MATERNAL OPIOID 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 reduces total costs and improves quality of care. 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. CMS approved a no-cost extension to December 31, 2025.

CLIENT PROFILE:

New Hampshire's *MOM Model* implementation created 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.

Funding received through the MOM Model complements 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.

FINANCIAL HISTORY-1371						
Rounded to $000 except cost per case	**SFY24**	**SFY25**	**SFY26**	**SFY27**	**SFY27**	**SFY27**
	Actual	**Adj Auth**	**Agency Request**	**Agency Budget**	**Governor's Budget**	**Governor's Budget**

TOTAL FUNDS	$1,397	$750	$1	$0	$1	$1
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

Note to the table: Any contract encumbrances remaining will be brought forward to SFY26.

FUNDING SOURCE:
100% Federal Medicaid Funds, Maternal Opioid Misuse Model (MOM Model)

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 MOM Model across the state.

STATE MANDATES:
N/A

FEDERAL MANDATES:
N/A

SERVICES PROVIDED:
Created and piloted a highly coordinated system of care for pregnant women with Opioid Use Disorder that provides 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 filling 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 has collaborated 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.

MTS GRANT AWARD FIN ADMIN
AU 4700-4258

PURPOSE: The Medicaid to Schools Financing Program funding from the Centers for Medicare and Medicaid Services will allow the Department of Health and Human Services and participating Local Education Agencies (LEAs) to access technical support, resources, and technology to effectuate a federally compliant claiming methodology by June 2026.

CLIENT PROFILE:
N/A

FINANCIAL HISTORY-4258						
Rounded to $000 except cost per case	SFY24	SFY25	SFY26	SFY27	SFY27	SFY27
	Actual	Adj Auth	Agency Request	Agency Budget	Governor's Budget	Governor's Budget
TOTAL FUNDS			$0	$0	$1,000	$1,000
GENERAL FUNDS			$0	$0	$0	$0
ANNUAL COST PER CASE-TOTAL	N/A	N/A	N/A	N/A	N/A	N/A
CASELOAD PMPM	N/A	N/A	N/A	N/A	N/A	N/A

Note to Table 100% Federal funds

FUNDING SOURCE:
100% Federal Medicaid Funds, State Grants for the Implementation, Enhancement, and Expansion of Medicaid and Chip School-Based Services

OUTCOME:
Maximize Medicaid reimbursement avoiding Federal audit.

STATE MANDATES:
N/A

FEDERAL MANDATES:

States are federally required to transition to a CMS approved reimbursement methodology for Medicaid-to-schools by June 30, 2026

SERVICES PROVIDED:
Technical assistance and software to transition LEAs to a CPE methodology will allow for recognition of Medicaid eligible costs and enable claiming of the full allowable federal share for services provided by the LEAs and encourage additional LEAs across the state to participate. A CPE methodology will enable claiming for both direct services and administrative services, thereby increasing total funding to the LEAs.

SERVICE DELIVERY SYSTEM:
State staff and contractors will facilitate engagement with community partners, assist with the development of a School Based Services reimbursement State Plan Amendment, as well as Medicaid Administrative Claiming plans and Random Moment Time Study implementation, and to provide comprehensive technical support to the LEAs as the New Hampshire Medicaid School Based Services program implements a Certified Public Expenditure (CPE) methodology. Transitioning to a CPE methodology will allow for recognition of Medicaid eligible costs and enable claiming of the full allowable federal share for services provided by the LEAs and encourage additional LEAs across the state to participate. A CPE methodology will enable claiming for both direct services and administrative services, thereby increasing total funding to the LEAs.

ADULT DENTAL BENEFITS
AU 4700-4308

PURPOSE:
This accounting unit provides funding for dental services to eligible and enrolled Medicaid members aged 21 and older through a single managed care Dental Organization (DO) as a Pre-paid Ambulatory Health Plan (PAHP).

