



Provider Manual



Table of Contents

Contents

INTRODUCTION	5
Welcome.....	5
Mission	5
How to Use This Manual.....	5
KEY CONTACTS AND IMPORTANT PHONE NUMBERS	6
Health Plan Information	6
PROVIDER SERVICES DEPARTMENT.....	7
PROVIDER RELATIONS DEPARTMENT.....	8
PRODUCT SUMMARY	9
VERIFYING ELIGIBILITY	11
Member Eligibility Verification.....	11
Secure Website.....	14
PRIMARY CARE PHYSICIAN	14
Missed Appointments	14
Provider Types That May Serve As PCPs	14
Member Panel Capacity	15
Member Disenrollment	15
Medical Home Model	16
Primary Care Physician (PCP) Responsibilities.....	17
Referrals	18
DHHS Immunization Program.....	19
Specialist Responsibilities.....	19
Mainstreaming	20
Appointment Accessibility Standards.....	20
Covering Providers	21
Telephone Arrangements.....	21
24-Hour Access.....	22
Hospital Responsibilities.....	22
Marketing Requirements.....	23

Advance Directives 23

Interpreter Services..... 24

Voluntarily Leaving the Network..... 24

CULTURAL COMPETENCY 24

BENEFIT EXPLANATION AND LIMITATIONS 26

 Services that are excluded and not covered: 32

 Value Added Benefits 32

*Substance Use Disorder Benefits 33

 SUD Provider Resource Line: 1-844-287-2737 34

CentAccount 35

 Prescription Drug Copayments..... 35

Network Development and Maintenance..... 36

 Tertiary Care 37

MEDICAL MANAGEMENT 37

 Overview..... 37

 Utilization Management..... 38

 Prior Authorization and Notifications 39

 Second Opinion 42

 Assistant Surgeon 42

 Clinical Information 42

 Clinical Decisions 43

 Medical Necessity..... 44

 Review Criteria 44

 New Technology 45

 Notification of Pregnancy..... 45

 Concurrent Review and Discharge Planning 45

 Retrospective Review 46

SPEECH THERAPY AND REHABILITATION SERVICES..... 46

 STRS Medical Necessity Criteria 46

 STRS Outpatient Treatment Request (OTR) 47

 STRS Appeals 48

RADIOLOGY AND DIAGNOSTIC IMAGING SERVICES..... 48

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT 48

EMERGENCY CARE SERVICES 49

WOMEN’S HEALTHCARE..... 51

CLINICAL PRACTICE GUIDELINES 52

CARE MANAGEMENT PROGRAM 53

 High Risk Pregnancy Program..... 53

 Complex Teams 54

 MemberConnections® Program 55

 Chronic Care/Disease Management Programs 56

BILLING AND CLAIMS SUBMISSION 56

 General Guidelines 56

 Clean Claim Definition 57

 Incomplete Claim Definition..... 57

 Timely Filing..... 57

 Electronic Claims Submission 58

 Paper Claims Submission..... 58

 Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA) 58

 Claim Payment..... 59

 Claim Requests for Reconsideration, Claim Disputes and Corrected Claims 59

 Contractual Terms 60

ENCOUNTERS..... 60

 What is an Encounter Versus a Claim? 60

CREDENTIALING AND RE-CREDENTIALING 61

 Credentialing Committee 62

 Re-Credentialing..... 63

 Right to Review and Correct Information 63

RIGHTS AND RESPONSIBILITIES 64

 Member Rights 64

 Member Responsibilities 65

 Provider Rights 65

 Provider Responsibilities 66

GRIEVANCES AND APPEALS PROCESS 67

 Member Grievances 67

 Appeals 68

Provider Complaints and Appeals 70

WASTE, ABUSE AND FRAUD 70

 Authority and Responsibility 71

QUALITY IMPROVEMENT..... 71

 Program Structure 72

 Practitioner Involvement..... 72

 Quality Assessment and Performance Improvement Program Scope and Goals 73

 Patient Safety and Quality of Care 74

 Performance Improvement Process..... 74

 Healthcare Effectiveness Data and Information Set (HEDIS) 74

 Provider Satisfaction Survey 76

MEDICAL RECORDS REVIEW 76

 Medical Records 76

 Medical Records Release 77

 Medical Records Transfer for New Members 78

 Medical Records Audits 78

INTRODUCTION

Welcome

Welcome to NH Healthy Families. We thank you for being part of NH Healthy Families network of participating physicians, hospitals, and other healthcare professionals. **Our number one priority is the promotion of healthy lifestyles through preventive healthcare.** NH Healthy Families works to accomplish this goal by partnering with the providers who oversee the healthcare of NH Healthy Families' members.

About NH Healthy Families

NH Healthy Families, is underwritten by Granite State Health Plan, a Managed Care Organization (MCO) contracted with the New Hampshire Department of Health and Human Services (DHHS) to deliver a Care Management program to citizens of New Hampshire eligible for Medicaid benefits including members eligible for The New Hampshire Health Protection Program (NHHPP). NH Healthy Families' parent company, Centene Corporation (Centene), has been providing comprehensive managed care services to individuals receiving benefits under Medicaid and other government-sponsored healthcare programs for more than 27 years. Centene operates local health plans and offers a wide range of health insurance solutions to individuals. It also contracts with other healthcare and commercial organizations to provide specialty services.

NH Healthy Families is a physician-driven organization that is committed to building collaborative partnerships with providers. NH Healthy Families serves our New Hampshire members consistent with our core philosophy that quality healthcare is best delivered locally.

Mission

NH Healthy Families strives to provide improved health status, successful outcomes, and member and provider satisfaction in a coordinated care environment. NH Healthy Families is designed to achieve the following goals:

- Ensure access to primary and preventive care services
- Ensure care is delivered in the best setting to achieve an optimal outcome
- Improve access to all necessary healthcare services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

All of our programs, policies and procedures are designed with these goals in mind. We are happy to have you as part of our network and hope that you will assist NH Healthy Families in reaching these goals.

How to Use This Manual

NH Healthy Families is committed to working with our provider community and members to provide a high level of satisfaction in delivering quality healthcare benefits. We are committed to provide comprehensive information through this Provider Manual as it relates to our operations, benefits, and policies and procedures for providers. This provider manual will be posted on the NH Healthy Families website at <http://www.NHhealthyfamilies.com>, where providers can review and print it free of charge. Providers will be notified of material changes to the provider manual. To request a hard copy of the

provider manual, or if you need further explanation on any topics discussed in the provider manual, please contact the Provider Services Department (Provider Services) at **1-866-769-3085**.

KEY CONTACTS AND IMPORTANT PHONE NUMBERS

The following chart includes several important telephone and fax numbers available to your office. When calling NH Healthy Families, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (TIN) number
- Member's ID number or Medicaid ID number

Health Plan Information

NH Healthy Families
 2 Executive Park Drive
 Bedford, NH 03110
 Phone: 1-866-769-3085
 Fax: 1-877-502-7255
<http://www.NHhealthyfamilies.com>

Department	Telephone Number	Fax Number
Provider Services	1-866-769-3085	1-877-502-7255
Member Services	1-866-769-3085 TDD/TYY 1-855-742-0123	1-877-502-7255
Prior Authorization Request Concurrent Review Case Management	1-866-769-3085	1-866-270-8027 1-877-295-7682 1-877-301-8595
NurseWise (24/7 Availability)	1-866-769-3085	
Cenpatico Behavioral Health/Substance Abuse	1-866-769-3085	1-866-694-3649
Prior Authorization Outpatient/Home Health, Physical, Occupational, Speech Therapy	1-866-769-3085	1-877-658-0322
To report suspected fraud, abuse or waste to NH Healthy Families	1-866-685-8664	
New Hampshire Department of Health and Human Services (DHHS)	1-800-852-3345	

Paper Claims Submission

NH Healthy Families
Attn: Claims
PO Box 4060
Farmington, MO 63640-3831

Claim Disputes Submission

NH Healthy Families
Attn: Claim Disputes
PO Box 4060
Farmington, MO 63640-3831

Electronic Claims Submission

NH Healthy Families
c/o Centene EDI Department
Call: 800-225-2573 ext. 25525 or e-mail to: EDIBA@centene.com

PROVIDER SERVICES DEPARTMENT

NH Healthy Families' Provider Services Department (Provider Services) is dedicated to making each participating provider's experience with NH Healthy Families a positive one. Provider Services and Provider Relations are responsible for oversight, coordination or initiation of the services listed below for all providers:

- Provider Credentialing and Contracting
- Provider Re-credentialing
- Provider and office staff initial and ongoing education and training - note : NH Healthy Families shall conduct initial training within 30 calendar days of entering into a contract.
- Hospital, facility and ancillary provider initial and ongoing education and training
- Distribution of the provider manual and provider reference materials – note: The Provider Manual will be made available to you no later than seven calendar days after inclusion into the network.
- Assistance with claims inquiries and other administrative services
- Assistance with installation, access and training regarding available web-based tools and functions
- Distribution of notices, bulletins, newsletters and similar information regarding program, process or policy updates or changes
- Secret shopper evaluations
- On-site quality reviews
- Frequent scheduled in-service meetings

Provider Services can be reached toll free at 1-866-769-3085, Monday – Friday 8 a.m. – 5 p.m.

PROVIDER RELATIONS DEPARTMENT

As a participating provider, you and your office staff will have a dedicated Provider Relations Specialist who will provide education and training material regarding NH Healthy Families administrative processes. Your Provider Relations Specialist will visit you or your designated office representative on a routine basis. Regularly scheduled in-service meetings are intended to be a proactive way for NH Healthy Families to build a positive relationship, identify issues, trends or concerns quickly; to answer questions; share new information regarding NH Healthy Families; and to address any changes within your practice (ex. change in office staff, new practice location) or scope of service. The main mission for each Provider Relations Specialist is to ensure you and your staff receives stellar service support from NH Healthy Families.

Providers and their office staff are encouraged to call or e-mail their dedicated Provider Relations Specialist for assistance at any time.

Provider Relations Specialists meets regularly with providers within their designated territories to:

- Coordinate and conduct on-site training and ongoing educational programs
- Respond to inquiries and provide clarification related to policies and procedures, contract language and operational issues
- Facilitate problem resolution relating to claims submission
- Manage the flow of provider credentialing/re-credentialing information.
- Ensure contract compliance
- Monitor network adequacy.
- Report any change to your practice (i.e. practice TIN, name, phone numbers, fax numbers, address, and addition or termination of providers, or patient acceptance status)
- Initiate credentialing of new providers to the practice
- Schedule an in-service training for new staff
- Conduct ongoing education for existing staff
- Obtain clarification of state and health plan policies and procedures and contract language
- Find out about special programs available for members and/or providers
- Request fee schedule information
- Ask questions regarding your membership list (patient panel)
- Get assistance relating to claims or encounter submissions, or
- Learn how to use electronic solutions on web authorizations, claims submissions, and check eligibility

Another key responsibility of the Provider Relations Specialist is to monitor network adequacy on a continual basis in order to ensure NH Healthy Families is in compliance with the State of New Hampshire’s access standards and, ultimately, to ensure network sufficiency for members that mirrors community or commercial health plan access standards. Your dedicated Provider Relations Specialist will keep you and your staff apprised of any network changes, new additions or needs within the geographic area you serve, and may - from time to time - survey you regarding your referral network and any preferences you may have with regard to certain providers to target for participation in the NH Healthy Families’ provider network.

PRODUCT SUMMARY

The first step of the New Hampshire Medicaid Care Management Program was implemented the fourth quarter of 2013. Step Two will begin at a later date to be determined. Step Three, The New Hampshire Health Protection Program (NHHP), became effective as of August 15th, 2014. Members with eligibility on August 15th, 2014 received coverage through the NH Medicaid Fee for Service program. Transition to the care management program is effective as of September 1, 2014. Below is a table depicting the categories of eligibility that will be implemented in each step.

Members	Step One	Step Two	Step Three	Excluded/ FFS
OAA/ANB/APTD/MEAD/TANF/Poverty Level – Non Duals	X			
Foster Care-With Member Opt Out	X			
Foster Care – Mandatory Enrollment (w/CMS waiver)		X		
HC-CSD(Katie Becket) – With Member Opt Out	X			
CHIP (transition to Medicaid expansion)	X			
TPL (non-Medicare) except members with VA benefits	X			
Auto eligible and assigned newborns	X			
Breast and Cervical Cancer Program (BCCP)	X			
Medicare Duals – With Member Opt Out	X			
Medicare Duals – Mandatory Enrollment (with CMS waiver)		X		
NH Health Protection Program (NHHP)			X	
Members with VA Benefits				X
Family Planning Only Benefit (in development)				X
Initial part month and retroactive/PE eligibility segments (excluding auto eligible newborns)				X
Spend-down				X
QMB/SLMB Only (no Medicaid)				X

VERIFYING ELIGIBILITY

Member Eligibility Verification

To verify member eligibility, please use one of the following methods:

1. Log on to the secure provider portal at <http://www.NHhealthyfamilies.com>. Using our secure provider website, you can check member eligibility. You can search by date of service and either of the following: member name and date of birth, or member Medicaid ID and date of birth. The eligibility response will indicate the eligibility category of the member (i.e standard Medicaid or NH Health Protection Program). Please note that you must submit a request to be enrolled with our provider web services in order to access information via the secure provider portal.
2. Call our automated member eligibility IVR system. Call from any touch tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24- hours a day. The automated system will prompt you to enter the member's Medicaid ID and the month of service to check eligibility.
3. Call NH Healthy Families' Provider Services. If you cannot confirm a member's eligibility using the methods above, please contact Provider Services at 1-866-769-3085. Provider Services will need the member name or member Medicaid ID to verify eligibility.

Through NH Healthy Families' secure provider web portal, primary care physicians (PCPs) are able to access a list of eligible members who have selected their services or were assigned to them. The patient list is reflective of all changes made within the last 24-hours. The list also provides other important information including date of birth and indicators for patients whose claims data show a gap in care, such as a missed Early Periodic Screening, Diagnosis and Treatment (EPSDT) exam. In order to view this list, log on to <http://www.NHhealthyfamilies.com>.

Since eligibility changes can occur throughout the month and the member list does not prove eligibility for benefits or guarantee coverage; please use one of the above methods to verify member eligibility for each date of service.

All new NH Healthy Families' members receive a NH Healthy Families' member ID card. The member ID card will include the following information:

- The NH Healthy Families' name
- The Member's Name
- The Member's Medicaid ID Number
- The Member's date of birth (DOB)
- The PCP's name
- The PCP telephone number
- The Plan Type for members on the NH Health Protection Program
- The Pharmacy Routing (BIN#)
- The Member Services 24-hour, seven days a week number: 1 - 866-769-3085

A new member ID card is issued only when a member reports a card lost, has a name change, requests a new PCP or for any other reason that results in a change to the information disclosed on the member ID card.

Since member ID cards are not a guarantee of eligibility, providers must verify members' eligibility on each date of service.

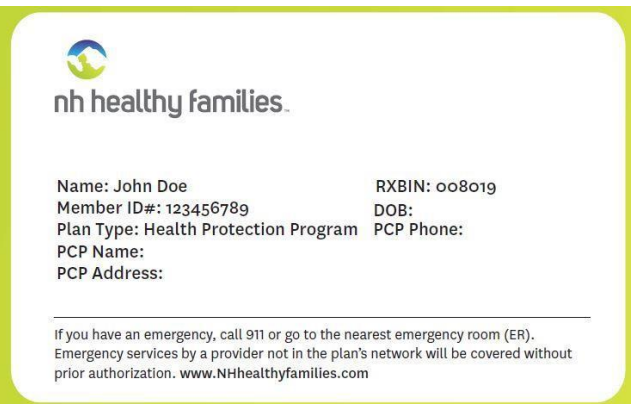
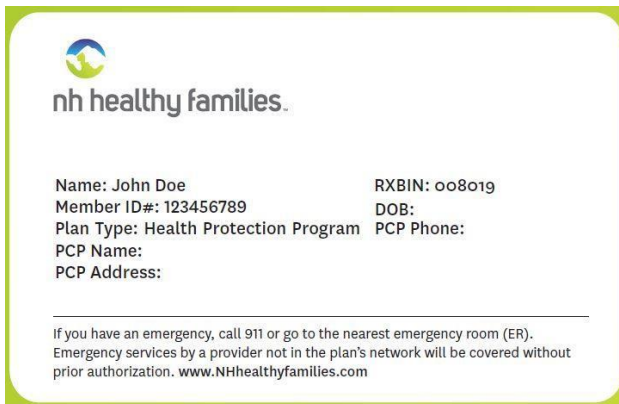
Member Identification Card

Whenever possible, in addition to their NH Healthy Families' member ID card, we recommend providers ask members to present a photo ID card each time non-emergency services are rendered. If you suspect fraud, please contact Provider Services at 1-866-769-3085 immediately. Members must keep and present the state-issued Medicaid ID card in order to receive benefits not covered by NH Healthy Families.

