

ADMINISTRATIVE RULES SUMMARY

TO: Medical Care Advisory Committee
FROM: Medicaid Policy/Bureau of Drug and Alcohol Services
DATE: October 27, 2016
RE: He-W 543 Medicaid Hospital Services

1. Status:

- Rule emailed to MCAC on November 1, 2016.
- **Rule requested to be on consent. MCAC deadline to request a DHHS presentation is November 8.**
- The Request for Fiscal Impact Statement for was submitted to LBA on October 27, 2016.

2. Target Dates:

- **Rule presented to MCAC (if requested):** November 15, 2016
- **JLCAR:** January 20, 2017

3. Rule Summary:

- **Reason for rulemaking (e.g., expiration, statutory change, policy change).**

Most of the rule is due to expire on November 21, 2016.

- **General overview of the rules.**

He-W 543 permits the Department of Health and Human Services to provide inpatient and outpatient hospital services to Medicaid recipients. It also provides describes coverage and billing for services in various scenarios such as patient transfers.

- **Description of the specific changes being proposed to the rule.**

No substantive policy changes are being proposed to the rule.

- **Description of who is affected generally by the rule; and who is impacted by the specific changes (e.g., Medicaid beneficiaries and/or providers).**

Hospitals and recipients of hospital services are affected by the rule.

- **Description of any specific eligibility changes.**

No changes to eligibility.

- **Description of any fiscal impact to recipients, providers, or the State of New Hampshire.**

There is no fiscal impact to the proposal.

4. Issues of Concern: None.

5. Department Contacts:

- Diane Peterson, OMBP Administrator, 271-4367, diane.peterson@dhhs.nh.gov
- Michael Holt, Rules Coordinator, Administrative Rules Unit, 271-9234, michael.holt@dhhs.nh.gov

Please send all comments (including specific language changes) to: diane.peterson@dhhs.nh.gov

CHAPTER He-W 500 MEDICAL ASSISTANCE

PART He-W 543 HOSPITAL SERVICES

Readopt with amendment He-W 543.01, effective 11-21-08 (Doc. #9324), as amended effective 7-1-12 (Doc. #10139), to read as follows:

He-W 543.01 Definitions.

(a) “Acute care” means those services provided to recipients, other than swing bed patients, in a hospital.

(b) “Border hospital” means a hospital which is located in a state bordering New Hampshire and which has not requested, and been granted, enrollment as an out-of-state hospital.

(c) “Budget neutrality factors” means adjustments applied to rate-setting methodology to reduce spending growth.

(d) “Centers for Medicare and Medicaid Services (CMS)” means the division of the federal Department of Health and Human Services that administers medicare, medicaid, the children’s health insurance program, and the health insurance marketplace.

(e) “Day outlier” means those cases for which the actual length of stay exceeds the trim point per diagnosis related group DRG.

(f) “Department” means the New Hampshire department of health and human services.

(g) “Diagnosis related group (DRG)” means the taxonomy of diagnoses as classified in the medicare DRG classification system which groups hospital inpatient cases according to factors such as principal diagnosis, age, and sex, and assigns a relative weight which represents hospital resource use associated with treatment for the diagnosis, pursuant to 42 CFR 412.60.

(h) “Generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or the recommendations of physician specialists practicing in relevant clinical areas or of various physician specialty societies.

(i) “Hospital” means any hospital providing acute care services, to include acute care rehabilitation services, not operating as a psychiatric hospital or an institution for mental diseases and which meets the requirements of 42 CFR 440.10.

(j) “In-state hospital” means a hospital which is located within the physical boundaries of New Hampshire.

(k) “Medicaid” means the Title XIX and Title XXI programs administered by the department which makes medical assistance available to eligible individuals.

(l) “Medically necessary” means:

(1) For individuals under age 21, reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness

or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and no other equally effective course of treatment is available or suitable for the EPSDT recipient requesting a medically necessary service; and

(2) For individuals age 21 and over, health care services that a licensed health care provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice, to a recipient for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms, and that are:

- a. Clinically appropriate in extent, site, and duration, and consistent with the established diagnosis or treatment of the recipient's illness, injury, disease, or its symptoms;~~terms of type, frequency of use,~~
- b. Not primarily for the convenience of the recipient or the recipient's family, caregiver, or health care provider;
- c. No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the recipient's illness, injury, disease, or its symptoms; and
- d. Not experimental, investigative, cosmetic, or duplicative in nature.

