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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: 18-0009

This file contains the following documents in the order listed:

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: 18-0009

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
January 1, 2019

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

7. FEDERAL BUDGET IMPACT:
FFY 2019: 158,700,000
FFY 2020: 219,400,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-F, pages 1-24

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-F, pages 1-3, 5-17, 21-22, TN 15-009
Attachment 3.1-F, pages 18-20, TN 16-0016
Attachment 3.1-F, pages 4, 23, 24 - new pages

10. SUBJECT OF AMENDMENT:
Managed Care – Addition of Granite Advantage 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 /s/ AL:

13. TYPED NAME: Thomas D. Pristow, MSW, ACSW

14. TITLE: Deputy Commissioner

15. DATE SUBMITTED: 08-06-2018

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: August 6, 2018

18. DATE APPROVED: September 13, 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2019

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Richard R. McGreal

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

23. REMARKS:

FORM HCFA-179 (07-92)

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

September 13, 2018

Jeffrey A. 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) No 18-0009, entitled *"Managed Care - Addition of Granite Advantage Program."* This SPA amends the NH Title XIX State plan to provide coverage to all Medicaid expansion beneficiaries through the State's managed care network which currently serves the majority of the Medicaid population in the state.

Transmittal # 18-0009 -- Managed Care - Addition of Granite Advantage Program
-- Effective January 1, 2019

Please note New Hampshire's 1915(b) waiver is concurrent to the State plan authority for the provision of alternative benefit plan coverage under the Granite Advantage Program; a State Plan Amendment (NH 18-0007) is still pending regarding this program.

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

State: New Hampshire

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], primary care case managers [PCCMs], and/or PCCM entities) 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 statewideness (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 a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6
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
   b. ☒The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

2. ☐PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Other (please explain below)

3. ☐PCCM entity
   a. ☐ Case management fee
   b. ☐ Shared savings, incentive payments, and/or financial rewards (see 42 CFR 438.310(c)(2))
   c. ☐ Other (please explain below)

Citation	Condition or Requirement

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

- ☐ Provision of intensive telephonic case management
- ☐ Provision of face-to-face case management
- ☐ Operation of a nurse triage advice line
- ☐ Development of enrollee care plans.
- ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State.
- ☐ Provision of enrollee outreach and education activities.
- ☐ Operation of a customer service call center.
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
- ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
- ☐ Coordination with behavioral health systems/providers.
- ☐ Coordination with long-term services and supports systems/providers.
- ☐ Other (please describe): _____

_____

_____

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 managed care program has been implemented. *(Example: public meeting, advisory groups.)*
If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110)

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

- DHHS Conducted a Request For Information released July 28, 2010, report published January 14, 2011, on the DHHS website.

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 was posted on the DHHS website.

- 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 continued 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, was 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 were 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

(CONTINUED)

The public process for the addition of the expansion population to mandatory managed care is as follows:

- Notice of formal public hearing for Monday, May 14, 2018 and Thursday, May 24, 2018, was published in a newspaper of statewide circulation on May 8, 2018. A notice of formal public hearing for Tuesday, June 5, 2018 was published in a newspaper of statewide circulation on June 1, 2018. The notices included an opportunity for submitting public comment through June 29, 2018.

- Regional stakeholder forums and focus groups will be held throughout the state in the September to November 2018 time period for providers, beneficiaries, and other stakeholders.

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

- The Department's website contains up to date information on Granite Advantage, which includes the addition of the expansion population to mandatory managed care. https://www.dhhs.nh.gov/ombp/medicaid/granite.htm.

- The Department also posted an announcement on the Department's website that the managed care Title XIX State Plan Amendment is available for review.

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 (including for PCCM entities) 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) 42 CFR 438.10(g)(2)(vii)	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, PCCMs and PCCM entities will be met.
1932(a)(1)(A) 42 CFR 438.4 42 CFR 438.5 42 CR 438.7 42 CFR 438.8 42 CFR 438.74 42 CFR 438.50(c)(6)	7. ☒ The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 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.

State: New Hampshire

Citation	Condition or Requirement
45 CFR 75.326	9. ☒ The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.
42 CFR 438.66	10. Assurances regarding state monitoring requirements: ☒ The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.

Citation | Condition or Requirement

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

E. Populations and Geographic Area

1. **Included Populations**. Please check which eligibility groups are included, if they are enrolled on **a Mandatory (M)** or **Voluntary (V**) basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment. Under the **Geographic Area** 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. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column.

