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Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: New Hampshire

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation	
42 CFR 431.202 AT-79-29 AT-80-34	**4.2 Hearings for Applicants and Recipients** The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

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State/Territory: New Hampshire

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29	Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

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Citation
42 CFR 431 Subparts P & Q
50 FR 21839
75 FR 48847
1903(u) of
the Act,
P.L. 99-509
(Section 9407)
P.L. 107-300
P.L. 111-3

4.4 Medicaid Eligibility Quality Control (MEQC)

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

☒ Yes

☐ Not Applicable. The State operates an Approved MEQC Pilot

(b) In accordance with 431.806(c), the State operates a Medicaid quality control claims processing assessment system that meets the requirements of 431.830 – 431.836.

☐ Yes.

☒ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

(c) In accordance with 431.806(b), Payment Error Rate Measurement (PERM) is implemented in accordance with 42 CFR Part 431, Subpart Q, in substitution to meet the statutory and regulatory ("traditional") Medicaid Eligibility Quality Control (MEQC) review during the State's PERM cycle year.

☒ Yes.

☒ Effective for FFY 13
☐ Effective for FFY ____
☐ Effective for FFY ____

☐ Not applicable.

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Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

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OMB No.: 0938-0193

State/Territory: New Hampshire

Citation	
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	4.5 **Medicaid Agency Fraud Detection and Investigation Program** The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

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4.5.1 Medicaid Recovery Audit Contractor Program

Citation	RAC Program
Section 1902(a)(42)(B)(i) of the Social Security Act	____The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan. __X__ The State is seeking an exception to establishing such program for the following reasons: See pages 36a.1 through 36a.6
Section 1902(a)(42)(B)(ii)(I) of the Social Security Act	____The State/Medicaid agency has contracts of the type(s) listed in Section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute. Place a check mark to provide assurance of the following: ____The State will make payments to the RAC(s) only from amounts recovered. ____The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

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4.5.1 Medicaid Recovery Audit Contractor Program

Continuation of page 36 re: "The State is seeking an exception to establishing such program for the following reasons:"

In accordance with 42 CFR 455.506(a), states may exclude managed care claims from review by Medicaid RAC's. Also, in accordance with 42 CFR 455.516, states may request to be excepted from some or all Medicaid RAC contracting requirements. New Hampshire requests an exception from all Medicaid RAC contracting requirements.

New Hampshire previously had a RAC contract with GOOLD Health Services (now Emdeon). At the time of the RAC reviews, there were no managed care organizations (MCO's) as part of NH Medicaid, and the RAC could review 100% of the Medicaid population. During the time that the RAC did complete reviews, the total amount of recoveries averaged $130,000/year. On December 1, 2013, NH implemented its managed care program. As of October 1, 2016, 95.62% (177,273) of the total Medicaid recipients (185,391) were enrolled in managed care, with 137,384 recipients in Medicaid managed care and 39,889 recipients in marketplace managed care plans for which NH Medicaid paid the premium as allowed through its 1115 Premium Assistance Program (PAP) waiver. Based on the average recovery amount/year, this would result in an average RAC yearly recovery amount of only $6,500 for the remaining fee for service Medicaid population (8,118) if the RAC contract were to continue. Because NH is requesting that managed care claims be excluded from review, one can see that this leaves very few claims for review or recovery from the fee for service program.

Justification for MCO Exclusion

1. The NH Medicaid program currently has multiple processes in place to monitor the services provided by the two MCO's. The external quality review organization, Health Services Advisory Group (HSAG), performs this function in NH, and has already conducted three annual audits. The most recent audit for SFY 2015-2016 demonstrated an average of 90.4% compliance with required elements.

2. The Department's Program Integrity (PI) Unit, as part of the Department's contracts with the MCO's, has a strong program integrity oversight of the two MCO plans which includes:

a. Monthly PI/MCO meetings to discuss issues, concerns and potential cases. The attendance for the monthly meetings for the state side includes the PI Liaison, the Director of the Medicaid Fraud Control Unit (MFCU), the attorney for the PI unit, the PI unit Business Analyst, and the Administrator for the PI unit. For the MCO's, it includes the Program Integrity Managers;
b. A well-defined, formalized program integrity process;
c. A referral form developed by the PI unit that the MCO must use when referring a provider to the PI unit for approval for the MCO to review;
d. Pharmacy encounter data has been added to the PI reporting system, EFADS, and implementation of access to the rest of the encounter data occurred in July 2015, which further enabled the PI unit staff to validate the program integrity efforts of the MCO's;
e. If the MCO has not reviewed a state-identified, potentially problematic provider within six months, then the State PI unit has the authority to step in and review the MCO provider;
f. Every MCO provider must also be enrolled in the NH Medicaid Program, for which the PI unit is charged with reviewing all Moderate and High Risk providers, as well as any Limited Risk provider with a history of actions taken against them.

3. Since the Department's MMIS system is relatively new with an implementation date of April 2013, claims processing is closely monitored. Once encounter data is accepted into the MMIS it will be "processed" as if it is a regular claim to identify what the potential payment would have been. This will further allow the PI unit to monitor the MCO activity by "pulling" the encounter data into the EFADS (Fraud and Abuse Detection) system to evaluate the services for appropriateness.

Justification for RAC Exception

1. As noted above, once the managed care populations are eliminated from the RAC reviews, the potential recovery is so small ($6,500), it is apparent that it would not be feasible for contractors to bid on a RAC contract.

