

STATE

NEW HAMPSHIRE

Attachment 4.11-A
Page 1STANDARD SETTING AUTHORITY FOR DISTRIBUTIONS

(a) Chapter 151, New Hampshire Revised Statutes Annotated, empowers the Division of Public Health, Department of Health and Welfare to develop, establish, and enforce basic standards for the care and treatment of persons in hospitals and other institutions in which medical, nursing or other remedial care are rendered and for the construction, maintenance and operation of such institutions to insure the safe and adequate treatment of persons in such institutions.

All institutions in which medical care and services may be provided under the New Hampshire Title XIX plan are subject to the licensure and standard-setting authority of N.H.R.S.A. 151. The Department of Health and Welfare, Division of Public Health is clearly a state authority as distinguished from a local authority.

(b) The Division of Public Health issues "Rules, Regulations and Standards for the Operation of Hospitals" and "Rules, Regulations, and Standards for the Operation of Nursing and Rest Homes." The Division of Welfare, and the Division of Public Health, maintain current copies of these regulations as amended and updated on file to be made available to the SRS on request.

These standards and regulations cover all aspects of organization, administration, medical and nursing services, and buildings and equipment which must be met to insure licensure and continuation of licensure. These standards conform to all standards for skilled nursing homes and for intermediate care facilities required by CFR 45, 205.190 and P.L. 92-603, Section 239(a). The Division of Public Health is the state agency authorized to survey and recommend certification for all Title XVIII facilities as well as Title Xix facilities.

OFFICIAL

Title XIX-NH
PCO 11 81-17-a

STATE New Hampshire

Attachment 4.14-B

Utilization review under 42 CFR Subpart F is provided through the Office of Medical Services, and under an interagency agreement, with the Bureau of Health Facilities Administration, Division of Public Health.

The Bureau of Health Facilities Administration provides all utilization review requirements under 42 CFR 456.350 through 456.381 and the Office of Medical Services provides all utilization review requirements under 42 CFR 456.400 through 456.438.

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

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603-271-4334

Harry H. Bird, M.D.
Commissioner

AGREEMENT BETWEEN THE COMMISSIONER OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

and

THE DIVISION OF HUMAN SERVICES,
THE DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES and
THE DIVISION OF PUBLIC HEALTH SERVICES

for

UTILIZATION CONTROL OF LONG TERM CARE FACILITIES

An agreement between the Commissioner of the Department of Health and Human Services, the Division of Public Health Services (DPHS), and the Division of Human Services (DHS), and the Division of Mental Health and Developmental Services (DMHDS).

I. PURPOSE

- a. In that the Commissioner of the Department of Health and Human Services is responsible for the Medicaid Program, specifically, the demonstration that the State has a satisfactory and effective program of control over the utilization of inpatient institutional services, the objective of this agreement is to define the administrative management guidelines for the various components relative to the Validation Survey and the submission of the HCFA-41, Quarterly Showing.
- b. This agreement delineates the responsibilities of the Division of Human Services, the Division of Mental Health and Developmental Services, the Division of Public Health Services, and the Office of the Commissioner.

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II. RESPONSIBILITIES

a. DIVISION OF HUMAN SERVICES (DHS)

1. DPHS/BHFA will call the Long Term Care Supervisor or designated staff person at DHS/OMS one week prior to the on-site review of the swing bed hospital or DHS nursing facility for the mentally retarded and request an alphabetical listing of the residents to be reviewed.
2. DHS will review the alphabetical listing for the facility requested, update if appropriate, and complete an interdepartmental memo assuring that the residents listed are to be reviewed by DPHS. The memo will be signed by the Long Term Care Supervisor or designated staff person assuring the completeness of the list. This memo will be delivered to DPHS/BHFA, either on the day requested or within one working day.
3. On the first day of the on-site review at the facility, the Inspection of Care team will compare the list in the memo and the current Medicaid census, which has been provided by the facility.
4. If there are any discrepancies in these two lists, DPHS/BHFA contact the Long Term Care Supervisor or designated staff person by telephone. DHS/OMS will reconcile the lists with current referrals, recent Prior Authorizations and verify valid recipients. DHS/OMS will provide DPHS with the corrected list within the timeframes requested.
5. One or two days prior to the scheduled exit interview, DHS/OMS will provide DPHS/BHFA with a list of any additional recipients who have entered the system since the start of the review.
6. At least 5 working days after the end of the quarter, DPHS/BHFA shall send a list of names of those recipients reviewed for Inspection of Care during the quarter. DHS/OMS will verify that each Medicaid recipient who should have been reviewed was seen, or that a medical record review was done. DHS/OMS will be responsible for conducting reviews on any missed cases.
7. DHS/OMS will reimburse DPHA/BHFA for Inspection of Care reviews in accordance with the appropriate and approved budget.

b. DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES (DMHDS)

1. Promulgates policy that is in compliance with Federal regulations (42 CFR Part 456) regarding utilization control and on-site Inspections of Care for all recipients of Medicaid institutional services rendered in ICF/MR-CPs (Community Programs).
2. Performs evaluation and admission review in conformance with 42 CFR 456.372 on all Medicaid applications/recipients referred for placement in any facility as listed in 11.b.1. and renders level of care determinations. This review and evaluation shall be conducted prior to the authorization of Medicaid payments.

