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Changes to the Reimbursement Methodology for the Medicaid Care Management (MCM 3.0) Program

11/15/2024

Providers may notice significant changes to reimbursement due to MCM 3.0 effective 09/01/2024. Please refer to the following guidance outlining these changes.
This guide provides the high-level changes; for more detailed questions please outreach to your Provider Engagement Administrator.

Primary Care and Prevention Focused Model of Care (PCPFCM) Fee Schedule

The PCPFCM fee schedule can be found on MMIS under Documents and Forms.
Link: PCPFCM Effective 9/1/2024

State Directed Payment Changes

Directed payments are payments made by managed care plans to healthcare providers under Medicaid managed care contracts. These payments are regulated by the Centers for Medicare and Medicaid Services (CMS).
Directed payments:

- Are applicable ONLY to Participating providers.
- Ensure a qualifying service's total reimbursement is at the full negotiated or fee schedule rate.

Removal of Lesser of Provision for State Directed Payments

The "lesser of" provision is a clause in contracts between payers and healthcare providers that states the insurance company will pay the lesser of the provider's billed charges or the negotiated rate.
The lesser of provision is removed for services that qualify as directed payments.

State Directed Payments - Qualifying Services

Community Residential Services	**Ambulance, stretcher, and wheelchair van**
Transitional Housing Programs	**DME Providers**
Inpatient: DRF, Critical Access, and PPS Hospital Inpatient Admissions	**Neuropsychology Testing**
NHH/Hampstead Inpatient Admissions	**Certain Primary Care Services (PCPFCM = PCP Focused Care Model)**
NHH/Hampstead Physician Services	**Birthing Centers**
SUD Services including Peer Recovery	**Private Duty Nursing**

Coordination of Benefits for State Directed Payments

The chart below outlines how coordination of benefits will be processed for directed payments. This is not an overpayment; please refer to the chart below for guidance.

All Primary Insurances (Medicare A/B, Medicare Advantage, Commercial, Etc.)

Claim Form	Service Type	Directed Payment COB Methodology
All	All Directed Payment services as indicated in the chart above.	Pay the difference between primary carrier's payment and NHHF allowed regardless of billed charge amount or member responsibility. If the primary pays more than NHHF allowed, no payment is made.

Non-Directed Payments

Medicare Part A & B

There are no changes to coordination of benefits (COB) payment methodology.

Medicare Advantage (Medicare Part C/Replacement)

Claims for members with Medicare Advantage coverage will be processed as commercial for dates of service and dates of discharge 09/01/2024 and after. Please see below for guidance on COB calculations.

Coordination of Benefits (COB) for Non-Directed Payments

Medicare Advantage and Commercial Primary

Claim Form	Service Type	Payment Methodology
CMS-1500	Professional	NHHF is responsible to pay the difference in primary payment and Medicaid allowable. If the primary payment is equal to or greater than our allowed amount, no payment will be made.
UB-04	Institutional (inpatient or outpatient)	NHHF is responsible to pay the difference in primary payment and Medicaid allowable. If the primary payment is equal to or greater than our allowed amount, no payment will be made.

Inpatient Payment Changes

Diagnosis Related Grouping (DRG) Outliers

New Hampshire Medicaid pays for day outliers for children under the age of six for medically necessary days in excess of the *trim point for a given *DRG. Outlier payments will be on a per diem basis at 60% of the calculated per diem amount.

*DRG payment is a method of reimbursing hospitals for patient care based on a patient's diagnosis-related group.

*Trim points are thresholds that identify when a length of stay is considered longer than the average stay.

Please visit the New Hampshire MMIS Health Enterprise Portal for the State Fee schedule for DRG rate updates including the day outliers for children under six.

Live Birth Delivery Add-on Payment

Providers will receive an additional payment of $75.00 per live birth that will be added to their DRG rate.

DRG Base Rate and Weight Changes

Please visit the New Hampshire MMIS Health Enterprise Portal for DRG rate Updates effective 09/01 and 10/01.

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Community Mental Health Center(CMHC) Exclusion List

Capitation is a negotiated per- member per- month (PMPM) rate paid to the CMHCs for patients that qualify for certain levels of care.

Effective 09/01/2024, the services that are included in capitation for CMHCs have changed. Most notably, SUD services are now included in capitation.

Please contact your Provider Engagement Administrator with any questions.

Sincerely,

NH Healthy Families