~~(m)~~ "Observation services" means services furnished by a hospital on the hospital's premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient.

~~(n)~~ "Out-of-state hospital" means a hospital located in a state not bordering New Hampshire, or a border hospital that has requested, and been granted, enrollment as an out-of-state hospital.

~~(o)~~ "Quality improvement organization (QIO)" means the organization or other agency established in accordance with 42 CFR 475 and contracted by the department, to perform utilization and quality control peer reviews in accordance with 42 CFR 476.

~~(p)~~ "Recipient" means any individual who is eligible for and receiving medical assistance under the medicaid program.

~~(q)~~ "Title XIX" means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

~~(r)~~ "Title XXI" means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the medicaid program.

Readopt He-W 543.02, effective 11-21-08 (Doc. #9324), to read as follows:

He-W 543.02 Recipient Eligibility. All recipients shall be eligible to receive inpatient and outpatient hospital services in accordance with He-W 543, and within the service limits described in He-W 530.

Readopt with amendment He-W 543.03, effective 11-21-08 (Doc. #9324), to read as follows:

He-W 543.03 Provider Participation.

(a) All ~~participating~~ in-state, out-of-state, and border hospital providers shall:

(1) Be licensed by the department in accordance with RSA 151, or ~~by the same-relevant~~ state licensing authority in the state within which the provider operates;

(2) Meet medicare participation requirements; and

(3) Be a New Hampshire enrolled ~~Title XIX~~ medicaid provider in accordance with the following:

a. In-state hospitals shall be enrolled as in-state hospital providers;

b. Out-of-state hospitals shall be enrolled as out-of-state hospital providers; and

c. Border hospitals shall be enrolled as border hospitals except as follows:

1. Enrollment as an out-of-state hospital shall be granted to any border hospital that requests such enrollment, either upon initial enrollment or at a later date; and

2. Border hospitals that are enrolled as out-of-state hospitals shall be subject to all out-of-state hospital requirements.

Readopt with amendment He-W 543.04, effective 11-21-08 (Doc. #9324), as amended effective 11-19-11 (Doc. #10131), to read as follows:

He-W 543.04 Prior Authorization.

(a) Out-of-state hospitals shall obtain prior authorization (PA) from the department before providing inpatient hospital services to recipients, except that authorization for emergency hospital services shall be obtained within 72 hours of admission.

(b) Inpatient hospital services at out-of-state hospitals shall be limited as follows:

(1) For recipients who are absent from the state, one of the following conditions shall be met:

a. Medical services are needed because of a medical emergency;

b. Medical services are needed and the recipient's health would be endangered if he or she were required to travel to his or her state of residence; or

c. Needed medical services, or necessary supplementary resources, are more readily available in the other state; or

(2) For recipients who are in state but request to receive services out of state, one of the following conditions shall be met:

a. Medical services are needed because of a medical emergency;

b. The recipient's attending physician has:

1. Proposed out-of-state hospitalization;
2. Determined that the proposed treatment plan is medically necessary; and
3. Determined that the proposed treatment is not available from resources and facilities within the state;

c. The recipient's attending physician has:

1. Proposed out-of-state hospitalization;
2. Determined that the proposed treatment plan is medically necessary; and
3. Determined that redirection to an in-state facility would jeopardize either the treatment of an episode of care or a long standing medical relationship between the recipient and a specific physician;

d. The recipient is age 18 or younger and the recipient's attending physician has:

1. Proposed out-of-state hospitalization;
2. Determined that the proposed treatment plan is medically necessary; and
3. Determined that referral to a pediatric specialist is appropriate and there is no such pediatric specialist available in New Hampshire;

e. The out-of-state hospital is an enrolled provider and only the ~~M~~medicare deductible and co-insurance are to be billed to NH ~~Title XIX~~medicaid;

f. The out-of-state hospital care is provided prior to a recipient's eligibility determination and coverage is retroactive to the time period in which the hospitalization occurred and the hospital is a medicaid enrolled provider; or

g. It is the general practice for recipients in a particular NH locality to use medical resources in another state and the costs of obtaining care at the out-of-state hospital will result in no higher costs than the costs of obtaining in state hospital care.

