



# Division of Medicaid Services

Henry Lipman, Medicaid Director

- **Department Unique Identifier:**
  - 05 Health and Social Services
  - 95 Health and Human Svcs Dept
  - 047 HHS: Ofc Medicaid Services
  - 470010 Division of Medicaid Services



Department of  
**HEALTH &  
HUMAN SERVICES**



## Agenda

1. DMS Mission and Overview
2. DMS Agency and Governor Budget Review
  - **\$60M+ in total fund reductions from Agency Budget to Governor Budget. An additional \$10M in Granite Advantage Reductions.**
3. Federal Considerations and Potential Budget Impact

## Appendix

1. Prioritized Need – Project Walk
2. Additional Overview of Key Accomplishments
3. DMS Quality Metrics and CMS Scorecard



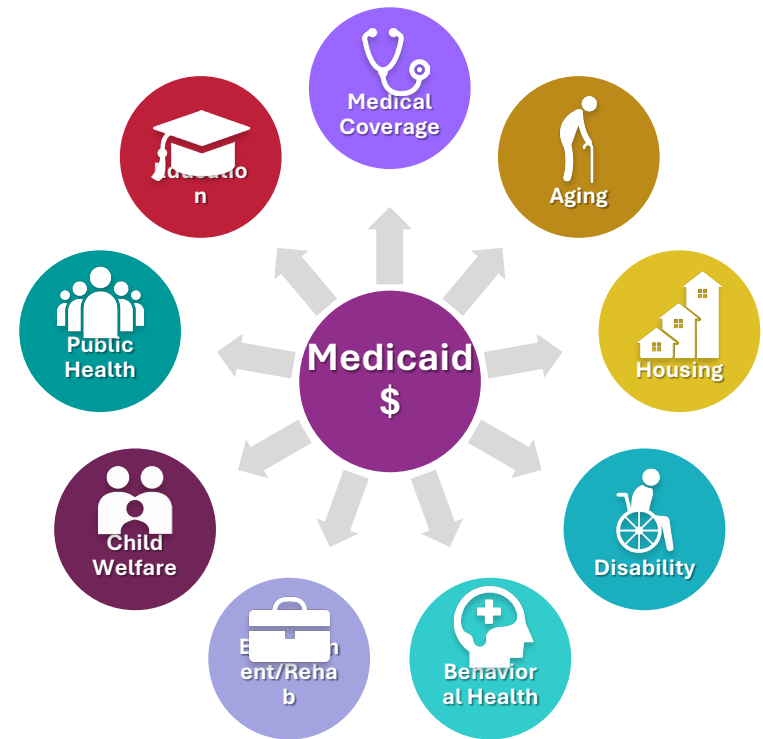
# DMS Mission & Overview



## NH Division of Medicaid (DMS) Mission

The mission of the Division of Medicaid Services is to serve the healthcare needs of New Hampshire Medicaid beneficiaries through an effectively and efficiently run Medicaid Care Management and Fee For Service Program.

DMS operates this publicly funded health insurance program in a fiscally sound fashion while continuously striving to improve the quality of service and care for the approximately 1 in 7 New Hampshire citizens who have Medicaid.



- ▶ Oversees the publicly funded health insurance program (Managed Care Organizations) for low-income and categorically needy.
  - ▶ **4<sup>th</sup> smallest** Medicaid program in the country.
  - ▶ Operates the fee for service dental benefit for individuals up to 21 years of age, and for adults under managed care.
- ▶ DMS is the lead Division within DHHS that interfaces with Centers for Medicare and Medicaid Services (CMS) for state plan, waiver, technical assistance and federal claiming in support for the following Divisions/Programs:
  - ▶ **Division for Behavioral Health** –Mental Health services; substance use disorder services, Children’s Mental health services, and housing services.
  - ▶ **Division of Long Term Supports & Services** -Developmental services; elderly & adult services including nursing facility rates.
  - ▶ **Division of Economic Housing and Stability** – Medicaid eligibility determinations and processing.
  - ▶ **Division for Children, Youth & Families** –in home supports and out of home placements.
  - ▶ **Division of Public Health** – Maternal and Child Health.
- ▶ Leverages State General Fund Investments in NH Medicaid’s key role.
  - ▶ The Division of Medicaid Services is the State’s lead in partnering with the Centers for Medicare and Medicaid Services to maximize general fund investments in health care.
  - ▶ Lead Medicaid service delivery of the Medicaid Care Management and Fee-for-Service Program, the Adult Dental Program, Children’s dental fee-for-service program, **Medicaid-to-School**, **Adult and Youth Community Re-Entry**, the **Maternal Opioid Misuse Model**, the State’s hospital Uncompensated Care program, in-home supports waiver, **SUD/SMI 1115 Waiver**, and **Mobile behavioral health crisis services**.



- **Adult and Youth Community Re-Entry:** Implemented January 1, 2025.
- **Adults:** 1115 Waiver approval to provide Medicaid-eligible incarcerated adults with behavioral health needs (e.g. **Children:** Youth re-entry is a federal requirement for State's to provide a limited Medicaid services benefit 30-days prior to youth's release).

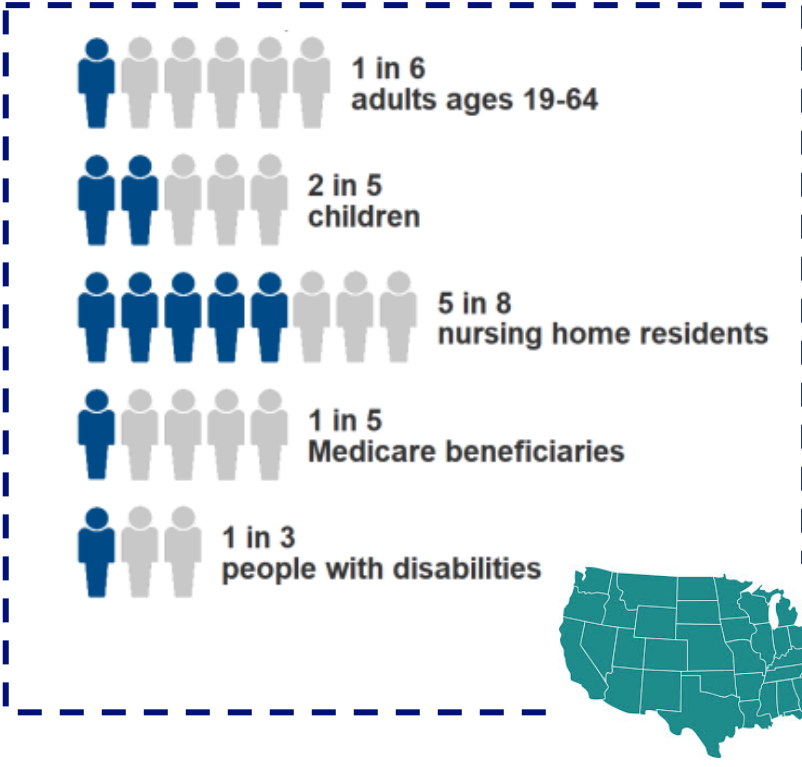
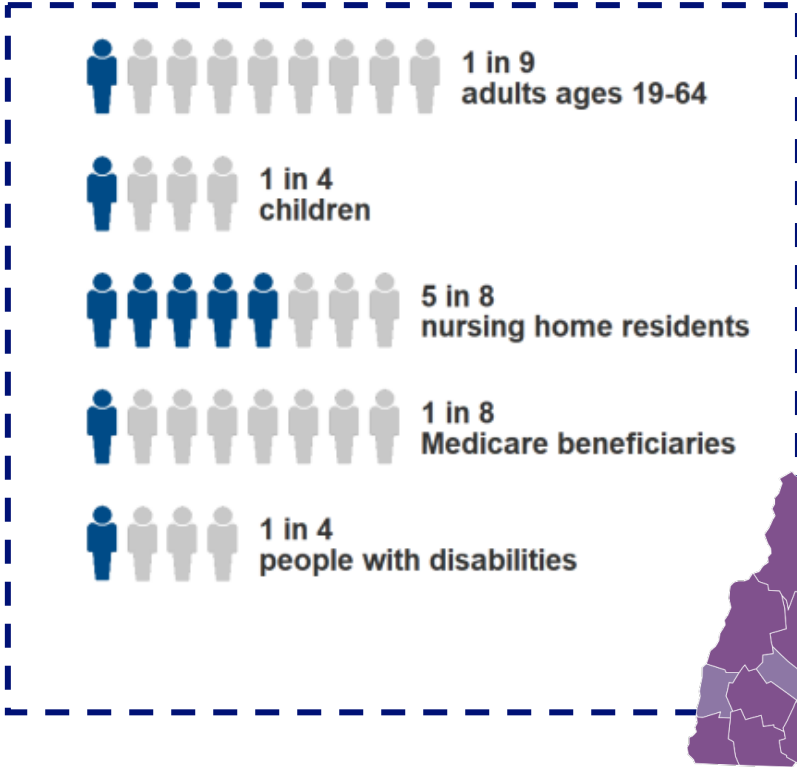
- **Successfully Completed the Medicaid Unwind:**
- DHHS conducted approximately 238,000 Medicaid redeterminations:
  - 165,000 (70%) retained coverage
  - 72,000 (30%) closed
    - 51% closed for failing to submit a renewal for or information required to verify eligibility; and
    - 49% closed for failing to meet eligibility standards (e.g. income, not requesting, age, etc.).

- **MCM 3.0 Re-Procurement:**
- Primary Care and Preventive Services Focused
- High-Cost Risk Pool for High-Cost Therapies
- Investments in Mental Health
- Strengthened Reliability and Quality



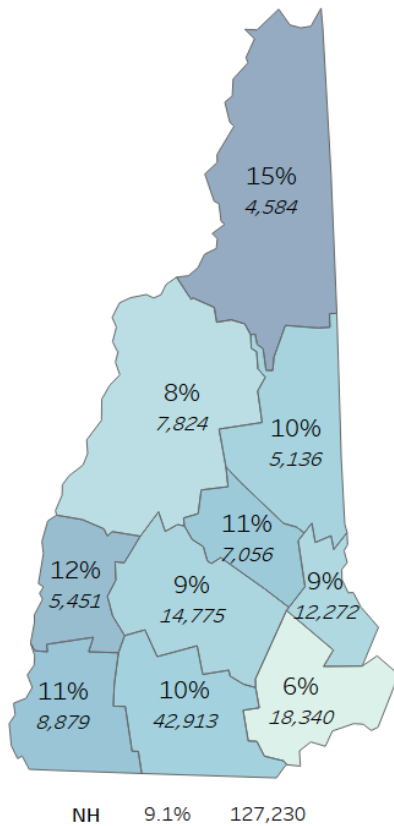
Medicaid covers approximately **185,000** Medicaid citizens or approximately 1 in 7 NH citizens

Medicaid covers more than **81,696,742** enrollees nationwide or 1 in 5 individuals

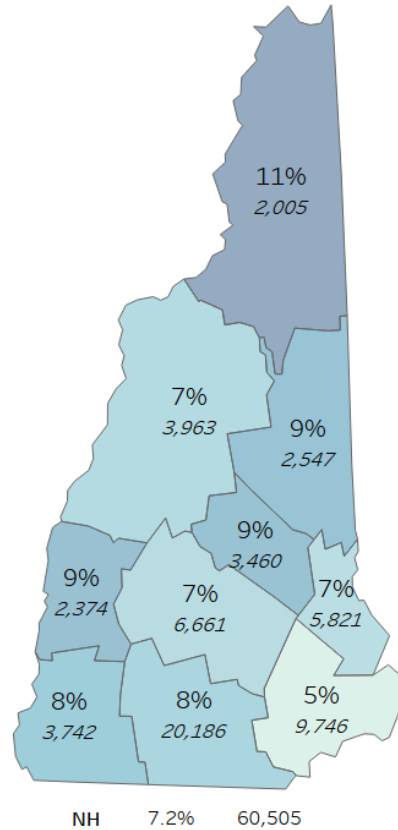


## NH Medicaid Full Benefit Enrollment as a Percent of Estimated General Population, 12/31/24

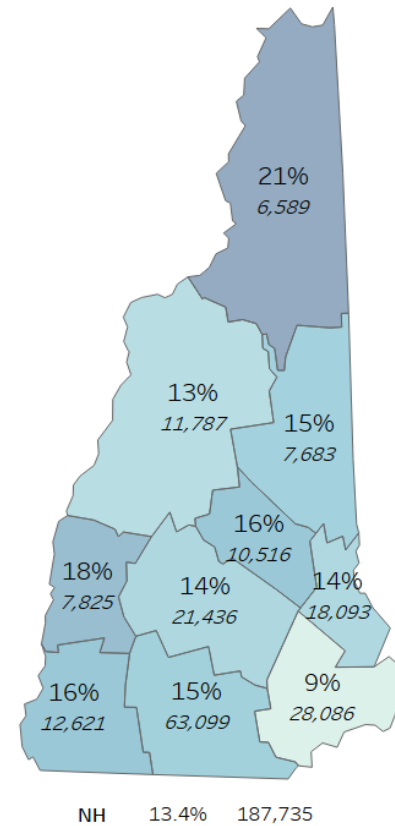
Standard Programs as a Percent of Total Population



