MATERNAL OPIOD MISUSE (MOM) MODEL
AU 4700-1371

PURPOSE:
The Maternal Opioid Misuse (MOM) Model funding from the Centers for Medicare and Medicaid Services provides an opportunity to test whether payments that support evidence-based, coordinated care delivery for pregnant and postpartum women with opioid use disorder and their infants. This funding can reduce Medicaid and Children's Health Insurance Program (CHIP) expenditures and improve the quality of care for this population of Medicaid and CHIP beneficiaries. Department of Health and Human Services, Division of Medicaid Service staff administer oversight of the grant. The grant is for five years from January 1, 2020, through December 31, 2024.

CLIENT PROFILE:
New Hampshire's *MOM Model* implementation will create coordinated interventions across key hospital, primary care systems, and supportive services to effect achievable outcomes and cost savings to the Medicaid program by reducing health impacts to the mother and child resulting from opioid exposure during pregnancy. The MOM Model service area is the Greater Manchester Region. This region is uniquely suited to implement the MOM Model due to its experience as the opioid epidemic epicenter in New Hampshire and its long and successful history of provider and community collaboration.

FINANCIAL HISTORY 4700-1371						
Rounded to $000 except cost per case	**SFY22**	**SFY23**	**SFY24**	**SFY25**	**SFY24**	**SFY25**
	Actual	**Adj Auth**	**Agency Request**	**Agency Request**	**Governor Budget**	**Governor Budget**
TOTAL FUNDS	$442	$1,099	$1,000	$750	$1,000	$750
GENERAL FUNDS	$0	$0	$0	$0	$0	$0
ANNUAL COST PER CASE-TOTAL	N/A	N/A	N/A	N/A	N/A	N/A
CASELOAD	N/A	N/A	N/A	N/A	N/A	N/A

Funding received through the MOM Model will complement existing efforts to prevent and address Opioid Use Disorder for pregnant and postpartum women and their infants. The goals for the MOM Model are threefold:

1. Support pregnant and postpartum Medicaid beneficiaries seeking Opioid Use Disorder treatment by leveraging existing integrated networks of care to:
    a. Implement data sharing across organizations to increase care coordination; and
    b. Improve engagement of pregnant women with Opioid Use Disorder in prenatal care, postpartum care, and treatment for OUD through multiple support mechanisms.

2. Coordinate interventions across New Hampshire's Department of Health and Human Services, Elliot Health System, and other partners to improve health outcomes for the mom and baby and decrease costs to Medicaid.
3. Test interventions and best practices to determine which, if replicated across New Hampshire, would best address the needs of this vulnerable population.

FUNDING SOURCE:
100% Federal Medicaid Funds, Maternal Order Misuse Model

Title/Description	Performance Measures		Current Baseline	FY2024 GOAL	FY2025 GOAL
	Output	Outcome			
Maternal Opioid Misuse (MOM) Model	Improve quality of care for pregnant and postpartum women with opioid use disorder and their infants.	Number of beneficiaries enrolled in the MOM Model.	41	70-90	100-120
Milestones	Yr. 4 Performance Payments for the Health Related Social Need Screening and Maternal Engagement in OUD Treatment Yr. 5 Performance Payments for Patient Activation, Pharmacotherapy at Delivery, and Postpartum Care and Family Planning	Additional funding for continued success of the program.	Year 1-3 requirements met	$300,000	$500,000

OUTCOME: The MOM Model improves access and care coordination for pregnant and postpartum women with Opioid Use Disorder in the Greater Manchester Region thereby improving health outcomes for this population, and for consideration for the replication the Model across the state.

STATE MANDATES:
N/A

FEDERAL MANDATES:
N/A

SERVICES PROVIDED:
Create and pilot a highly coordinated system of care for pregnant women with Opioid Use Disorder to provide a range of prevention and treatment services specific to the needs of women and the health of their babies. New Hampshire's MOM Model creates coordinated interventions across key provider and community support services to fill gaps in care coordination. The goal is to effect achievable outcomes and cost savings to the Medicaid program by reducing health impacts to the mother and child resulting from substance exposure. The University of New Hampshire is providing Program Management support for the MOM Model.

SERVICE DELIVERY SYSTEM:
DHHS is collaborating with Elliot Health System as the prime Sub-Recipient to implement the MOM Model to create a multi-sector intervention and robust care coordination system that will improve health outcomes for the Model's beneficiaries. DHHS leverages these efforts on past Integrated Delivery Network (IDN) experience in the Manchester region, bringing together providers across the care delivery system to improve integration of physical and behavioral health care and better coordinate other initiatives (e.g., Plan of Safe Care models) to accomplish its goals.

ADULT DENTAL BENEFITS
AU 4700-4308

PURPOSE:
This accounting unit provides funding for dental services to eligible and enrolled Medicaid members age 21 and older through a single managed care Dental Organization (DO) as a Pre-paid Ambulatory Health Plan (PAHP). The Adult Dental managed care program has a targeted effective date of April 1, 2023.

CLIENT PROFILE:
The Medicaid Adult Dental program will provide services to eligible and enrolled Medicaid members age 21 and older.

FINANCIAL HISTORY 4700-4308						
Rounded to $000 except cost per case	**SFY22**	**SFY23**	**SFY24**	**SFY25**	**SFY24**	**SFY25**
	Actual	**Adj Auth**	**Agency Request**	**Agency Request**	**Governor Budget**	**Governor Budget**
TOTAL FUNDS	$0	$2,738	$11,685	$11,685	$11,685	$11,685
GENERAL FUNDS	$0	$0	$0	$0	$0	$0
ANNUAL COST PER CASE-TOTAL	N/A	$74	$315	$315	$315	$315
CASELOAD PMPM	N/A	37,085	37,085	37,085	37,085	37,085

FUNDING SOURCE:
50% Federal funds / 50% Other funds

Title/Description	Performance Measures		Current Baseline	FY2024 GOAL	FY2025 GOAL
	Output	Outcome			
Adult Dental Program	Successfully launch a new benefit with sufficient provider access, beneficiary awareness, and operational continuity.	Assure quality and appropriate dental care to the adult population delivered in an efficient and cost-effective manner	0%	Fully implement adult dental program with established quality metrics and robust provider network; and evaluate rolling the existing fee for service children's dental benefit into the adult delivery model	Complete the evaluation of whether it is appropriate to have the children's dental benefit integration into adult model so that there is one dental delivery model with adequate provider access and standard quality measures.