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

FINANCIAL HISTORY-4308

Rounded to $000 except cost per case	SFY24	SFY25	SFY26	SFY27	SFY27	SFY27
	Actual	Adj Auth	Agency Request	Agency Budget	Governor's Budget	Governor's Budget
TOTAL FUNDS	$11,498	$11,680	$7,209	$7,426	$7,209	$7,426
GENERAL FUNDS	$0	$0	$0	$0	$0	$0

ANNUAL COST PER CASE-TOTAL	$2,946	$3,041	$1,876	$1,932	$1,876	$1,932
CASELOAD PMPM	46,831	46,112	46,114	46,114	46,114	46,114

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

Title/Description	Performance Measures		Current Baseline	FY2026 GOAL	FY2027 GOAL
	Output	Outcome			
Adult Dental Program DMS-1	Continue to develop the adult dental provider network through enrollment of additional providers. Prepare documents supporting funding of the adult dental program, including outcomes related to quality performance indicators; budget and finance reports; utilization reports, and provider, beneficiary, and other stakeholder narratives and statements.	Increase the number of enrolled dental providers. Assure quality and appropriate dental care to the adult population delivered in an efficient and cost-effective manner. Receive legislative appropriation approval to fund the adult dental benefit FY28 and 29.	100%	Increase the dental provider network.	Increase the dental provider network. Receive legislative appropriation approval to fund the adult dental benefit FY28 and 29.
Child Dental program Goal DMS-2	Pursue legislative changes to successfully integrate the children's dental benefit into the managed care dental delivery model with sufficient provider access, beneficiary awareness, and operational continuity.	Transition from the existing fee for service children's dental benefit model into the managed care dental delivery model.	0%	Create supporting legislative documentation to integrate the children's dental benefit into the dental organization contract.	Legislative approval to integrate the children's dental benefit into the dental organization contract.

OUTCOME:

Along with providing health care coverage, NH Medicaid assures Medicaid recipients have access to appropriate quality health care services, and which now includes comprehensive dental services for adults. 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 and dental care system, lower Medicaid spending, and improve health outcomes. DHHS developed a robust quality assurance program to produce information from Medicaid and related data supporting the development and oversight of Medicaid dental care system through Medicaid policy, programs, and 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 required 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 are provided through 1915(c) authority by amending the existing ABD, CFI and DD 1915(c) waivers for the waiver populations, and through 1115(a) 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 CHIP State Plan. CMS-approved State Plans serve as agreements between the State and 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) Request programmatic and reimbursement changes,
(c) Reflect changes in service limitations or scope of service, or
(d) Change eligibility for services.

New Hampshire's State Plans outline optional services and populations New Hampshire has elected to cover through Medicaid, including 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 administers its adult dental services through a managed care delivery system. A single Dental Organization, Northeast Delta Dental, receives a monthly capitation payment rate for each enrolled individual. The Dental Organization contracts with eligible providers and ensure the provision of covered services for beneficiaries consistent with federal and state requirements.

CHILD HEALTH INSURANCE PROGRAM
AU 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. States as of January 1, 2024, are required to provide 12-months of continuous coverage.

FINANCIAL HISTORY-7051						
Rounded to $000 except cost per case	SFY24	SFY25	SFY26	SFY27	SFY27	SFY27
	Actual	Adj Auth	Agency Request	Agency Budget	Governor's Budget	Governor's Budget

TOTAL FUNDS	$126,355	$120,391	$143,247	$146,463	$140,247	$135,463
GENERAL FUNDS	$45,106	$40,171	$48,537	$49,662	$45,537	$38,662
ANNUAL COST PER CASE-TOTAL	$3,291	$3,135	$3,731	$3,814	$3,653	$3,528
CASELOAD PMPM	38,388	38,397	38,397	38,397	38,397	38,397

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

Effective January 1, 2024, children enrolled in Medicaid have 12-months of continuous coverage in accordance with Section 5112 of the Consolidation Appropriations Act of 2023. CHIP enrollment as of September 30, 2024, stood at 18,247 flat enrollment is projected for SFY 26-27. The remaining monthly cases of 20,150 are Qualifying State clients that DMS is allowed to receive an additional 15% federal match over the standard 50%.

Title/Description	Performance Measures		Current Baseline	FY2026 GOAL	FY2027 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.
Child Health Insurance Program DMS-3	Continue implementation and operationalization of the new service delivery systems included in the MCM 3.0 program. Continue to effectively manage the MCM program throughout the remaining contract period.	Increased service utilization of primary care services, including wellness and prevention visits, health risk assessments, and comprehensive medication reviews.	100%	Continue to operationalize MCM Program 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 MCM members.	Continue to operationalize MCM Program 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 MCM members.

