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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: 14-011

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

November 6, 2014

Nicholas A. Toumpas, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Re: New Hampshire SPA TN 14-011

Dear Commissioner Toumpas,

Enclosed is an approved copy of New Hampshire's (NH) State Plan Amendment (SPA) 14-011, which was submitted to CMS on September 25, 2014 and entitled *"Managed Care – NH Health Protection Programs."* SPA 14-011 transmitted a proposed amendment to New Hampshire's approved Title XIX State Plan to enroll those NH Health Protection Plan individuals not covered through the Health Insurance Premium Program into managed care.

Transmittal # 14-011 --Managed Care – NH Health Protection Program
--Effective September 1, 2014

If there are questions, please contact Joyce Butterworth at (617) 565-1220 or by e-mail at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

cc: Kathleen Dunn, State Medicaid Director
Diane Peterson, Medicaid Business and Policy

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 14-011

2. STATE: NH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 USC § 1396u-2, 42 USC § 1396u-7

7. FEDERAL BUDGET IMPACT:
Remainder of FFY 2014: $36,656,917
FFY 2015: $453,270,402

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, pages 2,5,10,11,12,13,16

Attachment 3.1-F, page 14

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, pages 2,5,10,11,12,13,16, TN 12-006

Attachment 3.1-F, page 14 , TN 12-006

10. SUBJECT OF AMENDMENT:
Managed Care -- NH Health Protection Program

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: comments, if any, will follow

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME: Nicholas A. Toumpas

14. TITLE: Commissioner

15. DATE SUBMITTED:
SS September 25, 2014

16. RETURN TO:

Dawn Landry
Office of Medicaid Business and Policy/Brown Building
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 25, 2014

18. DATE APPROVED:
November 6, 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
September 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Richard R. McGreal

22. TITLE:
Associate Regional Administrator

23. REMARKS:

Pen & ink change to include Attachment 3.1-F, page 14

Division of Medicaid & Children's Health Operations
Boston, MA

FORM HCFA-179 (07-92)

Citation	Condition or Requirement

capitation payment as a fixed percentage of the MCOs capitation payment. The maximum performance incentive payments that could be made to the MCO are equal to the amount withheld. The standards that must be met for the MCO to receive the quality improvement and payment reform incentive payments are specified in the contract.

NH Health Protection Program (NHHPP) MCO capitation payments are made in the month of coverage, not on a retrospective basis as is done with current Medicaid MCO payments.

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met all of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

____ii. Incentives will be based upon specific activities and targets.

____iii. Incentives will be based upon a fixed period of time.

____iv. Incentives will not be renewed automatically.

____v. Incentives will be made available to both public and private PCCMs.

____vi. Incentives will not be conditioned on intergovernmental transfer agreements.

_X_vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

- DHHS Conducted a Request For Information released July 28, 2010, report published January 14, 2011, http://www.dhhs.nh.gov/ombp/documents/summary0111.pdf

Citation	Condition or Requirement

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.

Old Age Assistance (§1902(a)(10)(A)(ii)(IV)
Aid for Needy Blind (§1902(a)(10)(A)(ii)(IV)
Aid for Permanently and Totally Disabled (§1902(a)(10)(A)(ii)(IV)
Medicaid for Employed Adults with Disabilities (NH's Ticket to Work Incentive Act program) (§1902(a)(10)(A)(ii)(XV)
Temporary Assistance for Needy Families (§1902(a)(10)(A)(i)(I) and §1931
Poverty Level Children, Infants and Pregnant Women (§1902(a)(10(A)(i)(IV, VI and VII)
Targeted Low Income Children (§1902(a)(10)(A)(ii)(XIV)
Breast and Cervical Cancer (§1902(a)(10)(A)(ii)(XVIII)
Qualified Low Income Pregnant Women and Children (§1902(a)(10)(A)(i)(III)
Any of the above who also have Third Party Liability (excluding-Medicare)
NHHPP (§1902(a)(10)(A)(i)(VIII); those not enrolled in the Health Insurance Premium Payment Program (HIPP)

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.
NOTE: NH believes citation should be 1932(a)(2).

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. __X__ Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment.
(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)

Medicare beneficiaries will have the option to opt out of managed care and will be notified of this right concurrent with enrollment activity. Approximately 60 days prior to managed care commencement, a state generated correspondence will notify the Medicare beneficiary that the state Medicaid program is transitioning to managed care, describe the plans, explain plan enrollment processes and clearly state that managed care enrollment is optional for Medicare beneficiaries but that failure to communicate their intention to not enroll, will result in enrollment in

Citation	Condition or Requirement

n/a As described above, anyone listed in D.2 above will be able to opt out. All populations will be mandatorily enrolled in managed care, unless they are federally exempt and described in D.2 above. The D.2 groups will be voluntarily enrolled.

Anyone listed in F above will not be enrolled in managed care either voluntarily or mandatorily. They will remain in fee-for-service.

