



State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NICHOLAS A. TOUMPAS
COMMISSIONER

August 7, 2012

Richard McGreal, Associate Regional Administrator
Department of Health and Human Services
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, MA 02203

RE: Request for Additional Information NH SPA 12-006

Dear Mr. McGreal:

This letter formally acknowledges the receipt of your June 28, 2012 correspondence requesting additional information ("RAI") pursuant to 42 CFR §430.16(a)(ii). Within this letter the State of New Hampshire Department of Health and Human Services ("DHHS") intends to not only address the questions raised in your correspondence, but also raise other concerns lest the State be barred from raising these concerns at a later date.

The New Hampshire DHHS staff that prepared this SPA had numerous conference call work sessions with members of your Region I and Central Office team to ensure that the SPA was thorough and compliant prior to its submission. We had received a number of "informal questions" in early May and those were based on the content of the SPA. However, a number of the questions raised in the RAI concern data exchange requirements, capacity to implement a managed care program, network adequacy, enrollment functionality, and external quality review. While appropriate, these are matters properly addressed in the context of the CMS review and approval of the managed care contracts. In an effort to facilitate review, we also submitted the completed CMS managed care contract checklist. Consequently, when we received the RAI, the breadth and scope was something of a surprise. At a later date, I will follow-up with you in more detail on my concerns directly so that this letter remains focused on the substance of our response.

A. Beneficiary Access to Services

In response to Cindy Mann's letter of May 23, 2012, we received your "Monitoring Access to Care in New Hampshire's Medicaid Program" plan. We are still reviewing the plan and expect that we will have questions and comments relating to:

- **Current data, surveys or other applicable analysis used in developing historical levels of access to care. Specifically, the data selected would illustrate the participating provider network size and capacity, service utilization trends, and rate levels (baseline access information);**
- **We look forward to reviewing your analysis of the anticipated impact that the proposed transition to a managed care delivery system will have on each of the baseline indicators that you have identified.**
- **Evidence of ongoing overall beneficiary engagement efforts;**
- **A comprehensive description of the State's plan, policies and procedures relating to the initial certification of network adequacy for all MCOs and likewise for ongoing monitoring of the aforementioned. This should include the State's approach to working with stakeholders, including both providers, and potential and actual enrollees on the development, monitoring, and any corrective actions related to access, as needed.**

Given that your proposed managed care rates are based on 2010 fee-for-service (FFS) rates, CMS is interested in your strategy for ensuring that the access issues that have arisen in the FFS setting will not be replicated in the managed care delivery system.

DHHS submitted its comprehensive and systematic access analysis of its Medicaid primary and hospital level of care on June 22, which unequivocally demonstrates that New Hampshire does not have an access problem. CMS has responded with questions that are being addressed through that ongoing dialogue.

The managed care program was proposed and championed by DHHS due to its promise to preserve coverage, quality, and access for Medicaid recipients in the face of other types of changes, potentially damaging. We understand that your concerns about access may be related to pending hospital litigation in New Hampshire. However, development of the managed care program design began long before the hospital lawsuit and long before CMS had raised any concerns about access to care in New Hampshire. Importantly, access is statutorily defined by Congress to reflect several factors only one of which is rates.

The managed care rates were established using CMS required actuarial soundness methods and based on population and utilization data from 2008 through 2010. Sound rates were calculated by a premiere actuary firm, Milliman, Inc., and the three contracted MCOs have agreed to a rate within the range Milliman calculated. Managed care organizations are not required to follow New Hampshire fee for service rates. In fact, New Hampshire Medicaid selected its managed care contractors, in part, based on their experience with innovative care coordination techniques and payment reform as demonstrated in other state Medicaid programs. Therefore, there is no correlation between New Hampshire's fee for service provider network or rate structure and the three managed care programs' provider networks and rate structures.

B. MMIS

Managed care requires extensive sharing of data between the State agency and the MCO and the MCOs and the individual providers. Please describe New Hampshire's capacity to exchange data with the MCOs.

The Medicaid Care Management System Integration (MCM-SI) component of the implementation is outlined in the attached MCM-SI Project Plan document, *see* Appendix 1. Each data interface has been identified and planned in a phased implementation. Our strategy is to go-live with Care Management using the Hewlett Packard MMIS and transition to the ACS/Xerox MMIS when it is operational. Where possible, existing interfaces are being leveraged to exchange data with the MCOs.