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. States as of January 1, 2024, are required to provide 12-months of continuous coverage.

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 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 2017 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 a plan of care for the provision of medically needed services provided in the school.

Medicaid eligible students can receive appropriate medical care throughout the school day either on site at the school, in a provider's office, or via telehealth visits. In order for a service to be billable to Medicaid, the school must obtain an order from qualified treatment provider 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.

To implement a certified public expenditure reimbursement methodology, required by CMS, NH Medicaid anticipates a number of changes within the Medicaid to schools' program coming into effect by June 30,2026. To meet CMS transparency requirements of costs claimed, the NH Division of Medicaid Services, in partnership with the Department of Education, will transition the Medicaid to schools program from an in-kind

reimbursement methodology to a cost-based certified public expenditure reimbursement methodology. A certified public expenditure methodology will allow for both clinical and administrative payment to schools, which should expand the federal funding available to schools for Medicaid covered services to students in schools as determined by local communities. In 2024, DMS pursued, and NH was awarded a CMS grant opportunity for expansion of Medicaid school- based services, which will fund start-up costs to procure a vendor to support the transition to the new methodology. Governor and Council approved DMS authority to accept and expend the Medicaid to schools grant on October 28, 2024. (AU4258 above)

FINANCIAL HISTORY-7207						
Rounded to $000 except cost per case	**SFY24**	**SFY25**	**SFY26**	**SFY27**	**SFY27**	**SFY27**
	Actual	**Adj Auth**	**Agency Request**	**Agency Budget**	**Governor's Budget**	**Governor's Budget**
TOTAL FUNDS	$9,055	$17,000	$17,000	$17,000	$17,000	$17,000
GENERAL FUNDS	$0	$0	$0	$0	$0	$0
ANNUAL COST PER CASE-TOTAL	$1,358	$1,780	$1,780	$1,780	$1,780	$1,780
CASELOAD PMPM	6,668	9,548	9,548	9,548	9,548	9,548

Note: DMS has been awarded a $2.5 million grant, over three years, to support the implementation of a Certified Public Expenditure claiming methodology for schools required by the start of SFY 27; a new accounting was established as part of the Governor's phase.

SOURCE: 100% Federal Medicaid Funds

Title/Description	**Performance Measures**		**Current Baseline**	**FY2026 GOAL**	**FY2027 GOAL**
	Output	**Outcome**			
Medicaid to Schools Goal DMS-7	Implement a direct service and certified public expenditure, administrative claiming, and random moment time studies model that includes approved methodology, State Plan Amendments, and instructional guidance for school districts.	CMS approved model of direct service and certified public expenditure, administrative claiming, and random moment time studies for Medicaid to Schools.	75%	Fully implement certified public expenditure, administrative claiming, and random moment time studies model in Medicaid to Schools payment methodology.	Continue to develop implementation of certified public expenditure, administrative claiming, and random moment time studies 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 in State Fiscal Year (SFY) 2026, and in SFY 2027 will receive the higher of fifty percent of the Medicaid Certified Public Expenditure costs (service and administrative) or 50% of the Medicaid rate. It is expected that in most instances payments will be based on fifty percent of the Medicaid Certified Public Expenditure costs. The delivery of Medicaid covered medical services in the school setting increases access to care for Medicaid-eligible students, reduces barriers to care, 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 included in the student's plan of care. 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.

MEDICAID ADMINISTRATION
AU 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 behavioral health 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 9.8% of this accounting unit's 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 28.5% 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 61.7%

FINANCIAL HISTORY-7937

Rounded to $000 except cost per case	SFY24	SFY25	SFY26	SFY27	SFY27	SFY27
	Actual	Adj Auth	Agency Request	Agency Budget	Governor's Budget	Governor's Budget
TOTAL FUNDS	$70,092	$64,436	$56,022	$56,448	$51,779	$52,430
GENERAL FUNDS	$8,492	$8,704	$9,092	$9,299	$7,222	$7,422
ANNUAL COST PER CASE-TOTAL	N/A	N/A	N/A	N/A	$0	$0
CASELOAD	N/A	N/A	N/A	N/A	N/A	N/A

* The Agency Request includes a prioritized need in SFY26 of $240,000 (100% general funds) and SFY27 of $240,000 (100% general funds) for Project Walk. 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.