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4.5.1 Medicaid Recovery Audit Contractor Program

2. In addition to the standard edits and audits in the MMIS, the Department also utilizes Verisk – a prepay claim auditing system that reviews claims for compliance with specific NCCI edits as well as additional edits that the State has determined appropriate. Verisk generates reports to the PI unit when any provider "hits" an excessive number of edits.

3. The Department also contracts with a pharmacy benefits manager (PBM), Magellan. Our Medicaid Pharmacists work closely with the PBM establishing policies and procedures, as well as overseeing claims. The PBM does both concurrent and retrospective claims review, and makes appropriate referrals to the Program Integrity Unit.

4. For in-state and border hospital in-patient reviews, the Department contracts with a QIO. When the QIO identifies inappropriate claims for services, the PI unit, the fiscal agent, and the provider are notified. The fiscal agent then processes a recoupment and the provider is instructed to submit a corrected claim. The PI unit then begins a monitoring process and undertakes any further recoupments if the provider fails to submit a corrected claim or continues to submit an incorrect claim.

5. The Program Integrity Unit conducts all of the reviews on the non-MCO cases and, as previously mentioned, may also review problematic providers that have not been reviewed with the past six months by the MCO.

6. The types of actions that the PI unit may take as a result of provider reviews include the following:

a. Recoveries of any improper payments;

b. Cost avoids by (a) identifying errors in claims processing by the MMIS and (b) by recommending changes to program areas when providers are performing inappropriate services;

c. The PI unit is very focused on provider education as part of their review. Education may be done by the PI unit in either individual or group settings. Also, the PI unit may refer the case to the Provider Relations Unit of the fiscal agent for additional training in areas such as proper claims submission;

d. As required by federal regulations, any occurrences of potential fraud are referred to the MFCU for further action after suspension of payment due to the credible evidence of fraud;

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4.5.1 Medicaid Recovery Audit Contractor Program

e. Implementation of the EFADS is done with a dedicated Business Analyst in the PIU who develops and runs reports identifying potential areas for review. The Analyst also focuses on identifying any types of "patterns" in claim submissions that would help prevent any future inappropriate payments, or may indicate areas of potential fraud, waste or abuse.

7. The PI unit has a strong working relationship with the MFCU resulting in the frequent coordination of provider case work. Coordination includes:

- An effective, current MOU (Memorandum of Understanding) which allows for a clear, effective working standard between the MFCU and the PI unit.
- Quarterly (and as necessary monthly) meetings to share case updates, new fraud alerts and any cross-training that may be necessary.
- Open communications resulting in an open environment for the sharing of information to more effectively work provider reviews

8. The Program Integrity Unit is periodically reviewed by a number of federal and state agencies to ensure compliance with all program integrity regulations. Some of the outcomes of recent audits include:

a. CMS Program Integrity Oversight (completed every 3 years – last completed in NH in 2012). This review identified both Best Practices as well as vulnerabilities in the Program Integrity Unit which allowed the unit to strengthen its PI activities as a result of implementing a corrective action plan. The most recent review was performed in August 2016. Results are not yet available, but the PI unit will be responsive to the outcomes.

b. Legislative Annual Audit performed by KPMG. The Program Integrity Unit has historically met or exceeded all guidelines that were evaluated by KPMG, with no major audit findings being issued.

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4.5.1 Medicaid Recovery Audit Contractor Program

c. EFADS System which was part of the MMIS certification. The EFADS system is used by the PI unit on an ongoing basis. The PI unit's dedicated Business Analyst continually runs all required EFADS reports to validate functionality, which is also producing potential areas for review by the PI unit. The analyst also continually runs hundreds of different report scenarios in addition to the standard, required reports to (1) ensure functionality and (2) to possibly identify additional areas in which to focus PI review efforts. By using this new, up-to-date fraud detection system, the PI unit is able to quickly identify new areas for review.

d. PERM Audits. The PI unit is fully involved in the PERM audit process. The PI function is to review claims that have been identified by the PERM auditors as potential overpayments or erroneous payments. The PI reviewer thoroughly investigates each claim, and either supports the PERM findings, or presents policy, rules, etc., to refute the PERM. This role in the PERM audit process is another tool for the PI unit to use to potentially expand a provider review based on improper claims submission.

9. There are a number of additional Program Integrity Unit functions that impact and enhance program oversight.

a. Provider Enrollment Screening: With the implementation of enhanced provider screening on enrollment, a new position was created in the PI unit whose single function is to review all providers in the Moderate and High Risk categories. The PI unit advocated to have this position placed in the Program Integrity Unit, since it is well known that a strict oversight of provider enrollment is the first step in the prevention of fraud, waste and abuse in the Medicaid Program.

b. Recipient Explanation of Medical Benefits (REOMB's): All REOMB forms with comments are returned to the PI unit for review. It was felt that the PI unit was the most appropriate unit to evaluate the results of the REOMB's to determine if there were potential occurrences of fraud, waste or abuse occurring.