Granite Advantage Program as a Percent of Population Age 19 to 64



Total Program as a Percent of Total Population

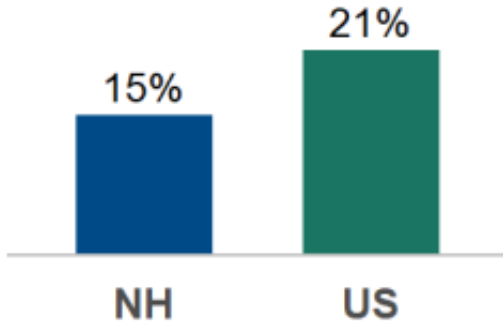




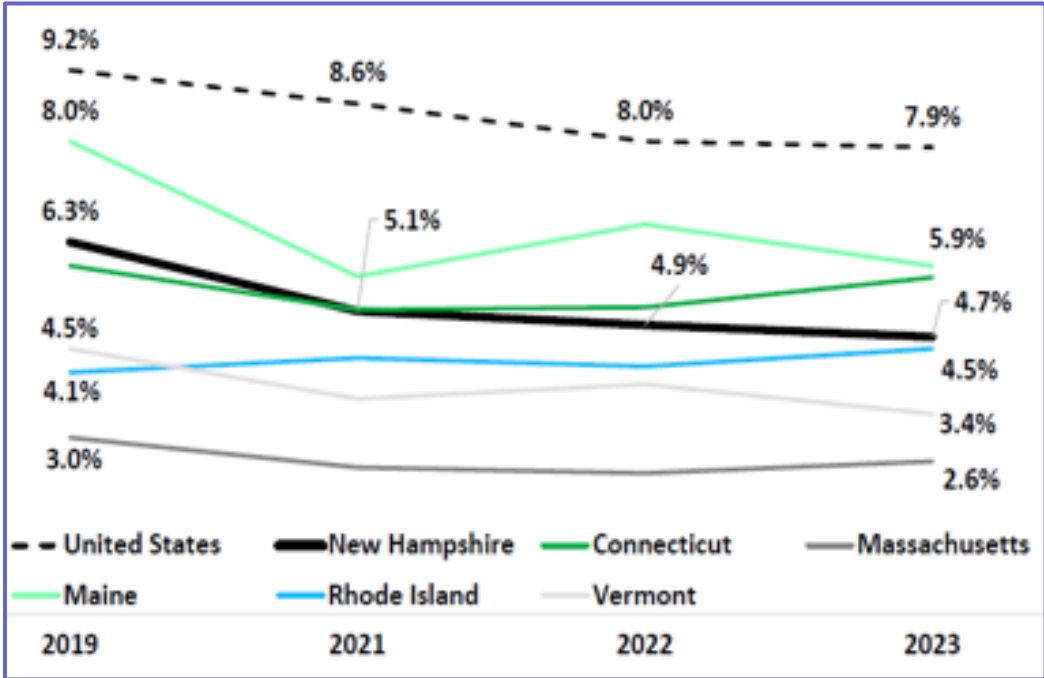
**22%**  
of births in  
NH are  
covered by  
Medicaid

National  
comparison:  
**42%**

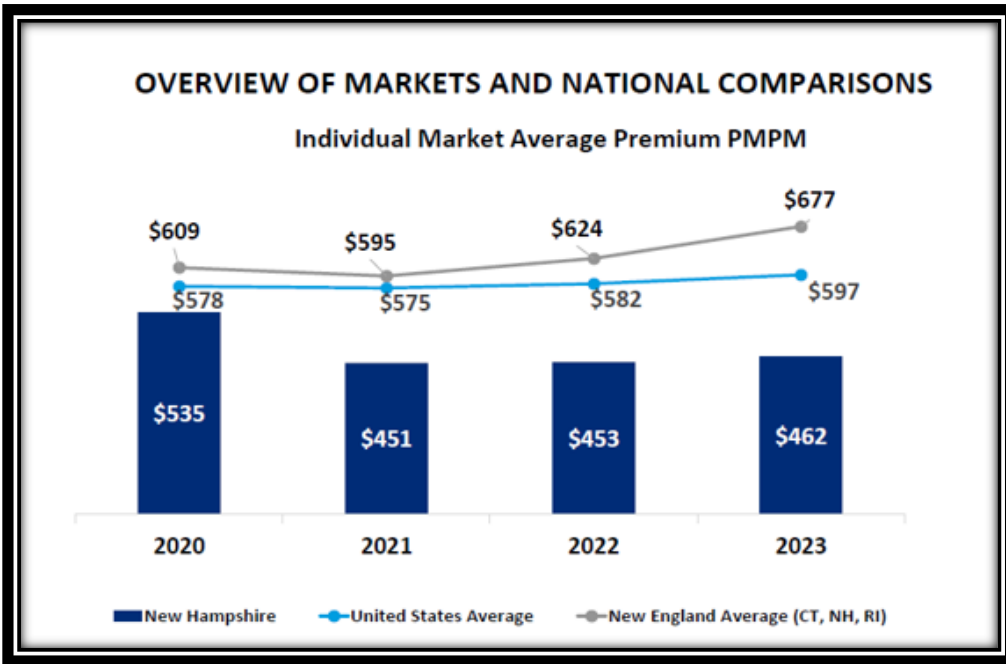
**Medicaid Coverage of Women Ages 15–49**



**National Uninsured Rate & New England States**



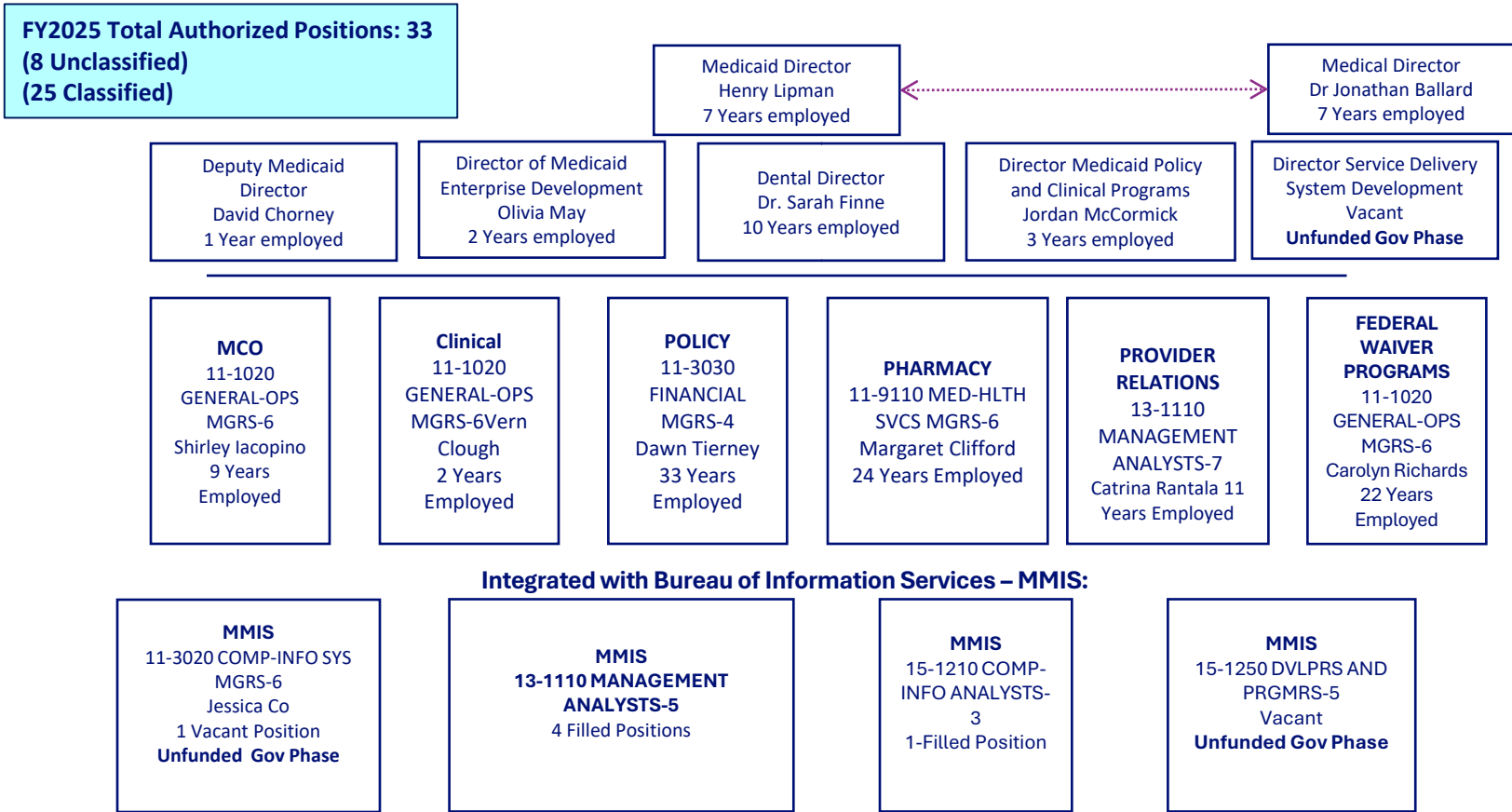
Medicaid Expansion’s Impact on the Individual Insurance Marketplace



- Average premiums in New Hampshire have **decreased** 15.6% in 2020 to 2021 due to the enactment of New Hampshire’s reinsurance program through a Section 1332 Waiver.
- New Hampshire’s premiums continue to remain significantly lower than the national average.
- A possible conclusion one could draw is that the combination of the 1332 Waiver by the New Hampshire Insurance Department and Medicaid Expansion have functioned to support the health of NH’s insurance markets, including lower premium rates.



### Tenure of Division Key Leaders



Governor Recommended Positions SFY26	# of Vacant Unfunded Positions	Vacancy Rate	4710 – Division of Medicaid Services Accounting Unit
			7937 Medicaid Administration
6	1	17%	Director’s Office
1	0	0%	Federal Waiver Programs
2	0	0%	MCO staff
2	0	0%	Pharmacy Staff
2	0	0%	Dental Staff
4	0	0%	Clinical Staff
3	0	0%	Provider Relations Staff
5	0	0%	Policy Staff
8	2	25%	MMIS staff
33	3	9%	DMS Total

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.



# DMS Agency and Governor Budget Review



Activity – Accounting Unit	Accounting Unit Title	Auth. FTE # SFY 2025	Budget Book Page #	Budget Briefing Book Page #
4700-1371	<p><b>MATERNAL OPIOID MISUSE MODEL</b></p> <ul style="list-style-type: none"> <li>100% Federal Funds</li> <li>Two contracts with encumbered funds brought forward from SFY 2025</li> <li>MOMM Grant and contracts expire 12/31/2025</li> </ul> <p><b>Key takeaway:</b> Fully federally funded program ends December 2025, and no new funds requested to sustain the program.</p>	0	885	1
4700-4258	<p><b>MTS GRANT AWARD FIN ADMIN</b></p> <ul style="list-style-type: none"> <li>100% Federal Funds</li> </ul> <p><b>Key takeaway:</b> Federal grant will cover all costs to transition to a new claiming methodology required by Centers for Medicare and Medicaid Services.</p>	0	886	3



Activity – Accounting Unit	Accounting Unit Title	Auth. FTE # SFY 2025	Budget Book Page #	Budget Briefing Book Page #
4700-4308	<p><b>ADULT DENTAL PROGRAM</b></p> <ul style="list-style-type: none"> <li>• 50% Federal 50 % Other Funds</li> <li>• Serves 46,114 Per Member Per Month (PMPM)</li> </ul> <p><b>Key takeaway:</b> State costs are funded by Centene Settlement Fund to provide legislated adult dental benefits administered by a managed care entity.</p>	0	887	4
4700-7051	<p><b>CHILD HEALTH INSURANCE PROGRAM</b></p> <ul style="list-style-type: none"> <li>• 65% Federal funds 34% General 1% Other</li> <li>• Serves 38,397 PMPM</li> </ul> <p><b>Key takeaway:</b> Medicaid benefits for CHIP eligibility group.</p>	0	887	7



Activity – Accounting Unit	Accounting Unit Title	Auth. FTE # SFY 2025	Budget Book Page #	Budget Briefing Book Page #
4700-7207	<p><b>MEDICAID TO SCHOOLS PROGRAM</b></p> <ul style="list-style-type: none"> <li>• 100% Federal Funds</li> <li>• Serves 9,548 PMPM</li> </ul> <p><b>Key Takeaway:</b> Current funding source for medically needed services delivered to Medicaid enrolled children with plan of care.</p>	0	888	9
4700-7937	<p><b>MEDICAID ADMINISTRATION</b></p> <ul style="list-style-type: none"> <li>• 83% Federal 17% General</li> <li>• Includes Federal Share of Disproportionate Share Hospital payments to New Hampshire Hospital</li> </ul> <p><b>Key takeaway:</b> 0.4% of total Medicaid budget and approximately 1 FTE to 5,600 Medicaid beneficiaries.</p>	33	889	12