Below is a copy of the Member Identification Card for the Standard Medicaid Product:



Below is a copy of the Member Identification Card for the NH Health Protection Program (NHHPP):



NH HEALTHY FAMILIES' WEBSITE

NH Healthy Families' Public Website

The NH Healthy Families' website can significantly reduce the number of telephone calls a provider will need to make. Utilizing the website allows immediate access to current provider and member information 24-hours, seven days a week. Please contact your Provider Relations Specialist or our Provider Services department at 866-769-3085 with any questions or concerns regarding the website.

The screenshot shows the NH Healthy Families website interface. At the top left is the logo and tagline: "nh healthy families. A health insurance company for New Hampshire's Medicaid population." The top right navigation includes "Search [español]", "Home", "Contact Us", "Newsroom", "Careers", and "Events". Below this are tabs for "Login", "For Members", "For Providers", and "Find a Provider". The main content area is split into two columns. The left column, titled "For Members", lists: "Member Login", "NH Medicaid", "Health Protection Program", "Value Add Benefits – Plan 'Extras'", and "Get Healthy Blog". The right column, titled "For Providers", features "Provider Login" and "Join Our Network" buttons. Below this is an "ambetter" logo with the text "from New Hampshire Healthy Families" and "For Premium Assistance Members" with a "Learn More" button. A green "Featured Items" banner is at the bottom, containing three items: "Join our Mailing List" (with an envelope icon), "Helping our Members" (with a photo of a child), and "Healthy Hat Trick" (with a photo of a group of people). A text box on the right of the featured items says "We Can Help to Manage As a reminder, your health is our #1 priority. ThatR..."

NH Healthy Families' website is located at <http://www.NHhealthyfamilies.com>. Providers can find the following information on the public website:

- Provider Manual
- Provider Billing Manual
- Information regarding electronic transactions
- Prior Authorization List and if a prior authorization is required (by entering a CPT, HCPCs or Revenue code)
- Forms
- NH Healthy Families News
- Clinical Guidelines
- Provider Bulletins
- Provider Newsletters
- Member Handbook

Secure Website

The NH Healthy Families' secure provider website enables providers to check member eligibility and benefits, submit and check status of claims, submit claims adjustments, request authorizations, and send messages to communicate with NH Healthy Families' staff. NH Healthy Families contracted providers and their office staff has the opportunity to register for our **secure provider website quickly and easily**. Here, we offer tools which make obtaining and sharing information easy! It's simple and secure! Go to <http://www.NHhealthyfamilies.com> to register. On the home page, select the Login link on the top right to start the registration process.

In addition to the features mentioned above, you may also:

- View members' health records
- View the PCP panel (patient list)
- View payment history
- View quality scorecard
- Contact us securely and confidentially

We are constantly updating our website with the latest news and information, so save our address to your Internet "Favorites" list and check our site often. You may sign up as soon as your contract is completed. Once you sign up, there is an instruction manual available on the site to answer any questions you may have.

"Provider agrees that all health information, including that related to patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care and other related purposes as permitted by the HIPAA Privacy Rule."

PRIMARY CARE PHYSICIAN

The primary care physician (PCP) is the cornerstone of NH Healthy Families' service delivery model. The PCP serves as the "medical home" for the member. The "medical home" concept assists in establishing a member-provider relationship, supports continuity of care, patient safety, leads to elimination of redundant services and ultimately more cost effective care and better health outcomes. NH Healthy Families offers a robust network of primary care providers to ensure every member has access to a medical home within the required travel distance standards: Two providers within 40 miles or 15 minutes.

Missed Appointments

NH Healthy Families requests that provider's contact the NH Healthy Families' member service department when one of our members' misses an appointment so we can outreach to the member and provide education on the importance of keeping their appointments. This outreach can also assist with reducing missed appointments and reduce the inappropriate use of emergency room services.

Provider Types That May Serve As PCPs

Physicians who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, physician assistants and advanced registered nurse practitioners. The PCP may practice in a solo or group setting or at an FQHC, RHC or outpatient clinic. NH Healthy Families may allow some specialists to serve as a member's PCP for members with multiple disabilities or with chronic conditions,

as long as the specialists agrees, in writing, and is willing to perform the responsibilities of a PCP as stipulated in this Provider Manual.

Member Panel Capacity

All PCPs may reserve the right to state the number of members they are willing to accept into their panel. NH Healthy Families DOES **NOT** guarantee that any provider will receive a certain number of members.

The PCP to member ratio shall not exceed the following:

- Physicians –1: 2,500
- Nurse Practitioner-1: 1,000
- Physician with physician extenders (Nurse Practitioner/Physician Assistant; and Certified Nurse Midwife for OB/GYNs only) may increase by 1,000 per extender.

The panel capacity for Federally Qualified Health Centers will be based upon those standards established by the Health Resources and Services Administration.

If a PCP desires a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact NH Healthy Families' Provider Services at 866-769-3085 or their assigned Provider Relations Specialist.

A PCP shall not refuse to treat members as long as the physician has not reached their requested panel size.

Providers shall notify NH Healthy Families in writing at least 45 days in advance of his or her inability to accept additional Medicaid covered persons under NH Healthy Families' agreements. In no event shall any established patient who becomes a Covered Person be considered a new patient. NH Healthy Families prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non- Medicaid members.

Member Disenrollment

Under certain circumstances, a PCP may remove a Member from his/her panel. A PCP may find that a satisfactory Patient/Provider relationship cannot be developed with a particular Member. The PCP may request a Member be transferred to another practice for any of the following reasons:

- Repeated disregard of medical advice.
- Repeated disregard of Member responsibilities.
- Ongoing personality conflicts between Physician and/or staff with the Member.
- Disruptive behavior that impairs the Provider's ability to provide service to the Member.*¹

*¹ A Member is protected from disenrollment due to diminished mental capacity, special needs, or behavioral health issue.

The PCP may disenroll a Member from his/her care under these circumstances, after NH Healthy Families receives appropriate notification. First, the PCP must send a request, in writing, to disenroll a Member from his or her practice stating the reasons for the proposed disenrollment to:

NH Healthy Families Network Operations

2 Executive Park Drive

Bedford, NH 03110

After NH Healthy Families receives notification from the Provider, the PCP must provide written notice to the Member and send a copy of the notice to the Provider Relations Department. The PCP must provide at least a 30 day notice to the Member for a transition of care and to allow time for the Member Services Department to contact the Member and assist them in selecting another PCP. The PCP is obligated to provide covered services to the Member until the change is completed. NH Healthy Families will provide a listing of other available PCPs to the Member. A PCP should never request a Member be dis-enrolled for any of the following reasons:

- Adverse change in the Member's health status or utilization of services, which are medically necessary for the treatment of a Member's condition.
- On the basis of the Member's age, gender, race, color, religion, national origin, ancestry, marital status, sexual orientation, income status, physical or mental condition or disability, pre-existing condition, occupation, and/or need for health care services.
- Previous inability to pay medical bills or previous outstanding account balances prior to the Member's enrollment with NH Healthy Families.

Medical Home Model

NH Healthy Families is committed to promoting a medical home model of care that will provide better healthcare quality, improve self-management by members of their own care and reduce avoidable costs over time. NH Healthy Families will actively partner with our providers, with community organizations, and groups representing our members to achieve this goal through the meaningful use of health information technology (HIT). NH Healthy Families support to PCPs acting as patient-centered medical homes shall include, but is not limited to, the development of systems, processes and information that promotes coordination of the services to the member outside of that provider's primary care practice.

From an information technology perspective, we offer several HIT applications for our network providers. Our secure **Provider Portal** offers tools that will help support providers in the implementing a medical home model of care. These tools include:

- Online Care Gap Notification
- Member Panel Roster including member detail information
- Care Service Plan
- Summary Member Health Record (MHR)
- Provider Overview Report

Assignment of Medical Home

NH Healthy Families offers a robust network of PCPs to ensure every member has access to a “medical home” within the required travel distance standards- two PCP’s within 40 miles or 15 minutes. For those members who have not selected a PCP during enrollment, NH Healthy Families will use a PCP auto-assignment algorithm to assign an initial PCP. The algorithm assigns members to a PCP according to the following criteria, and in the sequence presented below:

1. Member history with a PCP. The algorithm will first look to see if the member is a returning member and attempt to match them to previous PCP. If the member is new to NH Healthy Families, claim history provided by the state will be used to match a member to a PCP that the member had previous relationship where possible.
2. Family history with a PCP. If the member has no previous relationship with a PCP, the algorithm will look for a PCP that someone in the member’s family, such as a sibling, is or has been assigned to.
3. Geographic proximity of PCP to member residence. The auto-assignment logic will ensure members are assigned with the required travel distance standard – two PCPs within 40 miles or 15 minutes.
4. Appropriate PCP type. The algorithm will use age, gender, and language (to the extent they are known) and other criteria to ensure an appropriate match, such as children assigned to pediatricians and pregnant moms assigned to OB/GYNs.

Pregnant women should choose a pediatrician, or an appropriate PCP, for the care of their newborn baby before the beginning of the last trimester. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, NH Healthy Families will assign one for her newborn.

Health Homes

Health homes are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral healthcare and long- term community-based services and support.

The health home expands on the medical home model by building additional linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses.

Primary Care Physician (PCP) Responsibilities

The PCP shall serve as the member’s initial and most important contact. PCP’s responsibilities include, but are not limited, to the following:

- Establish and maintain hospital admitting privileges sufficient to meet the needs of all associated NH Healthy Families’ members, or entering into an arrangement for management of inpatient hospital admissions of members;
- Manage the medical and healthcare needs of members to assure that all medically necessary services are made available in a culturally competent and timely manner while ensuring patient safety at all times including members with special needs and chronic conditions;
- Educate members on maintaining healthy lifestyles and preventing serious illness;
- Provide screenings, well care and referrals to community health departments and other agencies in accordance with the New Hampshire DHHS requirements and public health initiatives;
- Based on provider assessment, conduct a behavioral health screen to determine whether the

- member needs behavioral health services;
- Maintain continuity of each member’s healthcare by serving as the member’s medical home;
- Offer hours of operation that are no less than the hours of operating hours offered to commercial and fee for service patients;
- Provide referrals for specialty and subspecialty care and other medically necessary services which the PCP does not provide;
- Ensure follow-up and documentation of all referrals including services available under the State’s fee for service program;
- Collaborate with NH Healthy Families’ case management program as appropriate to include, but not limited to, performing member screening and assessment, development of plan of care to address risks and medical needs, linking the member to other providers, medical services, residential, social, community and to other support services as needed;
- Maintain a current and complete medical record for the member in a confidential manner, including documentation of all services and referrals provided to the member, including but not limited to, services provided by the PCP, specialists, and providers of ancillary services.
- Adhere to the EPSDT periodicity schedule for members under age 21;
- Follow established procedures for coordination of in-network and out-of-network services for members, including obtaining authorizations for selected inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency services up to the point of stabilization; as well as coordinating services the member is receiving from another health plan during transition of care;
- Share the results of identification and assessment for any member with special healthcare needs with another health plan to which a member may be transitioning or has transitioned so that those services are not duplicated;
- Actively participate in and cooperate with all NH Healthy Families quality initiatives and programs; and
- Ensure coordination with community mental health programs, including obtaining consent from members to release information regarding primary care.

PCPs may have a formalized relationship with other PCPs to see their members when circumstances like vacation dictate. However, PCPs shall be ultimately responsible for the above listed activities for the members assigned to them, regardless of any additional PCP engagement.

Referrals

It is NH Healthy Families’ preference that the PCP coordinates members’ healthcare services; however, PCPs are encouraged to refer a member when medically necessary care is needed that is beyond the scope of what the PCP can provide. Electronic/Paper referrals are not required. The PCP must obtain Prior Authorization from NH Healthy Families NHHF for referrals to certain specialty providers as noted on the Prior Authorization list found elsewhere in the Provider Handbook and on the NHHF website. No Out of Network (OON) benefit is available for any of NHHF’s Medicaid or Health Care Exchange (Ambetter) products. All Out of Network service requests require Prior Authorization, and may be approved only if the requested services are not available timely within the NHHF Provider Network. NH Healthy Families , at its discretion, will determine which OON Provider a member will be authorized to see when an OON service is required. A provider is also required to promptly notify NH Healthy Families when prenatal care is rendered.

In accordance with State Law, providers are prohibited from making referrals to healthcare entities with

which the provider or a member of the providers' family has a financial relationship.

DHHS Immunization Program

Vaccines are available at no charge to public and private providers for eligible children ages newborn through 18 years through the DHHS Immunization Program (NHIP). DHHS requires providers who administer immunizations to qualified DHHS eligible children to enroll in the NHIP program. Providers should contact the DHHS at:

Immunization Program
Division of Public Health Services
New Hampshire Department of Public Health Services
29 Hazen Drive
Concord, NH 03301

Phone Number: 800-852-3345 ext. 4482

TDD Access Relay: 800-735-2964

Fax: 603-271-3850

Vaccine Shipping: 800-852-3345 ext. 4463

Vaccine Shipping Fax: 603-271-4932

<http://www.dhhs.state.nh.us/dphs/immunization/contact.htm>

NH Healthy Families' participating providers who administer vaccines must enroll in this program through the DHHS. Participating providers must utilize the NHIP program for New Hampshire Health Families' members.

NH Healthy Families will reimburse an administration fee per dose to providers who administer the free vaccine to eligible members. Please refer to the NH Healthy Families Provider Billing Manual for instructions on how to submit claims.

Specialist Responsibilities

NH Healthy Families encourages specialists to communicate to the PCP the need for a referral to another specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the members' care and ensure the referred specialty physician is a participating provider within the NH Healthy Families network and that the PCP is aware of the additional service request. The specialty physician may order diagnostic tests without PCP involvement by following NH Healthy Families' referral guidelines.

The specialist provider must:

- Maintain contact with the PCP
- Obtain authorization from NH Healthy Families' Medical Management Department (Medical Management) if needed before providing services
- Coordinate the member's care with the PCP
- Provide the PCP with consult reports and other appropriate records within five business days
- Be available for or provide on-call coverage through another source 24-hours a day for management of member care
- Maintain the confidentiality of medical information
- Actively participate in and cooperate with all NH Healthy Families quality initiatives and programs

Emergency admissions will require notification to NH Healthy Families’ Medical Management Department within one day of admission to conduct medical necessity review

All non-emergency inpatient admissions require notification to NH Healthy Families Medical Management Department five days prior to admission. Prior authorization will not be required unless the service itself is one that required prior authorization.

NH Healthy Families’ providers should refer to their contract for complete information regarding provider obligations and mode of reimbursement, or contact their Provider Relations Specialist with any questions or concerns.

Mainstreaming

NH Healthy Families considers mainstreaming of its members an important component of the delivery of care and expects its participating providers to treat members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership or physical or behavioral disabilities except where medically indicated. Examples of prohibited practices include:

- Denying a NH Healthy Families’ member a covered services or availability of a facility
- Providing a NH Healthy Families’ member a covered service that is different or in a different manner, or at a different time or at a different location than to other “public” or private pay members or based upon the NHHF program under which the member is enrolled (examples: different waiting rooms or appointment times or days)
- Subjecting a NH Healthy Families’ member to segregation or separate treatment in any manner related to covered services.

Appointment Accessibility Standards

NH Healthy Families follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. NH Healthy Families monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to first, ensure adequate appointment availability and second, reduce unnecessary emergency room utilization.

