

October 6, 2015

NH Department of Health & Human Services
SUMMARY OF CONTINUITY OF CARE PROVISIONS
MEDICAID CARE MANAGEMENT CONTRACT

EFFECTIVE SEPTEMBER 1, 2015

Emergency supply of prescription drugs provided

14.1.10. In accordance with Section 1927 (d)(5)(A and B) of the Social Security Act, the MCO shall respond by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization and reimburse for the dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug in an emergency situation when prior authorization cannot be obtained.

Medicaid State Plan services continue (up to 60 days)

23.1.13. Medicaid State Plan Services in place at the time a member transitions to an MCO will be honored for sixty (60) calendar days or until completion of a medical necessity review, whichever comes first. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO.

Prior authorizations for State Plan Home Health Services Step 1 services honored (up to 15 days)

23.1.14. When a member receiving State Plan Home Health Services and Step 1 services chooses to change to another MCO, the new MCO shall be responsible for the member's claims as of the effective date of the member's enrollment in the new MCO except as specified in Section 31.2.20. Upon receipt of prior authorization information from DHHS, the new MCO shall honor prior authorizations in place by the former MCO for fifteen (15) calendar days or until the expiration of previously issued prior authorizations, whichever comes first. The new MCO shall review the service authorization in accordance with the urgent determination requirements of Section 23.4.2.1.

EFFECTIVE OCTOBER 1, 2015

Prescriptions continue when changing MCOs (up to 60 days)

14.1.8. At the time a member with currently prescribed medications transitions to an MCO: upon MCO's receipt of (written or verbal) notification validating such prescribed medications from a treating provider, or a request or verification from a pharmacy that has previously dispensed the medication, or via direct data from DHHS, the MCO shall continue to cover such medications through the earlier of sixty (60) days from the member's enrollment date, or until completion of a medical necessity review. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO.

EFFECTIVE JANUARY 1, 2016

Existing care plans continue

15.2.5. For CFI participants enrolled prior to January 1, 2016, the existing care plan will remain in effect until expiration, until the member's needs change, or until a new plan has been developed and is signed by the member.

Care plans continue when changing MCOs (up to 90 days)

15.2.6. For CFI participants who transition to the MCO from another MCO, the existing care plan will remain in effect for up to 90 days following member transition to the new MCO.

Service Link relationships continue

10.11.3.5. If a member is already working with the statewide ServiceLink Resource Center (SLRC) network, the New Hampshire Aging and Disability Resource Center model or NH Community Passport Program (NHCP), the MCO shall partner with the SLRC network or NHCP to support the member's successful integration into the community. In addition, the MCO shall accept formal and informal referrals for transition from the treating physician, nursing facility, DHHS Long Term Care Unit, SLRC, NHCP, other providers, family, the State, and self-referrals; and identification, through the care coordination process, including, but not limited to: assessments, information gathered from nursing facility staff, or an affirmative response on Section Q of the Minimum Data Set.

Services continue during redetermination

15.2.9. The MCO shall coordinate with DHHS or its designee to ensure all clinical and financial redeterminations are conducted as specified by DHHS.

15.2.10. The MCO shall continue to provide the services authorized by the current eligibility determination and service authorization(s) during the time DHHS or its designee conducts a member's clinical and financial eligibility redetermination, a care coordinator develops a plan of care, and the MCO authorizes and initiates covered services in accordance with the member's new plan of care.

LTSS prior authorizations honored

23.1.15. Prior authorizations in place for long term services and supports at the time a member transitions to an MCO will be honored until the earliest of (a) the authorization's expiration date, (b) the member's needs changes, (c) the provider loses its Medicaid status or (d) otherwise approved by DHSS. The MCO shall also, in the member handbook, provide information to members regarding prior authorization in the event the member chooses to transfer to another MCO. In the event that the prior authorization specifies a specific provider, that MCO will continue to utilize that provider regardless of whether the provider is participating in the MCO network until such time as services are available in the MCO's network. The MCO will ensure that the member's needs are met continuously and will continue to cover services under the previously issued prior authorization until the MCO issues new authorizations that address the member's needs.

Penalty for failing to provide appropriate CFI services (vs Nursing Facility)

34.3.1. Liquidated damages up to \$100,000 per violation or failure may be imposed for Category 1 events. Category 1 events are monitored by DHHS to determine compliance and shall include and constitute the following:

34.3.1.3. A determination by DHHS that a member found eligible for CFI services was relocated to a Nursing Facility due to MCO's failure to arrange for adequate in-home services in compliance with this Agreement and He-E801.09.

EFFECTIVE JANUARY 1, 2016 – JANUARY 1, 2017

DHHS approval required for service plan reductions

15.4.2. The MCO shall authorize CFI services as outlined in Sections 10 and 15. The Department must approve any reduction to service plans recommended by the MCO during Year 1 of Step 2 Phase 2.

MCOs will pay participating providers at DHHS/CFI rates

21.2.10.1. For the first year of Step 2 the MCO may offer a contract to all willing providers enrolled to provide CFI services in New Hampshire's Medicaid program and meet the MCO's credentialing standard. In the first year of Step 2, the MCO shall reimburse providers for CFI services at the current CFI fee schedule in place at effective date of the contract with the provider. DHHS shall provide 30 day notice of changes to the CFI fee schedule and the MCO shall reimburse providers at the new rate beginning not later than 30 days following receipt of the notice.