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**State/Territory Name: New Hampshire**

**State Plan Amendment (SPA) #:08-011**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Companion Letter
- 3) CMS 179 Form/Summary Form (with 179-like data)
- 4) Approved SPA Pages



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**

May 7, 2018

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

Dear Commissioner Meyers,

This letter is being sent regarding the implementation of state plan amendment (SPA) #08-011 "*Targeted Case Management, Adults with Chronic Illnesses or Disabilities,*" which was approved on May 7, 2018, and updates state plan pages in response to interim final rules in the Centers for Medicare and Medicaid Services (CMS) Federal Register of December 4, 2007, Volume 72, No. 232. A Request for Additional Information (RAI) was issued on September 15, 2008, to which the state responded on March 5, 2018.

As part of the review of the SPA, the Centers for Medicare & Medicaid Services (CMS) and the state discussed and confirmed that subsequent to the RAI, rate changes were implemented for Targeted Case Management Children with Chronic Illnesses or Disabilities that did not undergo public notice or state plan changes. This letter serves to memorialize agreement that the state will update the rate methodology with a subsequent SPA submittal. Longstanding federal regulations at 42 CFR 447.205 require states to issue public notice of proposed changes in statewide methods and standards for setting Medicaid payment rates. Public notice is necessary to inform providers and other stakeholders of any changes states intend to make to their Medicaid payment methodologies, so that providers and others do not rely on prior payment methodologies. The notice must be issued at least one day prior to the effective date of the state's proposed change. CMS' November 2015 final rule modified these requirements slightly to authorize states to issue public notice on state websites or, as was previously allowable, in newspapers and state registers.

Please respond to this letter within 90 days of the date of the letter with a State plan amendment that addresses the issues described above or a corrective action plan describing how you will resolve the issues identified above. During the 90-day period, we are happy to provide any technical assistance that you need. State plans that are not in compliance with requirements referenced above are grounds for initiating a formal compliance process.

CMS is available to provide ongoing technical assistance to the state on this issue as the state moves forward in bringing the rate up to date. If there are questions, please contact Joyce Butterworth at (617) 565-1220 or by e-mail at [Joyce.Butterworth@cms.hhs.gov](mailto:Joyce.Butterworth@cms.hhs.gov).

Sincerely,

/s/

Richard R. McGreal  
Associate Regional Administrator

Enclosure/s

cc: Henry Lipman, State Medicaid Director  
Diane Peterson, Medicaid Business and Policy

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER: 08-011	2. STATE NH
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE June 12, 2008	

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

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

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:	7. FEDERAL BUDGET IMPACT: a. FFY 2008 none FFY 2009 not known
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Supplement 1 to Attachment 3.1-A Pages 3A (BEAS) through 3F (BEAS)  Attachment 4.19-B, Page 4d	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ): Supplement 1 to Attachment 3.1-A Pages 1, TN 87-12; 1a, TN 96-12; 1b, TN 96-12, 1c, TN 96-12, and 1d, TN 96-12  None

10. SUBJECT OF AMENDMENT:  
Targeted Case Management, Adults with Chronic Illnesses or Disabilities

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:   /s/	16. RETURN TO:  Dawn Landry Program Support/Brown Building Department of Health and Human Services 129 Pleasant Street Concord, NH 03301
13. TYPED NAME:      Nicholas A. Toumpas	
14. TITLE:      Commissioner	
15. DATE SUBMITTED: June 20, 2008	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:      June 20, 2008	18. DATE APPROVED:      May 7, 2018
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: June 12, 2008	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:

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State/Territory:     New Hampshire    

**CASE MANAGEMENT SERVICES**

**ADULTS WITH CHRONIC ILLNESSES OR DISABILITIES CASE MANAGEMENT**

**A. Target Group:**

The target population for this service is adults over the age of 18 years who live in a community setting who require assistance due to a chronic medical diagnosis and/or frailty associated with aging, including Alzheimer’s Disease or other types of dementia, meet clinical eligibility requirements established in RSA 151-E:3 I, and are participants in the Home and Community Based Care waiver NH 0060900R4.

  X   Target group includes individuals transitioning to a community setting. Case management services will be made available for up to     30     [insert a number; not to exceed 180] consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000).

