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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #:15-0009

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

February 18, 2016

Jeffrey Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Meyers,

Enclosed is an approved copy of New Hampshire's (NH) State Plan Amendment (SPA) 15-0009, received December 28, 2015 and entitled *"Managed Care – Step 2 – Voluntary to Mandatory"* transmitted a proposed amendment to New Hampshire's (NH) approved Title XIX State Plan to mandatorily enroll into managed care those populations who could previously opt out of the program effective November 1, 2015.

Transmittal # 15-0009 --Managed Care – NH Health Protection Program
--Effective November 1, 2015

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: 15-009

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
November 1, 2015

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, NH 1915(b)

7. FEDERAL BUDGET IMPACT:
FFY 2016: ($19,000,000)
FFY 2017: ($23,000,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-F, pages 1, 3 ,4,
Attachment 3.1-F, pages 2, 11, 12, 13,
Attachment 3.1-F, pages 5, 6, 7, 8, 9, 10, 14, 15, 16

NEW PAGE Attachment 3.1-F, page 11.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, pages 1, 3, 4, (TN 12-006)
Attachment 3.1-F, pages 2, 11, 12, 13 (TN 14-011)
Attachment 3.1-F, pages 5, 6, 7, 8, 9, 10, 14, 15, 16, (TN 12-006 & 14-011)

10. SUBJECT OF AMENDMENT:
Managed Care – Step 2 – Voluntary to Mandatory

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: 12/28/2015

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: 12/28/2015

18. DATE APPROVED: 02/18/2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 11/01/2015

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Richard R. McGreal

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Operations Boston, MA

23. REMARKS:

NH analyzed the cost of moving approximately 12,500 beneficiaries from FFS to managed care and determined the PMPM cost would be lower by $38M in FFY 2016 and $46M in FFY 2017 split 50/50 FFP.

Pen & ink change adding NEW PAGE Attachment 3.1-F, page 11.1 - CMS requested additional language for page 11. New page 11.1 added to accommodate overflow.

State: New Hampshire

OFFICIAL

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of New Hampshire enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on state wideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☒MCO
   a. ☒ Capitation

2. ☐PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

3. ☐PCCM (entity based)
   a. ☐ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

Citation	Condition or Requirement

For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

☐a. 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.

☐b. Incentives will be based upon a fixed period of time.

☐c. Incentives will not be renewed automatically.

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

☐e. Incentives will not be conditioned on intergovernmental transfer agreements.

☐f. Incentives will be based upon specific activities and targets.

CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, 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.)*

The public process and ongoing involvement for the *design and initial implementation* is as follows:

- 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

- Public legislative process regarding SB 147 (2011), http://gencourt.state.nh.us/bill_status/bill_docket.aspx?lsr=215&sy=2011&sortoption=&txtsessionyear=2011&txtbillnumber=sb147&q=1
- Regional stakeholder forums and focus groups conducted by Louis Karno & Associates and Pontifax; Stakeholder forums were held:
    - 9/13/11 in Keene, NH
    - 9/14 in Nashua, NH
    - 9/21 in Littleton, NH with remote sites from Lebanon and Berlin participating
    - 9/22 in Somersworth, NH
    - 9/23 in Manchester, NH
    - 9/29 in Concord, NH

  Focus groups were held in the fall of 2011 in Littleton, Berlin, Dover, Concord, Claremont, Somersworth, Portsmouth, Salem and Nashua, NH. Participants in the focus groups included consumers with physical disabilities, severe mental health issues, substance abuse issues, developmental disabilities, elderly needing long-term care assistance, low-income who receive public assistance, and consumers with limited English proficiency or other cultural barriers to health access. A summary of information about the public processes can be found at: http://www.dhhs.nh.gov/ocom/documents/nhmedicaidcaremgtsepreportfinal.pdf

- Monthly updates of Medical Care Advisory Committee (MCAC) commencing in 2011.
- Newspaper public notices February 3, 2012.
- DHHS hosted twelve public forums throughout the state from mid June 2012 through early July 2012 to orient the public to Step 1 planning and implementation.
- Public engagement of long term care populations will continue throughout the development of Step II.

The public process for Step II, the addition of voluntary populations as mandatory, as well as the eventual integration of waiver services, is as follows:

- Notice of formal public hearing for Tuesday, March 10, 2015, was published in a newspaper of statewide circulation on February 25, 2015. The notice also included a link to a listing of upcoming stakeholder forums and an opportunity for submitting public comment through April 10, 2015.

- Twenty five regional stakeholder forums and focus groups were held throughout the state beginning in August of 2014, with 11 of them occurring since December, 2014.