OUTCOME:
Along with providing health care coverage, NH Medicaid assures that Medicaid recipients have access to appropriate quality health care services and this will now include dental services. New Hampshire Medicaid continually seeks opportunities to evolve the Medicaid service delivery system into a more streamlined and value-based program. The adult dental program will include coordination of care to gradually increase appropriate use of both the health care system and dental care system, lower Medicaid spending, and improve health outcomes. DHHS has developed a robust quality assurance program to produce information from Medicaid and related data to support the development and oversight of Medicaid policy and programs while leading quality assurance and improvement activities. The program consists of a comprehensive set of measures reported by the Dental Organization, a system to manage and publicly report on those measures, monthly performance reporting, a managed care quality strategy,

the services of a federally required third-party external quality review organization (EQRO), and staff to manage the program. The measures provided by the Dental Organization consist of NH-specific measures as well as national standard measures from the Dental Quality Alliance (DQA).

STATE MANDATES:
Chapters 285 and 319, Laws of 2022 requires DHHS to implement an adult dental benefit by April 1, 2023. The adult dental benefit includes diagnostic, preventive, limited periodontal, restorative, and oral surgery services for all Medicaid eligible adults aged 21 and older. The removable denture portion of the benefit is limited to adults who participate in the Developmental Disability, Acquired Brain Disorder, and Choices for Independence 1915 (c) Waivers, and nursing facility residents.

FEDERAL MANDATES:
1915(b) Adult Dental Benefit

All provided dental services, including the denture benefit, are through a single managed care Dental Organization (DO) as a Pre-paid Ambulatory Health Plan (PAHP).

CMS requires the state to implement the benefit through another 1915(b) authority due to not administering the dental benefit through our existing Medicaid Care Management program.

Dentures provided through 1915c authority by amending the existing ABD, CFI and DD 1915c waivers for the waiver populations, and through 1115a authority for nursing home residents by an amendment to the existing SUD-SMI-SED TRA 1115 Demonstration Waiver.

SERVICES PROVIDED:
The State has both a Medicaid and a CHIP State Plan. CMS-approved State Plans serve as agreements between the State and the Federal government describing how the State administers its Medicaid and CHIP programs within federal and state budgetary parameters and policy priorities in an effort to secure federal matching funds for the State's program activities. The State Plans describe groups of individuals to be covered, services provided, provider reimbursement methodologies, and related administrative activities underway in the State.

The State must submit State Plan Amendments to the Centers for Medicare and Medicaid Services (CMS) for review and approval whenever an amendment is necessary to:

(a) Reflect changes in laws, regulations or policies,
(b) In order to request programmatic and reimbursement changes,
(c) To reflect changes in service limitations or scope of service, or
(d) To change eligibility for services.

New Hampshire's State Plans outline the optional services and populations New Hampshire has elected to cover through Medicaid, which will include the following adult dental services: diagnostic, preventive, limited periodontal, restorative, and oral surgery services.

This includes beneficiary cost sharing for individuals above 100% Federal Poverty Level (FPL) at ten percent (10%) of allowed charges for services performed during a visit up to five percent (5%) of annual household income (excluding costs for diagnostic and preventive services, and excluding populations specified under terms of the State's Medicaid Cost Sharing State Plan Amendment).

SERVICE DELIVERY SYSTEM:

New Hampshire Medicaid will administer its adult dental services through a managed care delivery system. A single Dental Organization, North East Delta Dental, will receive a monthly capitation payment rate for each enrolled individual. The Dental Organization will contract with eligible providers and ensure the provision of covered services for beneficiaries consistent with federal and state requirements.

MEDICAID ADMINISTRATION
4700 - 7937

PURPOSE:

Funding in this accounting unit represents costs associated with the management and operation of Medicaid programs serving citizens throughout New Hampshire. The New Hampshire Medicaid program is a complex network that provides health care and psychosocial support insurance coverage to participants who meet eligibility requirements. New Hampshire Medicaid covers all or part of the health care costs of low-income children, pregnant women, parents with children, senior citizens, and people with disabilities for medical and hospital services.

This account provides funding for staff costs, including salary and benefits, current expense, training and dues. These costs account for 7.4% of this accounting unit total budget. Funding is provided for administrative contracts for program support and quality review, Pharmacy Benefit Management, care management actuarial services, hospital cost settlements, dental consultants and the Alvarez & Marsal contract to continue to assist with implementing cost savings, operational efficiency, and service delivery initiatives. Contract costs account for 23.8% of this accounting unit total budget.

This account includes a budget for Class 049 Transfer to Other State Agencies, which funds the New Hampshire Hospital and Hampstead Hospital Disproportionate Share Hospital (DSH) payments and reimbursement to the Office of Professional Licensure and Certification at 100% federal funds. These expenses account for the largest portion of this accounting unit total funds budget at 68.8%.

FINANCIAL HISTORY 4700-7937						
Rounded to $000 except cost per case	**SFY22**	**SFY23**	**SFY24**	**SFY25**	**SFY24**	**SFY25**
	Actual	**Adj Auth**	**Agency Request**	**Agency Request**	**Governor Budget**	**Governor Budget**
TOTAL FUNDS	$47,661	$47,770	$61,528	$63,080	$62,282	$63,057
GENERAL FUNDS	$6,714	$8,120	$8,599	$8,804	$9,365	$8,793
ANNUAL COST PER CASE-TOTAL	N/A	N/A	N/A	N/A	N/A	N/A
CASELOAD	N/A	N/A	N/A	N/A	N/A	N/A

FUNDING SOURCE:
86% Federal funds / 14% General funds

Title/Description	**Performance Measures**		**Current Baseline**	**FY2024 GOAL**	**FY2025 GOAL**
	Output	**Outcome**			
Medicaid Administrative	Effectively dismantle the continuous eligibility requirement under the PHE, pursuant to CMS guidance and requirements through an aggressive messaging campaign during the PHE, and implementing system changes that will help streamline the redetermination process once the PHE ends.	Ensure the State's effective and timely response to the regulatory changes during the PHE unwind, with minimal disruption of coverage to Medicaid eligible individuals, and effectively transfer those who are no longer eligible at PHE end to the health care marketplace for coverage options.	The PHE is ongoing so DMS is pursuing voluntary redeterminations and other preparations ahead of the end of the PHE. With few exceptions, no disenrollment can take place.	Compliance with the Consolidated Appropriations Act, which, among other matters, decouples Continuous Enrollment Requirement	Consolidated Appropriations Act, which, among other matters, decouples Continuous Enrollment Requirement. Expectation to be fully back to pre-COVID operations by SFY25.