Type of Appointment	Scheduling Time Frame
Transitional care after inpatient stay (medical or behavioral) – PCP, Specialist or CMHC	Within 7 calendar days of discharge
Transitional care after inpatient stay (medical or behavioral) – Home care	Within 2 calendar days of discharge – must be ordered by PCP, specialty care provider or as part of discharge plan
PCP non-symptomatic office visit	Within 45calendar days of request
PCP non-urgent, symptomatic visits	Within 10 calendar days of request
PCP or other provider Urgent, symptomatic office visits	Within 48 hours

Type of Appointment	Scheduling Time Frame
Mental Health Providers	Care within 6 hours for a non-life threatening emergency Care within 48 hours for urgent care Appointment within 10 business days for a routine office visit
Post Discharge from New Hampshire Hospitals	Contact with community mental health center within 48 hours of psychiatric discharge from a New Hampshire Hospital and follow-up appointment to occur within 7 calendar days
Private Hospital Psychiatric Discharge	Follow-up appointment within 7 calendar days
Emergency Providers (medical and behavioral)	Immediately (24 hours a day, 7 days a week) and without prior authorization

All providers must offer hours of operation that are no less than the hours of operation offered to commercial and fee for service patients.

Covering Providers

PCPs and specialty physicians must arrange for coverage with another provider during scheduled or unscheduled time off and preferably with another NH Healthy Families network provider.

In the event of unscheduled time off, please notify Provider Relations of coverage arrangement as soon as possible. The covering physician is compensated in accordance with the fee schedule in their agreement, and, if not a NH Healthy Families network provider, he/she will be paid as a non- participating provider.

Telephone Arrangements

PCPs and Specialists must:

- Answer the member’s telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a member
- Identify and, when possible, reschedule broken and no-show appointments
- Identify special member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those people with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
 - o After hours telephone care for non-emergent, symptomatic issues within 30 minutes
 - o Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a provider’s absence
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the member’s medical record
- Provide for a system or service to address calls made after office hours.
- During after-hours, a provider must have arrangement for:
 - o Access to a covering physician
 - o An answering service
 - o Triage service, or

- o A voice message that provides a second phone number that is answered
- o Any recorded message must be provided in English and Spanish, if the provider's practice includes a high population of Spanish speaking members

24-Hour Access

NH Healthy Families' PCPs and specialty physicians are required to maintain sufficient access to covered physician services and shall ensure that such services are accessible to members as needed 24 hours a day, seven days a week.

Note: If after-hour urgent care or emergent care is needed, the PCP or his/her designee should contact the urgent care center or emergency department in order to notify the facility. Notification is not required prior to member receiving urgent or emergent care.

NH Healthy Families will monitor appointment and after-hours availability on an ongoing basis through its Quality Improvement program ("QIP").

Examples of unacceptable after-hours coverage include, but are not limited to:

- The provider's office telephone number is only answered during office hours
- The provider's office telephone is answered after-hours by a recording that tells patients to leave a message
- Returning after-hours calls outside thirty minutes

The selected method of 24-hour coverage chosen by the provider must connect the member or caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, the PCP, specialty physician, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

NH Healthy Families will monitor providers' offices through scheduled and un-scheduled visits conducted by NH Healthy Families Provider Relations staff.

Hospital Responsibilities

NH Healthy Families utilizes a network of hospitals to provide services to NH Healthy Families' members. Hospital services providers must be qualified to provide services under the New Hampshire Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations.

Hospitals must:

- Notify the PCP immediately or no later than the close of the next business day after a members' emergency room visit.
- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.
- Notify NH Healthy Families' Medical Management department by sending an electronic file of the ER admission by the next business day. The electronic file should include the member's name, Medicaid ID, presenting symptoms/diagnosis, DOS, and member's phone number.
- Notify NH Healthy Families' Medical Management department of all admissions within one (1)

business day.

- Notify NH Healthy Families' Medical Management department of all newborn deliveries within one business day of the delivery.

Marketing Requirements

All marketing materials utilized by NH Healthy Families must be approved by DHHS prior to distribution to members. Additionally:

NH Healthy Families nor its contracted providers will offer anything of value as an inducement to enrollment including the sale of other insurance to attempt to influence enrollment.

Neither NH Healthy Families nor its contracted providers will directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment.

NH Healthy Families or its contracted providers may not make any written or oral statements in marketing materials that a potential member must enroll with NH Healthy Families in order to obtain benefits or in order not to lose benefits.

NH Healthy Families may not make any assertion or statement in marketing materials that NH Healthy Families is endorsed by CMS, the Federal or State government or similar entity.

NH Healthy Families providers should not create and distribute any marketing materials to NH Healthy Families members' without prior approval by NH Healthy Families and DHHS.

Should you have any questions regarding these marketing requirements, please feel free to contact NH Healthy Families' Provider Services or your Provider Relations Specialist.

Advance Directives

NH Healthy Families is committed to ensure that its members are aware of and are able to avail themselves of their rights to execute advance directives. NH Healthy Families is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

PCPs and providers delivering care to NH Healthy Families' members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

NH Healthy Families recommends to its PCPs and physicians that:

- The first point of contact for the member in the PCP's office should ask if the member has executed an advance directive and the member's response should be documented in the medical record
- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the PCP's office and document this request in the member's medical record
- An advance directive should be included as a part of the member's medical record and include mental health directives

If an advance directive exists, the physician should discuss potential medical emergencies with the member and/or designated family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. If possible, a copy of the advance directive should be collected and placed in members' chart. Any such discussion should be documented in the medical record.

Interpreter Services

NH Healthy Families will make oral interpretation services available free of charge for each member or potential member. Members shall not be charged for interpretation services.

Voluntarily Leaving the Network

Providers must give NH Healthy Families notice of voluntary termination following the terms of their participating agreement with our health plan. In order for a termination to be considered valid, providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of medical records to the member's new provider upon request and facilitate the member's transfer of care at no charge to NH Healthy Families or the member.

NH Healthy Families will notify affected members in writing of a provider termination. The notice shall be provided by the earlier of (1) 15 calendar days after the receipt or issuance of the termination notice, or (2) 15 calendar days prior to the effective date of the termination. Affected members include all members assigned to a PCP and/or all members who have been receiving ongoing care from the terminated provider. If the terminating provider is a PCP, NH Healthy Families will request that the member elect a new PCP within 15 business days of the postmark date of the termination of the PCP notice to members and provide information on options for selecting a new PCP. If a member does not elect a PCP prior to the provider's termination date, NH Healthy Families will automatically assign one to the member.

Providers must continue to render covered services to members who are existing patients at the time of termination until the later of 60 days, the anniversary date of the member's coverage, or until NH Healthy Families can arrange for appropriate healthcare for the member with a participating provider.

Upon request from a member undergoing active treatment related to a chronic or acute medical condition, NH Healthy Families will reimburse the provider for the provision of covered services for a period of up to 90 days from the provider's termination date. In addition, NH Healthy Families will reimburse providers for the provision of covered services to members who are in the second or third trimester of pregnancy extending through the completion of postpartum care relating to the delivery.

Exceptions may include:

- Members requiring only routine monitoring
- Providers unwilling to continue to treat the member or accept payment from NH Healthy Families

NH Healthy Families will also provide written notice to a member within 7 days, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable.

CULTURAL COMPETENCY

Cultural competency within NH Healthy Families is defined as “the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused and family oriented. In particular, it is the promotion of quality services to understand, racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout

the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.”

NH Healthy Families is committed to the development, strengthening and sustaining of a healthy provider/member relationships, establishing multicultural principles and practices throughout its organizational systems of services and programs. NH Healthy Families strives to reduce healthcare disparities, and increase access by providing high quality, culturally competent healthcare. A key component of this goal is NH Healthy Families’ desire to respond to the healthcare needs of all individuals, regardless of their ethnic, cultural, or religious beliefs or native language. For this reason, NH Healthy Families has developed a Cultural Competency Plan (CCP), which is updated and delivered to its network Providers annually. The goal of the Cultural Competency section of this manual is to educate Providers on the key components of our CCP, define expectations for performance, highlight NH Healthy Families’ linguistic / translation services, and provide useful references for developing cultural competence. The CCP’s intent is to be inclusive, but flexible, in order to adapt to the changing needs of Members, and the addition of new components as the plan evolves.

NH Healthy Families’ members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

NH Healthy Families as part of its credentialing will evaluate the cultural competency level of its network providers and provide access to training and tool kits to assist provider’s in developing culturally competent and culturally proficient practices.

Network providers must ensure that:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them
- Medical care is provided with consideration of the members’ race/ethnicity and language and its impact/influence on the members’ health or illness
- Office staff that routinely interact with members have access to and participate in cultural competency training and development
- Office staff that is responsible for data collection and makes reasonable attempts to collect race and language specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children
- Treatment plans are developed with consideration of the members race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may influence the member’s perspective on healthcare
- Office sites have posted and printed materials in English and Spanish, and as required by New Hampshire Department of Health and Human Services (DHHS), any other required non-English language
- Family and Friends should not be used to provide interpretation services except on request from the member. Children shall never serve as an interpreter.

BENEFIT EXPLANATION AND LIMITATIONS

NH Healthy Families Benefits

NH Healthy Families' network providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this Provider Manual, please contact Provider Services at 866-769-3085, Monday through Friday. A Provider Services Representative will assist you in understanding the benefits.

NH Healthy Families covers, at a minimum, those core benefits and services specified in our Agreement with the New Hampshire DHHS. *NH Healthy Families members may not be charged or balance billed for covered services.*

This following list is not intended to be an all-inclusive list of covered services. All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines.

Covered Services	Limits or Requirements	Comments
Adult Day Care	Limited to age 18 and above	
Allergy Services		
Ambulatory Surgery Center	Some services require prior authorization.	
Anesthesia Services		
Audiology Services		
Bariatric Surgery	Prior authorization required.	
Behavioral Health Services*	Includes Community Based, Inpatient and Outpatient Services, Community Mental Health Center Services, and Psychology Services	Services administered by Cenpatico Behavioral Health. 1-866-769-3085.
Birthing Centers	Prior authorization required.	
Chemotherapy		
Chiropractic Care	Includes x-rays and modalities. Annual limit of 12 visits.	Covered by NHHPP only

Dental Services	For persons age 21 and over, limited to the medical services provided to treatment of acute pain or infection. Covered dental services for members under age 21 are those rendered in a physician's office as part of the standard EPSDT exam.	
Dialysis		
Durable Medical Equipment (DME)	Some items require prior authorization.	
Early Periodic Screening Diagnosis and Treatment	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are designed to provide preventative health care, diagnostic services, and early detection and treatment of disease or abnormalities to Medicaid eligible individuals under age 21.	
Emergency Room Services		
Enteral & Parenteral Nutrition for Home Use		
Family Planning		
Fluoride Varnish	For members up to age 5, limited to twice per year.	(PCP/Pediatrician visit)
FQHC & RHC Services		
Gender Reassignment Surgery		Treatment will not be denied or limited on the basis of race, color, national origin, sex, age, or disability. Health Services will not be denied or limited because they are ordinarily available to a different sex than the individual requesting them. Services will not be denied or limited for a transgender individual. Health Services will not be excluded or limited that are related to gender transition.
Hearing Aids and Related Services	Limited to one service every 2 years since the last date of service.	

High Cost Radiology	Prior authorization required.	(MRA,MRI,CT,PET Scan)
Home Health Care Services	Prior authorization required.	
Hospice Care	Prior authorization required.	
Hospital Services: Inpatient	Prior authorization required.	
Hospital Services: Outpatient	Some services require prior authorization.	
Hysterectomy	Not covered if performed for the purpose of an individual permanently incapable of reproducing;	Consent Form Required
Interpreter services – telephonic / face to face	Covered upon request free of charge	
Laboratory Services	Some services require prior authorization.	
Nurtur Disease Management	Asthma Weight Management Program Diabetes Congestive Heart Failure (CHF) Heart Disease COPD Smoking Cessation Puff Free TeleCare Management Program	
Maternity Care Services	Some services require prior authorization	Includes: <ul style="list-style-type: none"> • Nurse mid-wife services • Pregnancy related services • Services for conditions that might complicate pregnancy
Medical Nutrition Therapy	Authorization required.	Covered under the EPSDT program for NH Medicaid & NHHPP.

Medical Services Clinic	Prior authorization required. Limits based on the type of service delivered except for Methadone maintenance or for immunizations.	
Orthotics & Prosthetics (O&P)	Prior authorization required.	
Oxygen and Respiratory Services	Some services require prior authorization.	
Pain Management	Some services require prior authorization.	

Covered Services	Benefit Limitation	Comments
Physician, and Nurse Practitioner Services		
Podiatrist Services	Limited to 4 visits per calendar year	
Private Duty Nursing	Prior authorization required.	
Personal Care Services	Prior authorization required.	For members 18 and over who are chronically wheelchair bound, living in a non-institutional setting and able to self-direct their care.
Prescription Drugs	Please refer to PDL for covered medications Co-pays may apply Some exclusions apply	
Preventative Care	Certain limitations may apply	
Radiology and x-rays	15 per calendar year	
Sterilization Procedures Age 21 and over		Consent Form Required

Substance Use Disorder	<p>Prior authorization may be required.</p> <p>Services administered by Cenpatico Behavioral Health. 1-866-769-3085.</p>	<p>Services may include:</p> <ul style="list-style-type: none"> • Screening, brief intervention, and referral to treatment (SBIRT) • Substance use screenings • Individual, group, and family therapy • Intensive outpatient SUD services • Partial hospitalization • Medically monitored outpatient withdrawal management • Crisis intervention • Peer recovery support • Non-peer recovery support • Continuous recovery monitoring • Inpatient acute or psychiatric hospital services • Opioid treatment services • Medication assisted treatment • Medically monitored residential withdrawal management <p>Residential treatment services, including specialty services for pregnant and postpartum women.</p>
Telemedicine	Covered for specialist care only.	
Therapy (OT, PT, ST) Services (Outpatient)	Prior authorization required after initial evaluation	
Transplant Service	Prior authorization required.	

Transportation (Emergency Ambulance)		
Transportation (Non Emergent Medical)	Must be transportation to medically necessary services	
Vision Services and Eyewear	Treatment for routine vision care, includes one routine eye examine with refraction and eyewear once every two calendar years. Eyewear includes one pair of eyeglasses when there is a 1/2 diopter change in vision.	NH Healthy Families will offer members their choice of glasses from a standard set of frames or will give them a credit towards the frames of their choice.
Wheelchair Van Service	24 trips per year	

Services that are excluded and not covered:

(Please keep in mind that this may not be an all-inclusive list)

Non-Covered Services	Additional Detail	Comments
Abortions (Voluntary)		Not Covered
Alternative Medicine	Acupuncture, Biofeedback	Not Covered
Cosmetic or plastic surgery		Not Covered
Diagnosis and treatment of infertility, impotence and sexual dysfunction		Not Covered
Experimental procedures, drugs and equipment		Not Covered
Personal Comfort Items		Not Covered
Non-Medical Equipment		Not Covered
Physical exams required for employment, insurance or licensing.		Not Covered
Radial Keratotomy		Not Covered

Services not allowed by federal or state law		Not Covered
Weight reduction and control services	This includes: weight loss drugs or products, gym memberships or equipment for the purpose of weight reduction.	Not Covered
Intermediate Care Facility MR		Covered by FFS Medicaid
Medicaid to Schools Services		Covered by FFS Medicaid
Dental Benefit Services		Covered by FFS Medicaid

Non-Covered Services	Additional Detail	Comments
Acquired Brain Disorder Waiver Services		Covered by FFS Medicaid
Developmentally Disabled Waiver Services		Covered by FFS Medicaid
Choices for Independence Waiver Services		Covered by FFS Medicaid
In Home Supports Waiver Services		Covered by FFS Medicaid
Skilled Nursing Facility		Covered by FFS Medicaid
Skilled Nursing Facility Atypical Care		Covered by FFS Medicaid
Inpatient Hospital Swing Beds, SNF		Covered by FFS Medicaid
Intermediate Care Facility Nursing Home		Covered by FFS Medicaid
Intermediate Care Facility Atypical Care		Covered by FFS Medicaid
Inpatient Hospital Swing Beds, ICF		Covered by FFS Medicaid
Glenclyff Home		Covered by FFS Medicaid
Developmental Services Early Supports and Services		Covered by FFS Medicaid
New Substance Abuse Benefit Allowing MLDACs		Covered by FFS Medicaid
Home Based Therapy – DCYF		Covered by FFS Medicaid
Child Health Support Service – DCYF		Covered by FFS Medicaid

Non-Covered Services	Additional Detail	Comments
Intensive Home and Community Services – DCYF		Covered by FFS Medicaid
Placement Services – DCYF		Covered by FFS Medicaid
Private Non-Medical Institution For Children – DCYF		Covered by FFS Medicaid

Value Added Benefits

Value Added Benefits	Details
CentAccount	Dollar amounts awarded for the completion of healthy behaviors. To start receiving rewards the member must complete their Health Needs Assessment and complete a well care visit with their PCP.
Disease Management	Services to help members manage their chronic health conditions. This includes health coach services for asthma and diabetes. Health coaches can also help members quit smoking.
MemberConnections	Representatives trained to promote preventive health and to help members get the community services. MemberConnections representatives will even visit members in their homes when needed. For your NH Healthy Families members who need this type of assistance, complete a referral form or reach out to our call center at 1-866-769-3085.
Start Smart for Your Baby	Program design to support pregnant mothers. This program offers educational materials and personalized case management for those members with complex health conditions. We seek to provide our members helpful information and services as early as possible in pregnancy. If you verify pregnancy of a member, please complete a notice of pregnancy (NOP) form (available on our website) to start the flow of important supports as soon as possible.
Coupon Saver Program	Discount coupons for healthier eating and lifestyle choices at the grocery. Coupons are mailed quarterly to members and more are available on the website along with healthy recipes for healthier eating.

