PART He-W 506 MEDICAID CARE MANAGEMENT (MCM)

Readopt with amendment He-W 506.01, effective 7-1-14 (Document # 10631), to read as follows:

He-W 506.01 Purpose. The purpose of this part is to prescribe the requirements of the New Hampshire medicaid care management program as they pertain to medicaid recipients, including individuals determined eligible for medicaid coverage through the granite advantage health care program (granite advantage) in accordance with RSA 126-AA:2.

Readopt He-W 506.02, effective 11-1-15 (Document #10965), to read as follows:

He-W 506.02 Scope. This part shall apply to all medicaid recipients insofar as they are required to 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.

Readopt with amendment He-W 506.03, effective 5-24-18 (Document # 12537), to read as follows:

He-W 506.03 Definitions.

(a) "Action" means a managed care organization (MCO) activity including, but not limited to, the following activities identified in the definition of "adverse benefit determination" in 42 CFR 438.400(b):

(1) The denial or limited authorization of a requested service, including the type or level of service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(2) The reduction, suspension, or termination of a previously authorized service;

(3) The denial, in whole or in part, of payment for a service except when denial for payment for a service is solely because the claim does not meet the definition of a "clean claim";

(4) The failure to provide services in a timely manner, as described in the contracts between the department and the MCO;

(5) The failure of an MCO to act within the timeframes required for a service authorization, 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 MCO; or

(6) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, or other enrollee financial liabilities.

(b) "Alternative Benefit Plan (ABP) services" means the Secretary-approved coverage described in section 1937 of the Social Security Act and which aligns with and includes the traditional medicaid state plan services.

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

(d) "Clean claim" means a claim that does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

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

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

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

(1) For all services to recipients who are not enrolled in managed care; and

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

(h) "Granite Advantage Health Care Program (Granite Advantage)" means the granite advantage health care program established under RSA 126-AA, which authorizes medical assistance for individuals described in 42 U.S.C §1396a(a)(10)(A)(i)(VIII).

(i) "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.

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

(k) "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 (k)(2) above has been exhausted.

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

(m) "Member" means a recipient who has selected or who has been passively enrolled into an MCO.

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

(o) "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.

(p) "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.

Readopt with amendment He-W 506.04, effective 10-25-16 (Document # 12016), to read as follows:

He-W 506.04 Covered Services.

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

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

a. Dental services provided in the dental setting;

b. Intermediate care facility for individuals with intellectual disabilities;

c. Medicaid to schools program;

d. Skilled nursing facility;

e. Skilled nursing facility atypical care;

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;

l. The following drugs when billed by a pharmacy:

1. Drugs used for the treatment of hemophilia;

2. Carbaglu; and

3. Raviciti;

m. Zolgensma®, a gene therapy for spinal muscular atrophy ; and

n. The following services which are only offered to children involved with the division for children, youth and families:

1. Home based therapy;

2. Child health support service;

3. Placement services;

4. Intensive home and community services;

5. Private non-medical institutional care for children; and

6. Crisis intervention; and

o. Section 1915(i) of the Social Security Act, state plan home and community based services for high risk children with severe emotional disturbances.

(b) The services excluded in (a)(1) above shall be covered by medicaid on a fee-for-service basis except dental services which are covered as described in He-W 566.

(c) Covered services shall be provided by the MCO starting the same business day as a member's selection of or passive enrollment in an MCO.

(d) Covered state plan and ABP 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.

Readopt with amendment He-W 506.05 and He-W 506.06, effective 11-1-15, (Document #10965), to read as follows:

He-W 506.05 Enrollment in Managed Care.

(a) All medicaid recipients shall be enrolled in managed care unless the recipient is excluded from managed care as described in (b) below.

(b) The following individuals shall not be allowed to enroll in managed care:

(1) Recipients receiving certain financial 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 878.01;

(3) Recipients who are eligible under the qualified medicare beneficiary (QMB), specified low-income medicare beneficiary (SLMB), or qualified disabled working individual (QDWI) benefits only, and are not eligible for full medicaid coverage;

(4) Recipients who are eligible under the family planning expansion category (FPEC) in accordance with 1902(a)(10)(A)(ii) of the Social Security Act, 42 U.S.C. 1396a(a)(10)(A)(ii) and He-W 509;

(5) Individuals during a presumptive eligibility period; and

(6) Individuals in a retroactive eligibility period.