FUNDING SOURCE:

83% Federal funds / 17% General funds

STATE PHASE DOWN
AU 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 where 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 the dual eligible population's prescription drug costs. CMS calculates a per-member per-month rate based on actual cost of dual eligible population's prescription costs.

CLIENT PROFILE:
Medicaid clients covered by Medicare are eligible for the Part D subsidy. An individual is eligible for Part D if they are 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 18,126

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 by CMS. The PMPM rates for the second half of SFY25 were published by CMS in September-2024. The CY 2025 PMPM is $273.77 an 8.58% increase from CY 2024 PMPM.

FINANCIAL HISTORY-7939						
Rounded to $000 except cost per case	SFY24	SFY25	SFY26	SFY27	SFY27	SFY27
	Actual	Adj Auth	Agency Request	Agency Budget	Governor's Budget	Governor's Budget
TOTAL FUNDS	$51,949	$58,883	$60,683	$62,318	$60,683	$62,318
GENERAL FUNDS	$51,949	$58,883	$60,683	$62,318	$60,683	$62,318
ANNUAL COST PER CASE-TOTAL	$2,833	$3,156	$3,307	$3,351	$3,307	$3,351
CASELOAD PMPM	18,334	18,655	18,349	18,599	18,349	18,599

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. 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 processes 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 the individual the subsidy based on information received from the State and SSA, and CMS will notify the individual that they are eligible without having to file an application. However, the individual will need to choose a prescription drug plan. CMS enrolls FBDEs who fail to choose a plan, effective the month they attain dual status.

UNCOMPENSATED CARE POOL
AU 4700 - 7943

PURPOSE:
Per RSA 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 in the form of a combination of rate increase, directed payments and Disproportionate Share Hospital (DSH) payment under the Medicaid program effective SFY 2025. Effective State fiscal year 2021, the payment to Critical Access Hospitals was paid as a combination of a directed payments through the MCO contracts and an upper payment limit supplemental payment directly from the Department. Please see state mandates below. The total amount to be paid in SFY 2025 will be 80% of the Medicaid Enhancement Tax (MET) collected in the same Fiscal Year absent any change in RSA 167:64.

Absent any change in RSA 167:64, the SFY26 and SFY27 budget assumes 80% of the MET collected in the same Fiscal Year will be paid to the hospitals through rates, directed payments and DSH and supplemental payments each in the same proportion as SFY25.

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-7943						
Rounded to $000 except cost per case	SFY24	SFY25	SFY26	SFY27	SFY27	SFY27
	Actual	Adj Auth	Agency Request	Agency Budget	Governor's Budget	Governor's Budget
TOTAL FUNDS	$262,071	$244,832	$88,367	$92,166	$88,367	$92,166
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

* The portion of the 80% that is paid to hospitals in rates and directed payments is paid out of AU7948 (provider payments).

SOURCE:
50% Agency income (Hospital payment of Medicaid Enhancement Taxes) / 50% Federal Medicaid funds for DSH and Supplemental Payments, and an enhanced applicable federal match for rates and directed payments based on eligibility.

Title/Description	Performance Measures		Current Baseline	FY2026 GOAL	FY2027 GOAL
	Output	Outcome			
Disproportionate Share Hospital DMS-8	Appropriate payments to the hospitals and timely updates to the State Plan and managed care contracts.	Support the Governor and legislature as needed.	100%	Maintain compliance with current agreement.	Support the next settlement and development of legislative language necessary to implement the changes.

OUTCOME:
Additional payments 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 ended at the end of SFY24, and is now subject to a plan of the Commissioner of DHHS which was reduced to 80% and serves as the basis for the Agency Request for SFY26/27.