CentAccount Program Rewards

Category	Reward Type	Criteria	Frequency	Reward Amount
EPSDT Visits	Well Child Visits Infant	Must complete all 6 required visits in first 15 months of life	1 per lifetime	\$10
Wellness Screenings	Annual Adult WellVisit	Age 21+ With Assigned PCP	1 per year	\$10
Wellness Screenings	Child Well CareVisits	Age 2 – 20 With Assigned PCP	1 per year	\$10
Wellness Screenings	Diabetes Management (Must Complete A1C, LDL, Eye Exam, nephropathy screening all within a calendar year)	Identified Diabetics	1 per year for completing all four	\$20
Pregnancy (Start Smart)	Prenatal Visits	Must receive all encounter data. NOP required to start earning rewards	Reward for the 3rd, 6th, and 9th prenatal visit	\$10
Pregnancy (Start Smart)	Postpartum Visit	Postpartum visit must occur 21 – 56 days after delivery.	–	\$10

*Substance Use Disorder Benefits

As of July 1, 2016, new substance use disorder benefits became effective in New Hampshire for Medicaid members. Increased coverage to help support those needing help to get to recovery includes:

- Initial Assessments
- Crisis Intervention
- Individual, family, and group counseling
- Withdrawal management
- Suboxone and methadone administration & services
- Intensive outpatient and partial levels of care
- Inpatient rehabilitative services
- Peer recovery support

This new coverage will be added to the stable of existing services that are already in existence to address the needs of people in or trying to get to recovery:

- Integrated Care Management
- Provider Support and Referral Services
- Support for the Homeless
- Naloxone (Narcan) Training Support

SUD Provider Resource Line: 1-844-287-2737

The Substance Use Disorder Provider Resource Line (SUDPRL) is available to NH Healthy Families providers who are seeking a course of action for a patient who needs help with his or her addiction. The SUDPRL is staffed by specially-trained Case Managers who help you easily access information, options for treatment, and tools necessary for your patient's recovery.

The staff answering this phone line have years of experience and education focused in the area of substance use disorders. Our clinicians are independently Licensed Mental Health Specialists (LMHCs) with extensive experience in dealing with issues of behavioral health and substance use disorders including direct services.

The Substance Use Disorder (SUD) Case Manager provides you support in real time and directs you to the information or resources appropriate for the patient's treatment. The SUD Case Manager may provide any or all of the following services and resources:

- A fast assessment of your current patient's situation to determine the correct level of care. NH Healthy Families supports and has resources in-network for all four ASAM levels of treatment.
- Fingertip access to available care resources and the ability to make immediate referrals with no prior authorizations.
- Optional conversations on the spot with the patient if needed.
- The ability to coordinate a direct conversation with the Behavioral Health Medical Director
- A link to access educational material from Providers' Clinical Support System for Opioid Therapies (PCSS-O.org), National Resource
- Continuing coordination of care with inpatient or outpatient specialists or facilities
- Assistance with bridging the patient to an appropriate program

Depending on the needs of your patient, you may choose to follow a path independently with the patient or further engage the Case Manager to assist in choosing the right therapy or treatment. If clinically appropriate, the member will have an opportunity to enroll into CeltiCare Health's Integrated Case Management program to receive support and help with care coordination on an on-going basis

ASAM Treatment Levels

The SUD Case Manager can coordinate or assist with obtaining the following types of care for your patient:

- ASAM Level 1: Outpatient therapy
- ASAM Level 2: Outpatient program at a facility
- ASAM Level 3: Inpatient services at a facility
- ASAM Level 4: Admission to an acute level of care

CentAccount

A Health Needs Assessment (HNA) must be completed before member can earn rewards.

The goal of the CentAccount program is to increase appropriate utilization of preventive services by rewarding members for practicing a targeted healthy behavior. The program will strengthen the relationship with the medical home as members regularly access preventive services, and will promote personal responsibility for and ownership of the member's own healthcare. CentAccount also benefits members because it provides them with credits to purchase healthcare items, such as over-the-counter medications that they might otherwise not be able to afford. Services that will qualify for rewards through the program include completion of, annual adult well visits, EPSDT visits, certain disease-specific screenings, and completion of prenatal and postpartum care.

How does it work? Upon completion of the Health Risk Screening, located inside the members Welcome Packet, the member will receive a prepaid CentAccount card. Credit will be added to the account balance once the member receives certain screenings or preventive care. Members may use the cards to purchase approved healthcare goods and services at certain stores and pharmacies. CentAccount goods and services are those recognized by the Internal Revenue Service as healthcare expenses for flexible spending accounts. In addition to the aforementioned goods and services, members may use the cards to pay for licensed childcare services, utilities, public transportation, and telecommunication services (i.e. SafeLink if available, cell/home phones).

Non-Emergency Medical Transportation

NH Healthy Families will arrange for the non-emergency transportation of members for medically necessary services requested by the member or someone on behalf of the member. NH Healthy Families will require the transportation provider to schedule transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; and not be picked up prior to completion of treatment. NH Healthy Families requests its participating providers, including its transportation vendor, to inform our Member Services department when a member misses a transportation appointment so we can educate the member on the importance of keeping medical appointments.

Prescription Drug Copayments

A copayment may be required for each prescription

NH Healthy Families members may be charged a copayment at the pharmacy for covered prescription drugs, unless the prescription category is exempted or the member is included in the member exempt categories, as described below (see Members who are exempt from copayments).

A "copayment" or "copay" is the fixed amount the member may pay each time they fill and refill a prescription. Prescription drug copayment amounts are subject to change.

In 2018, prescription drug copayments are:

- \$1 copayment for each preferred prescription drug, approved by the New Hampshire Department of Health and Human Services (NH DHHS). The drugs on this list include both generic and brand name drugs carefully selected by the plan with help from a team of doctors and pharmacists. The NH Healthy Families List of Covered Drugs is called "Preferred Drug List (PDL)."
- \$2 copayment for each non-preferred prescription drug (if the prescribing provider determines that a preferred drug will be less effective and/or will have adverse effects for the member, the non-preferred

Provider Services Department 1-866-769-3085 (TDD/TTY 1-855-742-0123)

NH Health Families is underwritten by Granite State Health Plan, Inc.

drug will be \$1.00). NH Healthy Families Incorporates a Preferred Drug List. A notation of ‘Non-Formulary’ corresponds to drugs identified on the NH Healthy Families PDL indicating the trial and failure of preferred alternatives. The number of preferred drugs that must be tried prior to approval of non-formulary drugs varies by therapeutic drug class. To request approval of a non-formulary drug please submit rational via prior authorization request form to Envolve Pharmacy Solutions (fax 1-866-399-0929.)

- \$1 copayment for a prescription drug that is not identified as either a preferred or non-preferred prescription drug.
- Copayments are not required for family planning products or for Clozaril® (Clozapine) prescriptions.

Members who are exempt from copayments

NH DHHS determines whether a member is exempt from prescription copayments.

Members do not have to pay a copayment if they:

- Fall under the designated income threshold (100% or below the federal poverty level);
- Are under age 18 years;
- Are in a nursing facility or in an intermediate care facility for individuals with intellectual disabilities;
- Participate in one of the Home and Community Based Care (HCBC) waiver programs;
- Are pregnant and receiving services related to your pregnancy or any other medical condition that might complicate your pregnancy;
- Are receiving services for conditions related to your pregnancy and your prescription is filled or refilled within 60 days after the month your pregnancy ended;
- Are in the Breast and Cervical Cancer Program;
- Are receiving hospice care; or
- Are a Native American or Alaskan Native.

Members who qualify for any of these exemptions and are charged a copayment, may contact NH DHHS Customer Service Center toll-free at **1-844-ASK-DHHS** (TDD Relay Access: 1-800-735-2964), Monday through Friday, 8:00 a.m. to 4:00 p.m. ET.

Network Development and Maintenance

NH Healthy Families will ensure the provision of covered services as specified by the State of New Hampshire. Our approach to developing and managing the provider network begins with a thorough analysis and evaluation of the New Hampshire DHHS network adequacy requirements for the Managed Care Organization networks. NH Healthy Families will develop and maintain a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members, both adults and children, without excessive travel requirements, and that is in compliance with New Hampshire DHHS access and availability requirements. NH Healthy Families may not require a provider or provider group to enter into an exclusive contracting arrangement with NH Healthy Families as a condition for network participation.

NH Healthy Families offers a network of PCPs to ensure every member has access to a medical home within the required travel distance standards. Physicians who may serve as PCPs include internists, pediatricians, obstetrician/gynecologists, family and general practitioners, physician assistant and advanced registered nurse practitioners. In addition, NH Healthy Families will have available, at a minimum, the following specialists for members on at least a referral basis:

- Allergy
- Dermatology
- Family Medicine
- Internal Medicine
- General practice
- Cardiology
- Endocrinology
- Gastroenterology
- Hematology/Oncology
- Infectious Disease
- Nephrology
- Pulmonary Disease
- Rheumatology
- Neurology
- Obstetrics and Gynecology
- Ophthalmology
- Optometry
- Orthopedics
- Otolaryngology
- Pediatric (General)
- Pediatric (Subspecialties)
- Cardiology
- Hematology/Oncology
- Physical Medicine and Rehabilitation
- Podiatry
- Psychiatrist-Adult/General
- Psychiatrist-Child/Adolescent
- Psychologists/Other Therapies
- Surgery (General)
- Urology
- Vision Care/Primary Eye Care

In the event NH Healthy Families network is unable to provide medically necessary services required under the contract, NH Healthy Families shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances. For assistance in making a referral to a specialist or subspecialties for a NH Healthy Families' member, please contact our Medical Management team at 866-769- 3085 and we will identify a provider to make the necessary referral.

Tertiary Care

NH Healthy Families offers a network of tertiary care inclusive of level one and level two trauma centers, Hemophilia Centers, Neonatal intensive care units, perinatology services, comprehensive cancer services, comprehensive cardiac services and pediatric sub specialists available 24-hours per day in the geographical service area. In the event NH Healthy Families' network is unable to provide the necessary tertiary care services required, NH Healthy Families shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

MEDICAL MANAGEMENT

Overview

NH Healthy Families' Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m. (excluding holidays). After normal business hours, our 24 Hour Nurse Advice Line staff is available to answer questions about prior authorization. Medical Management services include the areas of utilization management, case management, disease management, and quality review. The department's clinical services are overseen by the NH Healthy Families' medical director ("Medical Director"). The Director of Medical Management has responsibility for direct supervision and operation of the department. To reach the Medical Director or VP of Medical Management contact:

Medical Management

Phone: 1-866-769-3085

Prior Authorizations: 1-866-270-8027

Concurrent Review: 1-877-295-7682

<http://www.NHhealthyfamilies.com>

Utilization Management

The NH Healthy Families Utilization Management Program (UMP) is designed to ensure members of NH Healthy Families network receive access to the right care, at the right place, at the right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care and ancillary care services.

NH Healthy Families' UMP seeks to optimize a member's health status, sense of wellbeing, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our program goals include:

- Monitoring utilization patterns to guard against over- or under- utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of case and/or disease management for members with complex healthcare needs or those at risk for significant healthcare expenses
- Development of an infrastructure to ensure that all NH Healthy Families' members establish relationships with their PCPs to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self-management
- Creation of partnerships with members/providers to enhance cooperation and support for UMP goals

Referrals – In support of the Medical Home healthcare delivery model, PCPs should coordinate the healthcare services for NH Healthy Families' members. PCPs can refer a member to an in network specialist when care is needed that is beyond the scope of the PCP's training or practice parameters; however, **paper referrals are not required**. To better coordinate a member's healthcare, NH Healthy Families encourages specialists to communicate with the PCP the need for a referral to another specialist rather than making such a referral themselves.

Notifications – A provider is required to promptly notify NH Healthy Families when prenatal care is rendered. Early notification of pregnancy allows the health plan to assist the member with prenatal care coordination of services.

Prior Authorizations – Some services require prior authorization from NH Healthy Families in order for reimbursement to be issued to the provider. All out-of-network services require prior authorization. To verify whether a prior authorization is necessary or to obtain a prior authorization, please use the Code Checker tool at <http://www.NHhealthyfamilies.com> or contact medical management at 866-769-3085.

Prior Authorization requests may be submitted electronically following the ANSI X 12N 278 transaction code specifications. For more information on conducting these transactions electronically contact:

NH Healthy Families c/o Centene EDI Department

1-800-225-2573, extension 25525

Or by e-mail at:

EDIBA@centene.com

Self-Referrals

The following services do not require prior authorization or referral:

- Emergency services including emergency ambulance transportation
- OB/GYN services with a participating provider
- Women’s health services provided by a Federally Qualified Health Center (FQHC) or Certified Nurse Practitioner (CNP)
- Family planning services and supplies from a qualified Medicaid family planning provider
- General optometric services (preventative eye care) with a participating provider

Note: Except for emergency and family planning services, the above services must be obtained through NH Healthy Families’ network providers.

Prior Authorization and Notifications

Prior Authorization is a request to the NH Healthy Families’ Utilization Management (UM) department for approval of services on the Prior Authorization list, before the service is delivered. Authorization must be obtained prior to the delivery of certain elective and scheduled services.

Routine Prior authorization should be requested at least five calendar days before the scheduled service delivery date or as soon as the need for service is identified. Services that require authorization by NH Healthy Families are listed in the *Benefits and Services Requiring Authorization* Table as contained in this Provider Manual. The PCP must contact the UM department via telephone, fax or through our website with appropriate supporting clinical information to request an authorization. All out-of-network services require prior authorization and will require NH Healthy Families’ Medical Director review and approval. Below is a Table reflecting those services that require prior authorization.

This list is not all-inclusive. Please visit <http://www.NHhealthyfamilies.com> and use the Prior Authorization Prescreen Tool or contact the medical management at 866-769-3085 for assistance.

Non-emergency Out of Network services are not covered unless the requested services are not able to be obtained timely within the NHHF Provider Network. All Out-of-Network (OON) services require Prior Authorization and will require NHHF Medical Director review and approval. NHHF, in its discretion, will determine which OON Provider a member will be authorized to see when an OON service is determined by NHHF to be required. **Authorization requests for non-emergency Out of Network care must be submitted to NHHF at least 10 calendar days prior to the proposed date of service,** (inclusive of all clinical information needed to make a coverage determination). If a non-emergency OON service request is received without at least 10 calendar days of lead time, services provided that are determined to be medically necessary by NHHF will be reimbursed at no more than 100% of the NH Medicaid fee schedule. App Prior Authorization requests must be submitted to the NHHF UM department via telephone, fax or through our website with appropriate supporting clinical information to request an authorization. Below is a Table reflecting those services that require prior authorization. This list is not all-inclusive. Please visit www.NHhealthyfamilies.com and use the Prior Authorization Prescreen Tool or contact the medical management at 866-769-3085 for assistance.