- Monthly updates continue to be provided to the Medical Care Advisory Committee (MCAC).

- The Department's website contains up to date information on Step II of managed care implementation at http://www.dhhs.nh.gov/ombp/caremgt/step2.htm

Citation	Condition or Requirement

D. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ☒ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. ☐ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3.. ☒ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A)
42 CFR 431.51
1905(a)(4)(C)

4... ☒ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)

5. ☒The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).

1932(a)(1)(A)
42 CFR 438
1903(m)

6. ☒ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

1932(a)(1)(A)
42 CFR 438.6(c)
42 CFR 438.50(c)(6)

7. ☒ _The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

1932(a)(1)(A)
42 CFR 447.362
42 CFR 438.50(c)(6)

8. ☐The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.

45 CFR 92.36

9. ☒The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

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Citation | Condition or Requirement

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. **Included Populations.** Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)					
Section 1931 Adults & Related Population 1905(a)(ii)					
Low-Income Adult Group					
Former Foster Care Children under age 21					
Former Foster Care Children age 21-25					
Section 1925 Transitional Medicaid age 21 and older					
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv))					
Poverty Level Pregnant Women – 1905(a)(viii)					
SSI and SSI related Blind Children, generally under age 18 - 1905(a)(iv)					
SSI and SSI related Disabled children under age 18					
SSI and SSI related Disabled adults age 18 and older - 1905(a)(v)					
SSI and SSI related Aged Populations age 65 or older - 1905(a)(iii)					

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Citation | Condition or Requirement

Population	M	Geographic Area	V	Geographic Area	Excluded
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)					
Recipients Eligible for Medicare					
American Indian/Alaskan Natives					
Children under 19 who are eligible for SSI					
Children under 19 who are eligible under Section 1902(e)(3)					
Children under 19 in foster care or other in-home placement					
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)					
Other: Parents and Other Care Taker Relatives (42 CFR 435.110)	X	Statewide			
Other: Pregnant Women (42 CFR 435.116)	X	Statewide			
Other: Infants and Children under age 19 (42 CFR 435.118)	X	Statewide			
Other: Former Foster Care Children (42 CFR 435.150))	X	Statewide			
Other: Optional Targeted Low Income Children (42 CFR 435.4 and 435.229)	X	Statewide			
Other: Children with Title IV-E Adoption Assistance or Foster Care or Guardianship Care (42 CFR 435.145))	X	Statewide			
Other: Children with Non IV-E Adoption Assistance (42 CFR 435.227)	X	Statewide			

State: New Hampshire

Citation | Condition or Requirement

Population	M	Geographic Area	V	Geographic Area	Excluded
Other: Children under age 19 who are eligible under 1902(3) and described in 42 CFR 435.225	X	Statewide			
Other: Transitional Medical Assistance (§1925)	X	Statewide			
Other: Extended Medical Assistance (42 CFR 435.115))	X	Statewide			
Other: Deemed Newborns (42 CFR 435.117)	X	Statewide			
Other: Breast and Cervical Cancer (42 CFR 435.213)	X	Statewide			
Other: Medicaid for Employed Adults with Disabilities (NH's Ticket to Work Incentive Act Program) (§1902(a)(10)(A)(ii)(XV)	X	Statewide			
Other: Aged, Blind and Disabled (42 CFR 435.121)	X	Statewide			
Other: Qualified Severely Impaired Blind and Disabled (§1902(a)(10(A)(i)(II)	X	Statewide			
Other: Disabled Working Individuals Receiving SSI (§1619(a))	X	Statewide			
Other: Disabled or Blind In States Using More Restrictive Requirements for Medicaid than the SSI Requirements Who Were Receiving SSI or SSI (including 1619(a)) But Become Ineligible Because of Earnings	X	Statewide			
Other: Blind and Disabled Individuals Who Were Eligible in December 1973 (42 CFR 435.133)	X	Statewide			

State: New Hampshire

Citation | Condition or Requirement

Population	M	Geographic Area	V	Geographic Area	Excluded
Other: Individuals Who Would Be Eligible Except for the Increase in OASDI Benefits Under Pub. L 92-336 (July 1, 1972) (42 CFR 435.134)	X	Statewide			
Other: Individuals Who Become Ineligible for Cash Assistance As A Result of OASDI Cost-Of- Living Increases Received After April 1977 (42 CFR 435.135)	X	Statewide			
Other: Individuals Eligible for SSI/SSP Except for Institutional Status (42 CFR 435.211)	X	Statewide			
Other: Individuals Receiving Home and Community-Based Waiver Services (42 CFR 435.217)	X	Statewide			
Other: Individuals Receiving Optional State Supplement Payments (42 CFR 435.234)	X	Statewide			
Other: Children Under Age 19 Who Are Eligible for Supplemental Security Income (SSI) under Title XVI	X	Statewide			
Other: Children under 19 who are receiving services through a family-centered, community based, coordinated care system funded under section 501(a)(1)(D) of title V and is defined by the state in terms of either program participation or special health care needs	X	Statewide			
Other: Adult Group (42 CFR 435.119)	X	Statewide			