Activity – Accounting Unit	Accounting Unit Title	Auth. FTE # SFY 2025	Budget Book Page #	Budget Briefing Book Page #
4700-7939	<p><b>STATE PHASE DOWN</b></p> <ul style="list-style-type: none"> <li>• 100% General funds</li> <li>• Funds Medicare Part D Premiums (Pharmacy)</li> <li>• Serves 18,349 PMPM</li> </ul> <p><b>Key takeaway:</b> Federally mandated program for Medicare drug coverage of dually-eligible individuals.</p>	0	890	13
4700-7943	<p><b>UNCOMPENSATED CARE FUND</b></p> <ul style="list-style-type: none"> <li>• 50 % Federal funds 50% Other</li> <li>• Other Funding is Medicaid Enhancement Tax</li> </ul> <p><b>Key takeaway:</b> Compensation to New Hampshire hospitals for some of the unpaid cost of care from the uninsured and Medicaid.</p>	0	890	15



# MEDICAID SERVICES - Accounting Units

Activity – Accounting Unit	Accounting Unit Title	Auth. FTE # SFY 2025	Budget Book Page #	Budget Briefing Book Page #
4700-7948	<p><b>MEDICAID CARE MANAGEMENT</b></p> <ul style="list-style-type: none"> <li>• 51% Federal Funds 34% Other 15% General</li> <li>• Serves 95,701 PMPM</li> </ul> <p><b>Key Takeaway:</b> 3 Managed Care Organizations administer Medicaid benefits for most Medicaid enrollees in a capitated model.</p>	0	891	17
4700-8009	<p><b>MEDICAID MGMT INFO SYSTEM</b></p> <ul style="list-style-type: none"> <li>• 76% Federal Funds 24% General</li> <li>• Includes MMIS, and the Fiscal Agent</li> <li>• Quality Assurance of changes to the MMIS</li> <li>• Provider and Beneficiary Communication and Service Delivery supports</li> <li>• Serves 35,000 plus providers and all Medicaid beneficiaries</li> </ul> <p><b>Key takeaway:</b> The foundational information systems for Medicaid payment operations and enhancements thereto.</p>	0	892	26



- The Department anticipates approximately \$28.9M in unencumbered general funds in AU7948 at the end of SFY25.
- Carrying forward funds in AU7948 on a restricted basis is a historical legislative budget practice that provides for coverage of unanticipated changes in the Medicaid program that would otherwise require an appropriation.
- This legislative budget practice lowers the amount of general funds that would need to be appropriated for the biennium.



## **Governor Adjustments to Budget**

1. Return to pre-PHE Medicaid redetermination eligibility processes
2. Increase of pharmacy cost-sharing
3. Premium for Children’s Medicaid above 255% of FPL and Granite Advantage above 100% of FPL
4. Contract Reductions of 25%

## **HB2 Items**

1. Drug purchasing based on lowest net cost
2. Suspension of Graduate Medical Education Payments
3. Suspension of Catastrophic Aid Payments to Hospitals
4. Biennium carry forward on a restricted basis
5. Medicaid-to-Schools authority to accept and expend



# MEDICAID SERVICES - Governor Phase

## Budget Reductions by AU

Division of Medicaid Services		SFY 2026				SFY 2027			
		Federal	General	Other	Total	Federal	General	Other	Total
7051 CHIP 101	CHIP premium of 5% to FPL >255%	-	(\$3,300,000)	-	(\$3,300,000)	-	(\$11,000,000)	-	(\$11,000,000)
7937 Medicaid Administration 010	Unfund positions	(\$221,183)	(\$188,415)	-	(\$409,598)	(\$226,373)	(\$192,836)	-	(\$419,209)
7937 Medicaid Administration 060	Benefits	(\$62,466)	(\$53,212)	-	(\$115,678)	(\$66,423)	(\$56,585)	-	(\$123,008)
7937 Medicaid Administration 102	Reduce Milliman contract 1 rate adjustment (MCO amendment cadence)	(\$250,000)	(\$250,000)	-	(\$500,000)	(\$250,000)	(\$250,000)	-	(\$500,000)
7937 Administration 102	Reduce Alvarez & Marsal contract in half	(\$1,727,500)	(\$1,727,500)	-	(\$3,455,000)	(\$1,727,500)	(\$1,727,500)	-	(\$3,455,000)
7948 MCM Revenue: 007 407145-44	Preferred Drug List Savings	-	(\$930,000)	\$930,000	\$0	-	(\$2,970,000)	\$2,970,000	\$0
7948 Medicaid Care Mgmt CI101	Increase Pharmacy Cost Sharing	(\$750,000)	(\$750,000)	-	(\$1,500,000)	(\$750,000)	(\$750,000)	-	(\$1,500,000)
7948 Medicaid Care Mgmt CI101	Tighten Eligibility Requirements	(\$5,712,000)	(\$5,712,000)	-	(\$11,424,000)	(\$11,424,000)	(\$11,424,000)	-	(\$22,848,000)
7948 Medicaid Care Mgmt CI101	Standard Medicaid Reduction (to balance budget)	(\$500,000)	(\$500,000)	-	(\$1,000,000)	(\$500,000)	(\$500,000)	-	(\$1,000,000)
	<b>Total</b>	<b>(\$9,223,149)</b>	<b>(\$13,411,127)</b>	<b>\$930,000</b>	<b>(\$21,704,276)</b>	<b>(\$14,944,296)</b>	<b>(\$28,870,921)</b>	<b>\$2,970,000</b>	<b>(\$40,845,217)</b>
2358 Granite Advantage Healthcare Revenue: non-federal funds	Medicaid premiums on Granite Advantage enrollees	-	-	-	-	-	-	12,000,000	12,000,000



- **Return to Normal - Eligibility Processing (AU7948)** - DHHS took advantage of CMS flexibilities to enable the Department to rely, to a greater extent than pre-PHE, on external data sources to verify income for Medicaid redeterminations.
  - These flexibilities have increased the passive renewal rate (renewals that do not require the beneficiary to submit a renewal form or verify income) from a low of 18% to a high of 85%.
  - Since December 2023, the passive renewal rate has been above 75% - meaning more than 75% of redeterminations are passively renewed.

**Estimated Cost Savings (AU7948)**

- **SFY26**: General Funds: \$5,712,000; Federal Funds: \$5,712,000
- **SFY27**: General Funds: \$11,424,000; Federal Funds: \$11,424,000



### Trend in NH Medicaid Enrollment by Eligibility Group Since the Start of COVID-19 Public Health Emergency

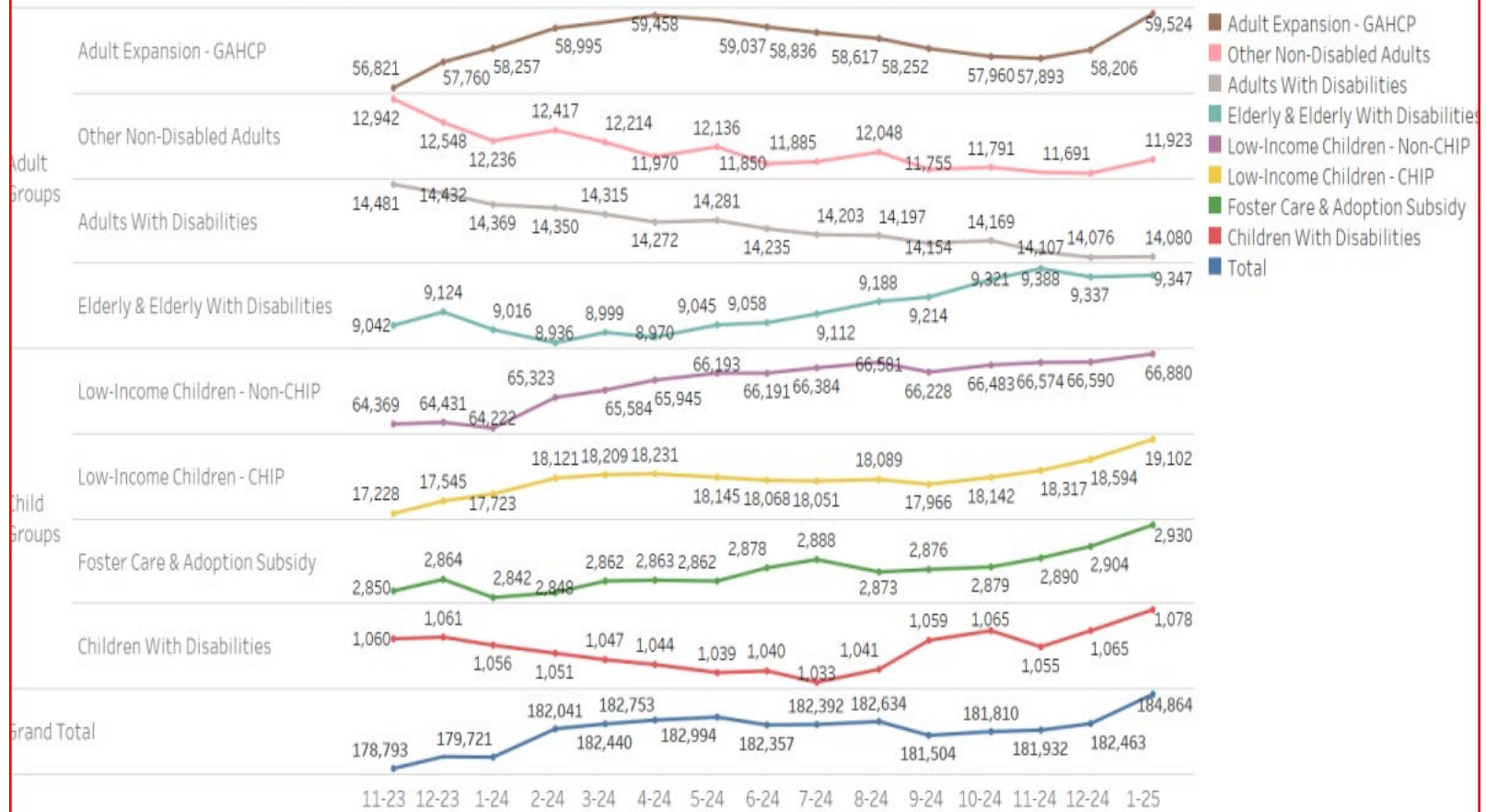
Period	Granite Advantage		Standard		Total	
3/16/2020 to 2/3/2025	59,945	+16.7% 8,580	125,503	-0.4% -552	185,448	+4.5% 8,028

#### Point in Time Trend

			% Δ 3/20	# Δ 3/20	Δ 3/23
Adult Groups	Adult Expansion - GAHCP	51,365	16.7%	8,580	-36,214
	Other Non-Disabled Adults	12,484	-4.8%	-604	-8,854
	Adults With Disabilities	16,393	-14.4%	-2,355	-4,019
	Elderly & Elderly With Disabilities	9,112	2.3%	206	-1,497
Child Groups	Low-Income Children - Non-CHIP	68,867	-2.8%	-1,931	-9,001
	Low-Income Children - CHIP	15,095	28.0%	4,223	-4,785
	Foster Care & Adoption Subsidy	2,827	3.1%	88	-702
	Children With Disabilities	1,277	-14.0%	-179	-47
Grand Total	177,420	4.5%	8,028	-65,119	



Start of Month Trend from 11/2023 Low Point to Present



**Medicaid Premiums**

- States are generally allowed to impose premiums, capped at 5% of a household’s income, on Medicaid beneficiaries with income at or above 150% of the federal poverty limit.
- States must have a mechanism in place to track household income to ensure cost-sharing and premium amounts do not exceed the 5% cap.

**Medicaid Cost-Sharing**

- Cost-sharing for children with household incomes below 133% of the FPL generally not allowed.
- Cost-sharing for Medicaid adults is generally allowed, within certain limits shown below.

Table 1: Allowable Cost Sharing Amounts for Adults in Medicaid by Income			
	<100% FPL	100% – 150% FPL	>150% FPL
<b>Outpatient Services</b>	up to \$4	up to 10% of state cost	up to 20% of state cost
<b>Non-Emergency use of ER</b>	up to \$8	up to \$8	No limit
<b>Prescription Drugs</b>	Preferred: up to \$4 Non-Preferred: up to \$8	Preferred: up to \$4 Non-Preferred: up to \$8	Preferred: up to \$4 Non-Preferred: up to 20% of state cost
<b>Inpatient Services</b>	up to \$75 per stay	up to 10% of state cost	up to 20% of state cost



**Premiums on households with kids (AU7051):** For households with income at or above 255% of the federal poverty line, and with children enrolled in Medicaid, impose a monthly premium of up to 5% of the household’s income.