Title/Description	Performance Measures		Current Baseline	FY2024 GOAL	FY2025 GOAL
	Output	Outcome			
Optimizing Federal Match	DMS staff provide clinical, contract management, system coordination, and ensure compliance with all state and federal rules and regulations to ensure continued Medicaid services and maximize opportunity for eligible federal funding	Phasing Out the Enhanced Federal Medical Assistance Percentage (FMAP). The legislation also delinks the FMAP bump from the PHE and provides for a phase-out of enhanced funding over nine months for states that adhere to certain conditions		Optimizing Federal match which reduces general fund requirement	Optimizing Federal match which reduces general fund requirement

STATE PHASE DOWN
4700 – 7939

PURPOSE:
State Phase down Contribution is a payment made by the state to the Federal government to defray a portion of the Medicare prescription drug expenditure for full-benefit dual eligible clients who Medicare Part D assumes Medicaid drug coverage. The State Phase down Contribution is the amount paid by the State to refund Medicare the general fund portion of drug expenditures for the dual eligible population for whom Medicare pays their prescription drug costs. CMS calculates a per-member per month rate based on actual cost of dual eligible prescription costs.

CLIENT PROFILE:
Medicaid clients covered by Medicare are eligible for the Part D subsidy. An individual is eligible for Part D if he or she is entitled to Medicare benefits under Part A or enrolled in Medicare Part B (42 CFR 423.30). This includes Medicare/Medicaid Full Benefit Dual eligible, Qualified Medicare beneficiary (QMB), Specialized Low Income Medicare beneficiary (SLMB), Qualified Disabled and Working Individual (QDWI), Qualified Individual, (QI). Current average monthly caseload is 24,015

FINANCIAL HISTORY 4700-7939						
Rounded to $000 except cost per case	**SFY22**	**SFY23**	**SFY24**	**SFY25**	**SFY24**	**SFY25**
	Actual	**Adj Auth**	**Agency Request**	**Agency Request**	**Governor Budget**	**Governor Budget**
TOTAL FUNDS	$52,005	$46,520	$54,861	$55,935	$47,916	$47,916
GENERAL FUNDS	$52,005	$46,520	$54,861	$55,935	$47,916	$47,916
ANNUAL COST PER CASE-TOTAL	$2,220	$2,001	$2,765	$2,862	$2,415	$2,452
CASELOAD PMPM	23,429	23,244	19,841	19,542	19,841	19,542

* Medicare Part D: Premium payments paid by the state to CMS for Medicare Pharmacy Insurance for dual eligible clients

	Rate/PMPM	**Member Months**	**SFY Exp**	**SFY Agy/PN**	**SFY Gov Budget**	**Difference**
SFY22	$222.53	269,879	$52,004,883			
SFY23	$233.44	284,155	$60,496,455			
SFY24	$240.09	256,443		$54,861,067	$47,915,850	($6,945,217)
SFY25	$246.94	252,282		$55,935,266	$47,915,850	($8,019,416)

*7939 State Phase Down is a federally mandated program, for dual eligible Part D coverage, where CMS sets the annual premiums. The rates for State Phase Down are updated on a calendar year basis. The PMPM rates for the second half of SFY24 are published in October-2023. The rates are set in the fall by the Federal government for the following calendar year.

FUNDING SOURCE:
100% General funds

OUTCOME:
The intent of the State Phase Down program is to make a monthly payment to the federal government to defray a portion of the Medicare drug expenditures for full-benefit dual eligible individuals whose Medicaid drug coverage is assumed by Medicare Part D.

FEDERAL MANDATES:
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173), commonly known as Medicare Part D.

SERVICES PROVIDED:

The State Phase Down Contribution (SPDC) is the amount paid by the State to CMS to defray a portion of the Medicare drug expenditures for the Medicaid dual eligible population for whom Medicare pays their prescription drug costs. Rate per client is $233.44 for CY 2023. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) requires CMS to calculate the payment rate for the Phased-Down State Contribution to Part-D each year. Growth factors equal to the annual percentage increase, in average per capita aggregate expenditures for covered Part D drugs in the U.S. for Part D eligible individuals for the 12-month period ending in July of the previous year calculate the rate. The base year period determined by federal statute is 2003.

SERVICE DELIVERY SYSTEM:

Medicare will automatically select and enroll individuals who have both Medicare and NH Medicaid into a prescription drug plan. DHHS process monthly payments to the federal government to defray cost of prescription drug expenses for dual eligible clients. The following groups are eligible:

- Full-benefit dual eligible (FBDEs), that is, persons eligible for both Medicare and full Medicaid benefits.
- Supplemental Security Income (SSI) recipients, including SSI recipients who do not qualify for Medicaid and individuals deemed to be SSI recipients.
- Medicare beneficiaries who are participants in the Medicare Saving Programs (MSP), which are QMB, SLMB, and QI.

CMS will automatically award them the subsidy based on information received from the States and SSA and notify them that they are eligible without having to file an application. However, they need to choose a prescription drug plan. CMS enrolls full-benefit, dual eligible who fail to choose a plan, effective the month they attain dual status.

UNCOMPENSATED CARE POOL
4700 - 7943

PURPOSE:

Per 167:64, the DHHS compensates New Hampshire hospitals for some of the unpaid cost of care from the uninsured and Medicaid, known as Uncompensated Care Costs (UCC). For non-Critical Access Hospitals, this compensation is a Disproportionate Share Hospital (DSH) payment under the Medicaid program. Effective State fiscal year 2021, the payment to Critical Access Hospitals is a combination of a directed payment from the MCOs and an upper payment limit supplemental payment. Please see state mandates below. The total amount will be 91% of the Medicaid Enhancement Tax (MET) collected in the same Fiscal Year.

CLIENT PROFILE:

All 26 acute care hospitals receive annual payments that represent services rendered at the hospital for uninsured and Medicaid-covered individuals. State owned facilities also receive DSH payments budgeted in the accounting units relative to New Hampshire Hospital and Hampstead Hospital.

FINANCIAL HISTORY 4700-7943						
Rounded to $000 except cost per case	**SFY22**	**SFY23**	**SFY24**	**SFY25**	**SFY24**	**SFY25**
	Actual	**Adj Auth**	**Agency Request**	**Agency Request**	**Governor Budget**	**Governor Budget**
TOTAL FUNDS	$244,665	$238,079	$244,822	$244,832	$244,822	$244,832
GENERAL FUNDS	$0	$0	$0	$0	$0	$0
ANNUAL COST PER CASE-TOTAL	N/A	N/A	N/A	N/A	N/A	N/A
CASELOAD	N/A	N/A	N/A	N/A	N/A	N/A

FUNDING SOURCE:
50% Agency income (Hospital payment of Medicaid Enhancement Taxes) / 50% Federal Medicaid funds

Title/Description	**Performance Measures**		**Current Baseline**	**FY2024 GOAL**	**FY2025 GOAL**
	Output	**Outcome**			
Disproportionate Share Hospital	Appropriate payments to the hospitals and timely updates to the State Plan.	Support the development of a new agreement, which will have a budget impact beginning in SFY25. Current agreement expires June 30, 2024.	100%	Maintain compliance with current agreement.	Support the next settlement and development of legislative language necessary to implement the changes.

OUTCOME:
Additional payment support service access for Medicaid beneficiaries since Medicaid regular payments do not typically cover the full cost care.