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State/Territory: New Hampshire

4.5.1 Medicaid Recovery Audit Contractor Program

c. Board Actions. Notifications of any professional board actions taken against any provider type are forwarded to the PI unit for the necessary, appropriate action that should be taken. Board actions could include simple documentation of a reprimand all the way up to a permanent loss of license in the State of NH. This notification listing is another tool that the PI unit uses in order to take appropriate action to ensure the integrity of the Medicaid Program by ensuring that any unlicensed or disciplined provider is not providing services to our clients. The PI unit has also established a process to ensure that this same information is forwarded to the two NH MCO's.

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Revision:

State/Territory: New Hampshire

4.5.1 (cont.) Medicaid Recovery Audit Contractor Program

Citation	RAC Program
Section 1902(a)(42)(B)(ii)(II)(aa) of the Social Security Act	The following payment methodology shall be used to determine State payments to Medicaid RAC's for identification and recovery of overpayments (e.g., the percentage of the contingency fee): ____The State attests that the contingency fee paid to the Medicaid RAC will not exceed the highest rate paid to Medicaid RAC's, as published in the Federal Register. _____The State attests that the contingency fee paid to the Medicaid RAC will exceed the highest rate paid to Medicare RAC's, as published in the Federal Register. The State will only submit FFP up to the amount equivalent to that published rate. _____The contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RAC's, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.
Section 1902(a)(42)(B)(ii)(II)(bb) of the Social Security Act	____The following payment methodology shall be used to determine State payments to Medicaid RAC's for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):

Revision:

State/Territory: New Hampshire

4.5.1 (cont.) Medicaid Recovery Audit Contractor Program

Citation	RAC Program
Section 1902(a)(42)(B)(ii)(III) of the Social Security Act	____The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902(a)(42)(B)(ii)(IV)(aa) of the Social Security Act	____The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902(a)(42)(B)(ii)(IV)(bb) of the Social Security Act	____The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section 1902(a)(42)(B)(ii)(IV)(cc) of the Social Security Act	____Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation
42 CFR 431.16
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation
42 CFR 431.18(b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

Citation
42 CFR 431.51
AT-78-90
46 FR 48524
48 FR 23212
1902 (a) (23)
of the Act
P.L. 100-93
(section 8(f))
P.L. 100-203
(section 4113)

4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual--

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act.

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is Department of Health and Human Services

Division of Public Health Services

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are):

Department of Health and Human Services

Division of Public Health Services

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation		
42 CFR 431.610 AT-78-90 AT-89-34	4.11(d)	The Department of Health and Human Services Division of Public Health (agency) Services which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation
42 CFR 431.105(b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

/ / Yes, as listed below:

/X/ Not applicable. Similar services are not provided to other types of medical facilities.

State/Territory: New Hampshire

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483 1919 of the Act (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483, Subpart D (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

/X/ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

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Revision: HCFA-PM-91-9 (MB) OMB No.:
October 1991

State/Territory: New Hampshire

Citation
1902(a)(58)
1902(w) 4.13 (e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

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statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Health maintenance organizations at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law or court decision exist regarding advance directives.

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State/Territory: New Hampshire .

Citation
42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (Section 9431)

4.14 Utilization/Quality Control

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

_X_ Directly

_____ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO--

(1) Meets the requirements of 434.6(a);

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

_____ Quality review requirements described in Section 1902(a)(30)(C) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the PRO designed under 42 CFR Part 462.

1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (section 9431)

_____ By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

State/Territory: New Hampshire .

Citation			
42 CFR 456.2 50 FR 15312	4.14	(b)	The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

☐ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of waiver of the requirements of Subpart C for:

☐ All hospitals (other than mental hospitals).

☐ Those specified in the waiver.

☒ No waivers have been granted.

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

/_/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/_/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

/_/ All mental hospitals.

/_/ Those specified in the waiver.

/X/ No waivers have been granted.

/_/ Not applicable. Inpatient services in mental hospitals are not provided under this plan.

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Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

/_/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

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/_/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

/_/ All skilled nursing facilities.

/_/ Those specified in the waiver.

/X/ No waivers have been granted.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: New Hampshire

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 /X/ (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

/_/ Facility-based review.

/_/ Direct review by personnel of the medical assistance unit of the State agency.

/_/ Personnel under contract to the medical assistance unit of the State agency.

/_/ Utilization and Quality Control Peer Review Organizations.

/_/ Another method as described in ATTACHMENT 4.14-A.

/X/ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/_/ Not applicable. Intermediate care facility services are not provided under this plan.

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Revision: HCFA-PM- 91-10 (MB)
DECEMBER 1991

State/Territory: New Hampshire

Citation

1902(a)(30) and 1902(d) of the Act, P.L. 99-509 (Section 9431) P.L. 99-203 (section 4113)

4.14 Utilization/Quality Control (Continued)

(f) The Medicaid agency meets the requirements of section 1902(a)(30) of the Act for control of the assurance of quality furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

X A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

___ A private accreditation body.

___ An entity that meets the requirements of the Act, as determined by the Secretary.

The Medicaid agency certifies that the entity in the preceding subcategory under 4.14(f) is not an agency of the State.