Procedures/Services	Inpatient Notification	Ancillary Services
<ul style="list-style-type: none"> ✓ All procedures and services performed by out of network providers (except ER, urgent care and family planning) 	<ul style="list-style-type: none"> ✓ All elective/scheduled admissions at least 5 business days prior to the scheduled date of admit 	<ul style="list-style-type: none"> ✓ Air Ambulance Transport (non-emergent fixed wing airplane)
<ul style="list-style-type: none"> ✓ Potentially Cosmetic including but not limited to: blepharoplasty, mammoplasty, otoplasty, rhinoplasty, septoplasty, varicose vein procedures, reconstructive or plastic surgery 	<ul style="list-style-type: none"> ✓ All services performed in out-of network facility 	<ul style="list-style-type: none"> ✓ DME - *certain services may require authorization. Please use the Prior Authorization Prescreen Tool at http://www.NHhealthyfamilies.com to verify what dual medical equipment requires prior

Procedures/Services	Inpatient Notification	Ancillary Services
<ul style="list-style-type: none"> ✓ Experimental or investigational 	<ul style="list-style-type: none"> ✓ Hospice care 	<ul style="list-style-type: none"> ✓ Home healthcare services including , home infusion, skilled nursing, and therapy <ul style="list-style-type: none"> • Home Health Services • Private Duty Nursing • Hospice • Furnished Medical Supplies & DME
<ul style="list-style-type: none"> ✓ High Tech Imaging (i.e. CT, MRI, PET) 	<ul style="list-style-type: none"> ✓ Rehabilitation facilities 	<ul style="list-style-type: none"> ✓ Orthotics/Prosthetics billed with an “L” code - Please use the Prior Authorization Prescreen Tool
<ul style="list-style-type: none"> ✓ Bariatric surgery 	<ul style="list-style-type: none"> ✓ Skilled nursing facility 	<ul style="list-style-type: none"> ✓ Therapy (ongoing services) <ul style="list-style-type: none"> Occupational Physical Speech
<ul style="list-style-type: none"> ✓ Obstetrical Ultrasound – two allowed in 9 month period, any additional will require prior authorization except those rendered by perinatologists. <p><i>For urgent/emergent ultrasounds, treat using best clinical judgment and it will be reviewed retrospectively.</i></p>	<ul style="list-style-type: none"> ✓ Transplants, including evaluation 	<ul style="list-style-type: none"> ✓ Hearing Aid devices including cochlear implants
<ul style="list-style-type: none"> ✓ Oral Surgery 	<ul style="list-style-type: none"> ✓ Observation Stays exceeding 24 hours require Inpatient Authorization 	<ul style="list-style-type: none"> ✓ Genetic Testing
<ul style="list-style-type: none"> ✓ Pain Management 	<ul style="list-style-type: none"> ✓ Notification for all Urgent/Emergent Admissions: <ul style="list-style-type: none"> ✓ Within 1 business following date of admission ✓ Newborn Deliveries must include birth outcomes 	<ul style="list-style-type: none"> ✓ Quantitative Urine Drug Screen
<ul style="list-style-type: none"> ✓ Certain Bio Pharmaceuticals and Specialty Injections (please refer to website for complete list) 		

Emergency room and post stabilization services never require prior authorization. Providers must notify NH Healthy Families of post stabilization services such as but not limited to the weekend or holiday provision of home health, durable medical equipment, or urgent outpatient surgery, within one business day of the service initiation. Providers should **notify NH Healthy Families of emergent inpatient admissions within one business day** of the admission for ongoing concurrent review and discharge planning. Maternity admissions require notification and information on the delivery outcome. Clinical information is required for ongoing care authorization of the service.

Failure to obtain authorization may result in administrative claim denials. NH Healthy Families' providers are contractually prohibited from holding any NH Healthy Families' member financially liable for any service administratively denied by NH Healthy Families for the failure of the provider to obtain timely authorization.

Authorization Determination Timelines

NH Healthy Families decisions are made as expeditiously as the member's health condition requires. For standard service authorizations the decision and notification will be made no more than 14 calendar days from receipt of the request (unless an extension is requested). "Necessary information" includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. Failure to submit necessary clinical information within forty-eight (48) hours of the request can result in an administrative denial of the requested service. For urgent/expedited pre-service requests, a decision and notification is made within 72 hours of the receipt of the request, unless sufficient information is not provided. For urgent concurrent review of ongoing inpatient admission and other services such as outpatient rehabilitation, home care or ongoing specialty care decisions are made within 24 hours of receipt of the request. Written or electronic notification includes the number of days of service approved, and the next review date. Determinations for diagnostic radiology services are made within **two (2) calendar days** after receipt of the request if all clinical information is received.

Second Opinion

NH Healthy Families will reimburse for a second opinion from a qualified health professional within the provider network or arrange for the member to obtain a second opinion outside the network. Medical Management may be contacted to assist in the coordination of second opinions.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the medical necessity of the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff bylaws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

Clinical Information

Authorization requests may be submitted by fax, phone or secure web portal. Authorization determinations may be communicated to the provider fax, phone, secure email, or secure web portal. Adverse determinations will be followed up in writing. When calling our prior authorization department, a referral specialist will enter demographic information and then transfer the call to a NH Healthy Families' nurse

for the completion of medical necessity screening. During heavy call volumes, a nurse may answer the telephone and complete the medical necessity screening during the call. For all services on the prior authorization list, documentation supporting medical necessity will be required.

NH Healthy Families' clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), NH Healthy Families is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the member.

Information necessary for authorization of covered services may include but is not limited to:

- Member's name, member ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g. primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate.

If additional clinical information is required, a nurse or medical service representative will notify the caller of the specific information needed to complete the authorization process.

Clinical Decisions

NH Healthy Families affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. NH Healthy Families does not reward practitioners or other individuals for issuing denials of service or care.

Participating providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating physician, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. The PCP, in consultation with the NH Healthy Families' Medical Director, is responsible for making utilization management (UM) decisions in accordance with the member's plan of covered benefits and established medical necessity criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Medical Necessity

Medical necessity is defined by NH Healthy Families as healthcare services, supplies or equipment provided by a licensed healthcare professional that are:

- Appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury
- In accordance with the standards of good medical practice consistent with evidence based and clinical practice guidelines
- Not primarily for the personal comfort or convenience of the member, family, or provider
- The most appropriate services, supplies, equipment, or level of care that can be safely and efficiently provided to the member
- Furnished in a setting appropriate to the patient's medical need and condition and, when supplied to the care of an inpatient, further mean that the member's medical symptoms or conditions require that the services cannot be safely provided to the member as an outpatient service
- Not experimental or investigational or for research or education

For member's 21 years of age and older the following definition of medical necessity shall be used: "Medically necessary" means health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a member for the purpose of evaluating, diagnosing, preventing or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

- Clinically appropriate in terms of type, frequency of use, extent, site, and duration, and consistent with the established diagnosis or treatment of the member's illness, injury, disease, or its symptoms;
- Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;
- No more costly than other items or service which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and
- Not experimental, investigative, cosmetic, or duplicative in nature.

For ESPDT services, the following definition of medical necessity shall be used: "Medically necessary" means reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the EPSDT member requesting a medically necessary service.

Review Criteria

NH Healthy Families has adopted utilization review criteria developed by McKesson InterQual® products to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. InterQual is utilized as a screening guide and is not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical expertise in treating the member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 866-769-3085. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted by calling NH Healthy Families main toll-free phone number and asking for the Medical Director. A case manager may also coordinate communication between the Medical Director and requesting practitioner.

Members, or healthcare professionals with the member's consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

NH Healthy Families
Grievance Coordinator
2 Executive Park Drive
Bedford, NH 03110
Phone: 1-866-769-3085
Fax: 1-877-301-8595

New Technology

NH Healthy Families evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the NH Healthy Families' population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department at 1-866-769-3085.

Notification of Pregnancy

Members that become pregnant while covered by NH Healthy Families may remain a NH Healthy Families member during their pregnancy. The managing or identifying physician should notify the NH Healthy Families' prenatal team by completing the Notification of Pregnancy (NOP) form within five days from the confirmation of pregnancy. Providers are expected to identify the estimated date of confinement and delivery facility. The NOP includes an optional prenatal vitamin order form. NH Healthy Families will facilitate the physician's order of a 90 day supply of prenatal vitamins for the member to be delivered to the managing provider's office by the member's next prenatal visit. See the Case Management section for information related to our Start Smart for Your Baby® program and our 17-P program for women with a history of early delivery.

Concurrent Review and Discharge Planning

Nurse Case Managers perform ongoing concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the member's attending physician. The Case Manager will review the member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within 24 hours of receipt of the request. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or c-section delivery does not require concurrent review, however; the hospital must notify NH Healthy Families within two business days of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services provided to a member, but for which authorization and/or timely notification to NH Healthy Families was not obtained due to extenuating circumstances (i.e. member was unconscious at presentation, member did not have their New Hampshire Medicaid card or otherwise indicated New Hampshire Medicaid coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within 30 calendar days following receipt of the request.

SPEECH THERAPY AND REHABILITATION SERVICES

NH Healthy Families offers our members access to all covered, medically necessary outpatient and home health physical, occupational and speech therapy services through Cenpatico, Specialty Therapy and Rehabilitative Services (STRS).

Providers need to adhere to the Covered Professional Services & Authorization Guidelines set forth in this Manual when rendering services. Network Providers may provide a covered initial evaluation/assessment to a member without seeking authorization from Cenpatico. Non-Network Providers must complete an Outpatient Treatment Request (OTR) form for all services. Once the evaluation/assessment is completed, all Providers must submit a fax or web authorization to Cenpatico to obtain authorization for services. Cenpatico does not retroactively authorize treatment.

Prior authorization for outpatient and home health occupational, physical or speech therapy services, should be submitted to Cenpatico STRS using the Outpatient Treatment Request (OTR) form located at <http://www.Cenpatico.com>. The completed form and necessary clinical information to include prescription, and most recent evaluation or re-evaluation should be sent to:

Cenpatico STRS Outpatient Therapies Prior Authorization
Fax number: 1-877-658-0322

Providers can also submit authorization online on the NH Healthy Families website at <http://www.NHHealthyFamilies.com>.

In the event that the practitioner is unable to provide timely access for a member, Cenpatico STRS will assist in securing authorization to a practitioner to meet the member's needs in a timely manner.

STRS Medical Necessity Criteria

Cenpatico STRS created and applies medical necessity criteria developed using Clinical Practice Guidelines of the physical, occupational and speech therapy professional associations, as well as InterQual Criteria for both Adult and Pediatric guidelines. The criteria can be found on the Cenpatico STRS website at: <http://www.Cenpatico.com>. Cenpatico STRS utilizes Occupational, Physical and Speech Therapists to process Outpatient Treatment Requests. Our specialized approach allows for real time interaction with the provider to best meet the overall therapeutic needs of the members.

STRS Outpatient Treatment Request (OTR)

When requesting sessions for outpatient and home health therapy services that require authorization, the Provider must complete an Outpatient Treatment Request (OTR) form and submit the completed form to Cenpatico for clinical review prior to provision of services. The OTR is located on our website at <http://www.cenpatico.com>. Providers may call the Customer Service department at 866-769-3085 to check status of an OTR. Providers should allow up to fourteen (14) calendar days after date of receipt to process non-urgent requests.

IMPORTANT:

- The OTR must be completed in its entirety. Failure to submit a completed request will result in an upfront rejection will not be processed, and providers will be required to resubmit to be considered for authorization. The following are considered an incomplete submission:
 - o Name of Provider is missing/illegible
 - o Contact name was not provided and/or is illegible
 - o Eligibility cannot be verified for the member with the information provided
 - o MD Signature on Prescription or Plan of Care is missing, outdated or stamped (must be actual or electronic signature)
 - o Documentation of Verbal Order is missing or out of date (not required if there is a prescription)
 - o Member already has an authorization on file for the same service with a different provider (transfer of provider letter from the member is required to process the request)
 - o Plan of Care or Evaluation missing or out of date
- A Plan of Care (POC). Specific requirements are as follows:
 - o Home Health: Must be updated and signed every 60 days
 - o EPSDT: Must be updated and signed every 6 months
- Physician prescription or physician signed POC must be included in submission
- Cenpatico will not retroactively certify routine sessions. Except in the following circumstances:
 - o Member did not have their Medicaid card or otherwise indicate Medicaid coverage (providers should check eligibility every 30 days)
 - o Services authorized by another payer who subsequently determined member was not eligible at the time of services
 - o Member received retro-eligibility from Department of Medicaid Services.
 - o Services occurred during a transition of care period
- The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of the authorization.
- Cenpatico's utilization management decisions are based on Cenpatico's established Medical Necessity Guidelines. Cenpatico does not reimburse for unauthorized services and each Provider Agreement precludes Network Providers from balance billing (billing a member directly) for covered services with the exception of copayment and/or deductible collection, if applicable. Cenpatico's authorization of covered services is an indication of Medical Necessity, not a confirmation of member eligibility, and not a guarantee of payment.

STRS Appeals

For outpatient and home health, physical, occupational, and speech therapy authorization appeals and retroactive authorization requests, please submit via fax to 1-866-714-7991 or via mail to:

Cenpatico
Attn: Appeals
12515 Research Blvd., Building 8, Suite 400
Austin, TX 78759

For more detailed information related to Grievances and Appeals, see the applicable section in this Manual. For more detailed information about Cenpatico STRS, please visit our website at <http://www.Cenpatico.com>.

RADIOLOGY AND DIAGNOSTIC IMAGING SERVICES

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, NH Healthy Families is using National Imaging Associates (NIA) to provide prior authorization services and utilization. NIA focuses on radiation awareness designed to assist providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA
- PET Scan

KEY PROVISIONS:

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment.

To reach NIA and obtain authorization, please call 866-769-3085 and follow the prompt for radiology authorizations. NIA also provides an interactive website which may be used to obtain online authorizations. Please visit <http://www.RadMD.com> for more information or call our Provider Services department at 866-769-3085.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21, provision of which is mandated by state and federal law. EPSDT services include periodic screening, vision dental and hearing services. In addition, the need for corrective treatment disclosed by such child health screenings must be arranged (directly or through referral) even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

NH Healthy Families and its providers will provide the full range of EPSDT services as defined in, and in accordance with, New Hampshire state regulations and New Hampshire Department of Health and Human Services' policies and procedures for EPSDT services. Such services shall include, without limitation, periodic health screenings and appropriate up to date immunization using the Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule and the American Academy of Pediatrics periodicity schedule for pediatric preventative care. This includes provision of all medically necessary services whether specified in the core benefits and services or not, except those services (carved out/excluded/prohibited services) that have been identified herein. The following minimum elements are to be included in the periodic health screening assessment:

- Comprehensive health and developmental history (including assessment of both physical and mental development);
- Comprehensive unclothed physical examination;
- Appropriate behavioral health and substance abuse screening;
- Immunizations appropriate to age and health history;
- Laboratory tests; Vision screening and services, including at a minimum, diagnosis and treatment for defects in vision, including eyeglasses;
- Dental screening and services;
- Hearing screening and services, including at a minimum, diagnosis and treatment for defects in hearing, including hearing aids; and
- Health education, counseling and anticipatory guidance based on age and health history.

Provision of all components of the EPSDT service must be clearly documented in the PCP's medical record for each member.

NH Healthy Families requires that providers cooperate to the maximum extent possible with efforts to improve the health status of New Hampshire citizens, and to actively participate in the increase of percentage of eligible members obtaining EPSDT services in accordance with the adopted periodicity schedules. NH Healthy Families will cooperate and assist providers to identify and immunize all members whose medical records do not indicate up-to-date immunizations.

Provider shall participate in the DHHS Immunization Program (NHIP). **Vaccines must be billed with the appropriate administration code and the vaccine detail code.**

EMERGENCY CARE SERVICES

NH Healthy Families defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairments of bodily functions, or (3) serious dysfunction of any bodily organ or part as per 42 CFR 438.114.(a).

Members may access emergency services at any time without prior authorization or prior contact with NH Healthy Families. If members are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or NH Healthy Families' 24 hour Nurse Triage Line (24 Hour Nurse Advice Line) at 866-769-3085 for assistance; however, this is not a requirement to access emergency services. NH Healthy Families contracts with emergency services providers as well as non-emergency providers who can address the member's non-emergency care issues occurring after regular business hours or on weekends.

Emergency services are covered by NH Healthy Families when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by NH Healthy Families. Emergency services will cover and reimburse regardless of whether the provider is in NH Healthy Families provider network and will not deny payment for treatment obtained under either of the following circumstances:

- A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or
- A representative from the Plan or a network provider instructs the member to seek emergency services.

Once the member's emergency medical condition is stabilized, NH Healthy Families requires notification for hospital admission or prior authorization for follow-up care as noted elsewhere in this handbook.