STATE MANDATES:
RSA 84-A
RSA 167:64
Hospital Lawsuit Settlement Agreement expired prospectively June 30,2024

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

SERVICES PROVIDED:
N/A

SERVICE DELIVERY SYSTEM:
N/A

MEDICAID MANAGED CARE (Medicaid Medical Payments)
AU 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 unwind of Medicaid Continuous Enrollment (MCE) connected with the Federal Public Health Emergency: The Department completed the unwind of MCE during SFY 2024 by completing redeterminations that were not voluntarily completed. Enrollment declined by slightly more than 69,000individuals. NH was among the earliest states to start and complete their unwind, in large part because the Department continued redetermination of eligibility work where individuals were proactive to complete their redeterminations.

As of October 1, 2023, post-partum coverage was extended to 12-months from 60-days through HB 2 2023. As of January 1, 2024, children have 12-months of continuous coverage, eligibility under a requirement by states federally. Legally residing mothers and children also have 12-months of continuous coverage as a function of legislation adopted under HB 2 2023 under a federal provision. As of January 1, 2025, states are required to provide under Section 5121 of the Social Security Act coverage of limited pre-release and post-release benefits for incarcerated children for adjudicated sentenced 18-21 years old and former foster care up to 26 years of age, Under the states' 1115 waiver the state adopted to provide a limited benefit pre-release for adults incarcerated who have an adjudicated status.

Standard Medicaid enrollment as of September 30, stood at 100,775 under this accounting unit: The DMS budget request reflects flat enrollment over the biennium.

7948 101 MEDICAL PAYMENTS TO PROVIDERS

FINANCIAL HISTORY-7948-MCO						
Rounded to $000 except cost per case	SFY24	SFY25	SFY26	SFY27	SFY27	SFY27
	Actual	Adj Auth	Agency Request	Agency Budget	Governor's Budget	Governor's Budget
TOTAL FUNDS	$665,019	$759,579	$860,543	$881,456	$846,619	$856,108
GENERAL FUNDS	$185,607	$189,475	$110,465	$109,794	$81,874	$72,785
ANNUAL COST PER CASE-TOTAL	$7,792	$8,598	$8,992	$9,211	$8,847	$8,946

CASELOAD PMPM	85,352	88,340	95,701	95,701	95,701	95,701

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 Medicaid eligible children:

7948 535 Out of Home Placements

FINANCIAL HISTORY-7948 DCY Out of Home Placements						
Rounded to $000 except cost per case	**SFY24**	**SFY25**	**SFY26**	**SFY27**	**SFY27**	**SFY27**
	Actual	**Adj Auth**	**Agency Request**	**Agency Budget**	**Governor's Budget**	**Governor's Budget**
TOTAL FUNDS	$57,460	$49,500	$37,500	$38,625	$37,500	$38,625
GENERAL FUNDS	$36,229	$24,750	$18,750	$19,313	$18,750	$19,313
ANNUAL COST PER CASE-TOTAL	$89,502	$81,683	$61,881	$63,738	$61,881	$63,738
CASELOAD PMPM	642	606	606	606	606	606

7948 535 In Home Supports

FINANCIAL HISTORY-7948 DCY In Home Supports						
Rounded to $000 except cost per case	**SFY24**	**SFY25**	**SFY26**	**SFY27**	**SFY27**	**SFY27**
	Actual	**Adj Auth**	**Agency Request**	**Agency Budget**	**Governor's Budget**	**Governor's Budget**
TOTAL FUNDS	$19,410	$23,000	$21,108	$21,741	$21,108	$21,741
GENERAL FUNDS	$9,705	$11,500	$10,554	$10,871	$10,554	$10,871
ANNUAL COST PER CASE-TOTAL	$11,728	$13,241	$12,152	$12,517	$12,152	$12,517
CASELOAD PMPM	1,655	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)

Title/Description	Performance Measures		Current Baseline	FY2026 GOAL	FY2027 GOAL
	Output	Outcome			
Medicaid Care Mgt DMS-3	Continue implementation and operationalization of the new service delivery systems included in the MCM 3.0 program. Continue to effectively manage the MCM program throughout the remaining contract period.	Increased service utilization of primary care services, including wellness and prevention visits, health risk assessments, and comprehensive medication reviews.	100%	Continue to operationalize MCM Program 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 MCM members.	Continue to operationalize MCM Program 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 MCM members.
Medicaid Care Mgt DMS-4	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 amendment request to include HCBS presumptive eligibility; and necessary information to CMS for approval of 1915(j) State Plan Amendment.	CMS approval of the SMI-SUD demonstration waiver amendment to include HCBS presumptive eligibility under the 1115 demonstration, and continued compliance with all applicable CMS requirements.	75%	Continued compliance and successful operation of the waivers and state plan amendments with budget neutrality or cost effectiveness depending on the waiver type.	Continued compliance and successful operation of the waivers and state plan amendments with budget neutrality or cost effectiveness depending on the waiver type.