FINANCIAL IMPACTS AND RISKS:
There is exposure for a provider payment shortfall in Accounting Unit 7948 Medicaid Care Management should MET underperform. The current Hospital Settlement Agreement, which will end at the end of SFY24, serves as the basis for the Agency Request for SFY24/25.

STATE MANDATES:
RSA 84-A
RSA 167:64
Hospital Lawsuit Settlement Agreement

FEDERAL MANDATES:
42 U.S.C. section 1396r-4

SERVICES PROVIDED:
N/A

SERVICE DELIVERY SYSTEM:
N/A

MEDICAID MANAGED CARE (Medicaid Medical Payments)
4700 - 7948

PURPOSE:
This Accounting Unit provides funding to Managed Care Organizations (MCO) and eligible providers for services paid under Standard Medicaid Fee-For-Service (FFS). The New Hampshire Medicaid program provides health care coverage to eligible beneficiaries.

CLIENT PROFILE:
Medicaid covers low-income children and adult residents, senior citizens, people living with disabilities, expectant mothers, low-income residents who receive care for breast and/or cervical cancer. While the majority of participants are children, those with complex needs such as the elderly, and adults and children who live with disabilities drive the majority of costs.

The current impact of COVID-19 on Medicaid Enrollment and Services: The Secretary of Health and Human Services declared the Public Health Emergency (PHE) for COVID-19 on January 31, 2020. Section 6008(a) of the Families First Coronavirus Response Act (FFCRA) provides a temporary 6.2 percentage point increase to the Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Social Security Act effective beginning January 1, 2020. Availability of the temporary increase continues for each calendar quarter through the end of the quarter in which the PHE ends.

Update: The Public Health Emergency (PHE) was renewed for another 90 days on January 11, 2023. On December 29, 2022, the Consolidated Appropriations Act, omnibus spending bill was signed into law. The law among other matters decouples the continuous enrollment requirement (CER) from the PHE and terminates this provision as of March 31, 2023. Beginning April 1, 2023 States can resume Medicaid disenrollment. States

would be eligible for phase-down of the enhanced FMAP (6.2 percentage points through March 2023; 5 percentage points through June 2023; 2.5 percentage points through September 2023; and 1.5 percentage points through December 2023) if they comply with certain rules. States cannot restrict eligibility standards, methodologies, and procedures and states cannot increase premiums as required in FFCRA. Further, states must also comply with federal rules about conducting renewals. Lastly, states are required to maintain up to date contact information, and attempt to contact enrollees prior to disenrollment.

In order to qualify for the temporary enhanced FMAP, DHHS must adhere to the following requirements under Section 6008(b) of the FFCRA:

FFCRA Authority	Provision	Termination Date
6008(b)(1)	Maintain eligibility standards, methodologies, or procedures that are no more restrictive than what the state had in place as of January 1, 2020 (maintenance of effort requirement).	Expires the first day of the month following the end of the calendar quarter in which the PHE ends.
6008(b)(2)	Not charge premiums that exceed those that were in place as of January 1, 2020.	Expires the first day of the month following the end of the calendar quarter in which the PHE ends.
6008(b)(3)	Ensure that individuals enrolled for benefits under the Medicaid state plan or waiver as of or after March 18, 2020, are treated as eligible for such benefits through the end of the month in which the PHE ends, unless the individual voluntarily terminates eligibility or is no longer a resident of the state.	Expires the first day of the month following the month in which the PHE ends.
6008(b)(4)	Cover, without imposition of any cost sharing, testing, services and treatments for COVID-19— including vaccines, specialized equipment, and therapies.	Expires the first day of the month following the end of the calendar quarter in which the PHE ends.

The exceptions to section 6008(b)(3), continuous enrollment requirements is if the beneficiary moves out of state, the beneficiary voluntarily chooses to end coverage, the person passes away, has fraudulently applied for Medicaid, or the State incorrectly opened the individual for Medicaid. The enhanced federal funding helps to support the increased Medicaid caseload costs resulting from the COVID-19 pandemic.

Enrollment as of February 1, 2023: 145,241 adults and 104,786 children in the New Hampshire Medicaid program as compared to 178,830 as of February 29, 2020. This includes 95,520 Medicaid expansion beneficiaries compared to 51,574 as of February 29, 2020, which increased in enrollment 85.2% over the period.

7948 101 Medical Payments to Providers

FINANCIAL HISTORY						
Rounded to $000 except cost per case	**SFY22**	**SFY23**	**SFY24**	**SFY25**	**SFY24**	**SFY25**
	Actual	**Adj Auth**	**Agency Request**	**Agency Request**	**Governor Budget**	**Governor Budget**
TOTAL FUNDS	$822,973	$725,941	$830,931	$789,570	$750,949	$759,894
GENERAL FUNDS	$211,690	$182,591	$225,202	$204,737	$185,516	$184,842
ANNUAL COST PER CASE-TOTAL	$6,590	$5,368	$6,654	$81,848	$72,160	$78,771
CASELOAD PMPM	124,880	135,231	124,880	115,762	124,880	115,762

Please refer to CHILD/YOUTH - FAMILY SERVICES ABUSE/ NEGLECT, CHINS, DELINQUENTS 4210-2958 and BUREAU OF CHILDREN'S BEHAVIORAL HEALTH for further program requirements for the following list of services for Medicaid eligible children:

7948 535 Out of Home Placements

FINANCIAL HISTORY						
Rounded to $000 except cost per case	**SFY22**	**SFY23**	**SFY24**	**SFY25**	**SFY24**	**SFY25**
	Actual	**Adj Auth**	**Agency Request**	**Agency Request**	**Governor Budget**	**Governor Budget**
TOTAL FUNDS	$32,788	$33,255	$34,252	$34,252	$34,252	$34,252
GENERAL FUNDS	$16,394	$16,627	$17,126	$17,126	$17,126	$17,126
ANNUAL COST PER CASE-TOTAL	$54,106	$54,876	$56,522	$56,522	$56,522	$56,522
CASELOAD	606	606	606	606	606	606

7948 563 in Home Supports

FINANCIAL HISTORY						
Rounded to $000 except cost per case	**SFY22**	**SFY23**	**SFY24**	**SFY25**	**SFY24**	**SFY25**
	Actual	**Adj Auth**	**Agency Request**	**Agency Request**	**Governor Budget**	**Governor Budget**
TOTAL FUNDS	$19,205	$19,198	$19,774	$19,774	$19,774	$19,774
GENERAL FUNDS	$9,603	$9,599	$9,887	$9,887	$9,887	$9,887
ANNUAL COST PER CASE-TOTAL	$11,057	$11,052	$11,384	$11,384	$11,384	$11,384
CASELOAD	1,737	1,737	1,737	1,737	1,737	1,737

FUNDING SOURCE:

The State's base federal matching rate is 50%. There are some exceptions, which afford higher federal medical assistance percentages (FMAP) rates, such as the Breast and Cervical Cancer Program (65% match) In addition, during the COVID-19 PHE period, New Hampshire benefited from the Families First Coronavirus Response Act (FFCRA) increased 6.2% federal matching rate through the end of the quarter in which the PHE ends.