Our members have many questions about their health, their primary care provider, and/or access to emergency care. Our health plan offers a nurse line service to help members proactively manage their health needs, decide on the most appropriate care, and encourage members to talk with their physician about preventive care.

24 Hour Nurse Advice Line is our 24 hour, seven day per week nurse line for members. Registered nurses provide basic health education, nurse triage, and answer questions about urgent or emergency access through the 24 Hour Nurse Advice Line service. Our staff often answers basic health questions, but is also available to triage more complex health issues using nationally-recognized protocols. Members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use 24 Hour Nurse Advice Line to request information about providers and services available in the community after hours, when the NH Healthy Families Member Services department ("Member Services") is closed. The 24 Hour Nurse Advice Line staff is available in both English and Spanish and can provide additional translation services if necessary.

We provide this service to support your practice and offer our members access to a registered nurse at any time – day or night. If you have any additional questions, please call Provider Services or 24 Hour Nurse Advice Line at 866-769-3085.

WOMEN'S HEALTHCARE

NH Healthy Families will provide direct access to a health specialist in network for core benefits and services necessary to provide women routine and preventive healthcare services in addition to the member's PCP if the provider is not a women's health specialist. Members are allowed to utilize their own PCP or any family planning service provider for family planning services without the need for a referral or a prior authorization. In addition, members will have the freedom to receive family planning services and related supplies from an out of network provider without any restrictions. Family planning services include but are not limited to:

- Consultation with trained personnel regarding family planning, contraceptive procedures, immunizations and sexually transmitted diseases
- Distribution of literature relating to family planning, contraceptive procedures, and sexually transmitted diseases
- Provision of contraceptive procedures and contraceptive supplies by those qualified to do so under the laws of the State in which services are provided
- Referral of members to physicians or health agencies for consultation, examination tests, medical treatment and prescription for the purposes of family-planning, contraceptive procedures, and treatment of sexually transmitted diseases as indicated
- Immunization services where medically indicated and linked to sexually transmitted diseases including but not limited to Hepatitis B and chlamydia immunizations
- Abortions will only be considered a covered benefit in the following situations: 1) If the pregnancy is the result of an act of rape or incest and 2) In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed in accordance with 42 CFR 441.202.

NH Healthy Families will make every effort to contract with all local family planning clinic and providers and will ensure reimbursement whether the provider is in or out of network.

CLINICAL PRACTICE GUIDELINES

NH Healthy Families clinical and quality programs are based on evidence based preventive and clinical practice guidelines. NH Healthy Families adopts guidelines based on the health needs of the membership and opportunities for improvement identified as part of the Quality Improvement program. The Guidelines are based on valid and reliable clinical evidence formulated by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field. Clinical Practice Guidelines are reviewed annually and updated to reflect the current standard of care. Practice Guidelines may be reviewed and updated off-cycle when nationally recognized updates are published. All guidelines are reviewed and approved annually by NH Healthy Families' Quality Improvement Committee. These guidelines are used for both preventive services as well as for the management of chronic diseases. NH Healthy Families providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Improvement Program. Following is a sample of the clinical practice guidelines adopted by NH Healthy Families.

The guidelines:

- Consider the needs of the Members.
- Are adopted in consultation with Network Providers.
- Are reviewed and updated periodically, as appropriate.

Preventive and chronic disease guidelines and recommendations include, but are not limited to:

- Guidelines for Adult, Adolescent, Pediatric Preventive Care
- Guidelines for Diagnosis and Management of Asthma.
- Clinical Practice Guidelines and Standards for Diabetes Care.
- Guidelines for the Diagnosis and Evaluation of the Child with Attention Deficit Hyperactivity Disorder (ADHD).
- Hypertension.
- Clinical Practice Guideline for the Treatment of patients with Major Depressive Disorder.
- Recommendations for Routine Perinatal Care.

The website provides access to new clinical practice guidelines as well as any updates or revisions to existing guidelines. Practitioners are advised how to access or receive copies of the guidelines through this Provider Manual, the NH Healthy Families' website, and in the Provider newsletters, Provider Report. For links to the most current version of the guidelines adopted by NH Healthy Families, visit our website at <http://www.NHHealthyFamilies.com>. If you would like more information or want to request a paper copy, please contact the Quality Improvement Department at 866-769-3085. The following is a sample of the clinical practice guidelines adopted by NH Healthy Families.

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: [Standards of Medical Care in Diabetes](#)
- [Center for Disease Control and Prevention \(CDC\)](#): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- [U.S. Preventive Services Task Force Recommendations](#) for Adult Preventive Health

CARE MANAGEMENT PROGRAM

NH Healthy Families' case management model is designed to help our NH Healthy Families' members obtain needed services, whether they are covered within the NH Healthy Families array of covered services, from community resources, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting.

The program is based upon a NH Healthy Families' model that uses a multidisciplinary case management team in recognition that a holistic approach yields better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the PCP or specialist office with administrative work.

The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation of an individualized care plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP. Our case management team will integrate covered and non-covered services and provide a holistic approach to a member's medical, as well as function, social and other needs. Our program incorporates clinical determinations of need, functional status, and barriers to care such as lack of caregiver supports, impaired cognitive abilities and transportation needs.

A case management team is available to help all providers manage their NH Healthy Families' members. Below are programs and components of special services that are available and can be accessed through the case management team. We look forward to hearing from you about any NH Healthy Families' members that you think can benefit from the addition of a NH Healthy Families' case management team member.

High Risk Pregnancy Program

The OB Case Management Team (CM) will implement our **Start Smart for Your Baby® (Start Smart) program**, which incorporates case management, care coordination, and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age. The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing case management to high and moderate risk members through the postpartum period and infants through the first year of life. A care manager with obstetrical nursing experience will serve as lead case manager for members at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead CM for newborns being discharged from the NICU unit and will follow them through the first year of life when they remain members. The OB/Neonate team has physician oversight advising the team on overcoming obstacles, helping identify high risk members, and recommending interventions. These physicians will provide input to NH Healthy Families' Medical Director on obstetrical care standards and use of newer preventive treatments such as **17 alphahydroxyprogesterone caproate (17-P)**.

NH Healthy Families offers a premature delivery prevention program by supporting the use of 17-P. When a physician determines that a member is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the NH Healthy Families' case manager who will check for eligibility. The care manager will coordinate the ordering and delivery of the 17-P directly to the physician's office. A prenatal care manager will contact the member and do an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing physician during the entire treatment period. Contact the NH Healthy Families' high risk pregnancy department for enrollment in the 17-P program.

Complex Teams

These teams will be led by clinical licensed nurses with either adult or pediatric expertise as applicable. For both adult and pediatric teams, staff will be familiar with evidence-based resources and best practice standards and experience with the population, the barriers and obstacles they face, and socioeconomic impacts on their ability to access services. The NH Healthy Families complex teams will manage care for members whose needs are primarily functional as well as those with such complex conditions as hemophilia, breast/cervical cancer, trauma, organ transplants, and renal dialysis. Foster care members and children with special healthcare needs are at special risk and are also eligible for enrollment in case management. NH Healthy Families will use a holistic approach by integrating referral and access to community resources, transportation, follow-up care, medication review, specialty care, and education to assist members in making better healthcare choices.

A **Transplant Coordinator** will provide support and coordination for members who need organ transplants. All members considered as potential transplant candidates should be immediately referred to NH Healthy Families case management department for assessment and case management services. Each candidate is evaluated for coverage requirements and will be referred to the appropriate agencies and transplant centers.

Special Needs

In addition to care managers, NH Healthy Families has a **Special Needs Coordinator** who is able to provide support and coordination for members who may have special healthcare needs. All members who have special healthcare needs should be referred to the NH Healthy Families case management department for assessment and case management services. NH Healthy Families considers members who have one or more of the following conditions as requiring special healthcare needs:

- Chronic illness such as asthma, diabetes, heart failure, chronic obstructive pulmonary disease;
- Mental illness
- HIV/AIDS
- Foster care needs or receiving services the Department of Child, Youth and Families (DCYF)
- Homeless

To contact a case manager call:
NH Healthy Families
Case Manager Department
Phone: 866-769-3085
Fax: 877-502-7255

MemberConnections® Program

MemberConnections is NH Healthy Families outreach program designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable. The program components are integrated as a part of our case management program in order to link NH Healthy Families and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of NH Healthy Families within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to MemberConnections through numerous sources. Members who phone NH Healthy Families to talk with NH Healthy Families' Member Services department may be referred for more personalized discussion on the topic they are inquiring about. Care managers may identify members who would benefit from one of the many MemberConnections components and complete a referral request. Providers may request MemberConnections referrals directly to the Connections Representative or their assigned care manager. Community groups may request that a Connections Representative come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Community Connections: Connection Representatives are available to present to group setting during events initiated by state entities, community groups, clinics, or any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what NH Healthy Families is all about, overview of services offered by NH Healthy Families, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and NH Healthy Families.

Home Connections: Connection Representatives are available on a full-time basis whenever a need or request from a member or provider arises. All home visits are pre-scheduled with the member unless the visit is a result of being unable to locate a member. Topics covered during a home visit include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive healthcare, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, and how to contact the health plan for assistance.

Phone Connections: Connection Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered and any additional questions answered.

Connections Plus®: Connections Representatives work together with the high risk OB team or SSI case management team for high risk members who do not have safe, reliable phone access. When a member qualifies, a Connections Representative visits the member's home and gives them a free, pre-programmed cell phone with limited use. Members may use this cell phone to call the health plan case manager, PCP, specialty physician, 24 Hour Nurse Advice Line, 911, or other members of their healthcare team. In some cases, the plan may provide MP-3 players with pre-programmed education programs for those with literacy issues or in need of additional education.

To contact the MemberConnections Team call:

NH Healthy Families
Phone: 866-769-3085

Chronic Care/Disease Management Programs

As a part of NH Healthy Families' services, Chronic Case Management Programs (CCMP) is offered to members. Chronic Care Management/Disease Management is the concept of reducing healthcare costs and improving quality of life for individuals with a chronic condition, through integrative care. Chronic care management supports the physician or practitioner/patient relationship and plan of care; emphasizes prevention of exacerbations and complications using evidence-based practice guidelines and patient empowerment strategies, and evaluates clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

NH Healthy Families' Disease Management, will administer NH Healthy Families' chronic case management program. NH Healthy Families' Disease Management's programs promote a coordinated, proactive, disease specific approach to management that will improve members' self-management of their condition; improve clinical outcomes; and control high costs associated with chronic medical conditions. NH Healthy Families' programs include but are not limited to: asthma, diabetes and congestive heart failure.

Not all members having the targeted diagnoses will be enrolled in the CCMP. Members with selected disease states will be stratified into risk groups that will determine need and level of intervention. High-risk members with co-morbid or complex conditions will be referred for case management program for evaluation.

To refer a member for chronic case management call:

NH Healthy Families
Health Coach
1-866-769-3085

BILLING AND CLAIMS SUBMISSION

General Guidelines

This Provider Manual describes general billing and claim submission guidelines. Please visit our website at <http://www.NHHealthyFamilies.com> for NH Healthy Families complete Provider Billing Manual.

NH Healthy Families processes its claims in accordance with applicable State prompt pay requirements.

Physicians, other licensed health professionals, facilities, and ancillary providers contract directly with NH Healthy Families for payment of covered services. It is important that providers ensure NH Healthy Families has accurate billing information on file. Please confirm with the Provider Relations department that the following information is current in our files:

- Provider name (as noted on current W-9 form)
- National Provider Identifier (NPI)
- Tax Identification Number (TIN)

- Taxonomy code
- Physical location address (as noted on current W-9 form)
- Billing name and address

Providers must bill with their NPI number in box 24Jb. We encourage our providers to also bill their taxonomy code in box 24Ja to avoid possible delays in processing. Claims missing the requirements will be returned, and a notice sent to the provider, creating payment delays. Such claims are not considered “clean” and therefore cannot be accepted into our system.

We recommend that providers notify NH Healthy Families as soon as possible, but no later than 30 days in advance of changes pertaining to billing information. Please submit this information on a W-9 form. Changes to a Provider’s TIN and/or address are NOT acceptable when conveyed via a claim form.

Claims eligible for payment must meet the following requirements:

- The member is effective on the date of service,
- The service provided is a covered benefit under the member’s contract on the date of service, and
- Referral and prior authorization processes were followed, if applicable.

Payment for service is contingent upon compliance with referral and prior authorization policies and procedures, as well as the billing guidelines outlined in this manual and the Provider Billing Manual located at <http://www.NHHealthyFamilies.com>.

Clean Claim Definition

A clean claim is defined as a claim received by NH Healthy Families for adjudication, in a nationally accepted format in compliance with standard coding guidelines and does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment. The following exceptions apply to this definition: (a) a claim for which fraud is suspected; and (b) a claim for which a Third Party Resource should be responsible.

Incomplete Claim Definition

An incomplete claim is defined as a claim that is denied for the purpose of obtaining additional information from the provider. The errors or omissions in the claim may result in; a) a request for additional information from the provider or other external sources to resolve or correct data omitted from the claim; b) the need for review of additional medical records; or c) the need for other information necessary to resolve discrepancies. In addition, incomplete claims may involve issues regarding medical necessity and include claims not submitted within the filing deadlines.

Timely Filing

Claims with dates of service prior to January 1, 2018:

Providers will make best efforts to submit first time claims within 180 days of the date of service; however, claims will not be accepted for payment after 365 days from the date of service. When NH Healthy Families is the secondary payer, the claims must be received within 365 calendar days from the date of disposition (final determination) of the primary payer. Claims received outside of this timeframe will be denied for untimely submission.

Claims with dates of service on or after January 1, 2018:

Claims will not be accepted for payment after 90 days from the date of service. When NH Healthy Families is the secondary payer, the claims must be received within 180 days for participating providers and 90 days

for non-participating providers, from the date of disposition (final determination) of the primary payer. Claims received outside of this timeframe will be denied for untimely submission.

Electronic Claims Submission

Network providers are encouraged to participate in NH Healthy Families' electronic claims/encounter filing program. The plan has the capability to receive an ANSI X12N 837 professional, institution or encounter transaction. In addition, it has the ability to generate an ANSI X12N 835 electronic remittance advice known as an Explanation of Payment (EOP).

For more information on electronic filing and what clearinghouses NH Healthy Families has partnered with, contact:

NH Healthy Families
c/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at:
EDIBA@Centene.com

Providers that bill electronically are responsible for filing claims within the same filing deadlines as providers filing paper claims. Providers that bill electronically must monitor their error reports and evidence of payments to ensure all submitted claims and encounters appear on the reports. Providers are responsible for correcting any errors and resubmitting the affiliated claims and encounters.

NH Healthy Families' Payer ID is 68069 and we work with the following clearinghouses:

- Emdeon
- Gateway
- SSI
- Availity
- Relay Healthy

Paper Claims Submission

All claims and encounters should be submitted as follows:

First time claims, corrected claims, claim disputes and requests for reconsideration:

NH Healthy Families
ATTN: CLAIMS DEPARTMENT
P.O. BOX 4060
Farmington, MO 63640-3831

Claim Dispute:

*Claim disputes must be accompanied by the Claim Dispute Form located at
<http://www.NHHealthyFamilies.com>

Electronic Funds Transfers (EFT) and Electronic Remittance Advices (ERA)

NH Healthy Families is pleased to partner with PaySpan® for Electronic Funds Transfers (EFT's) and Electronic Remittance Advices (ERA's). Through this service, providers can take advantage of EFTs

and ERAs to settle claims electronically at no cost to providers. As a Provider, you can gain the following benefits from using EFT and ERA:

- Reduce accounting expenses – Electronic remittance advices can be imported directly into practice management or patient accounting systems, eliminating the need for manual rekeying
- Improve cash flow – Electronic payments mean faster payments, leading to improvements in cash flow
- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds and multiple practices and accounts are supported
- Match payments to advices quickly – You can associate electronic payments with electronic remittance advices quickly and easily

For more information, please visit our provider home page on our website at <http://www.NHHealthyFamilies.com>. If further assistance is needed, please contact Provider Services at 866-769-3085.

Claim Payment

Clean claims will be adjudicated (finalized as paid or denied) at the following levels:

- 95% of clean claims within 30 calendar days of receipt or receipt of additional information
- 100% of all claims within sixty 60 calendar days of receipt

Interest will be paid at the interest rate published in the Federal Register in January of each year, for the Medicare program, on any clean claim not adjudicated within 30 days from the date of the claim receipt.