- This budget does not propose changing the federal poverty limit from 323%, which is 5<sup>th</sup> best in the country.

**Budget reduction estimate:**

- **SFY26:** \$3,300,000
- **SFY27:** \$11,000,000

**Pharmacy Cost-Sharing (AU7948):** Increase pharmacy cost-sharing from \$1 and \$2 to \$4.

- Households that pay premiums would be exempt from pharmacy cost-sharing due federal cap on cost sharing of 5% of income.

**Budget reduction estimate:**

- **SFY26:** General Funds:\$750,000 and Federal Funds: \$750,000
- **SFY27:** General Funds:\$750,000 and Federal Funds: \$750,000



### **Granite Advantage Premiums (AU2358)**

- Request a waiver from CMS to apply premiums, capped at 5% of income.
- Granite Advantage eligibility limit is capped at 138%.
- Premium would apply to Granite Advantage enrollees with income at or above 100% of the federal poverty line.

### **Budget reduction estimate (AU2358)**

- **SFY26:** \$0
- **SFY27:** \$12,000,000



**AU7937 - Class 102 - Contracts for Program Services**

This account provides funding for Medicaid *Contracts for Program Support* including quality review, **Pharmacy Benefit Management**, care management actuarial services, **Managed Care Medical Loss Ratio audits**, hospital cost settlements, dental consultants, and the Alvarez & Marsal contract to continue to assist with implementing cost savings, operational efficiency, and service delivery initiatives.

	SFY 2026	SFY 2027
Total Funds Agency Phase Contract Budget	\$15,682,481	\$15,996,300
Contract Budget Reductions	<b>(\$3,955,000)</b>	<b>(\$3,955,000)</b>
Total Funds Governor’s Budget	\$11,727,481	\$12,041,300
% of Total Contract Budget Reduced	<b>-25%</b>	<b>-25%</b>

The Milliman contract (actuarial and waiver services) was reduced by \$500k total funds each year (one actuarial rate setting cycle per year) and the Alvarez & Marsal contract was reduced by \$3,455,000 total funds each year



**Lowest Net Cost Drugs.** Current NH law requires the Medicaid program to always use generics first.

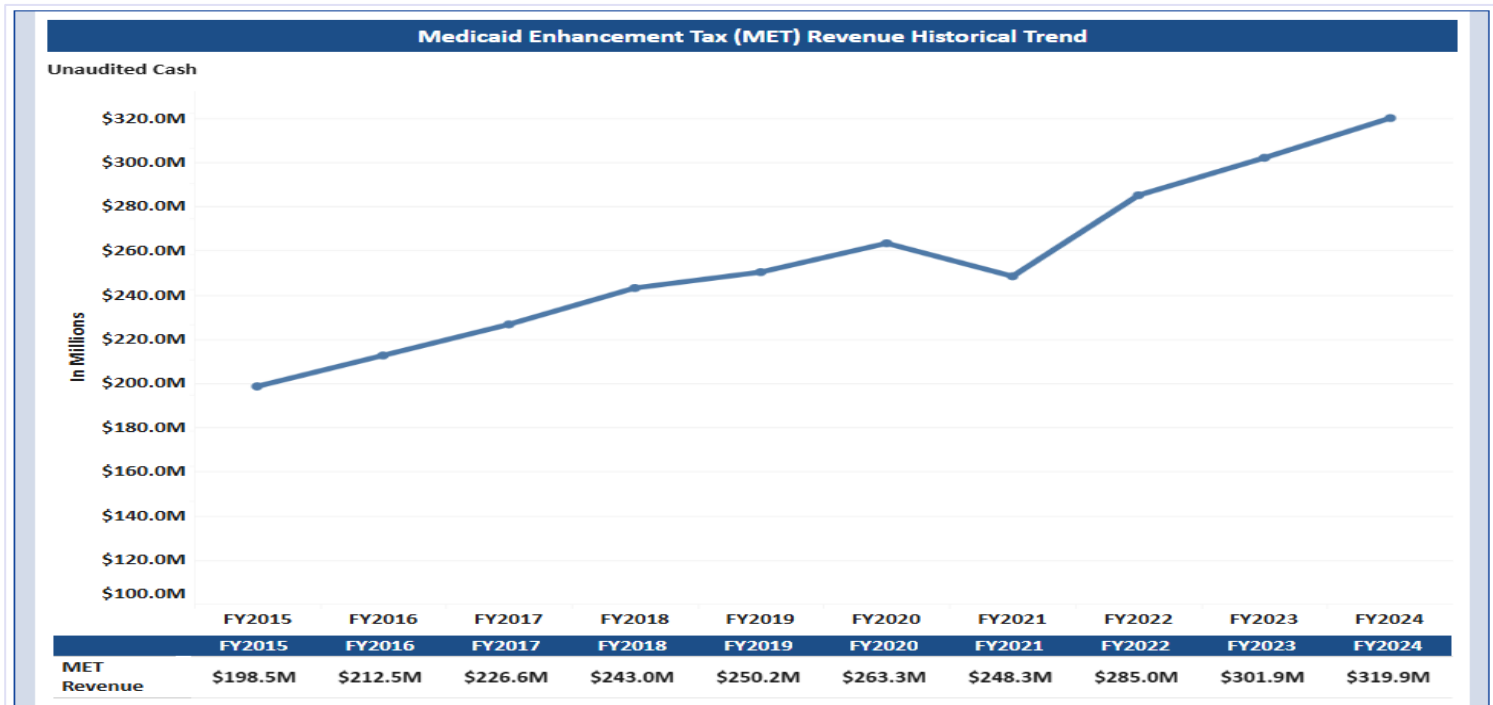
- There are times when the cost of a brand name drug and the corresponding rebate leads to a lower net cost to the Program than a generic drug.
- Proposed legislation included in this budget (and in SB119) would allow the Medicaid Program to purchase drugs that have the lowest net cost to the program regardless of whether such drug is a brand drug or a generic drug.

**Estimated Cost Savings (AU7948)**

- **SFY26:** General Funds: \$930,000
- **SFY27:** General Funds: \$2,970,000



- Medicaid Enhancement Tax (the “MET”):** enacted in 1991. The tax is assessed on the net patient services revenue of every general acute care hospital in New Hampshire at a rate of 5.4% for the taxable period ending June 30, 2017, and forward. The taxable period is the 12-month period beginning July 1 and ending June 30.
  - SFY25 Non-Binding Estimate: \$348 Million.**



## How Does NH Medicaid Use MET Dollars

- Medicaid uses MET revenue to reimburse hospitals and other Medicaid enrolled service providers (e.g. CMHCs, FQHCs, SUD providers, primary care, etc.) for the delivery of Medicaid coverable services to New Hampshire Medicaid beneficiaries.
- MET revenue is matched at the applicable FMAP and paid to hospitals and other Medicaid enrolled service providers through rates, directed payments, and disproportional share hospital (DSH)uncompensated care for Medicaid payments.
  - **Directed Payments:** A CMS approved state option to direct the MCO to pay a provider a specific rate.
  - **DSH Uncompensated Care Payments:** Hospital payments to subsidize uncompensated care costs related to services provided to Medicaid patients and the truly uninsured.

### *Illustrative Example of using MET to support rates or directed payments versus DSH uncompensated care payments*

Type of Payment	MET Used	FMAP (Federal Funds)	Total Funds
\$10M Medicaid Uncompensated Care Payments (e.g. DSH)	\$5M	\$5M	\$10M
\$10M in Rates or Directed Payment	~\$4.6M	~\$5.4M	\$10M



	SFY25 MET Proj	SFY26 MET Proj	SFY27 MET Proj
	\$319,200,000	\$337,000,000	\$350,000,000
Estimated 80% to Hospitals through Rates, Directed Payments and DSH	<b><u>\$255,360,000</u></b>	<b><u>\$269,600,000</u></b>	<b><u>\$280,000,000</u></b>
Rates (AU7948) <sup>1</sup>	\$76,000,000	\$80,238,095	\$83,333,333
Directed Payments (AU7948) <sup>1</sup>	\$95,660,000	\$100,994,424	\$104,890,351
DSH (AU7943)	\$83,700,000	\$88,367,481	\$91,776,316
<b>Total</b>	<b><u>\$255,360,000</u></b>	<b><u>\$269,600,000</u></b>	<b><u>\$280,000,000</u></b>

<sup>1</sup> Balance is included in 2358 (Granite Advantage)  
<sup>2</sup> SFY25 Non-binding MET estimate was \$348,393,269

- **What is the State Phasedown Contribution?**
  - The federally required amount that States are required to pay to cover the pharmaceutical cost of low-income Medicare beneficiaries who are fully enrolled in Medicaid and Medicare (e.g. Medicaid-Medicare Duals).
    - The CY2025 Phasedown rate is **\$273.77** per fully Medicaid-Medicare Dual
    - State Phase Down Contributions are federally required of all states.
    - The funding is 100% general funds, and future CY rates are not known prior to budgeting.
    - CMS is required to calculate the CY Phasedown rate in accordance with federal law.
      - The CY25 rate is calculated using the growth factor 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.
      - CMS notifies states in October each year of the rate applicable beginning the following January.



*Summary of service and eligibility changes since 2019, under production, and provided as a separate handout.*



- **What is Medicaid-to-Schools?** A DMS program that provides Medicaid coverage for medically necessary services documented in a student's IEP or 504 plan.
  - Parental consent to the IEP and 504 plans, and separately to bill Medicaid, is required.
  - To be covered by Medicaid the student must be Medicaid eligible, and the service must be a Medicaid covered service.
  
- **Transition to a Certified Public Expenditure Model.** NH must transition to a cost-based (certified public expenditure) methodology of financing the Medicaid-to-Schools program by June 2026 to comply with Federal CMS requirements. A Certified Public Expenditure model will:
  - Allow for administrative claiming of School expenses.
  - Better reflect the School's cost to administer and fund the Medicaid-to-School's program.
  
- **174 Local Education Agencies** are enrolled in the NH Medicaid to Schools Program.
  - **What is a Local Education Agency?** Also known referred to as an LEA, a local education agency is the education agency at the local level which exists primarily to operate schools or to contract for educational services. Those 174 enrollments can refer to either the enrollment of a single school or the enrollment of an entire district.
  
- **Federal CMS Grant Award.** NH Medicaid received \$2.5M in grant funding in July 2024 (3-year Grant) to support the transition to a Certified Public Expenditure claiming transition for the Medicaid to Schools program.



This table depicts federal reimbursement dispersed and students served since the Division of Medicaid Services assumed responsibility for managing the Medicaid-to-Schools program in SFY2019.

**Table 1**

<b>Year</b>	<b>Federal Reimbursement</b>	<b>Students Served</b>
SFY 2019	\$26,379,998	10,498
SFY 2020	\$8,223,474 <sup>1</sup>	9,003
SFY 2021	\$12,592,745 <sup>1</sup>	7,751
SFY 2022	\$13,630,742 <sup>1</sup>	8,001
SFY 2023	\$13,295,721 <sup>1</sup>	8,127
SFY 2024	\$8,889,268 <sup>1</sup>	6,668

<sup>1</sup> These amounts do not include the additional matching funds through the Families First Coronavirus Response Act. Matching FMAP payments to school districts for SFY 2024 totaled \$231,378.



# Federal Initiatives And Potential Budget Impacts



Currently Circulating Federal Risks to Medicaid Federal Funding  
(Congressional Budget Reconciliation)

	Proposal	Impact
<b>FMAP Reduction</b>	<p><b>Eliminating the enhanced FMAP for expansion:</b> Currently 90% for Granite Advantage</p> <p><b>Lowering the minimum FMAP:</b> NH currently receives the minimum of 50%</p> <p><b>Changing the formula used to calculate Medicaid FMAP:</b> Insufficient details to determine impact to NH as a minimum FMAP state.</p>	Reduction in federal funding through a reduced match rate, shifting cost to state without reducing overall cost
<b>Capping Federal Contribution</b>	<p><b>Block Grants:</b> Converting Medicaid to a per capita cap. States receive only a fixed federal contribution per beneficiary</p>	Funding structure for Medicaid changes entirely; all costs above a set capitation are borne by state
<b>State Revenue Reduction</b>	<p><b>Restricting use of provider taxes to finance state Medicaid costs:</b> all states but Alaska rely on these taxes to finance Medicaid</p>	Significant reduction in state revenue available for financing Medicaid without reduction in overall program cost



- **Work requirements legislation.** SB134, currently passed out of committee directing the Department to re-submit an 1115 Waiver to implement work requirements in Granite Advantage as set forth in RSA 126-AA:2, III.
  
- **System Implementation Costs.** Department estimates that system implementation would cost at least \$1.7 Million (not funded in the Governor’s proposed budget).
  
- **CMS Required Evaluation.** Pursuing work requirements through an 1115 waiver will also require the State to complete a CMS required evaluation, which is estimated to cost \$1.5M (not funded in the Governor’s proposed budget).
  