The Medicaid Care Management Systems Framework diagram, Exhibit 1 in the MCM-SI Project Plan, outlines the functions and planned interfaces. Initially capitation, kick payments and pharmacy lock-in will be handled manually. Appendix 2, is the MCM-SI Project Plan, lists all the planned interfaces and their phase of implementation.

Please describe the process by which NH will test to ensure that each of the functions specified in section 2.4 of the request for proposal (RFP), dated October 17, 2011, is functional. (Examples would include: receiving, updating and maintaining enrollment data from the State; submission of encounter data to the state). Please provide a project plan and a timeline.

Each of the system interfaces and functions will be tested before moving to a production schedule. The testing will include:

- Validation of file layouts – Confirmation that the data is in the correct layout.
- Validation of automated file transfer process – Confirmation that the files are produced and uploaded using the processes that will be used during production.
- Analysis and validation of data exchange – Confirmation that the data makes sense and is ending up in the right location.
- Execution of test scenarios – Testing the interfaces to make sure that all the different business variations have been anticipated and covered.
- Review of testing outcomes – Review of the MCO and DHHS systems to ensure all of the processes are accurate and complete.
- Tracking of testing defects – Tracking of defects to ensure they are resolved.
- Regression testing – Retesting, where needed, to ensure processes are working correctly.

A System Integration Test Plan will be produced to document the testing process and ensure that each of the functions in the contract are thoroughly tested.

Attached please also find two documents, the Medicaid Managed Care Systems Integration Project Plan (Appendix 1) and Medicaid Managed Care Systems Integration Project Workplan (Appendix 2).

C. Provision of Services to Persons with Mental Illness

- 1. Please describe how the NH Care Management Program will provide services to qualified individuals with mental illness in the most integrated setting appropriate. Please describe how NH will monitor that mental health services are delivered in the most appropriate setting.**
- 2. Please describe how the NH Care Management Program will address the risk of unnecessary institutionalization of individuals with disabilities.**

Response to #1 and #2: One initial point of clarification- the State of New Hampshire does not unnecessarily institutionalize individuals and will continue to ensure that individuals are not unnecessarily institutionalized under Care Management. New Hampshire has a strong emphasis on providing services that are community based and in the most integrated setting possible.

In addition to the points noted in our response to question 3, many of which pertain to improving access to services and community tenure, the contract between the State and the MCOs has a number of specific safeguards built in to ensure individuals are served in the most appropriate setting based on their needs.

- MCOs shall ensure that community mental health services are delivered in the least restrictive community based environment
- There are clear access to care standards in the MCO contracts that define timeframes for individuals accessing services, including medication visits with providers in the community to ensure individuals receive rapid treatment and follow-up in the community
- The MCOs need to maintain or increase the ratio of community based to office based services, as currently reflected in the consumer's person centered treatment plan, for each region in the State to be greater than or equal to the regional current percentage or 50%, whichever is greater
- To increase community based long term supports and services, there are requirements in the MCO contracts to expand the availability of Assertive Community Treatment Teams (ACT), community residential capacity and the MCOs are required to submit a plan to expand these services as part of the Program Management Plan submitted to DHHS and the contractual requirements that the MCOs continue implementation of New Hampshire's 10-Year Olmstead Plan.
- They are also required, as part of the Program Management Plan, to propose new and innovative interventions that will reduce admissions and readmissions to New Hampshire Hospital and increase community tenure for adults with a severe mental illness and children with a serious emotional disturbance
- Through the award of funds to New Hampshire under the Balancing Incentive Program (BIP), we are enhancing access and information on long term supports and services available in the community. The MCOs will partner with DHHS on this initiative to rebalance community based and institutional spending through a number of key initiatives, including, but not limited to:
 - i. Education and outreach to individuals and families on services available in the community
 - ii. Training for the provider community in evidence based and best practice models of care
 - iii. Navigation and Eligibility Coordination
 - iv. Expansion of Trauma based care initiatives
 - v. Futures Planning
 - vi. Options Counseling
- DHHS will be leading regional planning sessions, with the participation of the MCOs and Community Mental Health Centers, for the purpose of reducing the need for inpatient care and emergency department utilization to increase community tenure.
- The contract requires each of the MCOs to develop a collaborative agreement with New Hampshire Hospital to, at a minimum, address the Americans with Disabilities Act requirement that individuals be served in the most integrated setting appropriate to their needs, and ensure a seamless transition of care upon admission and discharge to the community. There are specific contractual requirements for the MCO to decrease discharges to homeless shelters and provide specific reports to DHHS on any discharges to homelessness.