   Under the **Notes** column, please note any additional relevant details about the population or enrollment.

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110	X			Statewide	
2. Pregnant Women	§435.116	X			Statewide	
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	X			Statewide	
4. Former Foster Care Youth (up to age 26)	§435.150	X			Statewide	
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119	X			Statewide	
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X			Statewide	
7. Extended Medicaid Due to Spousal Support Collections	§435.115	X			Statewide	

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120					N/A. do not cover as a 209(b) state.
9. Aged and Disabled Individuals in 209(b) States	§435.121	X			Statewide	
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April, 1977	§435.135	X			Statewide	
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137					N/A. do not cover as a 209(b) state.
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138					N/A. do not cover as a 209(b) state.
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA	X			Statewide	
14. Disabled Adult Children	1634(c) of SSA					N/A. do not cover as a 209(b) state

B. Optional Eligibility Groups

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220					N/A. Did not elect to cover.
2. Optional Targeted Low-Income Children	§435.229	X			Statewide	
3. Independent Foster Care Adolescents Under Age 21	§435.226					N/A. Did not elect to cover.
4. Individuals Under Age 65 with Income Over 133%	§435.218					N/A. Did not elect to cover
5. Optional Reasonable Classifications of Children Under Age 21	§435.222	X			Statewide	
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA					N/A. Did not elect to cover

Citation | Condition or Requirement

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230	X			Statewide	
8. Individuals eligible for Cash except for Institutionalized Status	§435.211	X			Statewide	
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217	X			Statewide	
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232					N/A. Not covered as a 209(b) state
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616 Agreements	§435.234	X			Statewide	
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236	X			Statewide	
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA					N/A. Did not elect to cover
14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA					N/A. Did not elect to cover
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1) of the SSA					N/A. Did not elect to cover
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA					N/A. Did not elect to cover
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA	X			Statewide	
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA					N/A. Did not elect to cover.
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA					N/A. Did not elect cover.
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219					N/A. Did not elect to cover.

Citation | Condition or Requirement

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214			X		
22. Individuals with Tuberculosis	§435.215					N/A. Do not cover
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213	X			Statewide	receive ALL benefits

C. Medically Needy

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)	X				Without a spenddown
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)	X				Without a spenddown
3. Medically Needy Children Age 18 through 20	§435.308					N/A
4. Medically Needy Parents and Other Caretaker Relatives	§435.310					N/A
5. Medically Needy Aged	§435.320					N/A
6. Medically Needy Blind	§435.322					N/A
7. Medically Needy Disabled	§435.324					N/A
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330	X				Without a spenddown

2. **Voluntary Only or Excluded Populations**. Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		X	Statewide	

Citation | Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare					Mandatory via 1915(b) authority
American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14				Mandatory via 1915(b) authority
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120				Mandatory via 1915(b) authority
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA				Mandatory via 1915(b) authority
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145				Mandatory via 1915(b) authority
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227				
Children with Special Health Care Needs - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds 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.					Mandatory via 1915(b) authority

* = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.

3**. (Optional) Other Exceptions**. The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Citation | Condition or Requirement

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance			This population is mandatory to enroll in managed care
Reside in Nursing Facility or ICF/IID--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).			This population is mandatory to enroll in managed care
Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program			This population is mandatory to enroll in managed care
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program			This population is mandatory to enroll in managed care
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).			This population is mandatory to enroll in managed care
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.		X	
Other (Please define): Individuals who: 1) are in a presumptive eligibility period; 2) receive certain financial VA benefits; 3) participate in NH's Health Insurance Premium Payment Program (HIPP); and 4) Medically needy		X	

1932(a)(4)
42 CFR 438.54

F. Enrollment Process

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

      State with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

   b. ☐ If applicable, please check here to indicate that the state provides an enrollment choice period, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the fee-for-service delivery system.

      i. Please indicate the length of the enrollment choice period:

      _____

Citation | Condition or Requirement

c. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.
   i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).
   ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:

_____

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

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 new 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. 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

Enrollees will be passively enrolled in a plan if they do not indicate a plan selection at application. The managed care enrollment process shall be the following:

- January 1, 2019 - June 30, 2019: New applicants and expansion enrollees transitioning from the Marketplace to managed care will be passively enrolled into a participating MCO and will be provided with a 90 day plan selection period to remain in or change plans;
- July 1, 2019 and beyond: All new applicants who do not select a plan as part of the application will be passively enrolled into a participating MCO and will be provided a 90 day plan selection period to stay or change plans.