- **Congressional Action?** Work requirements are currently under consideration by Congress and CMS. Appears possible that federal criteria around Medicaid work requirements will be included in the Congressional budget process or released by CMS.
  
- Federal proposals on work requirements could include a State Plan Amendment option, which would avoid the evaluation costs (of approximately \$1.5M) associated with an 1115 Waiver.

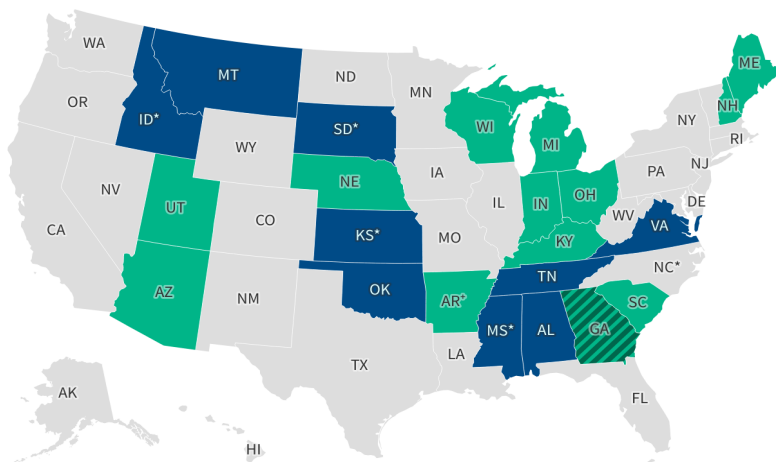


Figure 1

### Medicaid Work Requirement Waiver Requests & State Activity

The Trump administration approved 13 waivers with work requirements that were rescinded under the Biden administration or withdrawn by states. GA's work requirement waiver remains active as a federal court overturned the Biden administration's rescission.

- Approved and rescinded or withdrawn (13 states)
- Not approved (pending at the end of Trump administration) (9 states)
- ▨ Currently implemented^ (1 state)



Note: ^ =Although CMS withdrew work and premium requirements in Georgia's waiver, these provisions remain in place after a federal judge overturned the CMS withdrawal. \* = indicates recent state activity / consideration of work requirements (by state legislature or Governor). + = Arkansas implemented Medicaid work requirements in 2018, but they were ended in 2019 when a federal court found the approval unlawful. The state submitted a new work requirement request to the Biden administration in 2023; it remains pending.

Some states withdrew their approved or pending waivers themselves, often at the direction of Democratic Governors. For state-level detail on waivers approved or pending at the end of the Trump administration, see KFF's 1115 waiver tracker.

Source: KFF analysis of approved and pending waiver applications posted on Medicaid.gov and state activity

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Georgia and Arkansas have both made recent proposals to change how work requirements are implemented in those states.

**Georgia:** Removed requirement that individuals must document work every month.

- Individuals still need to meet the work requirement at the time of enrollment and at redetermination.
- Expands populations exempt from work requirements to include parents with children under the age of 6.

**Arkansas:** Removed requirement that individuals must report work hours.

- Arkansas will confirm whether an individual is working, caregiving, fulfilling other qualifying activities by using data, which could include job history, income, educational status whether a child lives at home, and other criteria.
- Individuals not meeting work requirements will not be terminated but will be required to participate in “success coaching”.



**1. Percent of Medicaid Adults 19-64 Who Work (any employment)**

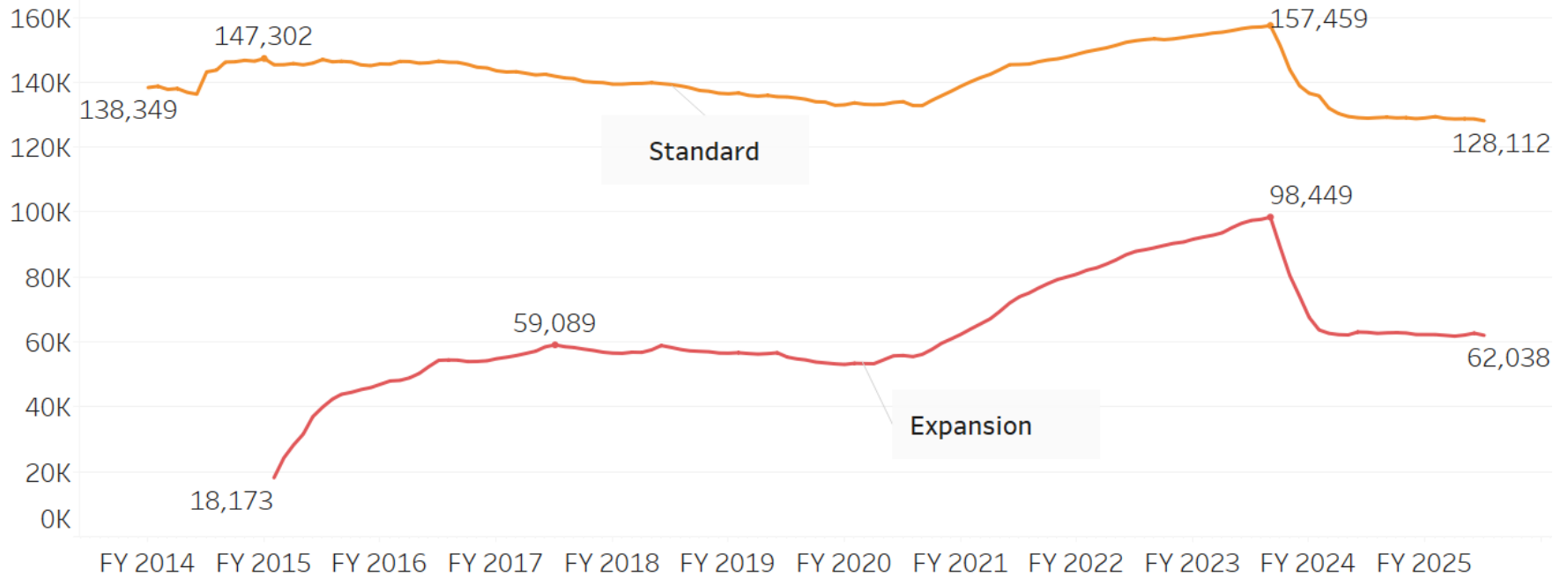
- 2022 KFF report (during higher PHE GAHCP enrollment) 70% NH; US 63%
- 2024 KFF report 65% NH; US 61%

**2. Percent of Medicaid Adults 19-64 Who Work (more in-depth report 2025 KFF Report)**

- **NH:** 63.1% working, 46.1% fulltime
  - **US average:** 63.6% work and 44.1% fulltime.
- **NH:** 69.4% had at least one fulltime worker in the household
  - **US average:** 66.1%.
- **Smaller Employers:** 64.3% of working NH Medicaid beneficiaries work for an employer with under 50 FTEs; the US average is 45.6%.
  - The most common two employers were agricultural/service followed by education/health for NH; for the US it is agriculture and education/health.



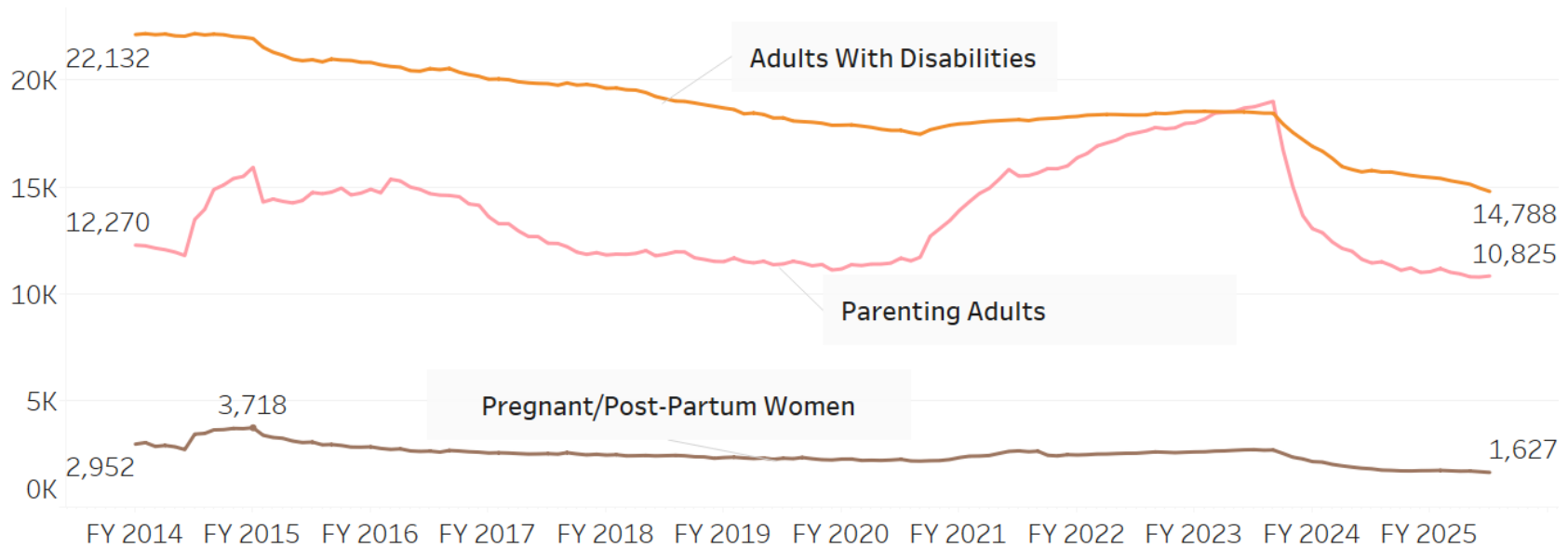
### Medicaid Enrollment at End of Month: Expansion vs Standard, July 2013 to January 2025



*Note, data contains retroactive enrollment spans. Because of this, the most recent two or three periods are slightly understated. Source: data contained in New Heights Data Warehouse as of 1/31/2025.*



Medicaid Enrollment at End of Month: Adult Disabled, Pregnant & Parenting Eligibility Categories, July 2013 to January 2025



Note, data contains retroactive enrollment spans. Because of this, the most recent two or three periods are slightly understated. Source: data contained in New Heights Data Warehouse as of 1/31/2025.



# Appendix

- **Project Walk - Prioritized Need Funded by the Governor's Budget**
- **Key Accomplishments**
  - Completion of Unwind and Enrollment Statistics
  - Community Re-entry
  - MCM 3.0 Re-procurement
  - Postpartum 12-months continuous coverage preliminary data
  - Dental Network Update
- **Quality Metrics and CMS Scorecard**

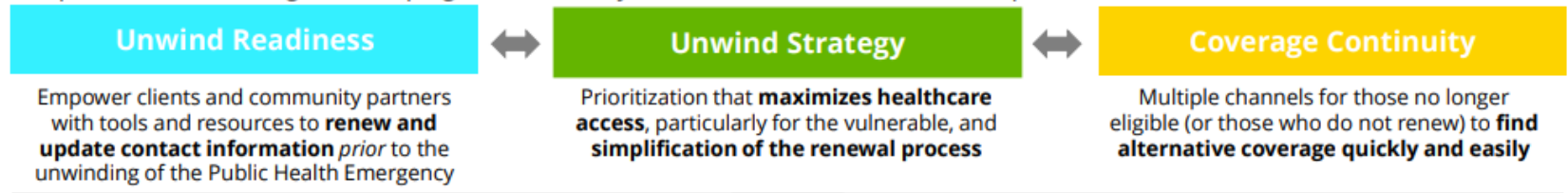


HB1 Budget Areas For Consideration								
Description	SFY 26				SFY 27			
	General	Federal	Other	Total	General	Federal	Other	Total
<p><b>Project Walk:</b> Project Walk provides activity-based therapy services to Medicaid beneficiaries who are impacted by neurological illnesses and/or disorders affecting their mobility who are not eligible for coverage of these services under a Home and Community Based Services (HCBS) waiver.</p>	\$240,000	\$0	\$0	\$240,000	\$240,000	\$0	\$0	\$240,000



## DHHS's Approach to the Continuous Enrollment Unwinding

New Hampshire DHHS has prioritized a community-based approach to maximize healthcare continuity; helping eligible Medicaid recipients retain coverage and helping others identify an affordable health insurance option for themselves and their families.