Title/Description	**Performance Measures**		**Current Baseline**	**FY2024 GOAL**	**FY2025 GOAL**
	Output	**Outcome**			
Medicaid Managed Care	Design RFP for re-procurement of MCM program that incorporates findings from the model review and accurately reflects the desired delivery system design of the MCM program.	High quality, competitive bidding process that is transparent with several qualified bidders that can participate in the next iteration of the MCM program.		Complete the re-procurement process and begin implementation of new MCM contract.	Finalize implementation of a new contract in a seamless manner that does not cause abrasion of members or providers; and operate a cost effective and high-performing program while maintaining quality coverage for Managed Care members.

Title/Description	Performance Measures		Current Baseline	FY2024 GOAL	FY2025 GOAL
	Output	Outcome			
Medicaid Waivers	Ensure compliance with CMS reporting and budget neutrality requirements or cost effectiveness depending on the waiver type. Submit all necessary documentation to CMS timely to ensure approval of SMI-SUD demonstration waiver renewal request, and necessary information to CMS for approval of 1915(j) State Plan Amendment.	CMS approval of the SMI-SUD demonstration waiver renewal request, and CMS approval of the 1915(j) State Plan Amendment request, and continued compliance with all applicable CMS requirements.	50%	Continued compliance and successful operation of the waivers and state plan amendments with budget neutrality or cost effectiveness depending on the waiver type. Draft any necessary administrative rules for the SMI-SUD demonstration waiver and 1915(j).	Continued compliance and successful operation of the waivers and state plan amendments with budget neutrality or cost effectiveness depending on the waiver type. Ensure all required administrative rules related to the waivers are implemented.
Medicaid Care Management	Implement legislatively approved programs where funding has been appropriated by the Legislature (Programs Approved by the Legislature/Priority Needs).	Create implementation plans and resource allocation for all approved, financed programs.	0%.	Identify implementation process.	Implement programs pursuant to legislative initiatives.

OUTCOME:

Along with providing health care coverage, NH Medicaid assures that Medicaid recipients have access to appropriate quality health care services. New Hampshire Medicaid continually seeks opportunities to evolve the Medicaid service delivery system into a more integrated and value-based program. Improvements in the coordination and integration of care will gradually increase appropriate use of the health care system, lower Medicaid spending trends, and improve health outcomes. With the advent of the State's managed care program, Medicaid Care Management, DHHS has developed a robust quality assurance program to produce information from Medicaid and related data to support the development and oversight of Medicaid policy and programs while leading quality assurance and improvement activities. The program consists of a comprehensive set of measures

reported by the Medicaid health plans, a system to manage and publicly report on those measures, monthly performance reporting, a managed care quality strategy, the services of a federally required third-party external quality review organization (EQRO), and staff to manage the program. The measures provided by the health plans are made up of NH specific measures as well as national standard measure sets: 1) Health Care Effectiveness Data and Information set (HEDIS) specifications to assist NH Medicaid in monitoring satisfaction, access, quality and outcomes of care. The SFY 2021 Quality report (the most current report) is available at https://medicaidquality.nh.gov

STATE MANDATES:

Pursuant to Chapter 258 of the Laws of 2017, the Medicaid Care Management Program's targeted re-procurement date is September 1, 2024.

RSA 126-A:5,XIX(a) and 2017, 258:1 prohibits service delivery of certain Medicaid services (i.e., long-term supports and services, including, specifically nursing facility services and home and community-based services provided under the Choices for Independence waiver, the developmental disabilities waiver, the in-home supports waiver, and the acquired brain disorder waiver) into the Medicaid managed care program. The Centers for Medicare and Medicaid Services authorizes the State's waiver programs under 42 U.S.C, section 1396(c).

Chapter 265 Laws of 2022 requires the Department to increase the income limit for the "In and Out" Medicaid program (i.e. the Spend Down eligibility category).

FEDERAL MANDATES

1915(b) Managed Care Waiver

Senate Bill 147, signed into law in June 2011 required the Department to transition the administration of NH's Medicaid from fee-for-service to a managed care delivery system. The initial transition to a managed care delivery system began on December 1, 2013. At that time, the Department did not have authority to mandate enrollment into managed care for those enrollees identified at 42 CFR 438.50(d)(1-3) which include dual eligible, children with special health care needs, and Native American tribe members. CMS approved the Department's initial 1915(b) waiver request on September 1, 2015 and has since approved three (3) renewal requests. The last approved renewal request was on July 1, 2022 for two years.

SERVICES PROVIDED:

The State has both a Medicaid and a CHIP State Plan. CMS-approved State Plans serve as agreements between the State and the Federal government describing how the State administers its Medicaid and CHIP programs within federal and state budgetary parameters and policy priorities in an effort to secure federal matching funds for the State's program activities. The State Plans describe groups of individuals to be covered, services provided, provider reimbursement methodologies, and related administrative activities underway in the State. The State must submit State Plan Amendments to the Centers for Medicare and Medicaid Services (CMS) for review and approval whenever an amendment is necessary to:

a) reflect changes in laws, regulations or policies,
b) in order to request programmatic and reimbursement changes,
c) to reflect changes in service limitations or scope of service, or

d) to change eligibility for services.

Noted below are services and populations covered under New Hampshire Medicaid and can be found in our State Plan link, sp-3-1f.pdf (nh.gov). Covered populations begin on page seven and covered services on page 18. Mandatory Medicaid services and eligibility group states must cover if it chooses to have a Medicaid program are as follows:

Mandatory Services

- Physician Services
- Hospital Inpatient and Outpatient Services
- Rural Health Clinic, Federally Qualified Health Centers (FQHCs)
- Home Health Services, to include durable medical equipment and supplies
- Nursing Facility (SNF, ICF) Services
- Dental Services (for children) and medical/surgical dental for adults
- Laboratory Services
- X-Ray Services
- Family Planning Services and Supplies
- Freestanding Birthing Centers
- Advanced Practice Registered Nurse/Nurse Midwife Services
- Tobacco Cessation Services for Pregnant Women
- Early Periodic Screening Diagnosis and Treatment for persons under 21 (EPSDT)
- Medical Transportation to medically necessary Medicaid covered services
- Medication Assisted Treatment (MAT)
- Immunosuppressant Rx for ESRD Transplant patients