- The MCOs are required to designate liaisons to New Hampshire Hospital to actively participate in team meetings and discharge planning to ensure that individuals receive treatment with the least restrictive environment complying with the Americans with Disabilities Act. In order to ensure rapid follow-up in the community, the MCOs are required to make contact with the member by phone within 3-days of discharge from NHH to support the member in attending any scheduled follow-up appointments, support the continued taking of any medications prescribed, and address any barriers that may have arisen.
- The MCO contracts require that follow-up post NHH stay occur within 7 calendar days after discharge. This is also a requirement in the provider contracts with an associated penalty for non-compliance. New Hampshire is in the process of implementing Project RED (Re-engineered Discharges) to reduce readmissions to the State Hospital and improve follow-up post discharge. Follow-up calls will be made to the consumer post discharge to ensure that they will be attending their follow-up appointments, address any barriers that may have arisen, review the medications they were prescribed, and answer any questions they may have, and document this process in the discharge planning system we have recently acquired. In addition, the care coordination requirements for the MCOs are intended to include intensive outreach efforts, including in person community outreach from the MCO, for high risk consumers and is also modeled after the Project RED requirements for all discharges from the State hospital.

These areas are also part of New Hampshire's Quality Management Plan.

3. Please provide a description of the current mental health delivery system and how it will be altered and/or will operate in conjunction with the MCO's.

Response: The current community mental health system providers are not anticipated to change under the implementation of a care management program in New Hampshire. All community mental health services, as defined in NH Administrative Rule He-M 426 are provided by a community mental health program designated by the State to provide services in its regionally defined service area. There are 10 designated community mental health programs in New Hampshire, and this is not anticipated to change. We anticipate that all of the community mental health programs in New Hampshire will contract with each of the 3 Managed Care Organizations to provide community mental health services on behalf of their covered members. In the event that any CMHC declines to participate the MCO will notify the NH DHHS and DHHS will review the action plan submitted by the MCO and designate an alternative provider of services in the region to ensure continuity of care and the availability of community mental health services for the region. DHHS has no indication that this will need to be exercised as an option at this time.

We do anticipate that the Managed Care Organizations will play a significant role in more effectively coordinating care for enrolled members within a person centered approach, resulting in improved outcomes and cost savings that can be reinvested into improved services for all members. A key objective in incorporating behavioral health services under care management is to ensure improved care for our population through better overall care coordination through a person centered approach.

The managed care organizations are expected to have a greater role in reviewing and providing authorization for services provided by the community mental health centers and a greater role in providing more opportunities for consumers who are ready to transition to alternative lower levels of care in the community, such as Peer Support Services, and be provided an opportunity to do so.

We also anticipate a number of enhancements to the service delivery system as a result of the managed care implementation in New Hampshire, including:

- Further development of New Hampshire's Olmstead plan initiatives, including additional community residential capacity, additional Assertive Community Treatment Teams, and a more efficient crisis response system.
- Access to care standards will ensure that consumers and families have more timely access to treatment and follow-up care post hospitalization. These standards have been built into the MCO contracts and provider contracts with the State of NH.
- We are partnering with the Managed Care Organizations to improve the discharge planning process at New Hampshire Hospital to reduce readmission rates, and there are specific performance targets established in the contract.
- New Hampshire Hospital is implementing a model developed by one of the MCOs called Project RED (Re-engineered Discharges) to reduce readmission rates and provide for rapid follow-up after discharge in the community. The discharge plan will be formally documented for all consumers leaving the state hospital. New Hampshire Hospital has hired a full time coordinator for Project RED, purchased the Project RED software application and protocols, and is in the process of setting up our first implementation team meetings with the vendor overseeing roll-out at New Hampshire Hospital.
- We will be expanding the availability of Evidence Based Practices of IMR and EBSE and there are specific performance targets established in the contract.
- The MCOs will be responsible for providing training to CMHC staff and expanding the availability of several Evidence Based Practices Illness Management and Recovery (IMR), Evidence Based Supported Employment (EBSE), Trauma Focused Cognitive Behavioral Therapy (TF-CBT) and Dialectical Behavioral Therapy (DBT) and suicide prevention as part of the contractual requirements thus enhancing these programs and services.
- The current mental health delivery system is not intended to change from the consumer perspective. New Hampshire is retaining the current infrastructure of community mental health specialists providing services through the network of community mental health programs in New Hampshire.
- New Hampshire will also be leveraging the Balancing Incentive Program grant funds through an active partnership with stakeholders, including the Managed Care Organizations, to improve access to community based services and supports.

