

CHAPTER He-W 500 MEDICAL ASSISTANCE

PART He-W 506 MEDICAID MANAGED CARE

He-W 506.01 Purpose. The purpose of this part is to prescribe the requirements of the New Hampshire medicaid managed care program as they pertain to medicaid recipients, including covered services, enrollment in managed care, selection of a managed care organization (MCO), and grievance and appeal rights.

Source. #10410, eff 9-13-13

He-W 506.02 Scope. This part shall apply to all medicaid recipients insofar as they are required to enroll in managed care or they voluntarily enroll in managed care. Those recipients who are not enrolled in managed care shall receive medicaid services on a fee-for-service basis in accordance with applicable rules in He-W 500.

Source. #10410, eff 9-13-13

He-W 506.03 Definitions.

(a) "Action" means an MCO activity including, but not limited to, the following activities identified in 42 CFR 438.400(b):

- (1) The denial or limited authorization of a requested service, including the type or level of service;
- (2) The reduction, suspension, or termination of a previously authorized service;
- (3) The denial, in whole or in part, of payment for a service;
- (4) The failure to provide services in a timely manner, as described in the contracts between the department and the MCOs; and
- (5) The failure of an MCO to act within the timeframes required for disposition of a grievance, standard resolution of an appeal, or expedited resolution of an appeal, as described in the contracts between the department and the MCOs.

(b) "Appeal" means a request to the MCO for the review of any action taken by the MCO.

(c) "Department" means the New Hampshire department of health and human services.

(d) "Enrollee" means a recipient who is enrolled in managed care and who has not yet selected an MCO. This term includes the following:

- (1) "Mandatory enrollee" means a recipient who is required to enroll, and has been enrolled, in managed care; and
- (2) "Voluntary enrollee" means a recipient who is exempt from mandatory enrollment, who has chosen to enroll in managed care by not affirmatively opting out of managed care.

(e) "Fair hearing" means an administrative appeal under He-C 200.

(f) "Fee-for-service" means the reimbursement method used by the department:

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(1) For all services to recipients who are not enrolled in managed care and to members whose MCO coverage has not yet begun; and

(2) For those services excluded from managed care for all recipients.

(g) “Grievance” means an expression of dissatisfaction about any matter other than an action that is communicated to the MCO, such as with regard to the quality of care or services provided, and aspects of interpersonal interactions with the MCO employees.

(h) “Managed care organization (MCO)” means an entity that has a comprehensive risk-based contract with the department to provide managed medicaid health care services.

(i) “Mandatory enrollment” means the process whereby a recipient is enrolled in managed care, unless otherwise exempt or excluded.

(j) “MCO grievance system” means the system through which members can complain, express dissatisfaction, or challenge an action made by the MCO, including:

(1) An MCO grievance process;

(2) An MCO appeal process; and

(3) Access to the department’s fair hearing process after (2) has been exhausted.

(k) “Medicaid” means the Title XIX and Title XXI programs administered by the department which makes medical assistance available to eligible individuals.

(l) “Member” means a recipient who has selected or been auto-assigned to an MCO.

(m) “Recipient” means any individual who is eligible for and is receiving medical assistance under the New Hampshire medicaid program.

(n) “Title XIX” means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

(o) “Title XXI” means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

Source. #10410, eff 9-13-13

He-W 506.04 Covered Services.

(a) Covered services provided through an MCO shall include:

(1) All covered state plan services except the following:

a. Dental services provided in the dental setting;

b. Intermediate care facility for the mentally retarded (ICFMR);

c. Medicaid to schools program;

d. Skilled nursing facility;

e. Skilled nursing facility atypical care;

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- f. Inpatient hospital swing beds, intermediate care facility;
- g. Inpatient hospital swing beds, skilled nursing facility;
- h. Intermediate care facility nursing home;
- i. Intermediate care facility atypical care;
- j. Glencliff Home;
- k. Early supports and services; and
- l. The following services which are only offered to children involved with the division for children, youth and families:
  - (i) Home based therapy;
  - (ii) Child health support service;
  - (iii) Placement services;
  - (iv) Intensive home and community services;
  - (v) Private non-medical institutional care for children; and
  - (vi) Crisis intervention; and

(2) Community mental health services described in He-M 426.

(b) The services excluded in (a)(1) above shall be covered by medicaid on a fee-for-service basis.

(c) Covered services shall be covered by the MCO starting the first day of the first month following a member's selection of or auto-assignment to an MCO, or the first day of the managed care program, whichever is later.

(d) Covered state plan services provided through an MCO shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under fee-for-service.

Source. #10410, eff 9-13-13

He-W 506.05 Enrollment in Managed Care.

(a) All medicaid recipients shall be enrolled in managed care unless:

- (1) The recipient is federally exempt from mandatory enrollment pursuant to 42 USC §1396a(u-2)(a)(2), as described in (b) below, and affirmatively opts out of managed care; or
- (2) The recipient is excluded from managed care as described in (c) below.