Mandatory Eligibility Groups

- Parents and Other Caretaker Relatives – household of one income monthly limit is $670 or roughly 67% FPL
- Pregnant Women with income up to 196% FPL
- Deemed Newborns – children born to women covered by Medicaid are automatically eligible for Medicaid for one year from the newborns' date of birth
- Infants and Children under Age 19 with income up to 196% FPL (this includes a 60 day post-partum period)
- Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
- Former Foster Care Children (to age 26) who age out of NH foster care. Section 1002 of the SUPPORT Act requires states to provide Medicaid coverage to Former Foster Care youth who were receiving Medicaid while in foster care under the responsibility of *any* state for individuals reached age 18 on or after January 1, 2023. There is no income or resource test for this group.
- Extended Medicaid due to the collection of spousal support with income up to 185% FPL
- Low-income aged, blind and disabled receiving state supplemental assistance[3] See table below
- Aged, blind and disabled individuals in 209(b) States (use more restrictive criteria than SSI)

- Qualified Medicare Beneficiaries (QMB) income less than or equal to 100% FPL.
- Specified Low-Income Medicare Beneficiaries (SLMB 120/135) income greater than 100% less than or equal to 135%
- Qualified Disabled and Working Individuals (QDWI) income less than or equal to 200% FPL

New Hampshire has elected to be a 209(b) state. Given this designation, New Hampshire must have a spenddown category for the aged, blind and disabled. If New Hampshire chose to forgo its 209(b) status, there is no requirement to have a medically needy category.

Effective January 1, 2023 the Standard of Need for OAA, APTD, ANB is:

Group Size	Independent Living Arrangement	Residential Care Facility	Community Residence
1 **2** **3**	**$928** **$1,372** **$1,817**	**$1,108**	**$990** (subsidized); **$1050 (**non-subsidized) **$1,108** (enhanced family care)

New Hampshire's State Plan outlines the optional services and optional populations New Hampshire has elected to cover through Medicaid, including but not limited to the following:

Optional and Waivered Services

- Prescription Drugs
- Adult Medical Day Care
- Ambulance Services
- Audiology Services
- Certified Midwifery Services
- Community Mental Health Center Service
- Home Visiting NH and Child/Family Health Care Support
- Hospice (required by RSA 126-A:4-e)
- Institution for Intellectual Disabilities (IID)
- Institution for Mental Disease (IMD) up to age 65 years
- Medical Services Clinic Services (e.g., methadone clinics)
- Personal Care Attendant Services (required by RSA 161-E:2)
- Occupational Therapy, Physical Therapy, Speech Therapy
- Private Duty Nursing
- Private Non-Medical Institution for Children (PNMI)
- Prosthetics and Orthotics
- Podiatrist Services

- Psychotherapy Services
- Several types of targeted case management services
- Substance Use Disorder (SUD) Services
- Various other DCY services that fall under "other diagnostic, preventive, screening, and rehabilitative services"
- Vision Care Services, including eyeglasses
- Wheelchair Van Services
- Transitional Housing
- Adult Dental Services beginning April 1, 2023
- Psychiatric Residential Treatment Facility (PRTF) services for youth
- 1915(i) Waiver State Plan Home and Community Based Services for High Risk Children with Severe Emotional Disturbance
- 1915(i) Waiver State Plan Home and Community Based Supportive Housing Based Services for chronically homeless and those at-risk of homelessness
- 1915(i) Waiver State Plan Fast Forward Home and Community-Based Services benefit children with severe emotional disabilities.
- 1915(i) Waiver Institution for Mental Disease (IMD) up to age 65 years
- Four 1915(c) Waivers Home and Community Based Services

Optional Eligibility Groups

- Optional Targeted Low Income Children with income greater than 196% FPL up to 318% FPL (CHIP/M-CHIP official eligibility group name)
- Adult Group - Individuals with income up to 138% FPL (Medicaid expansion/Granite Advantage)
- Medically Needy. These are individuals with significant health needs, but whose income is too high to qualify under other eligibility groups such as expectant mothers, children, parents, aged, blind and disabled. Medically needy known as spend down or "in and out medical assistance". Pursuant to Chapter 265 Laws of 2022 and pending CMS approval, the protected income limit for a household size of one will increase to $888 per month effective January 1, 2023.
- Home Care for Children Severely Disabled Children (HC-CSD) commonly known as Katie Beckett. The income limit is 300% of SSI Maximum benefit (sometime referred to as the NF CAP or "special income limit"). The monthly income limit in 2023 is $2,742. This figure adjusts annually by the Cost of Living Adjustment (COLA), when there is a COLA.
- Working Individuals with Disabilities (Basic Coverage Group-TWWIIA) commonly known as Medicaid for Employed Adults with Disabilities or MEAD income up to 450% FPL
- Working Individuals with Disabilities (Basic Coverage Group-TWWIIA) known as Medicaid for employed older adults with disabilities (MOAD) with income less than 250% FPL. NH RSA167:3-m limits eligibility for this group to individuals age 65 and older
- Individuals needing treatment for breast or cervical cancer – income up to 200 % FPL
- Individuals eligible for Family Planning Services income up to 196% FPL [2]
- Optional COVID 19 Eligibility Group- Under the above referenced FFCRA, states had the option to provide Medicaid coverage for COVID testing and testing services to uninsured residents during the PHE. New Hampshire chose to implement this optional eligibility group. Funding for this eligibility group is 100% FMAP, and the FMAP coverage ends the day the PHE ends. Originally, coverage of this group was

tied to the end of the PHE. The Consolidated Appropriations Act (CAA) of 2023 removed the requirement to provide coverage to the COVID-19 testing and treatment group through the end of the month in which the PHE ends. Coverage for this group now ends May 11, 2023.

[1]New Hampshire has elected to be 209(b) state. Given this designation, New Hampshire must have a spenddown category for the aged, blind and disabled. If New Hampshire chose to forgo its 209(b) status, it is not required to have a medically needy category.
[2] The income limit for this eligibility category can be no higher than for optional pregnant women.

SERVICE DELIVERY SYSTEM:

New Hampshire Medicaid has two key delivery systems:

1) Medicaid Care Management. New Hampshire administers its short-term medical services for roughly 240,614 as of November 1, 2022 budgeted average monthly enrollees through a managed care delivery system. New Hampshire's managed care delivery system is one in which currently three Managed Care Organizations, (MCOs) WellSense Health Plan; NH Healthy Families and AmeriHealth Caritas New Hampshire receive a monthly capitation payment rate for each enrolled individual. The plans contract with eligible providers and ensure the provision of covered services for beneficiaries consistent with federal and state requirements.

2) Standard Medicaid Fee-for-Service. New Hampshire also operates a Standard Medicaid fee-for-service system in which the State reimburses providers directly for covered services.

