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 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 who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)
	B. General Description of the Program and Public Process. For B.1 and B.2, place a check mark on any or all that apply.
1932(a)(1)(B)(i) 1932(a)(1)(B)(ii) 42 CFR 438.50(b)(1)	1. The State will contract with an __X_ i. MCO ____ ii. PCCM (including capitated PCCMs that qualify as PAHPs) ____ iii. Both
42 CFR 438.50(b)(2) 42 CFR 438.50(b)(3)	2. The payment method to the contracting entity will be: ____i. fee for service; _X__ii. capitation; ____iii. a case management fee; _X___iv. a bonus/incentive payment; ____ v. a supplemental payment, or ____vi. other. (Please provide a description below). The state will pay the agreed upon capitated rate on a two month retrospective basis. The state will also make performance incentive payments related to quality improvement and payment reform as specified in the contract. The performance incentives are funded with an amount withheld from each

Citation	Condition or Requirement
	capitation payment as a fixed percentage of the MCOs capitation payment. The maximum performance incentive payments that could be made to the MCO are equal to the amount withheld. The standards that must be met for the MCO to receive the quality improvement and payment reform incentive payments are specified in the contract.
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ____ii. Incentives will be based upon specific activities and targets. ____iii. Incentives will be based upon a fixed period of time. ____iv. Incentives will not be renewed automatically. ____v. Incentives will be made available to both public and private PCCMs. ____vi. Incentives will not be conditioned on intergovernmental transfer agreements. _X_vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

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

Citation	Condition or Requirement

- 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, Clarement, 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 I planning and implementation.
- Public engagement of long term care populations will continue by Louis Karno throughout the development of Step II.

1932(a)(1)(A)

5. The state plan program will X /will not___ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s):

   i. county/counties (mandatory) _____

   ii. county/counties (voluntary)_____

   iii. area/areas (mandatory)_____

   iv. area/areas (voluntary)_____

Citation	Condition or Requirement
	C. 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. __X_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. _X__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. __x_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) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. _X__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)	6. __X_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)	7. ____The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8. __X_The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. Eligible groups

Citation	Condition or Requirement
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. Old Age Assistance (§1902(a)(10)(A)(ii)(IV)) Aid for Needy Blind (§1902(a)(10)(A)(ii)(IV)) Aid for Permanently and Totally Disabled (§1902(a)(10)(A)(ii)(IV)) Medicaid for Employed Adults with Disabilities (NH's Ticket to Work Incentive Act program) (§1902(a)(10)(A)(ii)(XV)) Temporary Assistance for Needy Families (§1902(a)(10)(A)(i)(I)) and §1931 Poverty Level Children, Infants and Pregnant Women (§1902(a)(10(A)(i)(IV, VI and VII)) Targeted Low Income Children (§1902(a)(10)(A)(ii)(XIV)) Breast and Cervical Cancer (§1902(a)(10)(A)(ii)(XVIII)) Qualified Low Income Pregnant Women and Children (§1902(a)(10)(A)(i)(III)) Any of the above who also have Third Party Liability (excluding-Medicare)
	2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50. NOTE: NH believes citation should be 1932(a)(2). Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.
1932(a)(2)(B) 42 CFR 438(d)(1)	i. __X_Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)* Medicare beneficiaries will have the option to opt out of managed care and will be notified of this right concurrent with enrollment activity. Approximately 60 days prior to managed care commencement, a state generated correspondence will notify the Medicare beneficiary that the state Medicaid program is transitioning to managed care, describe the plans, explain plan enrollment processes and clearly state that managed care enrollment is optional for Medicare beneficiaries but that failure to communicate their intention to not enroll, will result in enrollment in

Citation	Condition or Requirement
	managed care requiring plan selection. Medicare beneficiaries who become eligible for Medicare mid-enrollment with managed care will not be disenrolled but will be notified of their option to disenroll if they so choose. All managed care enrolled individuals, including Medicare beneficiaries, will have the opportunity to disenroll from their plan whether selected by the member or auto assigned, within the first 90 days of plan enrollment, with or without cause. Medicare beneficiaries who disenroll during this period may either select a different plan or disenroll from managed care altogether.
1932(a)(2)(C) 42 CFR 438(d)(2)	ii. _N/A_ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. NH has no recognized tribes.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. _X_ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. _X_ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) of- 42 CFR 438.50(3)(iii)	v. _X_ Children under the age of 19 years who are in foster care or other out- the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. _X_ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. _X_ Children under the age of 19 years who are 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. Children described in (iii-vii) above will have the option to opt out of managed care and will be notified of this right concurrent with enrollment