(c) Prior authorization requests shall be submitted as follows:

(1) On Form 272H, "Request for Prior Authorization for Out of State Inpatient Admission:" (10/2015 edition);

(2) The form shall be signed and dated by a primary care physician, treating physician, or advanced practice registered nurse requesting the service;

(3) The person in (2) above shall certify that "...the requested treatments and/or procedures are medically necessary and cost effective in obtaining measurable, realistic goals for the above-named recipient"; and

(4) The form shall be submitted with physician's notes and clinical notes supporting the medical necessity for the requested services, including, but not limited to, the medical care plan, relevant diagnostic tests, and progress notes.

(d) The department shall grant prior authorization if the documentation on Form 272H supports the requirements in (b) above.

(e) If the department approves the PA request, the state's fiscal agent shall send written confirmation of the approval to the provider.

(f) The provider shall be responsible for determining that the recipient is ~~Title XIX~~ medicaid eligible on the date of service.

(g) If the department denies the ~~prior authorization-PA~~ request, the department shall forward a notice of denial to the recipient and the ordering provider on the department Form 272a, "Medical Assistance Program Denial for Prior Authorized Services," which includes the following information:

- (1) The reason for, and legal basis of, the denial; and
- (2) Information that a fair hearing on the denial may be requested within 30 calendar days of the date on the notice of the denial, in accordance with He-C 200.

Readopt with amendment He-W 543.05, effective 11-21-08 (Doc. #9324), to read as follows:

He-W 543.05 Covered Services.

(a) Covered services shall include those services described in the various service component rules found in this chapter which may be provided in a hospital setting as either an inpatient or outpatient hospital service.

(b) Inpatient hospital services shall be covered when those services are rendered:

- (1) By or under the direction of a physician or dentist;
- (2) To a recipient who has been admitted to a hospital as an inpatient;
- (3) For a continuous period of 24 hours or longer;
- (4) By a hospital offering room, board, and professional services; and

(5) By a ~~Title XIX-NH~~ medicaid participating hospital which meets the requirements set forth in He-W 543.03.

(c) Outpatient hospital services shall be covered when those services are rendered:

- (1) As preventive, diagnostic, therapeutic, rehabilitative, emergency, or palliative outpatient services;
- (2) Within the service limits set forth in He-W 530;
- (3) By or under the direction of a physician or dentist;

(4) To a recipient who has not been admitted as an inpatient;

(5) For a period of time less than 24 hours; and

(6) By a ~~Title XIX-NH~~ medicaid participating hospital which meets the requirements set forth in He-W 543.03.

(d) Observation ~~bed~~-services, as defined in He-W 543.01(m), shall be covered in accordance with He-W 543.05(c), above.

(e) Inpatient hospital services provided at an out-of-state hospital shall be covered pursuant to the prior authorization requirements of He-W 543.04.

(f) Organ transplant procedures and procurements shall be covered when performed as an inpatient service at an organ transplant facility approved by CMS and in accordance with the requirements and limits at He-W 531.

Readopt He-W 543.06 through 543.08, effective 11-21-08 (Doc. #9324), to read as follows:

He-W 543.06 Non-Covered Services.

(a) Services which are not described in the various service component rules in this chapter shall be non-covered in a hospital setting as either inpatient or outpatient hospital services.

(b) Services provided to recipients by psychiatric hospitals or in institutions for mental diseases shall be non-covered services under He-W 543.

He-W 543.07 Readmission to Hospital. A separate payment shall not be made for readmission to any hospital for the same diagnosis if the readmission occurs within 30 days of discharge, except for those cases where the department and QIO have given medical necessity approval in accordance with He-W 543.11.

He-W 543.08 Transfer of Recipient.

(a) A hospital which transfers or discharges a recipient from a unit in a hospital to the same type of unit in another hospital for continued inpatient hospital services shall be paid 100 percent of the per diem for each day of care, not to exceed the DRG rate, except for rehabilitative and newborn cases, which shall be paid in accordance with He-W 543.13(a).

(b) A hospital which transfers or discharges a recipient to a different type of unit in another hospital, or different type of unit within the same hospital for continued inpatient hospital services, shall be paid according to the DRG payment designated for the type of services provided, plus day outlier payments, if applicable.

(c) The receiving hospital which does not transfer a recipient to another hospital shall be paid the DRG rate, plus day outlier payments, if applicable, when the recipient is discharged.

(d) If a recipient is transferred back, or readmitted to the original admitting hospital unit for continuing treatment, only one DRG payment, plus day outlier payments if applicable, shall be paid for the combined initial admission and subsequent readmission to that hospital unit.