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Official

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: New Hampshire

Citation	4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals
42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act	____ The State has contracted with a Peer Review Organization (PRO) to perform inspection of care for: ____ ICFs/MR; ____ Inpatient psychiatric facilities for recipients under age 21; and ____ Mental Hospitals.
42 CFR Part 456 Subpart A and 1902(a)(30) of the Act	X All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services. ____ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan. ____ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan. ____ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

OFFICIAL

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hamsphire

Citation
42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

Citation (s)
42 CFR 433.36 (c)
1902(a) (18) and
1917(a) and (b) of
The Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

X The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917 (a) of the Act and regulations at 42 CFR 433.36 (c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

____ The State imposes liens on real property on account of benefits incorrectly paid.

X The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State Plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

____ The State imposes liens on both real and personal property of an individual after the individual's death.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

X Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) X The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917 (a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

X In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below:

All other Medicaid services paid on behalf of the individual with the exception of QMB/SLMB/QI-related services.

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

(b)

(3) Continued - Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1,2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New Hampshire

(4) ___ The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.

_X_ The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

___ The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

___ The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New Hampshire

(c) Adjustments and Recoveries - Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h) – (i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering medical claims incorrectly paid.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New Hampshire

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedures meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- Estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(4), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement,)
- individual's home,
- equity interest in the home,
- residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: New Hampshire

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

1917(b)(1)(C) (4) X If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

State/Territory: New Hampshire

(Reserved)

State/Territory: New Hampshire

(Reserved)

State/Territory: New Hampshire

(Reserved)

State/Territory: New Hampshire

(Reserved)

Revision: HCFA-PM-91-4 (BPD)
1991

OMB No.: 0938-

OFFICIAL

State/Territory: New Hampshire

Citation			
1916(c) of the Act	4.18(b)(4)	/_/	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5)	/_/	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18(b)(6)	/_/	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

State/Territory: New Hampshire

(Reserved)

State/Territory: New Hampshire

(Reserved)

State/Territory: New Hampshire

(Reserved)

State/Territory: New Hampshire

(Reserved)

Official

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: New Hampshire

Citation	4.19 Payment for Services
42 CFR 447.252 1902(a)(13) and 1923 of the Act	(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.
1902(e)(7)	ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

/_/ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

/X/ Inappropriate level of care days are not covered.

OFFICIAL

State/Territory: New Hampshire

Citation		
42 CFR 447.201 42 CFR 447.302 52 FR 28648 1902(a)(13)(E) 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19(b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements: (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys). (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan. ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
1902(a)(10) and 1902(a)(30) of the Act		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

OFFICIAL

*U.S. G.P.O.:1993-342-239:80149

OFFICIAL

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation
42 CFR 447.40
AT-78-90

4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

[X] Yes. The State's policy is described in ATTACHMENT 4.19-C.

[ ] No.

Official plan

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State/Territory: New Hampshire

Citation	4.19 (d)
42 CFR 447.252 47 FR 47964 48 FR 56046 42 CFR 447.280 47 FR 31518 52 FR 28141	

/X/ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

/X/ At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/ / Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

/X/ At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

/ / At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/ / Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

/ / (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

OFFICIAL

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hamsphire

Citation		
42 CFR 447.45 (c) AT-79-50	4.19 (e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

OFFICIAL

Revision: HCFA-PM-87-4 (BERC)
MARCH 1987

OMB No.: 0938-0193

State/Territory: New Hampshire

Citation		
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

OFFICIAL

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

OFFICIAL

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State New Hampshire

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

OFFICIAL

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation		
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: New Hampshire

OFFICIAL

Citation		
42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

OFFICIAL

Revision: HCFA-AT-81-34 (BPP) 10-81

State New Hampshire

Citation
42 CFR 447.342
46 FR 42669

4.19(k) Payments to Physicians for Clinical Laboratory Services

For services performed by an outside laboratory for a physician who bills for the service, payment does not exceed the amount that would be authorized under Medicare in accordance with 42 CFR 405.515(b), (c) and (d).

/X/ Yes

/_/ Not applicable. The Medicaid agency does not allow payment under the plan to physicians for outside laboratory services.

OFFICIAL

TN # 91-15
Supersedes
TN # 81-19

Approval Date 9/4/91 Effective Date 07/01/91

~~66(a)~~ 66b *

Revision: HCFA-PM-92-7 (MB)
October 1992

Official

State/Territory: New Hampshire

Citation

1903(i)(14) of the Act	4.19(1)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physican to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

* NH State Plan already has a page 66(a). Thus, we will call this page, page 66b.

Revision: HCFA-PM-94-8 (MB)
October 1994

State/Territory: New Hampshire

Citation		
	4.19 (m)	Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program
1928(c)(2)(C)(ii) of the Act	(i)	A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.
	(ii)	The State: ____sets a payment rate at the level of the regional maximum established by the DHHS Secretary. ____is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law. ____sets a payment rate below the level of the regional maximum established by the DHHS Secretary. __X_ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State. The State pays the following rate for the administration of a vaccine: rate = $6.20 for the first vaccine and $3.50 for each additional vaccine administered on the same day
	(iii)	Medicaid beneficiary access to immunization is assured through the following methodology: NH has been a Universal Purchase and Distribution State since 1991 and continues to pay for administration of the vaccine. The Medicaid Office works closely with the Division of Public Health's Vaccine program, and vaccines are distributed through an extensive Medicaid provider network of practitioners that are typically already utilized by Medicaid recipients. Medicaid recipients may call the Medicaid client services unit to find available providers, as well as to access information about language interpreter services as needed.

OFFICIAL

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hamsphire

Citation
42 CFR 447.25(b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services

☐ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.