CHILDREN'S BEHAVIORAL HEALTH SERVICES

Please refer to CHILD/YOUTH - FAMILY SERVICES ABUSE/ NEGLECT, CHINS, DELINQUENTS 4210-2958 and BUREAU OF CHILDREN'S BEHAVIORAL HEALTH for further program requirements for the following list of services for Medicaid eligible children:

- ***Infant Mental Health Initiative***
  Program Description: The Bureau of Children's Behavioral Health (BCBH) is developing new programming that includes intensive treatment and supportive programming for children ages birth to 6 who have behavioral health conditions or who are at risk for developing a behavioral health condition because of parental risk factors. Medicaid covers some of these services for Medicaid-eligible infants and children.
- ***Residential Treatment Program***
  Program Description: An initiative to transform this needed service from a longer-term placement service to a short-term episode of treatment to help move children from out of home treatment to community based treatment more rapidly. Intensive work to transform this service is underway and is critical to the development and expansion of the System of Care and child welfare transformation initiatives. Treatment services will be on a continuum from Level 1 (least intensive care; Independent Living) to Level 5 (highest intensity care). Youth Residential Treatment services are billable to Medicaid.

- ***1915i Fast Forward State Plan Amendment***
  Program Description: The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit children with severe emotional disabilities. Services include wrap-around facilitation/care coordination, Family Peer Support, Youth Peer Support, In Home Respite care, Out of home respite care, and Customizable Goods and Services. FAST Forward utilizes an evidence-based wraparound model that is a family- and youth-driven planning process for responding when children or youth experience serious emotional and behavioral concerns. The goals of High Fidelity Wraparound are to help families and youth identify their strengths and needs, and to create a child and family team to develop a plan that connects them to supports (some formal, some natural) and services in their communities. The 1915i supports the expansion and nurtures a flexibility to allow for an individualized approach that Wraparound effectively offers.

ADDITIONAL 7948 FUNDED SERVICES IN OTHER ACCOUNTING UNITS

- ***1915(i) Supportive Housing State Plan Amendment***
  Program Description: Per HB4, the Commissioner of the Department of Health and Human Services shall submit a State Plan Amendment (SPA) as provided in Section 1915(i) of the Social Security Act or a waiver under other provisions of the Act to the Centers for Medicare and Medicaid Services to create a state Medicaid benefit for supportive housing services. DHHS initially submitted the 1915(i) to CMS in June 2021. After several rounds of Technical Assistance (TA) from CMS and its contractors, the 1915(i) received approval on June 30, 2022 for an effective date of July 1, 2022. This information pertains only to Medicaid funded supportive housing services for eligible Medicaid beneficiaries. Please refer to the Bureau of Housing Supports briefing section for full Supportive Housing Program funding information.

CHILD HEALTH INSURANCE PROGRAM
4700 – 7051

PURPOSE:
This Accounting Unit provides funding to Managed Care Organizations and to providers for services paid under Fee-For-Service (FFS) to cover children as previously described under MEDICAID MANAGED CARE (Medicaid Medical Payments) 4700 - 7948

CLIENT PROFILE:
Medicaid Children's Health Insurance Program (CHIP) covers low-income children up to age 19 who have no other health insurance coverage and whose income is no higher than 318% of the federal poverty income limits. [1]

[1] Subject to the 5% MAGI disregard

FINANCIAL SUMMARY

FINANCIAL HISTORY 4700-7051						
Rounded to $000 except cost per case	**SFY22**	**SFY23**	**SFY24**	**SFY25**	**SFY24**	**SFY25**
	Actual	**Adj Auth**	**Agency Request**	**Agency Request**	**Governor Budget**	**Governor Budget**
TOTAL FUNDS	$132,441	$97,196	$122,570	$115,322	$112,999	$114,470
GENERAL FUNDS	$41,004	$32,396	$41,270	$38,736	$37,922	$38,736
ANNUAL COST PER CASE-TOTAL	$500	$383	$722	$723	$665	$718
CASELOAD	264,851	253,754	169,864	159,527	169,864	159,527

FUNDING SOURCE:
35% general funds / 65% federal funds

Title/Description	Performance Measures		Current Baseline	FY2024 GOAL	FY2025 GOAL
	Output	Outcome			
Child Health Insurance Program	Implement legislatively approved programs where funding has been appropriated by the Legislature (Programs Approved by the Legislature/Priority Needs).	Create implementation plans and resource allocation for all approved, financed programs.	0%.	Identify implementation process.	Implement programs pursuant to legislative initiatives.

OUTCOME:
Previously described under MEDICAID MANAGED CARE (Medicaid Medical Payments) 4700 - 7948

STATE AND FEDERAL MANDATES:
The FMAP rate for expenditures funded by CHIP allotments is equal to the "enhanced FMAP" (EFMAP) as determined under section 2105(b) of the Social Security Act (the Act), which is capped at 65 percent unless otherwise provided in the statute.

SERVICES PROVIDED:
Previously described under MEDICAID MANAGED CARE (Medicaid Medical Payments) 4700 - 7948

SERVICE DELIVERY SYSTEM:
Previously described under MEDICAID MANAGED CARE (Medicaid Medical Payments) 4700 - 7948

MEDICAID MANAGEMENT SYSTEM
4700 - 8009

PURPOSE:
The Medicaid Management Information System (MMIS) is a requirement of the Medicaid program under the Social Security Act, Title XIX. The objectives of the MMIS are to control Medicaid program and administrative costs; provide services to recipients, providers, and Medicaid stakeholders, operate Medicaid claims processing and computer capabilities, and ensure management reporting is accurate and timely for planning and control.

The MMIS system is additionally the source for reporting the T-MSIS (Transformed Medicaid Statistical Information System) data required by each state. T-MSIS collects Medicaid and Children's Health Insurance Program (CHIP) data from states into the a data base for research and policy on Medicaid and CHIP and helping the Centers for Medicare & Medicaid Services (CMS) conduct program oversight, administration, and integrity. To meet the reporting needs of states and CMS stakeholders, T-MSIS features an operations dashboard for state and territory use to validate a timely, accurate, and complete data set. T-MSIS is the only federal Medicaid data source for comprehensive information on eligibility, demographics, service use, and spending.

FINANCIAL HISTORY 4700-8009						
Rounded to $000 except cost per case	**SFY22**	**SFY23**	**SFY24**	**SFY25**	**SFY24**	**SFY25**
	Actual	**Adj Auth**	**Agency Request**	**Agency Request**	**Governor Budget**	**Governor Budget**
TOTAL FUNDS	$35,054	$205	$41,331	$45,305	$175	$175
GENERAL FUNDS	$8,465	$85	$9,793	$10,914	$88	$88
ANNUAL COST PER CASE-TOTAL	N/A	N/A	N/A	N/A	N/A	N/A
CASELOAD	N/A	N/A	N/A	N/A	N/A	N/A

FUNDING SOURCE:

The Centers for Medicare & Medicaid Service's (CMS) shares funding with the State of New Hampshire. Currently, Medicaid MMIS Fiscal Agent services for a certified CMS system are eligible for 75% Federal Funding for operational costs (based on certification of the MMIS in 2015) and 90% Federal Funds for Enhancement Projects. Quality Assurance Contractor Services required for MMIS Enhancement Projects are currently eligible for 90% Federal funding. The New Hampshire Medicaid Management Information System Health Enterprise System (MMIS) went live April 1, 2013 and was CMS certified in 2015, which yields a 75% federal match. Additional information on Source of Funds can be found in: CFDA #93.778, FAIN 2105NH5ADM.