(e) The hospital unit which receives and then transfers a recipient back to the original admitting hospital unit shall also be considered a transferring hospital and shall be paid in accordance with He-W 543.08(a) or He-W 543.08(b), as applicable, above.

Readopt with amendment He-W 543.09 through 543.13, effective 11-21-08 (Doc. #9324), to read as follows:

He-W 543.09 Split Eligibility. When a recipient is eligible for only part of a hospital stay, the ~~Title XIX~~ medicaid payment shall be made at 100 percent of the per diem for each day of care on which the recipient is ~~Title XIX~~ medicaid eligible, not to exceed the DRG rate, except for rehabilitative cases, which shall be paid in accordance with He-W 543.13(a).

He-W 543.10 Medicare Participation. For inpatient services, the 60-day lifetime reserve medicare inpatient hospital benefit for medicare-eligible recipients shall be used before ~~Title XIX~~ medicaid inpatient hospital payments are made.

He-W 543.11 Utilization Review.

(a) Evaluations of the quality, medical necessity, appropriateness of care, and length of stay determinations for all inpatient hospital services at in-state and border hospitals shall be made by the QIO in accordance with 42 CFR 456.100 and those sections of 42 CFR 456 described therein.

~~(b) The department shall monitor utilization of all outpatient and all out of state inpatient hospital services in accordance with 42 CFR 455 and 42 CFR 456. The department's program integrity unit shall monitor utilization of hospital services to identify, prevent, and correct potential occurrences of fraud, waste, and abuse, in accordance with 42 CFR 455, 42 CFR 447, 42 CFR 456, and He-W 520.~~

He-W 543.12 Third Party Liability. All third party obligations shall be exhausted before ~~Title XIX~~ medicaid may be billed, in accordance with 42 CFR 433.139.

He-W 543.13 Payment for Services.

(a) Payment for hospital services shall be made at rates established by the department in accordance with RSA 161:4, VI(a).

(b) Hospital providers shall submit claims for payment to the department's fiscal agent using the form currently designated and approved by CMS for this purpose.

(c) Hospital providers billing for newborns who do not have their own ~~Title XIX~~ medicaid identification number shall complete the claim form as follows:

(1) The newborn's name shall be entered in the patient field;

(2) The ~~Title XIX~~ medicaid identification number field shall be left blank; and

(3) The mother's name and ~~Title XIX~~ medicaid identification number shall be entered in the remarks section.

(d) Payment for inpatient hospital services shall be made for QIO approved acute care days of stay only.

(e) All outpatient hospital services rendered to a ~~NH Title XIX~~ medicaid recipient within 3 calendar days prior to his or her inpatient admission, with a calendar day beginning at 12:00 AM and ending at 11:59 PM, shall be inclusive of the inpatient payment and not be billed separately, with the exception of:

- (1) Prenatal outpatient services; and
- (2) Diagnostic and nondiagnostic outpatient services that are unrelated to the recipient's inpatient hospital admission.

APPENDIX B

Rule	State or federal statute the rule implements
He-W 543.01	42 CFR 412.60; 42 CFR 440.210; 42 CFR 440.220; 42 CFR 440.225; 42 CFR 476.1; 42 CFR 475
He-W 543.02	42 CFR 440.210; 42 CFR 440.220; 42 CFR 440.225
He-W 543.03	42 CFR 431.52; 42 CFR 476 Subpart C; 42 CFR 482.1,2,11,24,30; RSA 151; 42 CFR 440.10; 42 CFR 431.107, 108
He-W 543.04	42 CFR 431.15; 42 CFR 431.52; 42 CFR 440.230
He-W 543.05	42 CFR 440.2; 42 CFR 440.10; 42 CFR 440.20; 42 CFR 440.50; 42 CFR 440.130
He-W 543.06	42 CFR 440.10; 42 CFR 440.140; 42 CFR 440.160
He-W 543.07	42 CFR 456
He-W 543.08	42 CFR 412, Subpart A - F,H
He-W 543.09	42 CFR 440.210; 42 CFR 440.220; 42 CFR 440.225
He-W 543.10	42 CFR 433.139
He-W 543.11	42 CFR 455; 42 CFR 447; 42 CFR 456
He-W 543.12	42 CFR 433, Subpart D
He-W 543.13	42 CFR 431.107; 42 CFR 447.204; 42 CFR 447.250-255