OFFICIAL

Citation		
42 CFR 447.10(c) AT-78-90 ~~46 FR 42699~~ 46 FR 42669	4.21	Prohibition Against Reassignment of Provider Claims Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

Ohrit

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: New Hampshire

Citation

4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all requirements of:

(1) 42 CFR 433.138 and 433.139.
(2) 42 CFR 433.145 through 433.148.
(3) 42 CFR 433.151 through 433.154.
(4) Sections 1902(a)(25)(H) and (I) of the Act.

1902(a)(25)(H) and (I) of the Act

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A --

(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii) and (2)(ii)

(2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i) and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i) through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

Original

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: New Hampshire

Citation

42 CFR 433.139(b)(3)(ii)(A) ___ (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

(d) ATTACHMENT 4.22-B specifies the following:

42 CFR 433.139(b)(3)(ii)(C) (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).

42 CFR 433.139(f)(2) (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139(f)(3) (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

42 CFR 447.20 (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Official

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: New Hampshire

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

X State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

___ Other appropriate State agency(s)--

___ Other appropriate agency(s) of another State--

___ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

X The Secretary's method as provided in the State Medicaid Manual, Section 3910.

___ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

OFFICIAL

COOPERATIVE AGREEMENT
between
the New Hampshire Office of Child Support Enforcement Services
and
the New Hampshire Office of Medical Services

This agreement is entered into by the undersigned parties for the purpose of enforcing medical support obligations under section 1912 of the Social Security Act.

If it is determined to be in the best interests of the Division of Human Services, the Office of Child Support Enforcement Services shall, as an optional service under 45 CFR 306.10, receive referrals from the Office of Medical Services to secure and enforce the medical support obligation of an absent parent for a child for whom an assignment of medical support rights has been executed under 42 CFR 433.146; and, the Office of Medical Services shall reimburse the Office of Child Support Enforcement Services for administrative costs for any services which are not required by 45 CFR 306.50.

This agreement shall be amended if it is determined that the Office of Child Support Enforcement Services will receive referrals from the Office of Medical Services under 45 CFR 306.10, or for any other reason, with the consent of both parties.

Arthur A. Stukas, Administrator
Office of Child Support
Enforcement Services

12/14/88
Date

Philip P. Soule', Sr., Administrator
Office of Medical Services

12/14/88
Date

OMB No. 0938-0193

Revision: HCFA-AT-84-2 (BERC)
01-84

OFFICIAL

State New Hampshire

Citation
42 CFR Part 434.4
48 FR 54013

4.23 Use of Contracts

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

☐ Not applicable. The State has no such contracts.

Official

Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: New Hampshire

Citation
42 CFR 442.10
and 442.100
AT-78-90
AT-79-18
AT-80-25
AT-80-34
52 FR 32544
P.L. 100-203
(Sec. 4211)
54 FR 5316
56 FR 48826

4.24 Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services

With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.

_____ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

OFFICIAL

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation
42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

Official

Revision: HCFA-PM- (MB)

State/Territory: New Hampshire

Citation

1927(g)
42 CFR 456.700

4.26 Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

-Appropriate
-Medically necessary
-Are not likely to result in adverse medical results

1927(g)(1)(a)
42 CFR 456.705(b) and
456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

-Potential and actual adverse drug reactions
-Therapeutic appropriateness
-Overutilization and underutilization
-Appropriate use of generic products
-Therapeutic duplication
-Drug disease contraindications
-Drug-drug interactions
-Incorrect drug dosage or duration of drug treatment
-Drug-allergy interactions
-Clinical abuse/misuse

1927(g)(1)(B)
42 CFR 456.703
(d)and(f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

-American Hospital Formulary Service Drug Information
-United States Pharmacopeia-Drug Information
-American Medical Association Drug Evaluations

Official

State/Territory: New Hampshire

Citation

1927(g)(1)(D)
42 CFR 456.703(b)

D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

___ Prospective DUR
___ Retrospective DUR.

1927(g)(2)(A)
42 CFR 456.705(b)

E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927(g)(2)(A)(i)
42 CFR 456.705(b), (1)-(7))

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

-Therapeutic duplication
-Drug-disease contraindications
-Drug-drug interactions
-Drug-interactions with non-prescription or over-the-counter drugs
-Incorrect drug dosage or duration of drug treatment
-Drug allergy interactions
-Clinical abuse/misuse

1927(g)(2)(A)(ii)
42 CFR 456.705 (c) and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g)(2)(B)
42 CFR 456.709(a)

F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

-Patterns of fraud and abuse
-Gross overuse
-Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

Official

State/Territory: New Hampshire

Citation

927(g)(2)(C)
42 CFR 456.709(b)

F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

-Therapeutic appropriateness
-Overutilization and underutilization
-Appropriate use of generic products
-Therapeutic duplication
-Drug-disease contraindications
-Drug-drug interactions
-Incorrect drug dosage/duration of drug treatment
-Clinical abuse/misuse

1927(g)(2)(D)
42 CFR 456.711

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

1927(g)(3)(A)
42 CFR 456.716(a)

G.1. The DUR program has established a State DUR Board either:

X Directly, or
___ Under contract with a private organization

1927(g)(3)(B)
42 CFR 456.716
(A) AND (B)

2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs.
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- Medical quality assurance.

927(g)(3)(C)
42 CFR 456.716(d)

3. The activities of the DUR Board include:

- Retrospective DUR,
- Application of Standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

Official

Revision: HCFA-PM- (MB)

OMB No.