Within the eligibility populations identified above as Mandatory, the following populations shall also enroll on a mandatory basis:

- Beneficiaries who are also eligible for Medicare
- Individuals identified as members of Federally recognized tribes

Citation	Condition or Requirement

2. **Excluded Groups.** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

☐ Other Insurance--Medicaid beneficiaries who have other health insurance.

☐ Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

☐ Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☐ Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐ Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☒ Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

☒ Other (Please define): Individuals who:

- are in a presumptive eligibility period
- receive certain financial VA benefits, i.e., VA A&A Allowance, VA Frozen Pension, VA Disability-Veteran, VA NF Pension-Veteran, and VA Pension
- participate in the New Hampshire Health Insurance Premium Payment Program (HIPP)
- are Qualified Medicare Beneficiaries only (QMB) only
- are Specified Low Income Medicare Beneficiaries only (SLMB 120)
- are Qualifying Individuals only (SLMB 135); and
- are Qualified Disabled and Working Individuals only (QDWI)

1932(a)(4) F. Enrollment Process.

1. Definitions.

a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

Citation	Condition or Requirement

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

   a. ☒ The applicant is permitted to select a health plan at the time of application.

      i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

      The Division of Client Services and the district offices of the NH Department of Health and Human Services (the Department) provide information about Medicaid Care Management (MCM) to potential enrollees in person, online, and in print. The Bureau of Special Medical Services (BSMS) with the Department partners with community based organizations to target those populations entering into MCM to educate them about the managed care delivery system. The Department sends news enrollees, in staggered mailings, a reminder that mandatory enrollment is beginning, materials describing the managed care delivery system, benefits covered, which populations are excluded from enrollment, and enrollment materials. Each enrollee has a 60 day initial choice period. The enrollment materials include important action dates, guidance on plan shopping, and selection, enrollee rights and responsibilities (such as access to care coordination and to the appeals process), as well as how to obtain assistance with plan enrollment. Additionally, thirty days prior to open enrollment, MCO's are allowed to engage in an activity that publicly describes or promotes the details of a specific NH MCO health plan and includes brochures, direct mail, and information on each MCO member website. For non-English language speakers, the state requires the MCO's to identify languages, in addition to Spanish, to translate materials into. The Department ensures that the most essential forms, including information materials about managed care, are translated into Spanish at a minimum, and are posted on the Department website for potential clients.

      ii. What action the state takes if the applicant does not indicate a plan selection on the application.

      Enrollees who fail to make a voluntary MCO selection within the initial 60 days of the enrollment process will be assigned to an MCO. To 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.

Citation	Condition or Requirement

iii. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

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.

iv. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence.*)

The 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 default assignment. This correspondence will be followed by outreach from the assigned MCO including, but not limited to, a welcome call and a member benefit and welcome packet with plan details.

b. ☒ The beneficiary has an active choice period following the eligibility determination.

i. How the beneficiary is notified of their initial choice period, including its duration.

The Division of Client Services and the district offices of the NH Department of Health and Human Services (the Department) provide information about Medicaid Care Management (MCM) to potential enrollees in person, online, and in print. The Bureau of Special Medical Services (BSMS) with the Department partners with community based organizations to target those populations entering into MCM to educate them about the managed care delivery system. The Department sends news enrollees, in staggered mailings, a reminder that mandatory enrollment is beginning, materials describing the managed care delivery system, benefits covered, which populations are excluded from enrollment, and enrollment materials. Each enrollee has a 60 day initial choice period. The enrollment materials include important action dates, guidance on plan shopping, and selection, enrollee rights and responsibilities (such as access to care coordination and to the appeals process), as well as how to obtain assistance with plan enrollment.