Third Party Liability

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member.

NH Healthy Families is always the payer of last resort. NH Healthy Families' providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to NH Healthy Families members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform NH Healthy Families that efforts have been unsuccessful. NH Healthy Families will make every effort to work with the provider to determine liability coverage.

If third party liability coverage is determined after services are rendered, NH Healthy Families will coordinate with the provider to pay any claims that may have been denied for payment due to third party liability.

Claim Requests for Reconsideration, Claim Disputes and Corrected Claims

Claim requests for reconsideration, claim disputes or corrected claims must be submitted within 180 days from the original date of notification of payment or denial but not to exceed 15 months from the original date of service.

If a provider has a question or is not satisfied with the information s/he has received related to a claim, there are five effective ways in which the provider can contact...

1. Review the claim in question on the secure Provider Portal

Provider Services Department 1-866-769-3085 (TDD/TTY 1-855-742-0123)

NH Health Families is underwritten by Granite State Health Plan, Inc.

2. Contact Provider Service Representative at 866-769-3085
3. Submit an Adjusted or Corrected Claim to NH Healthy Families
4. Submit a “Request for Reconsideration” to NH Healthy Families
5. Submit a “Claim Dispute Form” to NH Healthy Families

Please refer to the NH Healthy Families’ Provider Billing Manual for detailed information on submitting claim disputes, reconsiderations, corrected claims or viewing claims in the secure provider portal

NH Healthy Families shall process, and finalize all corrected claims, requests for reconsideration, and disputed claims to a paid or denied status in accordance with State law and regulation.

Contractual Terms

This Provider Manual is incorporated by reference into the provider agreement and includes all policies in this manual, as well all Plan policies, which are referenced in the manual.

NH Healthy Families reimburses providers for covered services and supplies provided to members according to the contractual terms in individual provider agreements.

General conditions of payment:

Submitting cost and pricing information does not guarantee payment at the submitted rate.

Rates are based on:

- Established reimbursement rates based on the provider agreement.
- Compliance with NH Healthy Families’ administrative guidelines, including prior authorization and claim submission guidelines.
- Verification of medical necessity.
- Verification that the service is a covered service.
- Eligibility of the member on date of service.
- Adherence to proper Current Procedural Terminology and Healthcare Common Procedure Coding System (CPT/HCPCS) and other national coding guidelines.
- Reimbursement Policy terms, which may reduce or deny payment based on standard editing rules (such as National Correct Coding Initiative claim edits).

ENCOUNTERS

What is an Encounter Versus a Claim?

An *encounter* is a claim which is paid at zero dollars as a result of the provider being pre-paid or capitated for the services he/she provided our members. For example; if you are the PCP for a NH Healthy Families’ member and receive a monthly capitation amount for services, you must file an encounter (also referred to as a “proxy claim”) on a CMS 1500 for each service provided. Since you will have received a pre-payment in the form of capitation, the encounter or “proxy claim” is paid at zero dollar amounts. **It is mandatory that your office submits encounter data.** NH Healthy Families utilizes the encounter reporting to evaluate all aspects of quality and utilization management, and it is required by HFS and by the Centers for Medicare and Medicaid Services (CMS). Encounters do not generate an EOP.

A *claim* is a request for reimbursement either electronically or by paper for any medical service. A claim must be filed on the proper form, such as CMS 1500 or UB 04. A claim will be paid or denied with an explanation for the denial. For each claim processed, an EOP will be mailed to the provider who submitted

the original claim. Claims will generate an EOP. You are required to submit either an encounter or a claim for each service that you render to a NH Healthy Families' member.

Procedures for Filing a Claim/Encounter Data

NH Healthy Families encourages all providers to file claims/encounters electronically. See the Electronic Claims Submission section and the Provider Billing Manual for more information on how to initiate electronic claims/encounters.

Billing the Member

NH Healthy Families reimburses only services that are medically necessary and covered through the New Hampshire Department of Health and Human Services' MCO. In-network and out-of-network providers may not charge, or balance bill members for covered services except for any applicable copayments.

Member Acknowledgement Statement

A provider may bill a member for a claim denied as not being medically necessary, not a covered benefit, or the member has exceeded the program limitations for a particular service only if the following condition is met:

Prior to the service being rendered, the provider has obtained and kept a written member acknowledgement statement signed by the member stating,

I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under NH Healthy Families Network program as being reasonable and medically necessary for my care. I understand that NH Healthy Families through its contract with the New Hampshire Department of Health and Human Services determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care.

For more detailed information on NH Healthy Families' billing requirements, please refer to the Provider Billing Manual available on the website <http://www.NHHealthyFamilies.com>.

CREDENTIALING AND RE-CREDENTIALING

The credentialing and re-credentialing process exists to ensure that participating providers meet the criteria established by NH Healthy Families, as well as government regulations and standards of accrediting bodies.

Note: In order to maintain a current provider profile, providers are required to notify NH Healthy Families of any relevant changes to their credentialing information in a timely manner.

Physicians must submit at a minimum the following information when applying for participation with NH Healthy Families:

- Complete signed and dated New Hampshire Standardized Credentialing application or authorize NH Healthy Families access to the CAQH (Council for Affordable Quality Health Care).
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation

- Copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with New Hampshire regulations regarding malpractice coverage or alternate coverage.
- Copy of current New Hampshire Controlled Substance registration certificate (if applicable)
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy of W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Copy of current unrestricted medical license to practice in the state of New Hampshire.
- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at minimum, a five year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than 120 days
- Proof of highest level of education – copy of certificate or letter certifying formal postgraduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Copy of Medicare Certification

NH Healthy Families will verify the following information submitted for Credentialing and/or Re-credentialing:

- Current participation in New Hampshire FFS Medicaid
- New Hampshire license through appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements
- Review five year work history
- Review federal sanction activity individual, managing employee, business interests and business with transactions over \$25,000 against the EPLS and LEIE databases.

Once the application is completed, the NH Healthy Families' Credentialing Committee (Credentialing Committee) will render a final decision on acceptance following its next regularly scheduled meeting.

It is important to know that individual providers within a group will become effective as each completes his or her credentialing. Providers will receive a letter confirming when he or she has passed credentialing. Prior to your effective date you must request a Prior Authorization to see a NH Healthy Families member.

Credentialing Committee

The Credentialing Committee has the responsibility to establish and adopt as necessary, criteria for provider participation, termination, and direction of the credentialing procedures, including provider participation, denial, and termination.

Committee meetings are held at least quarterly and more often as deemed necessary.

Note: *Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.*

Site visits are performed at practitioner offices within 60 days of identification of two or more member complaints related to physical accessibility, physical appearance, and adequacy of waiting and examining

room space. If the practitioner's site visit score is less than 80 percent, the practitioner may be subject to termination and/or continued review until compliance is achieved. A site review evaluates appearance, accessibility, record-keeping practices and safety procedures.

Re-Credentialing

To comply with accreditation standards, NH Healthy Families conducts the re-credentialing process for recredentialing

providers at least every 36 months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status which may affect the ability to perform services the provider is under contract to provide. This process includes all practitioners, primary care providers, specialists, and ancillary providers/facilities previously credentialed to practice within the NH Healthy Families network.

In between credentialing cycles, NH Healthy Families conducts ongoing sanction monitoring activities on all network providers. This includes an inquiry to the appropriate New Hampshire State Licensing Agency for a review of newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry insures that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, NH Healthy Families reviews monthly reports released by the Office of Inspector General to review for any network providers who have been newly sanctioned or excluded from participation in Medicare/Medicaid.

A provider's agreement may be terminated if at any time it is determined by the NH Healthy Families Credentialing Committee that credentialing requirements are no longer being met.

Right to Review and Correct Information

All providers participating within the NH Healthy Families' network have the right to review information obtained by NH Healthy Families to evaluate their credentialing and/or re-credentialing application. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a provider to review references, personal recommendations, or other information that is peer review protected. Should a provider believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a practitioner, they have the right to correct any erroneous information submitted by another party. To request release of such information, a written request must be submitted to the NH Healthy Families' credentialing department. Upon receipt of this information, the provider will have 14 days to provide a written explanation detailing the error or the difference in information to the. The NH Healthy Families' Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

Right to Be Informed of Application Status

All providers who have submitted an application to join NH Healthy Families have the right to be informed of the status of their application upon request. To obtain status, contact the NH Healthy Families' Provider Relations department at 866-769-3085.

Right to Appeal Adverse Credentialing Determinations

Existing provider applicants who are declined for continued participation for reasons such as quality of care or liability claims issues have the right to request a reconsideration of the decision in writing within 14 days of formal notice of denial. All written requests should include additional supporting documentation

in favor of the applicant's reconsideration for participation in the NH Healthy Families' network. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two weeks of the final decision.

Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to NH Healthy Families within 30 days of the change. The Disclosure of Ownership and Control Interest Statement form is available at <http://www.NHHealthyFamilies.com>. Please contact NH Healthy Families' Provider Relations Department at 866-769-3085 if you have questions or concerns regarding this form.

RIGHTS AND RESPONSIBILITIES

Member Rights

NH Healthy Families' members have the following **rights**:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand
- To participate in decisions regarding his/her healthcare, including the right to refuse treatment
- To discuss treatment options about their specific condition and treatment options, regardless of cost or benefit coverage
- To seek second opinions
- To obtain information about available experimental treatments and clinical trials and how such research can be accessed
- To obtain assistance with care coordination from the PCP's office.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To express a concern or appeal about NH Healthy Families or the care it provides and receives a response in a reasonable period of time
- To file a complaint with New Hampshire Insurance Department if physical and behavioral health services received were not provided fairly
- To obtain medical necessity criteria for mental health and substance use disorder benefits upon request
- To be able to request and receive the plan NH Healthy Families uses to offer incentives to providers the NH Healthy Families network.
- To be able to request and receive a copy of his/her medical records, (one copy free of charge) and request that they be amended or corrected as specified in 45 CFR 164 and 42 CFR 438.100.
- To implement an advance directive as required in 42.CFR The right to implement an advance

directive as required in 42 CFR§438.10(g)(2)

- To choose his/her health professional to the extent possible and appropriate, in accordance with 42 CFR §438.6(m)
- To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
- Freedom to exercise the rights described herein, without any adverse effect on the member's treatment by NH Healthy Families, its providers or contractors.
- To receive information about NH Healthy Families, including: its services and utilization plans, practitioners and providers, the plan structure and operations and member rights and responsibilities. As well as, enrollment notices, informational materials, instructional materials, available treatment options and alternatives.—in a manner and format that may be easily understood as defined in the Provider Agreement and the Member Handbook
- To receive assistance from both the New Hampshire Department of Health and Human Services and the Enrollment Broker in understanding the requirements and benefits of NH Healthy Families.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- To receive sign language with oral interpretation services

Member Responsibilities

NH Healthy Families' members have the following **responsibilities**:

- To provide, to the extent possible, NH Healthy Families and participating network providers accurate and complete medical information.
- Follow the prescribed treatment of care you agreed to with your provider or letting the provider know the reasons the treatment can't be followed, as soon as possible. To make recommendations regarding NH Healthy Families member rights and responsibilities.
- To understand your health problems and participate in developing mutually agreed upon treatment goals with your provider to the highest degree possible.
- Make their primary care provider their first point of contact when needing medical care:
- Follow appointment scheduling processes; and
- Follow instructions and guidelines given by providers.

Provider Rights

NH Healthy Families' providers have the **right** to:

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for members' care
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in members' treatment plans
- Expect members to follow their directions, such as taking the right amount of medication at the right times
- Make a complaint or file an appeal against NH Healthy Families and/or a member
- File a grievance with NH Healthy Families on behalf of a member, with the member's consent.

- Have access to information about NH Healthy Families quality improvement programs, including program goals, processes, and outcomes that relate to member care and services
- Contact NH Healthy Families' Provider Services with any questions, comments, or problems,
- Collaborate with other healthcare professionals who are involved in the care of members

Provider Responsibilities

NH Healthy Families' providers have the **responsibility** to:

- Help members or advocate for members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
 - Recommend new or experimental treatments
 - Provide information regarding the nature of treatment options
 - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may self-administered
 - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
- Allow members to use their New Hampshire Medicaid ID card as proof of enrollment in NH Healthy Families until the member receives their NH Healthy Families' ID card
- Treat members with fairness, dignity, and respect
- Not discriminate against members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow members to request restriction on the use and disclosure of their personal health information
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
- Tell a member if the proposed medical care or treatment is part of a research experiment and give the member the right to refuse experimental treatment
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
- Respect members' advance directives and include these documents in the members' medical record
- Allow members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions
- Allow members to obtain a second opinion, and answer members' questions about how to access healthcare services appropriately
- Follow all state and federal laws and regulations related to patient care and patient rights
- Participate in NH Healthy Families' data collection initiatives, such as HEDIS and other contractual or regulatory programs
- Review clinical practice guidelines distributed by NH Healthy Families
- Comply with NH Healthy Families' Medical Management program as outlined in this handbook

- Disclose overpayments or improper payments to NH Healthy Families
- Provide members, upon request, with information regarding the provider’s professional qualifications, such as specialty, education, residency, and board certification status
- Required to cooperate with NH Healthy Families in identifying and establishing quality improvement goals, including use of Provider performance data, and its onsite visits for quality management and improvement goals.
- Obtain and report to NH Healthy Families information regarding other insurance coverage
- Notify NH Healthy Families in writing if the provider is leaving or closing a practice
- Contact NH Healthy Families to verify member eligibility or coverage for services, if appropriate
- Invite member participation, to the extent possible, in understanding any medical or behavioral health problems that the member may have and to develop mutually agreed upon treatment goals, to the extent possible
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language
- Not be excluded, penalized, or terminated from participating with NH Healthy Families for having developed or accumulated a substantial number of patients in the NH Healthy Families with high cost medical conditions
- Coordinate and cooperate with other service providers who serve Medicaid members such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships and school based programs as appropriate
- Object to providing relevant or medically necessary services on the basis of the provider’s moral or religious beliefs or other similar grounds
- Disclose to NH Healthy Families , on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between NH Healthy Families and the physician or physician group
- Provide services to children, youth members and their families in accordance with RSA 135-F – System of Care for Children’s Mental Health.

GRIEVANCES AND APPEALS PROCESS

Member Grievances

A member grievance is defined as any member expression of dissatisfaction about any matter other than an “adverse action”. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights.

The grievance process allows the member, (or the member’s authorized representative family member, etc. acting on behalf of the member or provider acting on the member’s behalf with the member’s written consent), to file a grievance either orally or in writing. . NH Healthy Families shall acknowledge receipt of each grievance in writing within 10 business days of receipt of the grievance. Any individuals who make a decision on grievances will not be involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, NH Healthy Families shall ensure that the decision makers are healthcare professionals with the appropriate clinical expertise in treating the member’s condition or disease. [42 CFR § 438.406] NH Healthy Families values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file a grievance on a member’s behalf. NH Healthy Families will provide assistance to both members and providers with filing a grievance by contacting our Member/Provider Services Department at 866- 769-3085.

Acknowledgement

Staff receiving grievances orally will acknowledge the grievance and attempt to resolve them immediately. Staff will document the substance of the grievance. The Grievance Coordinator will date stamp written grievances upon initial receipt and send an acknowledgment letter, which includes a description of the grievance procedures and resolution time frames, within 10 business days of receipt.

Grievance Resolution Time Frame

Grievance Resolution will occur as expeditiously as the member's health condition requires, not to exceed 45 calendar days from the date of the initial receipt of the grievance. Grievances will be resolved by the Grievance Coordinator, in coordination with other NH Healthy Families staff as needed. In our experience, most grievances are resolved at the staff level to the satisfaction of the member, representative or provider filing the grievance. Expedited grievance reviews will be available for members in situations deemed urgent and will be resolved within 3 calendar days of receipt. NH Healthy Families may extend the timeframe for disposition of a grievance for up to 14 calendar days if the member requests the extension or the health plan demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest. If the health plan extends the timeframe, it shall, for any extension not requested by the member, give the member written notice of the reason for the delay.

Notice of Resolution

The Grievance Coordinator will provide written resolution to the member, representative or provider within the timeframes noted above.