(c) Any recipient not enrolled in managed care shall receive medicaid services on a fee-for-service basis.

He-W 506.06 Selection of a Managed Care Organization.

(a) Recipients shall be passively enrolled in an MCO if they do not select a plan at application.

(b) Recipients shall select an MCO at application by:

(1) Utilizing the on-line NH Electronic Application System (NH EASY);

(2) A personal interview, as required in He-W 636.01 and He-W 644.01;

(3) A telephone application pursuant to He-W 802.03; or

(4) Calling the medicaid service center.

(c) The department shall send a notice to all recipients not excluded from managed care per He-W 506.05(b) specifying which MCO the recipient has been enrolled into.

(d) Passive enrollment shall be based on the following criteria:

(1) MCO participation of a primary care provider with whom the recipient 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) Family affiliation to an MCO;

(4) Previous enrollment with an MCO prior to a loss of medicaid eligibility;

(5) Provider-member relationship, to the extent obtainable; or

(6) If enrollment cannot be made utilizing (1)-(5) above, enrollment shall be based on the terms of the contract agreed to by the department and the MCO.

(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) Once during the 90 days following the date of the member's initial medicaid eligibility;

(2) During the first 12 months of enrollment, if the member has an established relationship with a primary care provider that is only in-network of a non-assigned MCO;

(3) During annual open enrollment periods and enrollments related to renegotiation and re-procurement; and

(4) When the department imposes an intermediate sanction specified in 42 CFR 438.702(a)(3).

(f) A member may request to change his or her MCO with cause after seeking redress through the MCO's grievance system, 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) Due to moral or religious objections of the MCO, the MCO does not provide the covered service the member needs;

(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.

(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 unless there are only 2 MCOs.

(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) A member shall be locked into an 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)-(3) or (f) above.

(j) A member shall disenroll from an MCO when the member has moved out of state and is no longer NH medicaid eligible or becomes exempt as described in He-W 506.05(b).

(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 (j) 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.

Readopt with amendment He-W 506.07, effective 9-13-13 (Document #10410), to read as follows:

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 803.01, 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.

(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.

Readopt He-W 506.08 and He-W 506.09, effective 5-24-18 (Document #12537), to read as follows:

He-W 506.08 MCO Appeal Process.

(a) The MCO appeal process shall address members' requests for the appeal of any adverse benefit determination or 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, the member's legal guardian appointed in accordance with He-W 803.01, or the member's provider acting on behalf of the member and with the member's written consent may file an appeal with the MCO. However, a provider acting as an authorized representative shall not request continuation of benefits pending the appeal even with written consent.

(d) All requests for appeals shall be made within 60 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 (g) below.

(f) The MCO shall resolve standard appeals within 30 calendar days from the day the MCO receives the appeal.

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

(h) The MCO shall resolve an expedited appeal within 72 hours of receiving the appeal.

(i) The MCO may extend the timeframes to resolve standard and expedited appeals up to 14 calendar days if:

(1) The member requests the extension; or

(2) The MCO demonstrates that there is a need for additional information in order to resolve the appeal and the extension is in the member's interest.

(j) If the MCO extends the timeframes not at the request of the member in accordance with (i)(2) above, then the MCO shall:

(1) Make reasonable efforts to give the member prompt oral notice of the delay by providing a minimum of 3 oral attempts to contact the member at various times of the day, on different days within 2 calendar days of the MCO's decision to extend the timeframe;

(2) Within 2 calendar days of the MCO's decision to extend, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and

(3) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

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

(1) The member requests a continuation of benefits on or before the later of the following:

a. Within 10 calendar days of the date the MCO mails the notice of action; or

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

(2) The appeal involves the termination, suspension, or reduction of previously authorized services;

(3) The services were ordered by an authorized provider; and

(4) The period covered by the original authorization has not expired.