(b) Recipients in the following aid categories shall be exempt from mandatory enrollment in managed care:

- (1) Children under the age of 19 years who are eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act;

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- (2) Children under the age of 19 years who are eligible for home care for children with severe disabilities (HC-CSD) pursuant to §1902(e)(3) of the Social Security Act and He-W 508;
  - (3) Children under the age of 19 years who are in foster care or other out-of-the-home placement;
  - (4) Children under the age of 19 years who are receiving foster care or adoption assistance under part E of subchapter IV of the Social Security Act;
  - (5) Children with special health care needs 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 of the Social Security Act; and
  - (6) Recipients who are Medicare dually eligible beneficiaries.
- (c) The following individuals shall not be allowed to enroll in managed care:
- (1) Recipients receiving benefits from the U.S. Department of Veterans Affairs;
  - (2) Recipients receiving in and out medically needy assistance in accordance with 42 CFR 435.301 and He-W 678.01; and
  - (3) Individuals who have qualified medicare beneficiary/specified low-income medicare beneficiary (QMB/SLMB) benefits only, and are not eligible for medicaid service coverage.
- (d) Any recipient not enrolled in managed care shall receive medicaid services on a fee-for-service basis.
- (e) Those recipients described in (b) above shall be allowed to disenroll from managed care at any time, with or without cause.
- (f) An enrollee may disenroll from managed care if he or she has moved out of state.

Source. #10410, eff 9-13-13

He-W 506.06 Selection of a Managed Care Organization.

- (a) The department shall send a notice of managed care enrollment and MCO selection to all recipients not excluded from managed care per He-W 506.05(c).
- (b) Recipients shall have 60 days from the date of the notice in (a) above to respond to the department, via writing, telephone, or by utilizing the on-line NH Electronic Application System (NH EASY), as follows:
- (1) Those recipients who are required to enroll in managed care shall select an MCO; and
  - (2) Those recipients exempt from mandatory enrollment per He-W 506.05(a)(1) shall either:
    - a. Select an MCO, thereby enrolling in managed care; or
    - b. Affirmatively indicate to the department their choice to not enroll in managed care.
- (c) An MCO shall be auto-assigned to:
- (1) Those recipients in (b)(1) above who do not select an MCO; and

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- (2) Those recipients in (b)(2) above who do not meet either of the requirements in (b)(2) above.
- (d) Auto-assignments shall be based on the following criteria:
- (1) MCO participation of a primary care provider with whom the enrollee has a pre-existing relationship as demonstrated by past claims history;
  - (2) MCO participation of a specialty care provider with whom the enrollee has a pre-existing relationship as demonstrated by past claims history;
  - (3) MCO selection by a household family member of the enrollee;
  - (4) MCO previously selected prior to a loss of medicaid eligibility; or
  - (5) If no assignment can be made utilizing (1)-(4) above, assignment shall be based on an algorithm, which has been contractually agreed to by the department and the MCO, that ensures equitable enrollment of enrollees across all MCOs.
- (e) A member may request to change his or her MCO selection without cause, by making a written or oral request to the department at any of the following times:
- (1) During the 90 days following the date of the member's initial selection of or the auto-assignment to the MCO, or the date the department sends the member confirmation of the member's selection or auto-assignment, whichever is later;
  - (2) At any time for members who are auto-assigned to the MCO and who have an established relationship with a primary care provider that is only in the network of a non-assigned MCO;
  - (3) At any time for members who were voluntary enrollees;
  - (4) During open enrollment every 12 months; and
  - (5) For 60 calendar days following an automatic re-enrollment if the temporary loss of medicaid eligibility causes the member to miss the annual re-enrollment/disenrollment opportunity. This provision shall apply to redeterminations only and shall not apply when an individual is completing a new application for medicaid eligibility.
- (f) A member may request to change his or her MCO selection with cause, by making a written or oral request to the department at any time for any of the following reasons:
- (1) The member requires related services simultaneously that are not available in the MCO's network and bifurcation of the care creates unnecessary risk to the member as determined by the member's treating provider;
  - (2) The member wants to select the same managed care plan as a household family member;
  - (3) Poor quality of care;
  - (4) Lack of access to covered services;
  - (5) The member has experienced a violation of his or her member rights, as established in 42 CFR 438.100; or
  - (6) The MCO's network providers are not experienced in the member's unique healthcare needs.

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(g) If a request made pursuant to (e) or (f) above does not include the selection of a different MCO, the department shall not act on the request.

(h) A member may request a department fair hearing of a denial of (e) or (f) above in accordance with He-C 200 without first exhausting the MCO appeal process.

(i) For members who are mandatory enrollees, the member shall be locked into the selected or auto-assigned MCO for a period of 12 months or until the next open enrollment period, whichever comes first, unless the member changes his or her MCO selection in accordance with (e)(1), (2), (5), or (f) above.

(j) A member may disenroll from an MCO if the member has moved out of state.

(k) An MCO may request the department to disenroll a member who is threatening or abusive such that the health or safety of other members, MCO staff, or providers is jeopardized.