Citation	Condition or Requirement

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

The Division of Client Services and the district offices of the NH Department of Health and Human Services (the Department) provide information about Medicaid Care Management (MCM) to potential enrollees in person, online, and in print. The Bureau of Special Medical Services (BSMS) with the Department partners with community based organizations to target those populations entering into MCM to educate them about the managed care delivery system. The Department sends news enrollees, in staggered mailings, a reminder that mandatory enrollment is beginning, materials describing the managed care delivery system, benefits covered, which populations are excluded from enrollment, and enrollment materials. Each enrollee has a 60 day initial choice period. The enrollment materials include important action dates, guidance on plan shopping, and selection, enrollee rights and responsibilities (such as access to care coordination and to the appeals process), as well as how to obtain assistance with plan enrollment. Additionally, thirty days prior to open enrollment, MCO's are allowed to engage in an activity that publicly describes or promotes the details of a specific NH MCO health plan and includes brochures, direct mail, and information on each MCO member website. For non-English language speakers, the state requires the MCO's to identify languages, in addition to Spanish, to translate materials into. The Department ensures that the most essential forms, including information materials about managed care, are translated into Spanish at a minimum, and are posted on the Department website for potential clients.

Citation	Condition or Requirement

iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

Enrollees who fail to make a voluntary MCO selection within the initial 60 days of the enrollment process will be default-assigned to an MCO. To default 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. If enrollees fail to make a voluntary MCO selection within the initial 60 days of the enrollment process, and the default-assignment processes noted above are not sufficient to default-assign someone, the state will assign the beneficiary to an MCO on a random assignment basis to ensure equitable enrollment among plans through the use of an algorithm. Currently, however, there is a 1/1 distribution as there are two MCO's as of 7/1/14.

iv. The state's process for notifying the beneficiary of the default assignment.

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 default 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.

c. ☐ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. The state's process for notifying the beneficiary of the auto-assignment. (*Example: state generated correspondence.*)

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.50

3. 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.

a. ☒The state assures it has an enrollment system that allows Beneficiaries 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.

b. ☒The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries 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).

c. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

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

d. ☒ 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 438.56

G. Disenrollment.

1. The state will☒/will not☐ limit disenrollment for managed care.

2. The disenrollment limitation will apply until the next annual open enrollment period, up to 12 months (up to 12 months).

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

Citation	Condition or Requirement

4. Describe the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

   A 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 default 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.

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

   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 health care 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.

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
42 CFR 438.50
42 CFR 438.10

☒The state assures that its state plan program is in compliance with 42 CFR 438.10(e) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible.

IP and OP hospital, including OP facility and ancillary services for dental procedures
Maternity and newborn kick payments
IP psychiatric facility services under age 21, under 22 if admitted prior to age 21
Physician and APRN services
Rural health clinic and FQHC services
Prescribed drugs
Community MH services, MH CM, and Rehab MH services including care coordination and administrative services only
Psychology
Ambulatory surgical center services
Laboratory/pathology and X-Ray

Citation		Condition or Requirement
		Family planning services Medical services clinics (mostly methadone clinics) PT, ST, OT Audiology services Podiatry services Home Health Services Private Duty Nursing, for NHHPP program, EPSDT only) Adult medical day care, for NHHPP program, EPSDT only) Personal care services, for NHHPP program, EPSDT only) Hospice Optometric services, eyeglasses Medical supplies and DME Non emergent medical transportation and mileage reimbursement for med necess travel Ambulance and Wheelchair van Service Independent care management (for NHHPP program, EPSDT only Home visiting service, for NHHPP program it is provided within the SUD benefit SUD as per He-W 513 for NHHPP population only Chiropractic services for NHHPP population only Emergency services and post-stabilization services
1932(a)(5)(D)(b)(4) 42 CFR 438.228	J.	☒The state assures that each managed care organization has established an internal grievance procedure for enrollees.
1932(a)(5)(D)(b)(5) 42 CFR 438.206 42 CFR 438.207	K.	Describe how the state has assured adequate capacity and services. The state Medicaid agency, through MCO contracts, meets the network adequacy assurance requirement through a robust set of time and distance standards determined at the county level. The Medicaid agency receives and evaluates semi-annual network adequacy reports from the MCO's. Additionally, the ERQO reports separately on combined managed care and fee-for-service network adequacy.
1932(a)(5)(D)(c)(1)(A) 42 CFR 438.240	L.	☒The state assures that a quality assessment and improvement strategy has been developed and implemented.
1932(a)(5)(D)(c)(2)(A) 42 CFR 438.350	M.	☒The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.

Citation	Condition or Requirement
1932 (a)(1)(A)(ii)	N. Selective Contracting Under a 1932 State Plan Option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will☒/will not☐ intentionally limit the number of entities it contracts under a 1932 state plan option.

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

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.)*

   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.

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