(l) If the MCO's action is upheld in a hearing, the MCO may institute recovery procedures against the member to recoup the cost of any continued benefits furnished to the member.

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

He-W 506.09 Department Fair Hearing Process.

(a) A member shall exhaust the MCO appeal process prior to filing a request for a fair hearing with the department, subject to the following:

(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, except that a member shall be deemed to have exhausted the MCO's appeal process if the MCO fails to adhere to the notice and timing for expedited and standard appeals as described in He-W 506.08(f), (h), and (j).

(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 120 calendar days of the date of the MCO's notice of the resolution of the appeal.

(d) A member in (b) above may request an expedited resolution of a department fair hearing if the department determines that the time otherwise permitted for a hearing could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function, and:

(1) The MCO adversely resolved the member's appeal, wholly or partially; or

(2) The MCO failed to resolve the appeal within 72 hours and failed to extend the 72-hour deadline in accordance with 42 CFR 438.408(c) and He-W 506.08(i).

(e) The department shall notify the member as expeditiously as possible as to whether the request for an expedited department fair hearing is granted or denied. If oral notice is provided, the department shall follow up with written notice, which might be made through electronic means.

(f) If the department denies the member's request for an expedited department fair hearing, the department shall schedule a department fair hearing within 90 days from the date the member filed an MCO appeal not including the number of days the member took to subsequently file for a department fair hearing.

(g) If the department grants the member's request for an expedited department fair hearing, then the department shall resolve the appeal within 3 business days after the department receives from the MCO the case file and any other necessary information. The MCO shall have no more than 3 days from the date the department notifies the MCO that it has granted the member's expedited appeal, to provide the case file to the department.

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

(1) The member received benefits pending the MCO appeal; and

(2) The member requests a department fair hearing and continuation of benefits within 10 calendar days of the date the MCO sends the notice of adverse decision of an MCO appeal to the member.

(i) If the member did not receive benefits pending the MCO appeal, then 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 date the MCO mails the notice of decision adverse to the member;

(2) The member requests continuation of benefits pending the department fair hearing;

(3) The department fair hearing involves the termination, suspension, or reduction of a previously authorized service;

(4) The service was ordered by an authorized provider; and

(5) The original authorization period for the service has not expired.

(j) Only the member, the member's authorized representative, or the member's legal guardian may request benefits pending a department fair hearing of a MCO decision.

(k) Providers acting as an authorized representative shall not request continuation of benefits pending the appeal even with written consent.

(l) If the MCO's adverse decision is upheld in a department fair hearing, the MCO may institute recovery procedures against the member to recoup the cost of any continued benefits furnished to the member.

APPENDIX

Rule	State or Federal Statute the Rule Implements
He-W 506.01	RSA 126-A:5, XIX; 42 U.S.C. 1396u–2(a); 42 U.S.C. 1396u-2; RSA 126-A:5, XXIII-XXV
He-W 506.02	RSA 126-A:5, XIX; §1932(a) of the SSA [42 USC 1396u-2(a)]; 42 USC 1396u-2

He-W 506.03	1932(a) of the SSA [42 USC 1396u-2(a)]; 42 USC 1396u-2; 42 CFR 438.2; RSA 126-A:5, XXIII-XXV
He-W 506.04	§1903(m) of the SSA [42 USC 1396b(m)]; 1932(a) of the SSA [42 USC 1396u-2(a)]; 42 USC 1396u-2; 42 CFR 438.210; §1932(a)(3) of the SSA; 42 U.S.C. 1396u-2(a)(3)
He-W 506.05	§1932(a)(4) of the SSA [42 USC 1396u-2(a)(4)]; §1915(b)(1) of the SSA [42 USC 1396n(b)(1)]; §1915(b)(4) of the SSA [42 USC 1396n(b)(4)]; 42 CFR 438.56 and .226
He-W 506.06	§1932(a)(4) of the SSA [42 USC 1396u-2(a)(4)]; 42 CFR 438.52; 42 CFR 438.700
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