Medicaid Care Mgt DMS-5	Continue developing community re-entry benefit for (i) justice involved youth in accordance with the Consolidated Appropriations Act; and (ii) incarcerated adults.	Delivery of community re-entry benefit to justice involved youth Medicaid members and incarcerated adults enrolled in Medicaid.	50%	Implement justice involved youth community re-entry at the county level.	Implement of adult community re-entry at the county level.
Medicaid Care Mgt DMS-9	Create implementation plans and resource allocation for all approved, financed programs.	Compliance with all legislative initiatives.	0%	Identify implementation process.	Implement programs pursuant to legislative initiatives.
Medicaid Care Mgt DMS-10	Implement service delivery plans for doulas, lactation consultants, and donor breast milk.	Compliance with all Momnibus legislative initiatives to improve maternal and child health outcomes.	25%	Enroll doulas and lactation consultants as Medicaid enrolled providers.	Continue to build out the provider network for doulas, lactation consultants, and donor breast milk.
Medicaid Care Mgt DMS-11	Support State legislative changes to allow Medicaid flexibility to prefer brand drugs over generics to maximize drug rebates, and subject to legislative further optimize the Medicaid PDL.	Realize net cost savings related to Medicaid pharmacy spend.	75%	Pursue enabling legislation for Medicaid to prefer brand drugs over generics to maximize drug rebates received by the State.	Realize net cost savings related to Medicaid pharmacy spend.

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 2024 Quality report (the most current report) is available at
https://medicaidquality.nh.gov/sites/default/files/Quality%20Strategy%20Effectiveness%20Analysis_July%202024%20F1_0.pdf

STATE MANDATES:
Pursuant to Chapter 258 of the Laws of 2017, the next five-year Medicaid Care Management Program's re-procurement date is September 1, 2029; the most recent re-procurement went into effect 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, 2024, 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(if above this FPL limit a 5-percentage point disregard of the FPL is applied to the applicable family size FPL when an individual is determined ineligible for being over income up to 201% of the FPL.)
- Deemed Newborns – children born to women covered by Medicaid are automatically eligible for Medicaid for one year from the newborn's date of birth

- Infants and Children under Age 19 with income up to 196% FPL. Effective January 1, 2024, all children under the age of 19 are entitled to 12-months continuous eligibility, regardless of changes in circumstances. Exceptions are if the child is no longer a resident, passes away, agency error or the family requests closure.
- 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 1,2025 the Standard of Need for OAA, APTD, ANB is:

Group Size	Independent Living Arrangement	Residential Care Facility	Community Residence
1 2 3	$ 981 $1,451 $1,934	$1,161	$1,043 (subsidized) $1,103 (non-subsidized) $1,161 (enhanced family care)

New Hampshire's State Plan outlines the optional services and optional eligibility groups 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)
- • 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
- 1915(j) Personal Care Services
- Transitional Housing
- Adult Dental Services beginning April 1, 2023
- Psychiatric Residential Treatment Facility (PRTF) services for youth
- 1915(i) Waiver State Plan Fast Forward Home and Community Based Services for High-Risk Children-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
- 1115 Demonstration Waiver Institution for Mental Disease (IMD) for individuals ages 21 to 65, with severe mental illness (SMI) to receive coverage for otherwise covered services furnished to them while they are short-term residents in residential and inpatient treatment settings that qualify as an IMD primarily to receive OUD/SUD/SMI/SED treatment, which are not otherwise matchable expenditures under section 1903 of the Social Security Act. On July 16, 2024, CMS approved NH's request to amend our 1115 Demonstration to provide targeted pre-release services to certain eligible incarcerated individuals. The waiver also includes the denture benefit for Nursing Home and Home and Community Based individuals.
- Four 1915(c) Waivers Home and Community Based Services, In Home Supports, Choices for Independence, Acquired Brain Disorder, and Developmental Disabilities