State/Territory: New Hampshire

Citation		
1927(g)(3)(C) 42 CFR 456.711 (a)-(d)	G.4	The interventions include in appropriate instances: - Information dissemination - Written, oral, and electronic reminders - Face-to-Face discussions - Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D) 42 CFR 456.712 (A) and (B)	H.	The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1927(j)(2) 42 CFR 456.703(c)	J.	Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

OFFICIAL

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State New Hampshire

Citation
42 CFR 431.115(c)
AT-78-90
AT-79-74

4.27 Disclosure of Survey Information and Provider or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

Revision: HCFA-PM-93-1 (BPD)
January 1993

Official

State/Territory: New Hampshire

Citation	4.28 Appeals Process
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)).	(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154. (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

4-27-93

1-1-93 or as required by federal law

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OFFICIAL

State New Hampshire

Citation		
Sec. 1902(a)(4)(C) of the Act P.L. 95-559, sec. 14 AT-79-42	4.29	Conflict of Interest Provisions The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that are prohibited by Section 207 or 208 of title 18, United States Code.

Not Approved

TN #
Supersedes
TN #

Approval Date

Effective Date

OFFICIAL

State/Territory: New Hampshire

Citation	
42 CFR 1002.203 AT-79-54 48 FR 3742 51 FR 34772	4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

/_/ The agency, under the authority of State law, imposes broader sanctions.

State/Territory: New Hampshire

Citation

(b) The Medicaid agency meets the requirements of--

1902(p) of the Act
P.L. 100-93
(secs. 7)

(1) Section 1902(p) of the Act by excluding from participation--

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

(B) Any HMO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that--

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

OFFICIAL

State/Territory: New Hampshire

Citation	
1902(a)(39) of the Act P.L. 100-93 (sec. 8(f))	(2) Section 1902(a)(39) of the Act by-- (A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and (B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.
	(c) The Medicaid agency meets the requirements of--
1902(a)(41) of the Act P.L. 96-272, (sec. 308(c))	(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and
1902(a)(49) of the Act P.L. 100-93 (sec. 5(a)(4))	(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

OFFICIAL

State/Territory: New Hampshire

Citation		
455.103 44 FR 41644 1902(a)(38) of the Act P.L. 100-93 (sec. 8 (f))	4.31	Disclosure of Information by Providers and Fiscal Agents The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections xx28(b)(9) and 1902(a)(38) of the Act.
435.940 through 435.960 52 FR 5967 54 FR 8738	4.32	Income and Eligibility Verification System (a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (Section 1137 of the Act and 42 CFR 435.940 through 435.960). (b) ATTACHMENT 4.32-A describes in accordance with 42 CFR 435.048(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested. (c) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information system (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

OFFICIAL

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: New Hampshire

Citation
1902(a)(48)
of the Act,
P.L. 99-570
(Section 11005)
P.L 100-93
(sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1987— 201-818/60437

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: New Hampshire

Citation
1137 of
the Act

P.L. 99-603
(sec. 121)

4.34 Systematic Alien Verification for Entitlements

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

/_/ The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

/_/ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

/_/ Total waiver

/_/ Alternative system

/_/ Partial implementation

Revision: HCFA-PM-90-2 (BPD)
JANUARY 1990

OMB No.: 0938-0193

State/Territory: New Hampshire

Citation

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation

1919(h)(1) and (2) of the Act, P.L. 100-203 (Sec. 4213(a))

(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.

/ / Not applicable to intermediate care facilities; these services are not furnished under this plan.

/X/ (b) The agency uses the following remedy(ies):

(1) Denial of payment for new admissions.

(2) Civil money penalty.

(3) Appointment of temporary management.

(4) In emergency cases, closure of the facility and/or transfer of residents.

1919(h)(2)(B)(ii) of the Act

/ / (c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.

1919(h)(2)(F) of the Act

/ / (d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:

/ / (1) Public recognition.

/ / (2) Incentive payments.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

OFFICIAL

State/Territory: New Hampshire

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR §488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR §488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

___ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: New Hampshire

OFFICIAL

Citation

c) Application of Remedies

42 CFR §488.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR §488.417(b) §1919(h)(2)(C) of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR §488.414 §1919(h)(2)(D) of the Act.

(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR §488.408 1919(h)(2)(A) of the Act.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Available Remedies

42 CFR §488.406(b) §1919(h)(2)(A) of the Act.

(i) The State has established the remedies defined in 42 CFR 488.406(b).

X (1) Termination
X (2) Temporary Management
X (3) Denial of Payment for New Admissions
X (4) Civil Money Penalties
X (5) Transfer of Residents; Transfer of Residents with Closure of Facility
X (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

OFFICIAL

State/Territory: New Hampshire

Citation

42 CFR
§488.406(b)
§1919(h)(2)(B)(ii)
of the Act.

(ii) ___ The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

___ (1) Temporary Management
___ (2) Denial of Payment for New Admissions
___ (3) Civil Money Penalties
___ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
___ (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR
§488.303(b)
1910(h)(2)(F)
of the Act.