### Unwind Readiness

Empower clients and community partners with tools and resources to **renew and update contact information** prior to the unwinding of the Public Health Emergency

### Unwind Strategy

Prioritization that **maximizes healthcare access**, particularly for the vulnerable, and **simplification of the renewal process**

### Coverage Continuity

Multiple channels for those no longer eligible (or those who do not renew) to **find alternative coverage quickly and easily**



#### Multi-Channel Outreach

- **Called and encouraged 40K households** to renew – targeted those with children and disabilities, the elderly and frail, and those with high healthcare utilization
- **Contacted 25K households** via text, email and phone to update their contact information
- **Sent over 120K “pink notices”** via mail, e-mail and text encouraging clients to renew. This increased renewal rates by ~30% and reduced the volume of future renewals



#### Community Engagement

- Proactively and iteratively sharing with providers lists of those with overdue renewals and those no longer eligible
- Enabling providers, guardians and other co-pilots access to NH Easy so they can view eligibility due dates and offer assistance
- Coordinating outreach via MCO's and navigators
- Conducting numerous community outreach forms



#### Risk-Based Strategy and Safeguards

- Prioritizing – at the outset – those clients more likely to have healthcare choices and less vulnerabilities
- Maximizing passive renewal, online renewals, and other enablers
- Providing ~60 days for renewal, giving families added time beyond 30 days
- Nudging clients to renew via notices, text, e-mail and calls
- Using multiple modality outreach for those who had lost contact with DHHS
- Advanced analytics to monitor outcomes and outliers throughout the unwind period



#### Post-Closure Outreach

- Identification/follow up for potentially vulnerable clients
- Adding procedural denial for over income to FFM referral
- Navigator outreach and support, including advertisements and in person community events
- Informing providers and MCO's of outcomes via NH EASY/interfaces
- Paths back for those who don't renew, including NH EASY reapply without starting over
- Retroactive reopen within 120 days with no gap in coverage (new)



### CMS Reporting and Closure Reasons – Grand Total (Mar. 23 – Jul. 24)

Renewal Metrics	Grand Total					
	Grand Total (CMS)		Protected		Non-Protected	
	Count	Percent	Count	Percent	Count	Percent
Total Renewals Due	237,617	100%	61,820	100%	175,797	100%
In Progress	1,212	0.5%	3	0.0%	1,209	0.7%
Renewals with Outcomes	236,405	99.5%	61,817	100.0%	174,588	99.3%
Retained MA (Successful renewal)	<b>164,870</b>	<b>69.7%</b>	<b>18,526</b>	<b>30.0%</b>	<b>146,345</b>	<b>83.8%</b>
<b>Total Closures (all reasons)</b>	<b>71,534</b>	<b>30.3%</b>	<b>43,291</b>	<b>70.0%</b>	<b>28,243</b>	<b>16.2%</b>
Not Referred to FFM	46,202	64.6%	26,598	61.4%	19,604	69.4%
<b>Referred to FFM</b>	<b>25,332</b>	<b>35.4%</b>	<b>16,693</b>	<b>38.6%</b>	<b>8,639</b>	<b>30.6%</b>
Procedural (Pilot)	11,263	15.7%	9,503	22.0%	1,760	6.2%
Non-Procedural	14,069	19.7%	7,190	16.6%	6,879	24.4%
<b>Total Closure by Reasons</b>	<b>71,534</b>	<b>100%</b>	<b>43,291</b>	<b>100%</b>	<b>28,243</b>	<b>100%</b>
Income	19,824	27.7%	14,181	32.8%	5,643	20.0%
Failed to Rede	34,897	48.8%	20,733	47.9%	14,164	50.2%
Categorically Ineligible	4,979	7.0%	3,692	8.5%	1,287	4.6%
Not Requesting/Living Arrangement	4,546	6.4%	2,625	6.1%	1,921	6.8%
Failed to Verify/Comply	1,998	2.8%	819	1.9%	1,179	4.2%
Does Not Meet Program Requirements	2,253	3.1%	618	1.4%	1,635	5.8%
Other	3,037	4.2%	623	1.4%	2,414	8.5%



\* This table does not include outcomes for individuals who reported a changes in circumstance outside of the renewal period.

\*\*Closure by reason percentages are for the closed individuals only (% of closure reasons), not the percent of renewals that close per month which is reflected in Total Closures by outcome row.



- Offering a Medicaid program is elective for states. All 50 states, and 6 territories, currently elect to offer a Medicaid program.
  - 41 States, including Washington D.C., have expanded Medicaid.
- States with a Medicaid program must cover select groups of people (e.g. low-income children, low-income pregnant and postpartum women, disabled individuals, and low-income elderly) and cover select groups of services that are known as **mandatory services**.
  - Participating states can elect coverage for additional services and populations that are known as optional.

### Medicaid Covered Services:

Mandatory	Optional
✓ Inpatient hospitalization	✓ Prescription drugs
✓ Outpatient hospital	✓ Eyeglasses and hearing aids
✓ Physicians	✓ Organ transplants
✓ Lab and x-ray	✓ Psychologists and other behavioral health
✓ Home health	✓ Dental
✓ Nursing facility	✓ Physical/occupational/speech therapies
✓ Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for children	✓ Rehabilitative
	✓ Intermediate care facilities for individuals with intellectual disabilities
	✓ Case management
	✓ Emergency hospital
	✓ Hospice
	✓ Transportation (Non-Emergency)
	✓ Prosthetic devices
	✓ Personal care

Highlighted optional benefits are commonly covered as Essential Health Benefits for plans on the Health Insurance Marketplace

Benefits can also be added through waivers.

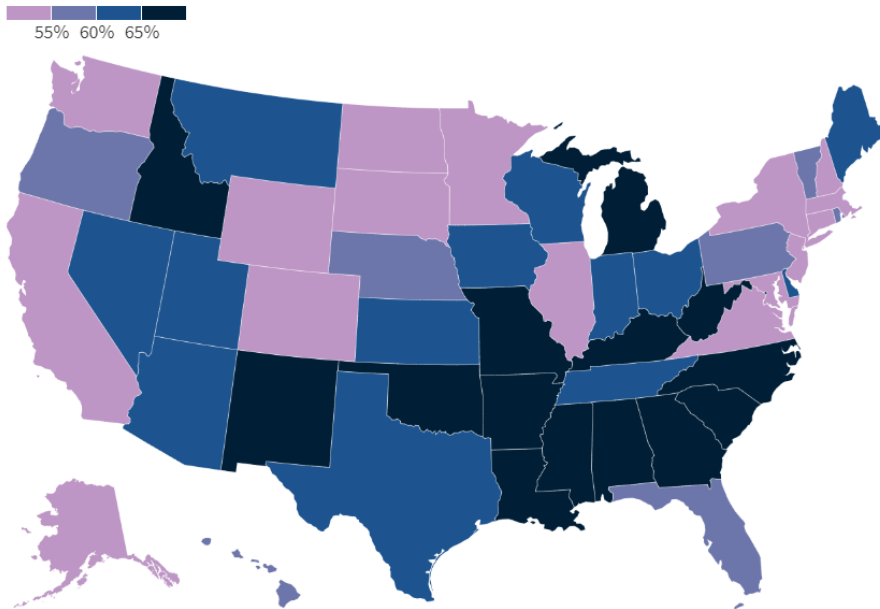


MANDATORY GROUPS	New Hampshire Eligibility Policy, if different	National Benchmark
Pregnant women (60 days postpartum) and children up to 6 years at 138% FPL	Pregnant women eligible for <b>12 months</b> postpartum	<b>48 other states</b> have adopted 12 months postpartum =
	Pregnant women $\leq$ <b>201%</b> FPL	NH ranks <b>34<sup>th</sup> highest income limit</b> , within 10% national median ↓
Children up to 19 years, $\leq$ 138% FPL	Children up to 19 years, $\leq$ <b>323%</b> FPL	NH has <b>5<sup>th</sup> highest</b> income limit ↑
Most individuals receiving SSI and related programs		
	<b>Optional Group:</b> Granite Advantage (Expansion population) $\leq$ <b>138% FPL</b>	Equivalent income limit with <b>41</b> out of 42 states that elected expansion =



Figure 5

The Federal Matching Rate Ranges from 50% to 77% Across States for FY 2025.



Note: FMAP = Federal Medical Assistance Percentage. These rates are in effect October 1, 2024 - September 30, 2025.  
 Source: Federal Register, November 21, 2023 (Vol 88, No. 223), pp 81090-81093 • Get the data • Download PNG

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### Comparison of FMAP- Selected States

#### New England States

CT, NH, MA = 50%  
 RI = 57.50% ↑  
 VT = 59.01% ↑  
 Maine = 61.29% ↓

#### Highest FMAP

MI = 76.9%  
 WV = 74.22% ↑  
 AL = 72.63% ↓  
 NM = 71.66% ↓

#### Lowest FMAP (50%)

California	New Hampshire
Colorado	New Jersey
Connecticut	New York
Maryland	Washington
Massachusetts	Wyoming

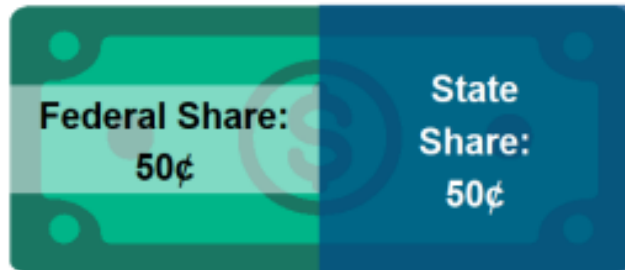
↑=increase from last year

↓=decrease from last year

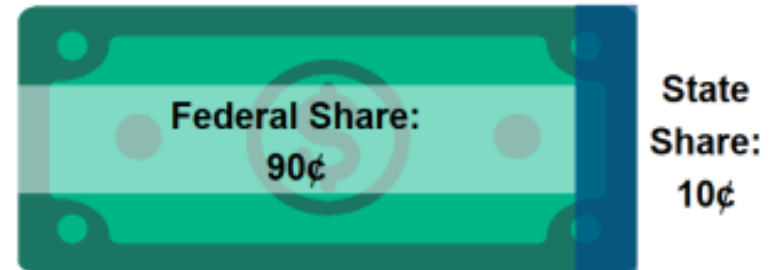


**Federal Medical Assistance Percentage or **FMAP****

In NH, the federal government pays **50%** of the cost of traditional Medicaid.



The federal government pays **90%** of the cost of the Medicaid expansion.



- **FMAP** is the share of state Medicaid costs paid by the federal government
- FMAP is calculated based on a 3-year average of state per capita personal income compared to national average
- No state can receive less than 50% or more than 83%
- States also receive “enhanced FMAPs” for expansion populations under the ACA and for the Children’s Health Insurance Program (CHIP)
- State share must be State public dollars or other allowable non-federal revenue.



### Examples of Special/Enhanced Federal Matching Percentages

Service/Population	Special/Enhanced FMAP Percentage
Granite Advantage	90%
Breast and Cervical cancer treatment	65%
Family planning	90%
DSH	50%
Rates/Directed Payments	Blended (50%-65%-90%) based on the individual’s eligibility category
Children’s Medicaid expansion	65%
Low-Income Children (non-CHIP)	50%

### FMAPs and Leverage of the State Dollar: Examples

Service/Population	Gross Spend	FMAP	State Spend \$\$	Federal Match \$\$
Granite Advantage	\$1,000	90%	\$100	\$900
Standard Medicaid	\$1,000	50%	\$500	\$500
Expanded Children’s	\$1,000	65%	\$350	\$650



## **Goals:**

- Increase coverage and appropriate service uptake in correctional facility settings prior to release
- Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry
- Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers
- Decrease recidivism

## **Adult Community Re-entry Initiative:**

- Authority provided through New Hampshire's 1115 Demonstration Waiver
- **Population:** Medicaid-eligible incarcerated adults with behavioral health needs (e.g. Serious Mental Illness or SUD)
- **Timeframe:** 45-days prior to release, a limited services benefit to eligible incarcerated adults
- **Services:** Tailored Medicaid services including MCO enrollment, enhanced care coordination, initial pre-release visits with community-based providers, pre-release re-entry care coordination meetings including community-based providers, peer support, medication assisted treatment (MAT), and a 30-day prescription drug supply provided upon release

## **Youth Community Re-entry:**

- Federal mandate for all states and territories
- **Population:** Medicaid enrolled eligible youth – CMS defined youth as up to age 21 and former foster care youth ages 21 up to 26.
- **Timeframe:** 30-days prior to release, a limited services benefit to eligible incarcerated youth
- **Services:** Targeted Case Management and Early and Periodic Screening, Diagnostic, and Testing Services (EPSDT) such as medical, dental, and behavioral health screenings



MCM 3.0 Featured Programmatic Changes (September 1, 2024 – August 30, 2029)



**Primary Care and Preventive Services Model of Care.** MCM programmatic changes to build authentic patient/primary care provider relationships, and incentivize provider-delivered care coordination, health risk assessments and comprehensive medication reviews.



**High-Cost Pharmacy Risk Pool for High-Cost Therapies.** Shifts risk from the State to the MCOs by including high-cost drugs and therapies in MCM. MCOs share in the utilization management and risk of new high-cost drugs and gene therapies.



**Focused MCO-delivered Care Management for priority populations.** Focuses enhanced MCO care management on previously incarcerated members, DCYF-involved children, infants with low-birthweight and/or NAS, and members with a behavioral health inpatient facility admission within past 12 months. Allows State to identify additional priority populations.



**Restructure of CMHC Capitation Model.** Further aligns funding with state behavioral health investments and program goals.