Optional Eligibility Groups

- Optional Targeted Low-Income Children with income greater than 196% FPL up to 318% FPL and who are not covered by other insurance. (CHIP/M-CHIP population official eligibility group name; if above this FPL limit a 5-percentage point disregard of the FPL is applied to the applicable family size FPL when an individual is determined ineligible for being over income at 318% up to 323% of the FPL.
- Adult Group - Individuals with income up to 138% FPL (Medicaid expansion/Granite Advantage) - Individuals with income up to 138% FPL (this figure includes the 5 percentage points of the FPL for the applicable family size that is subtracted from income only when an individual is determined ineligible for being over income.)

Individuals with MAGI-based income above 133 percent FPL. This eligibility group will be limited to children under age 19 who have income above 196% FPL and equal to 318% FPL and who have other insurance. This eligibility group will allow NH to continue to cover children with income at our M-CHIP levels and comply with federal claiming.

- 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 95 Laws of 2024 (HB1236) and pending CMS approval, the Department will increase the protected income limit by creating an income disregard equal to the Social Security's Cost of Living Adjustment (COLA). The first disregard will be effective January 1, 2025, and then applied July 1 annually thereafter, when there is a COLA.
- 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 2025 is $2,829. This figure adjusts annually by the Cost-of-Living Adjustment (COLA), when there is a COLA. Only the income and resources of the child is used when determining eligibility.
- 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 aged 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]
- [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:

1) New Hampshire Medicaid has two key delivery systems: Medicaid Care Management. New Hampshire administers its short-term medical services inclusive of the Granite Advantage Health Care Program (GAHCP) for roughly 183,000 as of September 30,2024 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. Dental services for Adults 21 years of age and older are provided through a Dental Management Organization, which currently is Delta Dental.

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 medical and dental coverages.

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

MEDICAID MANAGEMENT SYSTEM
AU 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 a database 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-8009						
Rounded to $000 except cost per case	SFY24	SFY25	SFY26	SFY27	SFY27	SFY27
	Actual	Adj Auth	Agency Request	Agency Budget	Governor's Budget	Governor's Budget
TOTAL FUNDS	$40,738	$175	$47,788	$50,288	$47,788	$50,288
GENERAL FUNDS	$10,185	$88	$11,947	$11,966	$11,947	$11,966
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

Table Notes: SFY 24-25 the funding was originally accounted for in HB2. The MMIS system processes over $2.3 billion in claims for the provider community annually and is the vehicle to which federal claiming and quality metrics tied to claims generated. As a percentage of expenditures, the MMIS system runs at 1.8% of claim dollars, and the federal match runs between 75% to 90%.

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.

Title/ Description	Performance Measures		Current Baseline	FY2026 GOAL	FY2027 GOAL
	Output	Outcome			
Medicaid Management Information System DMS-6	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%	Continue upgrades to existing MMIS, assuming necessary procedural and fiscal approvals occur. Extension of the Pharmacy Benefit Management (PBM) system and procure a Systems Integration layer of the future MMIS architecture.	Continuing high availability operation of existing MMIS system and upgrades.

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 - 026 GC Agenda 053123 Conduent.pdf

SERVICES PROVIDED:

The MMIS system investments made over the past two biennium have dealt with outdated infrastructure that were no longer supportable and had security risks. The current biennium has dealt with regulatory requirements related to program integrity and interoperability, and advanced planning for extending systems and will continue development activities during the period of SFY 2026 through SFY 2027. There are further development of MMIS capabilities through approved capital expenditures that position the MMIS system to be modular, which will allow components to be

competitively procured. The “central nervous system” module is system integration. This is the module that allows other vendors to be utilized and allows the system to be leveraged. The modules that are slated to follow include data analytics, pharmacy benefit management and the module for serving the approximate 30,000 Medicaid Providers. In addition, MMIS functionality will be further developed to remain compliant with state and federal requirements; such as regulatory requirements going into effect in this period and including further interoperability standards.