4. **Please describe how NH will monitor the MCOs to ensure that patients transitioned from fee-for-service to managed care for the purposes of mental health service are transitioned in a timely manner.**

Response: Individuals who receive services from the community mental health centers will continue to do so under care management, as they are the only designated providers that can deliver these services to the SMI and SED populations in NH. They will continue to receive services from the same provider group and there will be no transition from the individual consumer perspective. DHHS will work closely with the enrollment broker to ensure that individuals receiving services from the CMHCs are enrolled in a managed care plan prior to the implementation date. Subject to the contractual provisions between the State and the CMHCs, they cannot steer consumers towards a specific plan, however they are required through the provision of targeted case management services, to provide and review enrollment materials with individuals to convey the importance of choosing a plan, and helping the individual make an informed decision by reviewing all plan options with them. Prior authorizations for those services at the CMHCs subject to prior authorization are required by contract to continue in order to ensure continuity of care.

For the enrollment process for managed care, New Hampshire will be drawing upon our successful experience with the Medicare Part D program where we closely monitored the enrollment and transition from Medicaid pharmacy to a Medicare pharmacy benefit. The close monitoring that New Hampshire established for this transition ensured that individuals were rapidly enrolled, barriers to enrollment were quickly identified, and New Hampshire continued to fund and support pharmacy benefits for those who were unable to enroll until those barriers could be quickly addressed.

D. State Capacity to Implement Managed Care

1. Please describe the MCO readiness review that the State will conduct. What criteria will determine whether or not the MCOs are ready to implement? Will the State generate any reports based upon the readiness review? Please provide an outline of the contents of these reports. Please describe the State's plan for monitoring implementation activities and detecting problems. What process with the State follow if a problem is detected (include timeline)?

DHHS reviews progress of the MCO's implementation activities through weekly conference calls. In addition DHHS has planned three formal milestone events in the implementation of the Care Management Program in New Hampshire. In the beginning of August a check point is scheduled with each of the Managed Care Organizations. They are to present their progress and status, which will include;

- Network development, by provider type and through Geo Access analysis.
- Subcontractor status;
 - Overall plan of subcontracting
 - Process and oversight of subcontractors
 - Status overview of contracts established to date.
- Overview of status of required documentation as part of the contract.
- Further status on;
 - Hiring of staff for NH program
 - Operational status
 - Systems development

Following this check point meeting the first readiness review is scheduled for the first week of September during which the department will review the following;

- Network Adequacy Review
 - By provider type
 - Geo Access analysis
 - Contracting and credentialing status
- Review of Member-facing activities
 - Member call center readiness
 - Status of member materials
 - Status of provider directory
 - Comprehensive systems test of data exchange between NH eligibility system (New Heights) and the MCO's MCIS system
- Inventory of plans as identified in contract, policies & procedures and other materials that require DHHS approval
 - Comprehensive list of outstanding items
 - Tracking toward submission dates
- Review of subcontractor readiness
- Review of staffing plan
- Review of all implementation tracking issues that are identified as behind or at risk
- Review of MCO status on all 42 CFR requirements

A second readiness review is scheduled for the first week of November during which the Department will review the following:

- Review of issues raised in Readiness Review #1
- Review of all implementation tracking issues that are identified as behind or at risk
- Initial feedback, issues from first days of enrollment
- System Testing of
 - Loading of provider file
 - Prior authorization system edits
 - Claims adjudication
 - Encounter submission
 - Subcontractor systems as needed
- Review of Behavioral Health, care management and Non-Emergency Transportation transition plans

From each of these meetings feedback will be provided to the MCOs where DHHS sees a need for correction in their respective implementation efforts. When an MCO is behind on their planned implementation activities a Corrective Action Plan will be required, please see section 7.6.3.2 of the Care Management contract. Please also note the consequences for not meeting implementation requirements, plan requirements, failure to meet Corrective Action Plan, etc. described in Section 32 of the Care Management contract.