Citation	Condition or Requirement
	activity. Approximately 60 days prior to managed care commencement, a state generated correspondence will notify these children that the state Medicaid program is transitioning to managed care, describe the plans, explain plan enrollment processes and clearly state that managed care enrollment is optional for children described in (iii-vii) above but that failure to communicate the intent to not enroll, will result in enrollment in managed care requiring plan selection. Children who become described as one of the categories above mid-enrollment with managed care, will not be disenrolled but will be notified of their option to disenroll if they so choose. All managed care enrolled individuals, including children described in (iii-vii) above, will have the opportunity to disenroll from their plan whether selected by the member or auto assigned, within the first 90 days of plan enrollment, with or without cause. Children described in (iii-vii) above who disenroll during this period may either select a different plan or disenroll from managed care altogether.
	E. Identification of Mandatory Exempt Groups
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* In New Hampshire this population of children is identified as "children with special health care needs," which is defined in RSA 132:13, II, as "children who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally." These children's clinical care cases are managed in a distinct organizational unit within DHHS. Their identities can be readily determined by coordinating with this unit and appropriate communications about opt-out rights targeted to them.
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: ____i. program participation, __X ii. special health care needs, or ____iii. both

Citation		Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	3.	Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. __x__i. yes ____ii. no
1932(a)(2) 42 CFR 438.50 (d)	4.	Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; Because NH is a "§209(b)" state, Medicaid is not provided on the basis of receipt of SSI. In order to identify individuals who are open Medicaid and who have SSI, a query would be made of our eligibility system New HEIGHTS that would identify individuals under age 19 who have SSI income of their own. We would use the list of identified children to target the appropriate state generated correspondence regarding enrollment in managed care and in plans. ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; This is an eligibility group for which a report can easily be generated within New HEIGHTS to identify all the children eligible under this category. iii. Children under 19 years of age who are in foster care or other out-of-home placement; This is an eligibility group for which a report can easily be generated within New HEIGHTS to identify all the children eligible under this category. iv. Children under 19 years of age who are receiving foster care or adoption assistance. This is an eligibility group for which a report can easily be generated within New HEIGHTS to identify all the children eligible under this category.
1932(a)(2)	5.	Describe the state's process for allowing children to request an exemption from

Citation	Condition or Requirement
42 CFR 438.50(d)	mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* If a child who was not captured as an optional enrollee through the above processes, presented as and is confirmed to be a recipient of special medical services by the distinct organizational unit responsible for clinical care case management of these children, requested to opt out of managed care, this request would be honored.
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Recipients who are also eligible for Medicare. The DHHS eligibility determination system, New HEIGHTS identifies individuals who are Medicare eligible. New HEIGHTS also conducts routine cross matches with Social Security Administration and learns of changes in Medicare status even if that has not been disclosed by the recipient. ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. There are no recognized tribes in New Hampshire so this section does not apply.
42 CFR 438.50	F. <u>List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment</u> • Members with VA Benefits • Spend-down • QMB/SLMB Only (no Medicaid)
42 CFR 438.50	G. <u>List all other eligible groups who will be permitted to enroll on a voluntary basis</u>

Citation	Condition or Requirement
	n/a As described above, anyone listed in D.2 above will be able to opt out. All populations will be mandatorily enrolled in managed care, unless they are federally exempt and described in D.2 above. The D.2 groups will be voluntarily enrolled. Anyone listed in F above will not be enrolled in managed care either voluntarily or mandatorily. They will remain in fee-for-service.
	H. Enrollment process
1932(a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: i. the existing provider-recipient relationship (as defined in H.1.i).

Enrollees who fail to make a voluntary MCO selection within the initial 60 days of the enrollment process will be auto-assigned to an MCO. Auto-assignment processes will provide for verification of paid claims data within the past 6 months on fee-for-service, to determine a regular site of primary or specialty care (if no primary care encounters are identified) and assign the enrollee to an MCO which has a contract with the provider that the enrollee's past claims history demonstrates an existing relationship. If this process fails to identify a provider relationship, 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.