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 15 days following their plan 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. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process.
    i. Please indicate the length of the enrollment choice period:

    _____

c. ☐ If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.
    i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

d. ☒ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.
    i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

Citation	Condition or Requirement

DHHS shall use the following factors in its auto-assignment methodology:

- Preference to an MCO with which there is already a family affiliation;
- Previous MCO enrollment, when applicable;
- Provider-Member relationship, to the extent obtainable; and
- Equal assignment among the MCO's.

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.

1932(a)(4)
42 CFR 438.54

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.

42 CFR 438.52

a. ☒ The state assures that, per the choice requirements in 42 CFR 438.52

i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;
iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

42 CFR 438.52

b. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs 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.

Citation	Condition or Requirement

42 CFR 438.56(g)

c. ☒ 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.

42 CFR 438.71

d. ☒ The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.

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 for 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.

4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. (*Examples: state generated correspondence, enrollment packets, etc.*)

The Department will inform Medicaid beneficiaries of their right to disenroll without cause during the 90 days following their initial enrollment through the eligibility determination notice. The MCO shall provide Members and their representatives with written notice of disenrollment rights at least sixty (60) calendar days before the start of each re-enrollment period.

Citation	Condition or Requirement

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

A Member may request disenrollment "with cause" to DHHS at any time during the coverage year when:

- The Member moves out of state;
- The Member needs related services to be performed at the same time; not all related services are available within the network; and receiving the services separately would subject the Member to unnecessary risk; or
- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the Agreement, violation of rights, or lack of access to providers experienced in dealing with the Member's health care needs.

A Member may request disenrollment "without cause", at the following times:

- During the ninety (90) calendar days following the date of the Member's initial enrollment into the MCO or the date of the DHHS Member notice of the initial auto-assignment/enrollment, whichever is later;
- For Members who have an established relationship with a PCP that is only in the network of a non-assigned MCO, the Member can request disenrollment during the first twelve (12) months of enrollment at any time;
- Every twelve (12) months;
- During enrollment related to renegotiation and re-procurement;
- For sixty (60) calendar days following an automatic reenrollment if the temporary loss of Medicaid eligibility has caused the Member to miss the annual enrollment/disenrollment opportunity (this provision applies to re- determinations only and does not apply when a Member is completing a new application for Medicaid eligibility); and
- When DHHS imposes a sanction on the MCO.

State: New Hampshire

Citation	Condition or Requirement

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 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) state plan amendments.

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

List all benefits for which the MCO is responsible.

Complete the chart below to indicate every State Plan-Approved service that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Inpatient Hospital	3.1A 3.1B	1, 1a 2, 2-a	1 1
Outpatient Hospital including ASC's	3.1A 3.1B	1, 1a 2, 2-a	2a 2a
RHC	3.1A 3.1B	1, 1a 2, 2-a	2b 2b
FQHC	3.1A 3.1B	1, 1b 2, 2-a+	2c 2c
Lab, X-Ray	3.1A 3.1B	1, 1b,2-b 2, 2-a+	3 3
Family Planning	3.1A 3.1B	2, 2a 2, 2-a(1)	4c(i), 4c(ii) 4c(i), 4c(ii)
Physician	3.1A 3.1B	2, 2-a(cont) 2b, 2-c	5a 5a
Organ Transplants	Attch 3.1E	1	n/a
Podiatrist	3.1A 3.1B	2, 2-b 3, 3-a	6a 6a
Optometrist	3.1A 3.1B	3, 3-b 3, 3-a	6b 6b