2. What specific steps has the State taken to ensure a safe and smooth member experience while accomplishing multiple concurrent transitions? (Examples: CHIP, individuals subject to passive enrollment, individuals with mental health conditions, duals, individuals with special needs)

The call of the question is not especially clear. DHHS assumes that by flagging CHIP in connection to 'transition' that CMS means the recent transition of our combination Title XIX program to a Medicaid expansion mode of administration. This initiative was completed on July 1, 2012 some six months prior to the expected commencement of the Care Management program. As such, these children will already be seamlessly integrated within the State Medicaid program and their experience enrolling in Care Management will be precisely the same as it is for all other Medicaid children. Moreover, for CHIP enrollees who were enrolled prior to the transition to Medicaid Expansion, DHHS believes these children will actually have an easier time, not a harder time, moving to a managed care environment since they will have had prior experience with a managed care product.

As it relates to individuals with mental health conditions, duals, or individuals with other special needs, DHHS must emphasize that a core guiding principal in the design and implementation of the Care Management initiative has been whole person centered delivery of all aspects of care be they medical care or customer service. Whether speaking of the enrollment activities that DHHS will directly supervise or the integration with a member's selected MCO, the clear expectation for all involved is that the individual needs of the member dictate the level of attention and coordination provided. This core philosophy is not limited to members who fall into specific categories but rather permeates the overall operation of the initiative.

The Care Management contract contains significant oversight and detail ensuring continuity of care for the members. Section 10 of the Care Management contract describes detailed expectations on Care Coordination and speaks to the need for safe and smooth member experience. In addition Section 12 of the contract details additional specific requirements on the continuity and transition of care for members with mental health conditions. Sections 13.1.7 and 21.1.11 specifically detail requirements to ensure prior authorizations for the member are honored while transitioning from Fee For Service to Care Management.

To ensure that members experience continuity of care in situations where providers will no longer be or are not part of the MCO's network, or in the unforeseen circumstance that the contract with an MCO needs to be terminated, specific requirements are described in the contract to ensure minimal interruption for the member. See for example, Sections 19.2.14, 19.2.16, 19.2.17, 19.2.18, etc.

The Department will ensure through review of the MCO specific plans, policies and procedures, as well as the review of the implementation efforts, that the MCOs are in compliance with the contractual requirements and has providers and systems in place to ensure the continuity and appropriate transition of care for our members.

3. How will the State assure that subcontractors, e.g., Durable Medical Equipment (DME) and other vendors are in place and prepared to serve the newly enrolled population? What are the State criteria for this assessment?

Through the status meetings, review of the subcontractor agreements and network development checks, DHHS is reviewing the implementation status of contracts with the subcontractors that the MCOs are intending to engage. Through a list of subcontractors identified by each MCO, it is known to DHHS whether they are providing certain services through a subcontractor or directly.

Through the readiness reviews DHHS will review whether the MCO is able to process claims through their systems as well as the subcontractor systems to ensure that all parties are ready to commence provision of services to members. The systems verification will focus on member specific data flows and processing as well as provider specific data flows and processing.

E. Network Adequacy

1. Please provide a copy of the criteria the State will use to assess whether the MCO networks are adequate. Please walk CMS through the review process that will occur at the state level to determine network adequacy.

As part of implementation and ongoing oversight of the Care Management program, DHHS will enforce the New Hampshire Insurance Department Standards for Geographic Accessibility (NH INS 2701.06), currently in place as the requirement for all commercial insurance carriers licensed in the State of New Hampshire. Sections 18 and 19 of the Care Management contract address access and network management. Specifically, Section 18.2.1 requires the MCO to adhere to very specific geographic access requirements to ensure all of the members have adequate access to the services (Table 1). Section 18.3 articulates the timeliness standards for various services (Table 2). The MCOs are required to demonstrate Network Adequacy prior to the start of the program, with the use of Geo Access reports. After “go-live,” Section 18.3.5 of the Care Management contract requires the MCOs to submit quarterly reporting on geographic and timely access to their provider network, with a requirement to implement a Corrective Action Plan if there is a failure in meeting these timely access standards.

