same Medicaid coverage you currently have. They may offer additional incentives or programs, and those are highlighted in the side-by-side comparison provided in the enrollment packet.
- Do I need prior authorization and/or referral to go to a specialist? Does this vary from health plan to health plan? How does it work with Meridian? How does it work with NH Healthy Families? How does it work with Well Sense?
 - Plans must honor existing PAs for up to 90 days of the program December 1st start date. But if it is a new condition/issue that requires a specialist, if the plan would require a Prior Authorization for that service, it must be requested consistent within their process.
 - Meridian: a) Referrals: Meridian members do not need a referral from their PCP to see an in-state specialist of their choice as long as the specialist is enrolled with the NH Medicaid program. A referral is also not needed for an out-of-state specialist as long as the specialist is enrolled with the NH Medicaid program and is a Meridian Network Provider. If the specialist is not a Meridian Network Provider, let Meridian know so they may invite them to join the Meridian Provider Network. b) Prior Authorization: Meridian's Prior Authorization rules allow them to engage their care coordination teams and to validate clinical appropriateness of the requested service. At Meridian, most outpatient services are not subject to a prior authorization requirement.
- If I am already having treatment with my doctor and they do not take Meridian/Well Sense/NH Healthy Families, do I need to switch doctors in the middle of my treatment?
 - During the first 90 days of the program clients can continue to work with out of network providers.
- How does the transportation piece work? How does CTS work; how will I get transportation services and/or request them?
 - You would request transportation services from the Health Plan. Processes may vary, please consult with the Plans and/or Member Handbooks.
- Will Meridian/Well Sense/NH Healthy Families cover my lab work if my provider sends me to the lab in their hospital?
 - If medically necessary and the lab is in the network.
- Do you – Meridian/Well Sense/NH Healthy Families --have a member handbook so I can view it before I make a choice of which MCO to pick?
 - All Member Handbooks are available on the Health Plan websites.
- If I have to fill an Rx for a controlled substance for my child every month am I going to need to get permission each month from Meridian/Well Sense/NH Healthy Families before I fill them?
 - Processes vary at each Plan. Consult them with questions on specific Rx protocols.