**B. Areas of State in which services will be provided (§1915(g)(1) of the Act):**

- X   Entire State
- Only in the following geographic areas [Specify areas]

**C. Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1):**

- Services are provided in accordance with §1902(a)(10)(B) of the Act.
- X   Services are not comparable in amount, duration, and scope (§1915(g)(1)).

TN No:   08-011    
Supersedes  
TN No:   87-12  

Approval Date   05/07/2018  

Effective Date:   06/12/2008

**CASE MANAGEMENT SERVICES, ADULTS WITH CHRONIC ILLNESSES OR DISABILITIES  
(continued)**

**D. Definition of Services (42 CFR 440.169):** Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

Upon intake, the case manager shall conduct a comprehensive assessment, which includes, but is not limited to (a) utilization of a formal tool to evaluate the participant's status based on face to face interview; (b) biopsychosocial history; (c) functional status; (d) living environment, including accessibility; (e) social environment; (f) risk, including the potential for abuse, neglect, and exploitation; (g) ability to participate in the community; and (h) a medical eligibility assessment.

Annually, or as needs change, (a) update the formal comprehensive assessment tool identified above; and (b) medical eligibility assessment.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual.
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

**CASE MANAGEMENT SERVICES, ADULTS WITH CHRONIC ILLNESSES OR DISABILITIES CASE MANAGEMENT (continued)**

**D. Definition of Services (continued):**

- ❖ Monitoring and follow-up activities: Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Monitoring includes:

- At least one monthly telephone call with the participant to include a review of services;
- At least one face to face contact every sixty days to include a review of services;
- A quarterly review of participant record to ensure the delivery of services; and
- A quarterly review of all reported complaints, incidents, related to the delivery of services.

  X   Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 FR 440.169(e))

TN No: 08-011  
Supersedes  
TN No: 96-12

Approval Date 05/07/2018

Effective Date: 06/12/2008



**CASE MANAGEMENT SERVICES, ADULTS WITH CHRONIC ILLNESSES OR DISABILITIES CASE MANAGEMENT (continued)**

**E. Qualifications of Providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b))[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]:**

1. Case management providers shall be licensed in accordance with requirements of state law including RSA 151.
2. Case management agencies shall employ a full-time administrator responsible for the development and implementation of the policies of the case management agency and for compliance with applicable rules;
3. Case management providers shall establish and maintain agency written policies and procedures regarding the areas required by administrative rule He-E 805, and shall ensure that they are properly followed and enforced.
4. Case managers shall meet the following minimum requirements:
  - (a) Have demonstrated knowledge of the local service delivery system and the resources available to participants;
  - (b) Have demonstrated knowledge of the development and provision of integrated, person-centered services; and
  - (c) Have a degree in a human-service related field and one year of supervised experience, or a similar combination of training and experience.

**F. Freedom of Choice (42 CFR 441.18(a)(1)):**

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

**Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):**

N/A Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

**CASE MANAGEMENT SERVICES, ADULTS WITH CHRONIC ILLNESSES OR DISABILITIES CASE MANAGEMENT (continued)**

**G. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):**

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

**H. Payment (42 CFR 441.18(a)(4):**

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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TN No: 96-12

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**CASE MANAGEMENT SERVICES, ADULTS WITH CHRONIC ILLNESSES OR DISABILITIES CASE MANAGEMENT (continued)**

**I. Case Records (42 CFR 441.18(a)(7):**

Providers maintain case records that document for all individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii) the name of the provider agency (if relevant) and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan.

**J. Limitations:**

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations, providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

**[Specify any additional limitations.] (N/A)**

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Supersedes  
TN No: 96-12

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PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT  
HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

19. Case Management Services (continued):

b. Adults with Chronic Illnesses or Disabilities Case Management Services

Payment rates for case management services provided to Medicaid recipients who are adults with chronic illnesses or disabilities are made in accordance with a fee schedule established by the department. No provider shall bill or charge the department more than the provider's usual and customary charge. The rate is applicable to all public and private providers.

Case management providers are paid using a day as a unit of service. The rate for the service is \$8.52/day and is limited to 25 days/month. The rate was set based on comparisons with other states and to applicable services and rates in NH.

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TN No: new page

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