The grievance response shall include, but not be limited to, the decision reached by NH Healthy Families, the reason(s) for the decision, the policies or procedures which provide the basis for the decision, and a clear explanation of any further rights available to the enrollee. A copy of verbal complaints logs and records of disposition or written grievances shall be retained for ten years. Grievances may be submitted by written notification to: NH Healthy Families

Grievance Coordinator
2 Executive Park Drive
Bedford, NH 03110
Phone: 1-866-769-3085; Fax Number: 1-866-270-9943

Appeals

An appeal is the request for review of an adverse action. An adverse action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service excluding technical reasons; the failure to render a decision within the required timeframes; or the denial of a member's request to exercise his/her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the NH Healthy Families network. The review may be requested in writing or orally, however oral requests must be followed up in writing unless an expedited resolution is requested. Members, or someone on their behalf (such as their treating provider) with the Member's written consent, may request that NH Healthy Families review the adverse action to verify if the right decision has been made. Appeals must be made within 60 calendar days from the date on NH Healthy Families notice of action.

NH Healthy Families shall acknowledge receipt of each standard appeal in writing within 10 business days after receiving an appeal. NH Healthy Families shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires, but shall not exceed 30 calendar days from the date NH Healthy Families receives the appeal. NH Healthy Families may extend the timeframe of the standard for resolution of the appeal up to 14 calendar days if

the member requests the extension or NH Healthy Families demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's best interest. For any extension not requested by the member, NH Healthy Families shall provide written notice to the member of the reason for the delay.

Expedited Appeals

Expedited appeals may be filed when either NH Healthy Families or the member's provider determines that the time expended in a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. In instances where the member's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals and NH Healthy Families will make reasonable attempts to give the member oral notification of the denial and follow up with a written notice within two calendar days.

Decisions for expedited appeals are issued as expeditiously as the member's health condition requires, not exceeding 72 hours after initial receipt of the appeal. NH Healthy Families may extend the 72 hour time period by up to fourteen (14) calendar days if the member requests an extension, or if the health plan justifies a need for additional information and how the extension is in the member's interest. NH Healthy Families will also make reasonable efforts to provide oral notice. Within two (2) calendar days, NH Healthy Families will give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

Notice of Resolution

Written notice shall include the following information:

- The decision reached by NH Healthy Families;
- The date of decision;
- Reason for determination;
- Written statement of the clinical rationale, including how the requesting provider or member may obtain clinical review or decision-making criteria;
- For appeals not resolved wholly in favor of the member the right to request a State fair hearing and information as to how to do so; and
- The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the member may be held liable for the cost of those services if the hearing decision upholds the NH Healthy Families decision.

NH Healthy Families will make reasonable efforts to provide oral resolution notices for an expedited appeal. A written resolution notice will also be provided.

Call, fax or mail all appeals to:

NH Healthy Families
Appeal Coordinator
2 Executive Park Drive
Bedford, NH 03110
Phone: 866-769-3085
Fax: 866-270-9943

State Fair Hearing Process

NH Healthy Families will include information in the Member Handbook, online and via the appeals process to members of their right to appeal directly to the New Hampshire Department of Health and

Human Services. The member has the right to appeal to the New Hampshire Department of Health and Human Services only after exhausting all appeal rights with NH Healthy Families. A member may request a state fair hearing within 120 calendar days from NH Healthy Families notice of resolution of the appeal. An appeal that is not resolved wholly in favor of the member by NH Healthy Families may be appealed by the member or the member's authorized representative to the New Hampshire Department of Health and Human Services for a fair hearing conducted in accordance with 42 CFR 431 Subpart E. Adverse actions include reductions in service, suspensions, terminations, and denials. NH Healthy Families denial of payment for New Hampshire Medicaid covered services and failure to act on a request for services within required timeframes may also be appealed.

Reversed Appeal Resolution

In accordance with 42 CFR §438.424, if the NH Healthy Families or the state fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, NH Healthy Families will authorize the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. Additionally, in the event that services were continued while the appeal was pending, NH Healthy Families will provide reimbursement for those services in accordance with the terms of the final decision rendered by the DHHS and applicable regulations.

To File A Medicaid State Hearing:

New Hampshire Department of Health and Human Services
105 Pleasant Street
Concord, NH 03301-6521
Phone: 800-852-3345 ext. 4292
TDD Access: 800-735-2964

Provider Complaints and Appeals

A **Complaint** is a verbal or written expression by a provider which indicates dissatisfaction or dispute with NH Healthy Families' policy, procedure, claims, or any aspect of NH Healthy Families functions. NH Healthy Families logs and tracks all complaints whether received verbally or in writing. A provider has 30 days from the date of the incident, such as the original remit date, to file a complaint. After the complete review of the complaint, NH Healthy Families shall provide a written notice to the provider within 30 calendar days from the received date of the Plan's decision.

An **Appeal** is the mechanism which allows providers the right to appeal actions of NH Healthy Families such as a claim denial, or if the provider is aggrieved by any rule, policy or procedure or decision made by NH Healthy Families.

WASTE, ABUSE AND FRAUD

Waste Abuse and Fraud (WAF) System

NH Healthy Families takes the detection, investigation, and prosecution of waste, abuse and fraud very seriously, and has a waste, abuse and fraud (WAF) program that complies with New Hampshire and federal laws. NH Healthy Families, in conjunction with its management company, Centene, successfully operates a waste, abuse and fraud unit. NH Healthy Families performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system; please review the Billing and Claims section of this manual. The Special Investigation Unit (SIU) performs prospective and retrospective audits which, in some cases, may result in taking actions against those providers, individually or as a practice,

Provider Services Department 1-866-769-3085 (TDD/TTY 1-855-742-0123)

NH Health Families is underwritten by Granite State Health Plan, Inc.

commit waste, abuse, and/or fraud. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Any other remedies available to rectify

Some of the most common WAF practices include:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of Benefits
- Claims for services not rendered

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call OIG's Hotline at 800-HHS-TIPS (1-800-447-8477), directly to a Medicaid Fraud Control Unit (MFCU), or our anonymous and confidential WAF hotline at 1-866-685-8664. NH Healthy Families and Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.

Please Note: *Due to the evolving nature of wasteful, abusive and fraudulent billing, NH Healthy Families and Centene may enhance the WAF program at any time. These enhancements may include but is not limited to creating, customizing or modifying claim edits, and upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of adherent billing patterns.*

Authority and Responsibility

The NH Healthy Families' Director of Compliance and Regulatory Affairs has overall responsibility and authority for carrying out the provisions of the compliance program. NH Healthy Families is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The NH Healthy Families' provider network will cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations.

QUALITY IMPROVEMENT

NH Healthy Families' culture, systems and processes are structured around its mission to improve the health of all enrolled members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of healthcare provided to all members, including those with special needs. This system provides a continuous cycle for assessing the quality of care and service among plan initiatives including preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to

support the interventions.

The program directs activities designed to improve the health for all of its enrolled Members, meet the cultural and linguistic needs of its diverse membership, and serve those with complex and special needs.

NH Healthy Families recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, NH Healthy Families will provide for the delivery of quality care with the primary goal of improving the health status of its members. Where the member's condition is not amenable to improvement, NH Healthy Families will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. This will include the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the NH Healthy Families' QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of its members.

Program Structure

The NH Healthy Families' Board of Directors (BOD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to members. The BOD oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Improvement Committee (QIC) is a senior management committee with physician representation that is directly accountable to the BOD. The purpose of the QIC is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the Quality Improvement (QI), Utilization Management (UM), and Credentialing programs.

The following sub-committees report directly to the Quality Assessment and Performance Improvement Committee:

- Credentialing Committee
- Grievance and Appeals Committee
- Utilization Management Committee
- Health Effectiveness Data and Information Set (HEDIS) Steering Committee Performance Improvement Team
- Member, Provider, Hospital and Community advisory committees
- Joint Operations Committees
- Peer review Committee (Ad Hoc Committee)
- Pharmacy & Therapeutics Committee
- Utilization Management Committee

Practitioner Involvement

NH Healthy Families recognizes the integral role practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through Provider representation. NH Healthy Families encourages PCP, Behavioral Health, Specialty, and OB/GYN representation on key quality committees such as but not limited to, the:

Provider Services Department 1-866-769-3085 (TDD/TTY 1-855-742-0123)

NH Health Families is underwritten by Granite State Health Plan, Inc.

- Quality Improvement Committee
- Credentialing Committee
- Utilization Management Committee
- Pharmacy & Therapeutics Committee
- Select ad-hoc committees

NH Healthy Families also encourages provider engagement through participation in its Provider Advisory committees.

Quality Assessment and Performance Improvement Program Scope and Goals

The scope of the QAPI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to the NH Healthy Families members. The QAPI Program incorporates all demographic groups, care settings, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, long term care (depending upon the product), and ancillary services, and plan operations.

NH Healthy Families primary QAPI Program goal is to improve Members' health status, through a variety of meaningful quality improvement activities, implemented across all care settings and aimed at improving quality of care and services delivered.

To that end, the NH Healthy Families QAPI Program monitors the following:

- Compliance with preventive health guidelines and practice guidelines
- Acute and chronic care management
- Provider network adequacy and capacity
- Selection and retention of providers (credentialing and re-credentialing)
- Behavioral healthcare
- Delegated services, vendor and entity oversight
- Continuity and coordination of care and between medical and behavioral healthcare
- Utilization Management, including under and over utilization
- Compliance with member confidentiality laws and regulation
- Employee and provider cultural competency
- Provider access and appointment availability
- Provider and Health Plan after-hours telephone accessibility
- Member satisfaction
- Provider satisfaction
- Member grievance, complaints and appeals
- Provider complaints
- Member enrollment and disenrollment
- PCP changes
- Department performance and service
- Patient safety and quality of care
- Marketing practices
- NCQA Accreditation status
- Performance improvement activities and progress towards goals
- Pharmacy services
- Quality of care and adherence to guidelines, measured through HEDIS percentages

Patient Safety and Quality of Care

Patient Safety is a key focus of the NH Healthy Families' QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a member. NH Healthy Families' employees (including medical management staff, member services staff, provider services, complaint coordinators, etc.), panel practitioners, facilities or ancillary providers, members or member representatives, Medical Directors or the BOD may advise the Quality Improvement (QI) Department of potential quality of care issues. Adverse events may also be identified through claims based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated. Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

The NH Healthy Families QIC reviews and adopts an annual QAPI Program and Work Plan based on managed care Medicaid appropriate industry standards and the National Committee for Quality Assurance (NCQA) standards. The QIC adopts traditional quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving health outcomes or the service.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each QI initiative is also designed to allow NH Healthy Families to monitor improvement over time.

Annually, NH Healthy Families develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QIC activities, reporting and studies from all areas of the organization (clinical and service) and includes timelines for completion and reporting to the QIC as well as requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

NH Healthy Families communicates activities and outcomes of its QAPI Program to both members and providers through avenues such as the Member Newsletter, Provider Newsletter and the NH Healthy Families website at <http://www.NHHealthyFamilies.com>.

At any time, NH Healthy Families providers may request a printed copy of our program material, additional information on the health plan programs including a description of the QAPI Program and a report on NH Healthy Families progress in meeting the QAPI Program goals by contacting the Quality Improvement department at 866-769-3085.

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality

Assurance (NCQA) which allows comparison across health plans. HEDIS gives purchasers and consumers the ability to distinguish between health plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the New Hampshire State Medicaid contract.

As both the New Hampshire and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the health plan, but to the individual provider as well. New Hampshire purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in preventive health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs such as 'pay for performance' and 'quality bonus funds'. These programs pay providers an increased premium based on scoring of such quality indicators used in HEDIS.

How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data.

Administrative Data: Consists of claim and encounter data submitted to the health plan. Measures typically calculated by using administrative data include: annual mammogram, annual Chlamydia screening, appropriate treatment of asthma, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid Data: Consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of member medical records to abstract data for services rendered but that were not reported to the health plan through claims/encounter data or for measures where the measured value is not reported anywhere but the medical record. Accurate and timely claim/encounter data and submission of appropriate CPT II codes can reduce the necessity of medical record reviews (see NH Healthy Families website and HEDIS brochure for more information on HEDIS and what codes can be used to reduce medical record reviews). Measures typically requiring medical record review include: childhood immunizations, well child visits, diabetic HbA1c, LDL, eye exam and nephropathy, controlling high-blood pressure, cervical cancer screening, and prenatal care and postpartum care.

Who will be conducting the Medical Record Reviews (MRR) for HEDIS?

NH Healthy Families will contract with a national MRR vendor, to conduct the HEDIS MRR on its behalf. Medical record review audits for HEDIS are usually conducted February through May each year. At that time, you may receive a call from a Medical Record Review Representative if any of your patients are selected in the HEDIS samples. Your prompt cooperation with representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with NH Healthy Families which allows them to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.

- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as diabetes, eye exam and blood pressure.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement department at 1-866-769-3085.

Provider Satisfaction Survey

NH Healthy Families conducts an annual provider satisfaction survey which includes questions to evaluate provider satisfaction with our services such as claims, communications, utilization management, and provider services. The survey is conducted by an external vendor. Participants are randomly selected by the vendor, meeting specific requirements outlined by NH Healthy Families, and the participants are kept anonymous. We encourage you to respond timely to the survey as the results of the survey are analyzed and used as a basis for forming provider related quality improvement initiatives. Results of the provider satisfaction survey will be made available on NH Healthy Families' website.

Consumer Assessment of Healthcare Provider Systems (CAHPS) Survey

The CAHPS survey is a member satisfaction survey that is included as a part of HEDIS and NCQA accreditation. It is a standardized survey administered annually to members by an NCQA certified survey vendor. The survey provides information on the experiences of members with health plan and practitioner services and gives a general indication of how well we are meeting the members' expectations. Member responses to the CAHPS survey are used in various aspects of the quality program including monitoring of practitioner access and availability.

MEDICAL RECORDS REVIEW

Medical Records

NH Healthy Families' providers must keep accurate and complete medical records. Such records will enable providers to render the highest quality healthcare service to members. They will also enable NH Healthy Families to review the quality and appropriateness of the services rendered.

To ensure the member's privacy, medical records should be kept in a secure location. NH Healthy Families requires providers to maintain all records for members for at least 10 years. See the Member Rights section of this handbook for policies on member access to medical records.

Required Information

Medical records means the complete, comprehensive member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the member's participating primary care physician or provider, that document all medical services received by the member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages.
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.).
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail.

- All entries must be dated and signed, or dictated by the provider rendering the care.
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses.
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented.
- An up-to-date immunization record is established for pediatric members or an appropriate history is made in chart for adults.
- Evidence that preventive screening and services are offered in accordance with NH Healthy Families' practice guidelines.
- Appropriate subjective and objective information pertinent to the member's presenting complaints is documented in the history and physical.
- Past medical history (for members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses and, discharge summaries, and
- ER encounters; for children and adolescents (18 years and younger) past medical history relating to prenatal care, birth, any operations and/or childhood illnesses.
- Working diagnosis is consistent with findings.
- Treatment plan is appropriate for diagnosis.
- Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to the member.
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns.
- Signed and dated required consent forms.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Laboratory and other studies ordered as appropriate.
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review.
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases.
- Health teaching and/or counseling is documented.
- For members 10 years and over, appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried).
- Documentation of failure to keep an appointment.
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed.
- Evidence that the member is not placed at inappropriate risk by a diagnostic or therapeutic problem.
- Confidentiality of member information and records protected.
- Evidence that an advance directive has been offered to adults 18 years of age and older.

Medical Records Release

All member medical records shall be confidential and shall not be released without the written authorization of the member or a member's legal guardian or authorized representative. When the release of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis. Providers and community mental health programs must obtain written consent from the member to release information to coordinate care regarding primary care and mental health services or substance abuse services or both.

Providers shall provide documentation of all instances in which consent was not given, and if possible, the

reason why, and submit this information to NH Healthy Families on each occurrence but no later than thirty (30) calendar days following the end of the fiscal year.

Medical Records Transfer for New Members

When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.

All PCPs are required to document in the member's medical record attempts to obtain historical medical records for all newly assigned NH Healthy Families' members. If the member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers, then this should also be noted in the medical record.

Medical Records Audits

NH Healthy Families will conduct random medical record audits as part of its QAPI Program to monitor compliance with the medical record documentation standards noted above. The coordination of care and services provided to members, including over/under utilization of specialists, as well as the outcome of such services also may be assessed during a medical record audit. NH Healthy Families will provide written notice prior to conducting a medical record review.



nh healthy families™

1-866-769-3085

2 Executive Park Drive Bedford, NH 03110

<http://www.NHhealthyfamilies.com>