Title/Description	Performance Measures		Current Baseline	FY2024 GOAL	FY2025 GOAL
	Output	Outcome			
Medicaid Management Information System	Identify and implement essential updates to the MMIS in order to ensure the MMIS can support necessary Medicaid tasks and comply with federal standards and reporting requirements.	CMS approval of advanced planning documents. Complete necessary steps to ensure compliance with State legislative updates and updated systems that align to federal guidance.	25%	Upgrades implemented to existing MMIS, assuming necessary procedural and fiscal approvals occur. Extension of the Pharmacy Benefit Management (PBM) system and complete planning for a Systems Integration layer of the future MMIS architecture.	Continuing high availability operation of existing MMIS system, while implementing a Systems Integration layer. Planning will be underway to procure a Provider module that replaces older MMIS technology.

OUTCOME:

During this reporting period, the MMIS system will remain responsible for their contracted scope of services: provider management, benefits administration, eligibility verification, claims adjudication and payment, third-party liability, member management, fiscal agent, federal reporting, and provider enrollment. The full list of functions performed by the MMIS can be found in the contract as linked in the G&C notes from June 30, 2021 - Item #6 (https://sos.nh.gov/media/zfwhirh0/006-gc-agenda-063021.pdf)

SERVICES PROVIDED:

The MMIS system has consistently extended systems capabilities in previous State Fiscal Years (SFY) and will continue these improvement activities during the period of SFY 2024 through SFY 2025. There will be further expansion of MMIS capabilities with State mandates to include Adult Dental Benefits, updating multiple formats of Federal Reporting, improvements to the features and user experience for Providers, and creating new interfaces that can communicate data across applications adjacent to the MMIS. In addition, MMIS functionality will further increase by being compliant with

federal mandates to address Electronic Visit Verification (which will require CMS certification), Patient Directed Payment Method, and potential interface technology enhancements to adopt emerging Fast Healthcare Interoperability Resources (FHIR) standards.

MEDICAID TO SCHOOLS
AU 4700-7207

PURPOSE:
This account is the appropriation for the Medicaid to Schools program. Under N. H. Law, RSA 186-C, public schools are required to provide certain medical services and supports to students with special education needs. Under SB 235 expanded eligibility and services, this program allows schools to seek partial reimbursement for medically related, non-educational, expenses for Medicaid eligible students.

CLIENT PROFILE:
Medicaid eligible public school students with plan of care for the provision of medically needed services provided in the school.

Medicaid eligible students are able to receive appropriate medical care throughout the school day either via care delivered on site at the school, care provided in a provider's office throughout the school day, or via telehealth visits. In order for a service to be billable to Medicaid, the school must obtain an order from qualified treatment and the service must be prescribed in the student's Individual Education Plan/ Section 504 Plan/ or Healthcare Plan and indicated by an ICD-10 diagnosis.

While the Medicaid to schools program saw some deviation from normal service utilization over the pandemic, billing for in person medical services has returned to baseline as schools have returned to full-time in person learning for the 2021-2022 school year.

NH Medicaid anticipates a number of changes within the Medicaid to schools program in the coming years. In an effort to meet CMS requirements for transparency of costs claimed, the NH Division of Medicaid Services, in partnership with the Department of Education, will be transitioning from an in-kind to a cost-based claiming structure to allow for both clinical and administrative payment to schools. Additionally, in response to the Bipartisan Safer Communities Act and subsequent direction from CMS, the New Hampshire Medicaid to Schools program is exploring various opportunities to expand the provision of medical services to students in schools, with a particular focus on behavioral healthcare.

FINANCIAL HISTORY 4700-7207						
Rounded to $000 except cost per case	**SFY22**	**SFY23**	**SFY24**	**SFY25**	**SFY24**	**SFY25**
	Actual	**Adj Auth**	**Agency Request**	**Agency Request**	**Governor Budget**	**Governor Budget**
TOTAL FUNDS	$14,381	$17,032	$17,017	$17,017	$17,017	$17,017
GENERAL FUNDS	$0	$0	$0	$0	$0	$0
ANNUAL COST PER CASE-TOTAL	$1,632	$1,793	$1,793	$1,793	$1,793	$1,793
CASELOAD	8,811	9,000	9,270	9,548	9,270	9,548

FUNDING SOURCE:
100% Federal Medicaid Funds

Title/Description	**Performance Measures**		**Current Baseline**	**FY2024 GOAL**	**FY2025 GOAL**
	Output	**Outcome**			
Medicaid to Schools Program	Implement a direct service and administrative claiming model that includes approved methodology, State Plan Amendments, and instructional guidance for school districts.	CMS approved model of direct service and administrative claiming for Medicaid to Schools.	0%	Complete the necessary planning steps to enable an effective administrative claiming model that allows for maximum federal financial participation.	Fully implemented administrative claiming model in Medicaid to Schools payment methodology.

OUTCOME:
School districts will receive fifty percent of the Medicaid rate established by the State of NH for services provided as outlined in He-W 589 until there is a CMS approved change to the Medicaid to Schools claiming methodology. The delivery of Medicaid covered Medical services in the school setting increases access to care for Medicaid-eligible students, reduces barriers to care (including behavioral healthcare), allows children needing consistent medical services to miss fewer hours in school, and reduces stigma for students with IEP/504 plans and medical diagnoses requiring support services.

STATE MANDATES:
- RSA 186-C

- RSA 167:3-K
- He-M 1301
- He-W 589
- SB 684, Chapter 6

FEDERAL MANDATES:
Services provided under a state plan authority.

SERVICES PROVIDED:
Medically related services outlined in a Medicaid eligible student's plan of care are covered. Such services include occupational therapy, physical therapy, speech, language and hearing services, rehabilitative assistance, nursing services, psychiatric and psychological services, mental health services, vision services, specialized transportation to obtain covered services, medical exams and evaluations, and supplies and equipment related to vision, speech, language and hearing services.

SERVICE DELIVERY SYSTEM:
School districts enroll as NH Medicaid providers. Enrolled schools obtain the NH Medicaid identification numbers of eligible students and bills NH Medicaid for eligible services. Qualified staff, as outlined in He-W 589, must provide all services; certain services require referrals or orders from physicians or other health care related professionals.