**Certified Community Behavioral Health Centers.** Integrates behavioral health and SUD in one location. Two CMHCs, Manchester and Nashua, implemented on 1/1/25 as a CCBHC.



**Strengthened Reliability, Quality, Safety, and Access in the performance of the NEMT program.** Elevated standards and remedies applied to MCOs' performance of oversight of their NEMT brokers and transportation providers.

# Integrated Pharmacy Benefit Management

*Streamlines existing systems and improves cost-savings*

## Integrated Medication Management

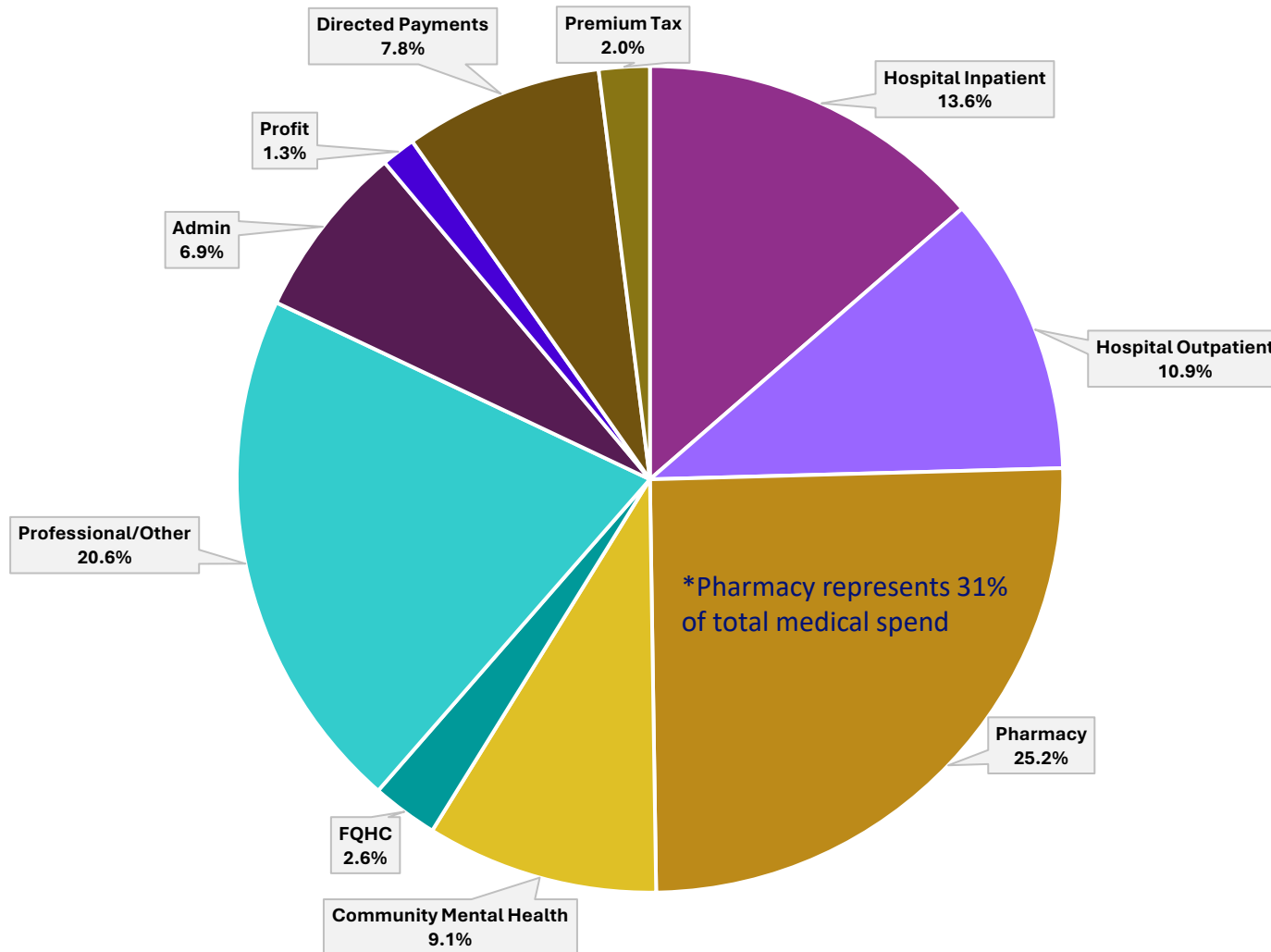
- Increase provider capabilities for reimbursable Rx review activities
- Contract criteria for polypharmacy review and DHHS authority on PA review criteria
- Member incentives for engagement in medication review
- Extend Rx efficiency analyses

## High-Cost Pharmacy Risk Pool

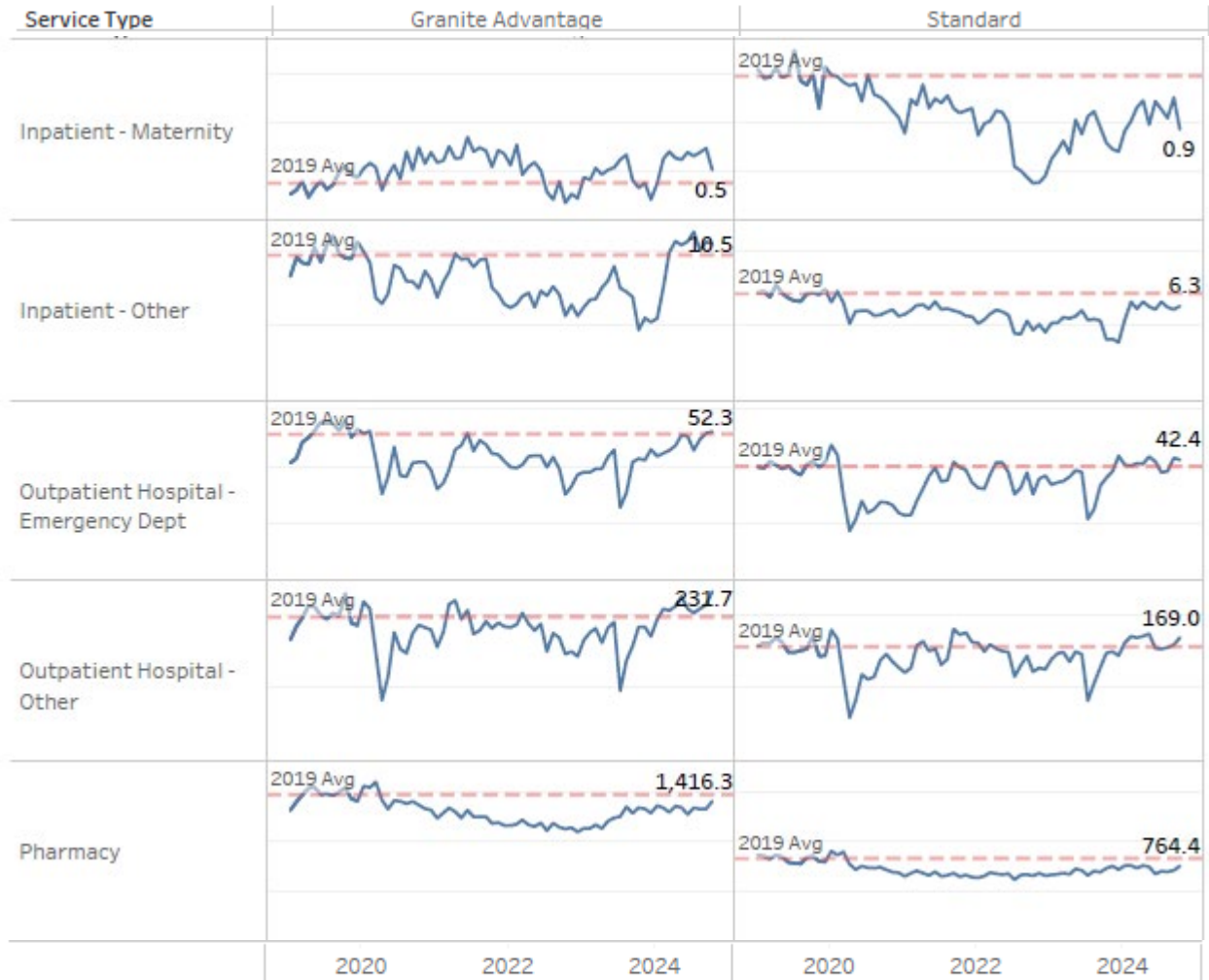
- Strategy for financial management of largest and least predictable cost area for MCM program
- Allocates funding to MCOs based on outlier cost pharmacy claims
- Expected effect: Sharing Risk with MCOs and promoting MCO engagement in the course of care and treatment



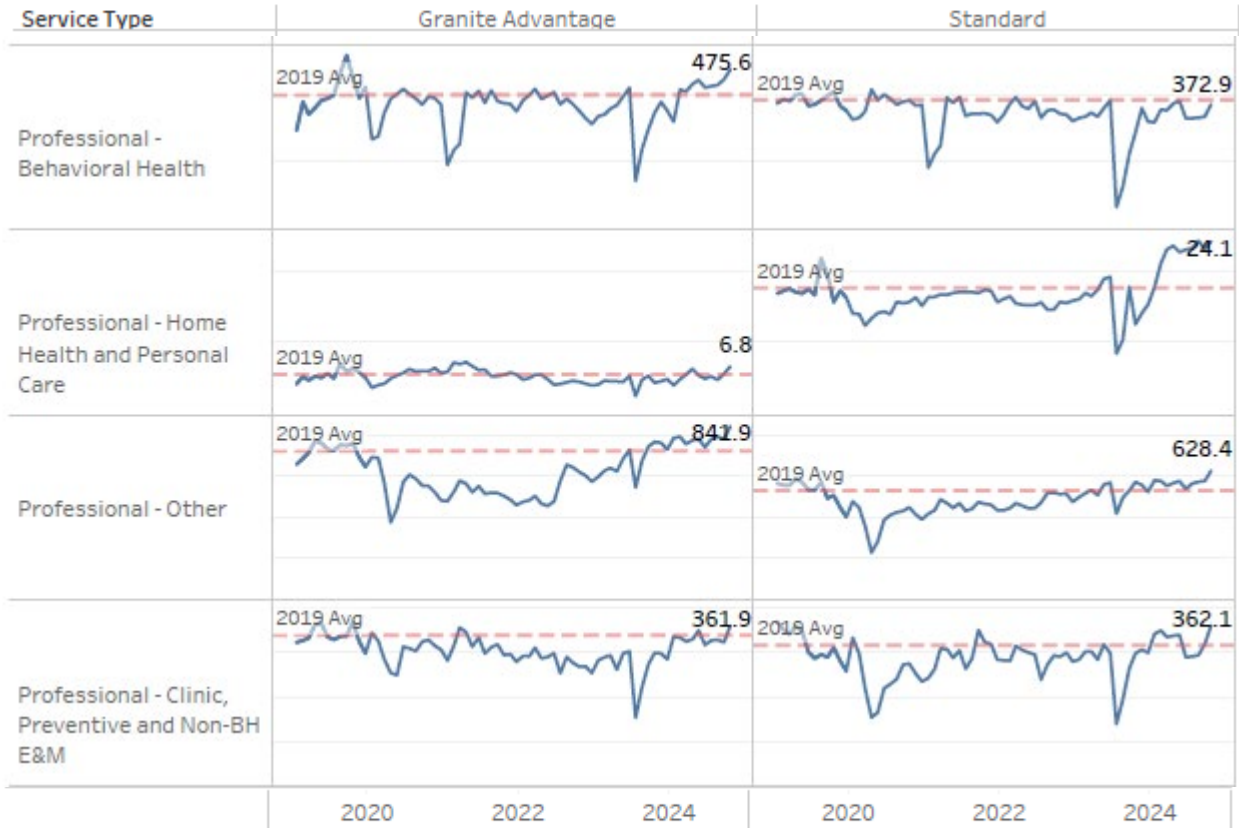
### Amendment #2 MCO Capitation Rate Funding



Claims Paid Per 1,000 Member Months by Service Month and Service Type  
 January 2019 to October 2024 (Medical Lag 90 days; Pharmacy Lag 90 days)



Claims Paid Per 1,000 Member Months by Service Month and Service Type  
 January 2019 to October 2024 (Medical Lag 90 days; Pharmacy Lag 90 days)



## Emerging Data for Continuously Enrolled Postpartum Women

- Expanded 12-month continuous postpartum coverage began October 2023.
- Initial data focuses on women who delivered in August-October of 2023.
- The data below represent claims during the period of expansion starting on the 61st day after delivery. Due to the timing of claims runout and data availability, these data are preliminary.
  - 95% Received medical services
  - 52.4% received mental health or SUD services
  - 26.7% received preventative visits
  - 3.2% received heart or hypertension services



# MEDICAID SERVICES - Dental Provider Network Update

## Total Unique Providers and Unique Locations

# Unique Providers	# Unique Locations	# Unique Oral Surgeons	# Unique Oral Surgeons Locations
190	132	24	23

## Border Unique Providers in MA /ME/VT

# Unique Providers	# Unique Locations
51	23

Take 5 Providers	Off Directory Providers	EPO Providers	Treating Special Needs Patients Only
11	59	59	12

## Mobile Event Totals as of 02/07/2025

	Event Total	Members Scheduled	Members Treated
Totals	143	1,874	1,459



## County Breakdown

State	County	Contracted
NH	Belknap	26
NH	Carroll	18
NH	Cheshire	21
NH	Coos	34
NH	Grafton	32
NH	Hillsborough	103
NH	Merrimack	30
NH	Rockingham	66
NH	Strafford	30
NH	Sullivan	29
MA	Essex	31
MA	Middlesex	49
MA	Norfolk	10
MA	Worcester	16
ME	Penobscot	1
ME	York	8
VT	Windsor	8

## Summary

A total of 190 unique providers/ 132 unique locations as of 02/07/2025. This is including Tele-dentistry, Mobile and IDH's.