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

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

Citation	Condition or Requirement

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

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

Enrollees who fail to make a voluntary MCO section within 60 days of the enrollment process and the auto-assignment processes as noted in i. and ii are not sufficient to auto-assign someone, state will assign beneficiary to an MCO. For those beneficiaries for whom it is not possible to determine any prior patient/provider relationship, or family member plan selection, the state will randomly assign members to ensure equitable enrollment among plans through the use of an algorithm. The algorithm included within the contracts calls for the plan with the highest technical RFP bid score will receive 2 enrollees to the other two plans 1 enrollee for a 2/1/1 distribution of members who did not make a plan selection. Pursuant to the contract terms, this algorithm will be employed during year one of the contract at which time the state will determine if a better methodology exists (such as 2 enrollees to the plan with the highest member satisfaction over the prior year, for example).
The technical scoring of the RFP bids consisted of an interdepartmental team of 10 members who read each proposal and scored them based on 11 domains, including but not limited pharmacy, care coordination, disease management, quality, member services, administration, behavioral health. Each team member scored each plan and then the team came together for consensus building to assign a score (maximum of 1100) to each plan. The plan with the highest technical score from this process will receive the 2 enrollees in the algorithm to the other two plans' 1 enrollee.

1932(a)(4)
42 CFR 438.50

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

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

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

Citation	Condition or Requirement

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

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

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

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

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

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

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

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

Citation | Condition or Requirement

RFP bid score will receive 2 enrollees to the other two plans 1 enrollee for a 2/1/1 distribution of members who did not make a plan selection. Pursuant to the contract terms, this algorithm will be employed during year one of the contract at which time the state will determine if a better methodology exists (such as 2 enrollees to the plan with the highest member satisfaction over the prior year, for example). The new assignment methodology for year two, if any, would reward those MCOs that demonstrate superior performance and/or improvement on one or more key dimensions of performance, pursuant to the contract.

The technical scoring of the RFP bids consisted of an interdepartmental team of 10 members who read each proposal and scored them based on 11 domains, including but not limited pharmacy, care coordination, disease management, quality, member services, administration, behavioral health. Each team member scored each plan and then the team came together for consensus building to assign a score (maximum of 1100) to each plan. The plan with the highest technical score from this process will receive the 2 enrollees in the algorithm to the other two plans 1 enrollee.

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

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

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

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

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

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

Citation	Condition or Requirement
	3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs. __X_This provision is not applicable to this 1932 State Plan Amendment.
	4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.) _x__ This provision is not applicable to this 1932 State Plan Amendment.
	5. _X___ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less. ___This provision is not applicable to this 1932 State Plan Amendment.
1932(a)(4) 42 CFR 438.50	J. Disenrollment 1. The state will_X__/will not___ use lock-in for managed care. 2. The lock-in will apply for _12___ months (up to 12 months). 3. Place a check mark to affirm state compliance. _X___The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c). 4. Describe any additional circumstances of "cause" for disenrollment (if any). Disenrollment provisions apply whether the individual is mandatorily or voluntarily enrolled in managed care. Members may disenroll if they move out of state, need related services simultaneously that are not available in the plan's network and bifurcation of the care creates risk, if the member wants to enroll in the same plan as a family member, or for other reasons such as lack of access to covered services, violation of member rights, or lack of network providers experienced in the member's unique healthcare needs. An MCO may disenroll a member who is threatening or abusive such that the health or safety of other members, MCO staff or providers is jeopardized.

Citation	Condition or Requirement
	K. Information requirements for beneficiaries Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	__x__The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM)

- Intermediate Care Facility (ICF) for Mentally Retarded
- Medicaid to Schools Services
- Dental Benefit Services
- Acquired Brain Disorder Home and Community Based Care (HCBC) Services
- Developmentally Disabled HCBC Services
- Choices for Independence HCBC Services
- In Home Supports HCBC Services
- Skilled Nursing Facility
- Skilled Nursing Facility Atypical Care
- Inpatient Hospital Swing Bed, SNF
- ICF Nursing Facility
- ICF Atypical Care
- Inpatient Hospital Swing Bed, ICF
- Glencliff Home (State run ICF)
- Developmental Services Early Supports and Services
- Home Based Therapy – Division of Children, Youth and Families (DCYF)
- Child Health Support Services (DCYF)
- Intensive Home and Community Services (DCYF)
- Placement Services (DCYF)
- Private Non-Medical Institution for Children (DCYF)
- Crisis Intervention (DCYF)

1932 (a)(1)(A)(ii)	M. 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.

Citation	Condition or Requirement

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

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

Based on the relative size of New Hampshire, only 1.2 million in total population and approximately 120,000 in any given month on Medicaid, 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.

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

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

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this 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

Citation	Condition or Requirement

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. 3/31/2014)