(l) The department shall approve a request for disenrollment in (k) above when no other option is available that would ensure the health and safety of other members, MCO staff, or providers.

(m) If the department approves an MCO request for involuntary disenrollment, the member may request a department fair hearing of the disenrollment in accordance with He-C 200 without first exhausting the MCO appeal process.

(n) Members appealing involuntary disenrollment may request a continuation of services pending appeal as outlined in 42 CFR 431.230.

Source. #10410, eff 9-13-13

He-W 506.07 MCO Grievance Process.

(a) A member who is dissatisfied with any matter other than an action, as defined in He-W 506.03(a), shall utilize the MCO grievance process exclusively.

(b) The MCO grievance process shall address members' expression of dissatisfaction about any matter other than an action including, but not limited to:

- (1) The quality of care or services provided;
- (2) Aspects of interpersonal interactions with providers or MCO employees; or
- (3) Failure to respect the member's rights.

(c) Actions, as defined in He-W 506.03(a), shall be subject to the MCO appeal process but not subject to the MCO grievance process.

(d) A member, or the member's authorized representative, appointed in accordance with He-W 603.01, shall file a grievance with the MCO either orally or in writing.

(e) Members shall be notified of the disposition of grievances as follows:

- (1) Either orally or in writing for grievances not involving clinical issues; and
- (2) In writing for grievances involving clinical issues.

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(f) Members shall not have the right to a department fair hearing in regard to the disposition of a grievance.

(g) The MCO grievance process shall not preclude a member's ability to pursue client rights protection under He-M 204.

Source. #10410, eff 9-13-13

He-W 506.08 MCO Appeal Process.

(a) The MCO appeal process shall address members' requests for the appeal of any action taken by the MCO.

(b) A member who wants to appeal an action taken by the MCO shall utilize the MCO appeal process.

(c) A member, the member's authorized representative appointed in accordance with He-W 603.01, or the member's provider acting on behalf of the member and with the member's written consent shall file an appeal with the MCO.

(d) All requests for appeals shall be made within 30 calendar days of the date on the MCO's notice of action.

(e) All requests for appeals shall be made either orally or in writing. An oral request for an appeal shall be followed by a written request, unless the request is for expedited resolution as described in (f) below.

(f) A person in (c) above may request an expedited resolution of a request for appeal when taking the time needed for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

(g) A member's benefits shall be continued during an appeal if:

(1) The member requests continuation of benefits; and

(2) The member files a timely appeal, meaning on or before the later of the following:

a. Within 10 calendar days of the date on the MCO's notice of action; or

b. The intended effective date of the MCO's proposed action.

(h) If the MCO's action is upheld in a hearing, the member may be liable for the cost of continued benefits.

(i) The MCO grievance process shall not preclude a member's ability to pursue client rights protection under He-M 204.

Source. #10410, eff 9-13-13

He-W 506.09 Department Fair Hearing Process.

(a) A member shall exhaust all levels of resolution and appeal within the MCO grievance system, as defined in He-W 506.03(j), prior to filing a request for a fair hearing with the department, as follows:

(1) Grievances shall not be the subject of a department fair hearing; and

(2) The MCO shall have resolved an appeal under He-W 506.08 and provided notice of that resolution prior to the member requesting a fair hearing with the department.

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(b) If the member does not agree with the MCO's resolution of an appeal, the member may file a request, in accordance with He-C 200, for a department fair hearing.

(c) Requests for a department fair hearing shall be made in writing within 30 calendar days of the date of the MCO's notice of the resolution of the appeal.

(d) A member's benefits shall be continued during a department fair hearing if:

(1) The member requests a department fair hearing within 10 calendar days of the MCO's notice of the MCO's resolution of the appeal; and

(2) The member requests continuation of benefits.

(e) If the MCO's adverse decision is upheld in a department fair hearing, the member may be liable for the cost of continued benefits.

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APPENDIX

<b>RULE</b>	<b>STATE OR FEDERAL STATUTE THE RULE IMPLEMENTS</b>
He-W 506.01	RSA 126-A:5, XIX; §1932(a)of the Social Security Act (SSA); 42 U.S.C. 1396u-2
He-W 506.02	RSA 126-A:5, XIX; §1932(a)of the SSA; 42 U.S.C. 1396u-2
He-W 506.03	§1932(a) of the SSA; 42 CFR 438.2; 42 U.S.C. 1396u-2
He-W 506.04	§1903(m) of the SSA; §1932(a)(3) of the SSA; 42 CFR 438.210; 42 U.S.C. 1396u-2(a)(3)
He-W 506.05	§1932(a)(4) of the SSA; 42 CFR 438.56 and .226
He-W 506.06	§1932(a)(4) of the SSA; 42 CFR 438.52
He-W 506.07	42 CFR 438 Subpart F; 42 CFR 438.228
He-W 506.08	42 CFR 438 Subpart F; §1932(a)(5)(iii) of the SSA
He-W 506.09	42 CFR 438 Subpart F; §1932(a)(5)(iii) of the SSA