(e) ___ State Incentive Programs

___ (1) Public Recognition
___ (2) Incentive Payments

OFFICIAL

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

OFFICIAL

State/Territory: New Hampshire

Citation
1137 of
the Act

P.L. 99-603
(sec. 121)

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/_/ The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

/_/ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

/_/ Total waiver

/_/ Alternative system

/_/ Partial implementation

Revision: HCFA PM-90-2 (BPD)
JANUARY 1990

OMB No.: 0938-0193

State/Territory: New Hampshire

Citation

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation

1919(h)(1) and (2) of the Act, P.L. 100-203 (Sec. 4213(a))

(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.

/ / Not applicable to intermediate care facilities; these services are not furnished under this plan.

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/X/ (b) The agency uses the following remedy(ies):

(1) Denial of payment for new admissions.

(2) Civil money penalty.

(3) Appointment of temporary management.

(4) In emergency cases, closure of the facility and/or transfer of residents.

1919(h)(2)(B)(ii) of the Act

/ / (c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.

1919(h)(2)(F) of the Act

/ / (d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:

/ / (1) Public recognition.

/ / (2) Incentive payments.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

Citation	4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States
1902(a)(80) of the Act, P.L. 111-148 (Section 6505)	X The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: New Hampshire

Citation	4.36 Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C) and 1902(a)(53) of the Act	The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

OFFICIAL

Revision: HCFA-PM-91- 10 (BPD)
DECEMBER 1991

State/Territory: New Hampshire

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	4.38	Nurse Aide Training and Competency Evaluation for Nursing Facilities

(a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.

X (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).

X (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.

(d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.

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___ (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.

___ (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

State/Territory: New Hampshire

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.

(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.

(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.

(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.

(k) For program reviews other than the initial review, the State visits the entity providing the program.

(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

OFFICIAL

State/Territory: New Hampshire

Citation	
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
	(n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
	(o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
	(p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
X	(q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
	(r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

OFFICIAL

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State/Territory: New Hampshire

Citation	
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.
	(t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
	(u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
	(v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
	(w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
X	(x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
	(y) The State has a standard for successful completion of competency evaluation programs.

OFFICIAL

State/Territory: New Hampshire

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	X	(aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	___	(cc) The State includes home health aides on the registry.
	___	(dd) The State contracts the operation of the registry to a non State entity.
	X	(ee) ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	___	(ff) ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

OFFICIAL

Official

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: New Hampshire

Citation		
Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)); P.L. 101-508 (Sec. 4801(b)).	4.39	**Preadmission Screening and Annual Resident Review in Nursing Facilities**

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.

___ (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

Revision: HCFA-PM-93-1 (BPD)
January 1993

Official

State/Territory: New Hampshire

4.39 (Continued)

____ (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

Official

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992

OMB No.:

State/Territory: New Hampshire

Citation	4.40 Survey & Certification Process	
Sections 1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act P.L. 100-203 (Sec. 4212(a))	(a)	The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
1919(g)(1)(B) of the Act	(b)	The State conducts periodic education programs for staff and residents (and their representatives). **Attachment 4.40-A** describes the survey and certification educational program.
1919(g)(1)(C) of the Act	(c)	The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. **Attachment 4.40-B** describes the State's process.
1919(g)(1)(C) of the Act	(d)	The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? _____
1919(g)(1)(C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1)(C) of the Act	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

Official

Revision: HCFA-PM-92-3 APRIL 1992 (HSQB) OMB No:

State/Territory: New Hampshire

1919(g)(2)(A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. **Attachment 4.40-C** describes the State's procedures.
1919(g)(2)(A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2)(A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2)(A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2)(B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2)(C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

Official

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APRIL 1992

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1919(g)(2)(D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. **Attachment 4.40-D** describes the State's programs.
1919(g)(2)(E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2)(E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2)(E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. **Attachment 4.40-E** describes the State's complaint procedures.
1919(g)(5)(A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5)(B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5)(C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5)(D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

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State/Territory: New Hampshire

Citation	4.41 Resident Assessment for Nursing Facilities
Sections 1919(b)(3) and 1919 (e)(5) of the Act	(a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.
1919(e)(5) (A) of the Act	(b) The State is using:
	X the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or
1919(e)(5) (B) of the Act	____ a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

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Citation
1902(a) (68) of
the Act,
P.L. 109-171
(section 6032)

4.42 Employee Education About False Claims Recoveries

(a) The Medicaid Agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by Section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of Section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g. a state mental

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health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of Section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

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(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in Section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

Citation 1902(a)(69) of the Act, P.L. 109-171 (section 6034)	4.43	Cooperation with Medicaid Integrity Program Efforts The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under Section 1936 of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

Citation	4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States
1902(a)(80) of the Act, P.L. 111-148 (Section 6505)	X The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire .

4.46 Provider Screening and Enrollment

The State Medicaid agency gives the following assurances*:

Citation
1902(a)(77)
1902(a)(39)
1902(kk);
P.L. 111-148 and
P.L. 111-152

42 CFR 455
Subpart E

PROVIDER SCREENING
X Assures that the State Medicaid agency complies with the process for screening providers under Section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.

HP
The current system is capable of some limited screening. After much discussion in various workgroups as to how the new requirements could be met, it has been determined that there are significant challenges to implementing the requirements in the current system. These challenges are related to (a) lack of fiscal agent resources/staff, and (b) contract obligations, i.e., the fiscal agent contract would have to be amended.

Xerox
Re-enrollment has begun under the new fiscal agent in accordance with the process flow that was part of the new system design. Some provider notification of the new requirements has been accomplished, and additional, detailed notification documents have been prepared. However, in order to fully implement these new regulatory requirements, it has been determined that the originally designed work flow process for the new MMIS must first be refined and that then the additional provider notification must be completed.