Table 1: MCO Provider Geographic Standards

Provider Type	Number of Providers Available Statewide
PCPs	Two (2) within forty (40) minutes or fifteen (15) miles
Specialists	One (1) within sixty (60) minutes or forty-five (45) miles
Hospitals	One (1) within sixty (60) minutes or forty-five (45) miles
Mental Health Providers	One (1) within forty-five (45) minutes or twenty-five (25) miles
Pharmacies	One (1) within forty-five (45) minutes or fifteen (15) miles
Tertiary or Specialized services (Trauma, Neonatal, etc.)	One within one hundred twenty (120) minutes or eighty (80) miles

Table 2: MCO Provider Timeliness Standards

Visit Type	Timely Service Delivery (calendar days unless otherwise specified)
Transitional Care after Inpatient Discharge	7 days for physician; 2 days for nurse or counselor
Non-symptomatic and Preventive Care	30 days
Non-urgent, Symptomatic Care	10 days
Urgent, Symptomatic Care	48 hours
Emergency Medical and Psychiatric Care	24 hours, seven days per week
Behavioral Health Care: Routine Care	10 days
Behavioral Health Care: Urgent Care	48 hours
Behavioral Health Care: Non-life Threatening Emergency	6 hours

Section 32 addresses remedies that may be deployed should MCO fail to comply with the contract. Specifically, Section 32.7.1 imposes penalties of up to \$1,000 per day of occurrence until correction for the “failure to provide a sufficient number of providers in order to ensure member access to all covered services and to meet the geographic access standards and timely access to service delivery specified” in the contract.

In addition to MCO self-regulation and reporting, DHHS will, through its EQRO, assure that Medicaid managed care enrollees have access to and the availability of an adequate provider network. The successful EQRO bidder (see Question Part G) will plan and conduct surveys to assess the availability and access to providers for each MCO. Surveys of primary care providers, behavioral health providers and selected specialists, including women’s health and special needs providers, will be conducted annually. Other practitioners, such as medical specialists, will be surveyed on an as needed basis. Access and availability surveys will involve a statistically valid number of telephone calls to provider offices to determine access and availability standards for specific appointment standards including routine appointments, non-urgent appointments and after hour calls.

Finally, consistent with 42 CFR 438.66 (b), the State, as a function of quality assurance and improvement, will monitor all grievance and appeals requests related to access. DHHS may, through its EQRO, trigger an immediate specific provider or specialty specific investigation into member access.

2. What are the standards and expectations for MCOs to contract with current FFS providers serving this population (e.g., children's hospitals, pediatricians, clinics)? How will the State monitor on a regular basis the status of each MCOs network?

It is DHHS’s expectation that most of the FFS providers will contract with multiple MCO’s. Please see the State’s monitoring activities as described in question 1 of this Network Adequacy section. Monitoring will follow similar processes as described in Question 1.

At the end of its staged rollout, DHHS intends to have statewide managed care for all populations. The result will be a very small FFS population. DHHS intends to include as a part of its EQRO procurement scope of services FFS assessments of access and availability activities analogous to the MCO surveillance above for its FFS population, including telephone surveys and immediate specific provider investigations.

For a more complete discussion of MCO monitoring on a regular basis, please see Question 1 above. Briefly, after “go-live,” Section 18.3.5 of the Care Management contract requires the MCOs to submit quarterly reporting on geographic and timely access to their provider network, with a requirement to implement a Corrective Action Plan if there is a failure in meeting these timely access standards.

F. Enrollment Broker

Please provide a copy of the New Hampshire’s strategy for performing enrollment broker functions. This plan should include tasks, responsible units/persons, monitoring activities and timelines. How will information on providers and subcontractors be provided to potential enrollees to allow timely consideration and selection of a plan?

<u>No.</u>	<u>Task</u>	<u>Description</u>	<u>Responsible Units</u>	<u>Timeline</u>	<u>Monitoring Activities</u>
1	Outreach and Education	Member Notification Provider Notification Special Interest Groups Enrollment Packets	Outreach and Education Committee, Christine Shannon, Team lead		
2	MCO Selection and Opt-out	Process MCO enrollment requests, including: -Telephone Enrollments - Web-Based Enrollments - U.S. Mail Enrollments - Auto-Assignment Enrollments - Administrative Enrollments -One-on-one enrollments	Telephone: Medicaid Client Services (MCS) Call Center and Maximus-temporary call center. Web, US mail, Auto: DFA, New Heights Administrative: One-on-one: ServiceLink saa	Enrollment begins 11/1/12 Auto Enrollment begins 12/14/12	New Heights reports issued weekly, to include # enrolled in each MCO, method used to enroll, and number opting out of managed care.
3	MCO Disenrollment Processing	Process member disenrollments from MCO			
4	Transfers between MCOs	Process "For Cause" and "Without Cause" MCO change requests or transfers	Telephone: Medicaid Client Services Call Center.	After client's initial 90 days, going forward,	New Heights reports issued weekly or by request, giving # of transfers, and reasons for transfers.
5	Annual Health Plan Changes	Process Annual Right to Change (ARC) MCO requests	Telephone: Medicaid Client Services Call Center. Web, US mail: New Heights and DFA One-on-one: ServiceLink	11/1/2013	New Heights reports issued weekly, or by request, giving # of transfers and current enrollee #s in each MCO.