A Total of 143 Mobile Events, 1,874 Members scheduled, and 1,459 members treated.

We have a total of 24 Participating Oral Surgeons at 23 locations.

- o Mary Hitchcock Memorial Hospital - 2 Oral Surgeons.
- o Hanover Street Family Dental - 1 Location and 1 Oral Surgeon
- o Chelmsford Oral Surgery - 4 Oral Surgeons
- o Lowell Oral Surgery Associates INC -1 Location in MA and 4 Oral Surgeon
- o Nashua Oral Surgeon - 1 Location and 4 Oral Surgeons
- o Catholica Medical Center Poisson Dental Facility - 1 Location and 1 Oral Surgeon
- o Concord Hospital Family Health Center – 1 Location and 1 Oral Surgeon (Dr. Leonard Weldon NPI:1174569099)
- o Concord Oral Surgery PA – 1 Location and 3 Oral Surgeons
- o Dental Health Works of Cheshire County INC – 1 Location and 1 Oral Surgeon (Dr. Leonard Weldon NPI:1174569099)
- o Elliot OMS Center – 1 Location and 3 Oral Surgeons

\*Please note Dr. Leonard Weldon NPI:1174569099 practice at both Dental Health Works of Cheshire County INC and Concord Hospital Family Health Center.

\*Dr. Sotirios Diamantis practice at Nashua Oral Surgery, Chelmsford Oral Surgery and Lowell Oral Surgery Associates INC.

\*Dr. Thomas Throbridge practice at Nashua Oral Surgery, Chelmsford Oral Surgery and Lowell Oral Surgery Associates INC.

\*Dr. Amy Field practice at Nashua Oral Surgery, Chelmsford Oral Surgery and Lowell Oral Surgery Associates INC.

\*Dr. Jeffery Stone practice at Nashua Oral Surgery, Chelmsford Oral Surgery and Lowell Oral Surgery Associates INC.



## ASSURE DELIVERY OF QUALITY AND APPROPRIATE CARE

- Monitoring preventive care and treatment quality measures
- Requiring evidence based clinical practices.



## ASSURE ACCESS TO QUALITY CARE



- Member travel time and distances standards to providers.
- Monitoring member service utilization and experience of care.
- Monitoring member grievances and appeals.

## ASSURE VENDOR CONTRACT COMPLIANCE

- Identify issues through system wide performance monitoring.
- Conduct annual external audit.
- Enforce liquidated damages and corrective action.



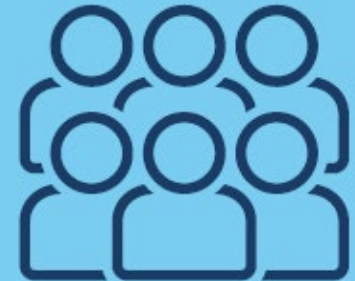
## MANAGE CONTINUOUS PERFORMANCE IMPROVEMENT



- Quality withhold and performance incentive program.
- Alternative payment models.
- Performance based member auto-assignment program.
- Performance improvement projects.

## TARGET POPULATION HEALTH ACTIVITIES

- Mental health quality.
- Substance use/misuse quality.
- Members with special needs quality.
- Identification of disparities



## ASSURE DATA VALIDITY



- Conduct annual external data audit.
- Conduct ongoing internal systematic data validation.

**Consumer guide** can support informed decisions about choosing a health plan. The guide is provided to newly eligible Medicaid members and existing Medicaid members during open enrollment.

The guide includes quality data about:

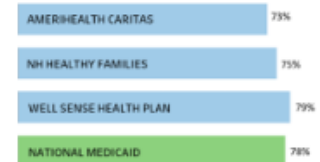
- Member satisfaction with the health plan;
- Member utilization of preventative care such as prenatal care; and
- Member adherence to evidence-based treatment to manage physical and behavioral health conditions.

<https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/dms1070.pdf>

## NH Health Plan Satisfaction and Quality of Care Ratings (2023)

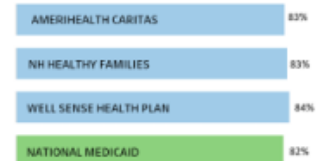
### Rating of Health Plan - Adults

This measure captures the percent of adults who gave their health plan a rating of 8, 9 or 10 on a scale of 1 through 10. The lowest rating is a 1 and the highest is a 10.<sup>1</sup>



### Rating of Health Plan - Children

This measure captures the percent of parents or guardians who gave their child's health plan a rating of 8, 9 or 10 on a scale of 1 through 10. The lowest rating is a 1 and the highest is a 10.<sup>1</sup>



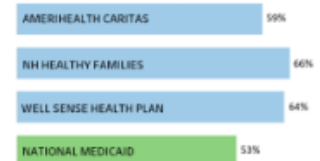
### Well Child Visits for Children Age 3 - 11

This measure captures the percent of children 3-11 years of age who had at least one well child visit with a primary care provider within the past year.<sup>2</sup>



### Adolescent Well Visits Age 12-17

This measure captures the percent of adolescents 12-17 years of age who had at least one comprehensive well-care visit with a primary care provider within the past year.<sup>3</sup>



The New Hampshire Medicaid Care Management (MCM) Quality Strategy has provided a roadmap to achieve higher level of performance by embedding key quality measures into the Quality Strategy that align with the MCM priorities and focus areas with a goal of achieving these goals by 2026 measurement year (which will be reported in 2027).

The quality measures have been embedded into two Quality Strategy goals and associated objectives:

**Goal 1:** Assure quality and appropriate care delivered to NH Medicaid Managed Care Population

- **Objective 1.1:** Ensure that calendar year 2026 selected NH identified priority primary care and prevention measure rates show improvement
- **Objective 1.2:** Ensure that calendar year 2026 selected NH identified priority behavioral health measure rates show improvement

**Goal 6:** Conduct key population health quality activities

- **Objective 6.2:** Increase provider-delivered Care Coordination and MCO-delivered Care Management in the Managed Care Population



Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
<b>Goal 1: Assure quality and appropriate care delivery to the NH Medicaid Managed Care population.</b>		
<i>Objective 1.1 – Ensure that calendar year 2026 selected NH identified priority primary care and preventive care measure rates show improvement.</i>		
Prenatal and Postpartum Care – Timeliness of Prenatal Care (PPC)	81.9% (CY 2022)	86.9% (CY 2026)
Prenatal and Postpartum Care – Postpartum Care (PPC)	80.6% (CY 2022)	85.6% (CY 2026)
Lead Screening Rate in 1-Year-Olds (DHHS-developed)	65.7% (CY 2022)	73.7% (CY 2026)
Lead Screening Rate in 2-Year-Olds (DHHS-developed)	57.2% (CY 2022)	65.2% (CY 2026)
Well-Child Visits in the First 30 Months of Life (W30) – First 15 Months	59.3% (CY 2022)	62.3% (CY 2026)
Well-Child Visits in the First 30 Months of Life (W30) – 15 – 30 Months	75.9% (CY 2022)	78.9% (CY 2026)
Child and Adolescent Well Care Visits (WCV)	57.5% (CY 2022)	60.5% (CY 2026)
Adult Well Care Visits (DHHS-developed)	36.2% (CY 2022)	39.2% (CY 2026)
Provider-Based Health Risk Assessment Screening (DHHS-Developed)	TBD	TBD

TBD indicates a new measure, DHHS expects baseline results for CY 2025



Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
<b>Goal 1: Assure quality and appropriate care delivery to the NH Medicaid Managed Care population.</b>		
<i>Objective 1.2 – Ensure that calendar year 2026 selected NH identified priority behavioral health measure rates show improvement.</i>		
Follow-up After Emergency Department Visit for Mental Illness – 7 Days (FUM)	63.3% (CY 2022)	67.3% (CY 2026)
Engagement of Substance Use Disorder Treatment (IET)	25.0% (CY 2022)	29.0% (CY 2026)
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	76.3% (CY 2022)	80.3% (CY 2026)



Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective (year)
<b>Goal 6: Conduct Key Population Health Quality Activities</b>		
<i>Objective 6.2 – Increase provider-delivered Care Coordination and MCO-delivered Care Management in the Managed Care Population.</i>		
Percent of members who are receiving Provider-based care coordination.	TBD	TBD
Percent of priority population members who are receiving MCO-based care management.	TBD	50% (SFY 2026)

TBD indicates a new measure, DHHS expects baseline results for CY 2025



See NH’s Quality Strategy:

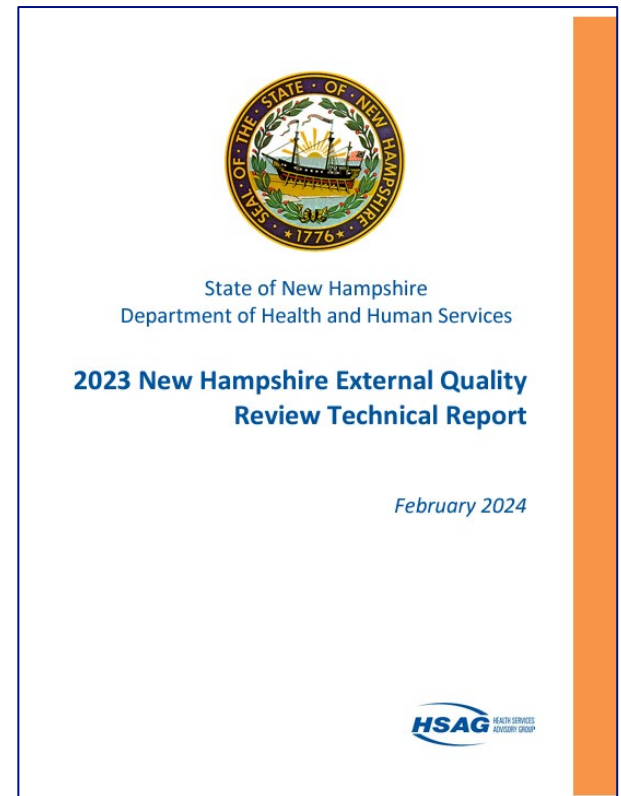
[https://medicaidquality.nh.gov/sites/default/files/New%20NHampshire%20Comprehensive%20Medicaid%20Quality%20Strategy%20Revision%20%238\\_final.pdf](https://medicaidquality.nh.gov/sites/default/files/New%20NHampshire%20Comprehensive%20Medicaid%20Quality%20Strategy%20Revision%20%238_final.pdf)



The New Hampshire Medicaid Care Management (MCM) Program contracts with an External Organization to perform annual reviews of the NH Medicaid Care Management Organizations as federally required by 42 CFR 438.350.

External Quality Review activities include:

- Annual MCO contract compliance audit;
- Annual performance measure validation audit;
- Annual MCO provider network adequacy validation;
- Validation of MCO performance improvement projects;
- Medicaid member interview studies;
- Medicaid provider satisfaction surveys; and
- Additional quality studies.



See the most recent Technical Report:

<https://medicaidquality.nh.gov/sites/default/files/NH%20EQRO%20Technical%20Report%20SFY%202023.pdf>



## NH 2024 Scorecard Summary

### NH Reported:

- 94.1% (32 measures) of the Adult Core Set
- 100% (18 measures) of the Behavioral Health Core Set
- 100% (27 measures) of the Child Core Set
- 100% (9 measures) of the Maternity Core Set

NH data can be found here: <https://www.medicaid.gov/state-overviews/scorecard/main?focusStates=%5B%22NH%22%5D>



## NH 2024 Scorecard Observations

- Overall, 2024 Scorecard showing NH performing moderate-to-excellent
  - **11 poor or moderately** performing CMS Scorecard Metrics for NH
    - **10** are performing better than prior years and achieving correct directionality on most recent available trend
    - **9** are linked to current quality levers and/or 3.0 priority areas
    - **1** metric, Asthma Medication Ratio (AMR), showing poor performance with a continued decline
  - **10 excellently** performing CMS Scorecard metrics
    - **9** are linked to current quality levers and/or 3.0 priority areas





# Questions?

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Department of  
**HEALTH &  
HUMAN SERVICES**