42 CFR 455.410

ENROLLMENT AND SCREENING OF PROVIDERS
X Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.

X Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider.

*Note: NH is transitioning its MMIS from one fiscal agent (HP) to a new fiscal agent (Xerox, formerly known as ACS), which results in some unique challenges to implementation of the new requirements.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

4.46 **Provider Screening and Enrollment (cont.)**
The State Medicaid agency gives the following assurances:

Citation
1902(a)(77)
1902(a)(39)
1902(kk);
P.L. 111-148 and
P.L. 111-152

42 CFR 455.410

ENROLLMENT AND SCREENING OF PROVIDERS (cont.)

HP
This function requires a change to the provider enrollment application and agreement. This is not administratively or fiscally feasible as the state is nearly ready to move to a new fiscal agent and provider enrollment approach.

Xerox
Screening is built into the Xerox work flow design, but additional provider notification is necessary before this can be activated. The enrollment of ordering or referring physicians and other professionals will require a modification to the provider enrollment application and the on-line enrollment system. These modifications are not administratively feasible at the current time, but the state plans to carry out this requirement at a future date.

42 CFR 455.412

VERIFICATION OF PROVIDER LICENSES
_X_ Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers' licenses have not expired or have no current limitations.

HP
HP verifies that providers are licensed as required, but no crosscheck of licensure data bases is done. The challenge to implementing this in the current system is (a) lack of fiscal agent resources/staff, and (b) contract obligations, i.e., the fiscal agent contract would have to be amended.

Xerox
This criteria is built into the new MMIS.

42 CFR 455.414

REVALIDATION OF ENROLLMENT
_X_ Assures that providers will be revalidated regardless of provider type at least every 5 years.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

4.46 Provider Screening and Enrollment (cont.)
The State Medicaid agency gives the following assurances:

Citation
1902(a)(77)
1902(a)(39)
1902(kk);
P.L. 111-148 and
P.L. 111-152

42 CFR 455.416

TERMINATION OR DENIAL OF ENROLLMENT
X Assures that the State Medicaid agency will comply with Section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

42 CFR 455.420

REACTIVATION OF PROVIDER ENROLLMENT
X Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

HP
This requirement is done to some extent. Complete compliance with the new regulations would be a challenge due to (a) lack of fiscal agent resources/staff, and (b) contract obligations, i.e., the fiscal agent contract would have to be amended.

Xerox
This is built into the new MMIS.

42 CFR 455.422

APPEAL RIGHTS
X Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432

SITE VISITS
X Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

HP
The Department has designed its site visit program and stands at the ready. However, the current MMIS system is not designed to flag providers by risk category. This is currently an implementation challenge because of (a) lack of fiscal agent resources/staff, and (b) contract obligations, i.e., the fiscal agent contract would have to be amended.

Xerox
The Department stands ready to implement site visits as soon as reenrollments are completed under Xerox and providers are referred.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

4.46 Provider Screening and Enrollment (cont.)
The State Medicaid agency gives the following assurances:

Citation
1902(a)(77)
1902(a)(39)
1902(kk);
P.L. 111-148 and
P.L. 111-152

42 CFR 455.434

CRIMINAL BACKGROUND CHECKS
__X__Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

It is the Department's understanding that this is on hold at the federal level. We are working on this requirement and could implement under HP and Xerox on a limited basis, but would need more time to fully implement.

42 CFR 455.436

FEDERAL DATABASE CHECKS
__X__Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

HP
The current system is unable to do this. This would be an implementation challenge due to (a) lack of fiscal agent resources/staff, and (b) contract obligations, i.e., the fiscal agent contract would have to be amended.

Xerox
The new system has the capability to electronically do the database checks. We are reviewing work flow processes to determine if it is included in the actual work flow process. Regardless, the Department is confident that it can be implemented when the new MMIS comes on-line.

42 CFR 455.440

NATIONAL PROVIDER IDENTIFIER
__X__Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

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State/Territory: New Hampshire

4.46 Provider Screening and Enrollment (cont.)
The State Medicaid agency gives the following assurances:

Citation
1902(a)(77)
1902(a)(39)
1902(kk);
P.L. 111-148 and
P.L. 111-152

42 CFR 455.450

SCREENING LEVELS FOR MEDICAID PROVIDERS
_X_ Assures that the State Medicaid ageancy complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

HP
The Department has prepared internal processes and documents necessary to meet the departmental work flow aspect of this requirement. HP is unable to implement the front end identification process due to (a) lack of fiscal agent resources/staff, and (b) contract obligations, i.e., the fiscal agent contract would have to be amended.

Xerox
This is part of the process flow and the system design for the new MMIS. The new system is being evaluated and refined as its phase-in occurs, and the Department is prepared to implement this requirement once MMIS implementation is fully accomplished.

42 CFR 455.460

APPLICATION FEE
_X_ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in Section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

HP
Meetings have been ongoing regarding this requirement. This is an implementation challenge under the current system due to (a) lack of fiscal agent resources/staff, and (b) contract obligations, i.e., the fiscal agent contract would have to be amended.

Xerox
This requirement is ready to be implemented once adequate provider notice is accomplished.

42 CFR 455.470

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS
_X_ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under Section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.