<u>No.</u>	<u>Task</u>	<u>Description</u>	<u>Responsible Units</u>	<u>Timeline</u>	<u>Monitoring Activities</u>
6	Enrollment Related Interfaces	New Heights to MMIS New Heights to MCOs MCOs to New Heights	See System Integration Plan, Kerri Coons		The interfaces will be automatically scheduled to run and pick up files according to a pre-arranged schedule. If an interface file is not available or if there is a problem with the file, an automated notice will be distributed to the New Heights Helpdesk and the MCOs for manual research and intervention.
7	Enrollment Data Reconciliation	Perform a Daily and Weekly Enrollment Transaction Reconciliation of all Enrollment, Disenrollment, and related transactions received from the Department and forward to the respective MCOs	See System Integration Plan, Kerri Coons		The monthly roster will be transmitted at the end of the month and will be used by the MCOs to reconcile with the daily change files. Any discrepancies will be worked individually between the New Heights Helpdesk and the MCOs.
8	Provider Network Directory Database	Develop and maintain a database of participating providers for each MCO and process weekly update file (additions, deletions and changes) and a monthly full-file replacement.	We are working on Maximus getting a database from each MCO but currently the plan is to use the 3 MCO websites for provider lists.		
9	DHHS Enrollment Call Centers: Temporary Call Center contracted by Maximus OMBP Medicaid Client Services(MCS) Call Center	Operate an MCO enrollment selection call center to support enrollment, disenrollment	Carol Sideris, Commissioner's Office, Betsy Hippensteel, Medicaid Client Services	Temporary Call Center: 11/1/12 thru 1/1/13 MCS Call Center: begin 11/1/13--ongoing	Approve scripts used by Call Center, monitor live calls, and receive weekly reports on performance measures to include, but not be limited to, abandoned call rate, average speed of answer, call resolution rate, and average call time.
10	Standard and Ad Hoc Reporting	Reporting on call center and enrollment/disenrollment and opt-out			

G. External Quality Review Organization

For the provision of services through the use of a managed care entity, States must meet the requirements at 42 CFR 438 subpart E (§310 - 370 inclusive) regarding External Quality Reviews. Please describe the status of the State's activities regarding EQRO contracts.

The State is currently drafting the request for proposals for its EQRO and intends to have a contract with an EQRO beginning March 1, 2013. To date, the State has completed its review of federal requirements, reviewed the EQROs of several states, and completed a rough draft of the NH Medicaid EQRO scope of work. The following timeline outlines the remaining major milestones:

EQRO Procurement Time Table

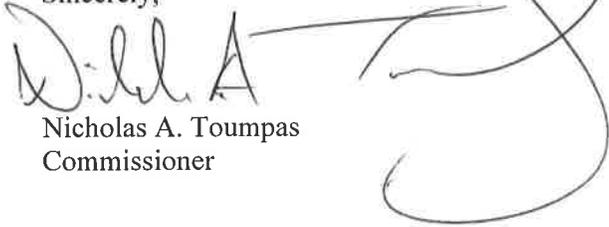
Procurement Task	Target Date for Completion
• Complete EQRO draft for internal review	• August 6, 2012
• Post EQRO	• August 13, 2012
• Proposals due	• October 1, 2013
• Review and selection of the successful vendor; begin contracting	• October 10, 2012
• Contract to Governor and Council for review	• December 1, 2012
• Begin EQRO program	• March 31, 2013

H. Response to Informal Questions

Please see attached redlined version as well as fixed text version for reference, Appendixes 3 and 4 respectively.

Please also note that as it pertains to the response to informal questions, the response to Q12(c) was incorrect. DHHS misunderstood the call of the question. The corrected answer, no later than 15 days from auto-assignment, is contained in the redlined and fixed text SPAs attached.

Sincerely,


Nicholas A. Toumpas
Commissioner

Enclosures

cc: Kathleen Dunn, RN, MPH, State Medicaid Director