H. Enrollment process

1932(a)(4)

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

Enrollees who fail to make a voluntary MCO selection within the initial 60 days of the enrollment process will be auto-assigned to an MCO. To auto assign individuals, the state will determine if a household member has selected a plan already, and enroll the non-assigned member into the same plan as their household member. For individuals for whom it is not possible to determine any household member plan selection, the state will randomly assign members to ensure equitable enrollment among plans.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

MCO provider networks for Medicaid beneficiaries are limited to Medicaid-participating providers. At program commencement, this will ensure beneficiaries a relationship with providers who have traditionally served Medicaid beneficiaries. The state does hope that the MCOs will be successful in enrolling providers

Citation | Condition or Requirement

who had previously chosen not to serve Medicaid recipients to increase diversity in our network and increase access opportunities.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

Enrollees who fail to make a voluntary MCO selection within the initial 60 days of the enrollment process and the auto-assignment processes as noted in i. and ii are not sufficient to auto-assign someone, state will assign beneficiary to an MCO. For those beneficiaries for whom it is not possible to determine any family member plan selection, the state will randomly assign members to ensure equitable enrollment among plans through the use of an algorithm. The algorithm included within the contracts calls for the plan with the highest technical RFP bid score will receive 2 enrollees to the other two plans 1 enrollee for a 2/1/1 distribution of members who did not make a plan selection. Pursuant to the contract terms, this algorithm will be employed during year one of the contract at which time the state will determine if a better methodology exists (such as 2 enrollees to the plan with the highest member satisfaction over the prior year, for example). Currently there is a 1/1 distribution as there are two MCOs as of 7/1/14.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will__x__/will not____ use a lock-in for managed care.

Members who are mandatorily enrolled in managed care are locked in until or unless their category changes to a voluntary category such as Medicare beneficiary or foster care child, or to an excluded category such as a member with Veterans benefits. Members who enroll voluntarily who do not disenroll from managed care will not be locked into managed care for a period of 12 mos; they may disenroll at any time. All managed care enrolled individuals may disenroll from a selected plan within 90 days of their plan enrollment with or without cause. If after 90 days they have not disenrolled, they will be locked into that plan until the next annual open enrollment period, up to 12 months. If the member disenrolls from a plan within the 90

day window and does not disenroll from managed care (if that option applies) they must select a new plan with which to enroll.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be sixty days.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

State generated Selection Confirmation Letter will specify the specific MCO the beneficiary has been assigned to (as well as the fact that they have 90 days to select a different plan). This letter will be sent to the beneficiary no later than fifteen days following their auto assignment. This correspondence will be followed by outreach from the assigned MCO including but not limited to welcome call, member benefit and welcome packet with plan details.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

State generated correspondence advising members of their auto-assignment and that they may disenroll without cause within 90 days of their enrollment date. The correspondence to members who voluntarily participate in managed care will inform them of their choice to disenroll from managed care generally as well as the option to disenroll from their autoassigned plan in favor of a new plan. Mandatory members who disenroll from an autoassigned plan will have to select a new plan with which to enroll.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

For those recipients for whom it is not possible to determine any family member plan selection, the state will randomly assign members to ensure equitable enrollment among plans through the use of an algorithm. The algorithm included within the contracts calls for the plan with the highest technical

Citation	Condition or Requirement

RFP bid score will receive 2 enrollees to the other two plans 1 enrollee for a 2/1/1 distribution of members who did not make a plan selection. Pursuant to the contract terms, this algorithm will be employed during year one of the contract at which time the state will determine if a better methodology exists (such as 2 enrollees to the plan with the highest member satisfaction over the prior year, for example). Currently there is a 1/1 distribution as there are two MCOs as of 7/1/14.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The state will run reports on at least a monthly basis to determine the rate of autoassignment. The state target for member selection of plans is 80% leaving only 20% for autoassignment. Should performance fall short of this goal, work will commence to increase communication effectiveness and outreach strategies to elevate the percentage of members who self select a plan. These monthly reports will seek not only the rate of autoassignment but also look for trends among the autoassigned individual such as but not limited to, are they mandatory or voluntary groups, what eligibility category are they, what regions of the state do they come from, age, and gender.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _X_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _X_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

Citation	Condition or Requirement

3. ____The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

__X_This provision is not applicable to this 1932 State Plan Amendment.

4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

_x__ This provision is not applicable to this 1932 State Plan Amendment.

5. _X__The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will_X__/will not___ use lock-in for managed care.

2. The lock-in will apply until the next annual open enrollment period, up to 12 months (up to 12 months).

3. Place a check mark to affirm state compliance.

_X___The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

Disenrollment provisions apply whether the individual is mandatorily or voluntarily enrolled in managed care. Members may disenroll if they move out of state, need related services simultaneously that are not available in the plan's network and bifurcation of the care creates risk, if the member wants to enroll in the same plan as a family member, or for other reasons such as lack of access to covered services, violation of member rights, or lack of network providers experienced in the member's unique healthcare needs.
An MCO may disenroll a member who is threatening or abusive such that the health or safety of other members, MCO staff or providers is jeopardized.

Citation	Condition or Requirement

1. The state will__X__/will not__ ____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. __X___ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

Based on the relative size of New Hampshire, only 1.2 million in total population, dilution of the covered population further than among two or three plans is not feasible for either the state or an MCO. Having two to three plans in a small state such as New Hampshire likely means significant overlap in the networks and consistent access for members. As of 7/1/14, there are only two MCO plans participating.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

New Hampshire cannot sustain more than two to three MCO's. See response in M.2 above.

4. ____ The selective contracting provision in not applicable to this state plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this informatioin collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review the instructions, search existing data resources, gather the data needed, and complete and review the