State: New Hampshire

Citation | Condition or Requirement

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Other Practitioner: Clinical Psychologist (psychotherapy)	3.1A 3.1B	3, 3-b 3, 3-a	6d 6d
Other Practitioner: Pastoral Counselor (psychotherapy)	3.1A 3.1B	3, 3-b 3, 3-b	6d 6d
Other Practitioner: MLADC, LADC	3.1A 3.1B	3, 3-b 3, 3-b	6d 6d
Other Practitioner: APRN	3.1A 3.1B	3, 3-b 3, 3-b	6d 6d
Other Practitioner: Certified Midwives	3.1A 3.1B	3, 3-b 3, 3-b	6d 6d
Home Health	3.1A 3.1B	3, 3-b.1 3, 3-b.1	7 7
Durable Medical Equipment (DME)	3.1A 3.1B	3, 3-c 3, 3-b.1	7c 7c
Audiology	3.1A 3.1A 3.1B 3.1B	3a, 3c 4, 4a 3, 3-b.1 4, 4b	7d 11c 7d 11c
Medical Services Clinic (e.g., methadone)	3.1A 3.1B	4, 4a 4, 4a	9 9
PT, ST, OT	3.1A 3.1B	4, 4a 4, 4b	11 11
Prescribed Drugs except for Carbaglu and Ravicti, and drugs used for the treatment of Hepatitis C and Hemophilia, all of which are covered under the Medicaid fee for service program.	3.1A 3.1B	5, 5a, 5a(1)-5a(5) 4, 4b-4g	12a 12a
Prosthetics, Orthotics (includes hearing aids)	3.1A 3.1B	5, 5-b 5, 5-a	12c 12c
Eyeglasses	3.1A 3.1B	5, 5-b 5, 5-a	12d 12d
Other Diagnostic, Screening, Preventive, Rehab Community Mental Health Services Adult Medical Day Care Home Visiting	3.1A 3.1B	5, 6, 6-a 5, 5-b	13 13
Inpatient psychiatric facility services for under age 21, under 22 if admitted prior to age 21; and over age 65	3.1A 3.1B	7, 7-a 6, 6c 6, 6a 5, 5d, 6, 6a	15a 14a, c 15a 14 a, c
Nurse midwife	3.1A 3.1B	7, 7-a 6, 6b	17 17
Hospice	3.1A 3.1B	7, 7-b 6, 6-c	18 18

State: New Hampshire

Citation | Condition or Requirement

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Transportation - Emergency	3.1A 3.1B	9, 9-a, 8, 8-a,	24a 24a
Non-Emergency Medical Transportation (NEMT)	3.1A 3.1B	Adden 1, p 1-4 Adden 1, p 1-4	24a 24a
Emergency hospital	3.1A 3.1B	9, 9-c 8, 8-c	24e 24e
EPSDT services for under age 21 as defined at 1905(r), with the exception of dental services which are covered under the Medicaid fee for service program. EPSDT services delivered by the MCO also include all services reviewed on an individual basis and deemed to meet the medical necessity criteria specific to EPSDT in the federal and state regulations.	3.1A 3.1B	2, 2-a 2, 2-a(1)	4b 4b
Tobacco Cessation Counseling for Pregnant Women	3.1A 3.1B	2, 2-a 2b, 2-c	4d 4d
Private Duty Nursing	3.1A 3.1B	3a, 3-c 4, 4a	8 8
Personal Care in Home	3.1A 3.1B	9, 9-c 8, 8-c	24f 24f
Freestanding birth center	3.1A 3.1B	11 11	28(i) 28(i)
Substance Use Disorder (SUD) Services • Screenings • Individual, group, family treatment • Intensive Outpatient • Partial Hospitalization • Med monitored Op w/drawal mgmt • Crisis intervention • Peer recovery support • Non-peer recovery support • Continuous recovery monitoring • Evaluations • Med monitored residential w/drawal mgmt • Rehab in res tx and rehab facility	3.1A 3.1B	6 pre-a 1, 6 pre-a2, 6 pre-a3 5-a.1, 5-1.2, 5-a.3	13d 13d

Citation	Condition or Requirement
1932(a)(5)(D)(b)(4)	J. ☒ The state assures that each MCO has established an internal grievance and appeal system for enrollees.
1932(a)(5)(D)(b)(5) 42 CFR 438.62 42 CFR 438.68 42 CFR 438.206 42 CFR 438.207 42 CFR 438.208	K. Services, including capacity, network adequacy, coordination, and continuity. ☒ The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met. ☒ The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.
1932(c)(1)(A) 42 CFR 438.330 42 CFR 438.340	L. ☒ The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.
1932(c)(2)(A) 42 CFR 438.330 42 CFR 438.340 42 CFR 438.364	M. ☒ The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.
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.

Citation	Condition or Requirement

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 populations 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.

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

Citation | Condition or Requirement

Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.**	§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.**	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)
States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364

Citation | Condition or Requirement

Compliance Dates	Sections
CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) **no later than one year from the issuance of the associated EQR protocol.**	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) **no earlier than the issuance of the associated EQR protocol.**	§ 438.358(c)(6)

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 information 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 instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. TBD – currently 4/30/17)