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3. Performs a Medicaid continued stay review for each recipient in a ICF/MR-CP at least every six months using the annual inspection of care report and utilization review report alternately.
4. Assigns a length of stay as appropriate.
5. Issues denial notices information concerning the appeals process as appropriate.
6. Appears at fair hearings requested pursuant to the policy, rules and regulations concerning level of care denials rendered by DMHDS.
7. Upon request of DPHS, provides the names of all Medicaid recipients at a specified facility, to be reviewed as part of the Inspection of Care, as defined in Appendix A attached.
8. Requests DPHS to provide information upon request to the appropriate agency as to the observations made during the Inspection of Care review.
9. In accordance with 42 CFR 456.602(g), the Medical Director of DMHDS will be available as needed to consult with DPHS.
10. Prepares the Quarterly Showing (HCFA-41) pages relevant to ICF/MR-CPS.
11. Attends the Validation Survey entrance and exit conferences with HCFA representatives and provides the Validation Survey Team with any additional information requested, as appropriate.

c. DIVISION OF PUBLIC HEALTH SERVICES (DPHS)

1. DPHS will call the designated staff person at DMHDS or DHS approximately one week before the specific IOC is due and request that they provide a list of the individuals that are to be reviewed during the onsite review.
2. DPHS will perform an on-site Inspection of Care (IOC) review of each Medicaid recipient in ICF/MR's and Swing-Bed facilities annually, in accordance with federal regulations (42 CFR Part 456 and the State Medicaid Manual Part 9).
3. The Inspection of Care team shall:
 - A. Conduct an entrance conference with the Administrator of the facility or his/her designee;
 - B. Have personal contact with and observation of each Medicaid recipient in the facility;
 - C. Review each recipient's record;
 - D. Conduct an exit conference with the appropriate facility administrative personnel;

12/1/93

Official

- E. Issue a written report in accordance with 42 CFR 456.611 to Division of Human Services (DHS) or Division of Mental Health and Developmental Services (DMHDS) for each facility reviewed.
4. DPHS will follow the procedures agreed upon to ensure that each Medicaid recipient identified as residing in the facility to be surveyed is reviewed.
5. DPHS will provide the appropriate agency with a list of all members of the Inspection of Care team and the qualifications of the team members.
6. DPHS will provide information upon request to the appropriate agency as to the observations made during the Inspection of Care review.
7. DPHS will notify the appropriate agency if there are any changes in exit dates for Inspection of Care review.
8. DPHS will submit an annual Inspection of Care budget request to the Office of the Commissioner at the same time as the DPHS Medicare/Medicaid Budget is submitted.
9. DPHS will bill the appropriate agency for Inspection of Care reviews upon completion of the reviews in accordance with the agreed procedures and within the budget approved by the Office of the Commissioner.

d. OFFICE OF THE COMMISSIONER

1. Reviews proposed policy, rules and Title XIX State Plan Amendments for appropriateness and compliance with applicable Federal regulations.
2. Reviews correspondence to HCFA and makes recommendations relative to the Department's position on issues relative to utilization control.
3. Submits the HCFA-41, Quarterly Showing.
4. Represents the Department at Validation Survey entrance and exit conferences and provides the Validation Survey team with additional information requested, as appropriate.
5. Reviews and recommends to the Commissioner the annual Inspection of Care budget request.
6. Recommends to the Commissioner the Department's course of action in the event that the Department is sanctioned by HCFA.

The agreement shall remain in effect until terminated by mutual consent of the parties.

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AGREEMENT BETWEEN THE COMMISSIONER OF THE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

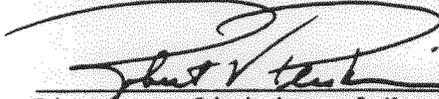
and

THE DIVISION OF HUMAN SERVICES
THE DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES
THE DIVISION OF PUBLIC HEALTH SERVICES

for

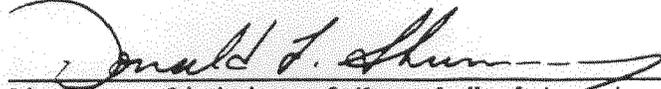
UTILIZATION CONTROL ON LONG TERM CARE FACILITIES

5/20/91
Date



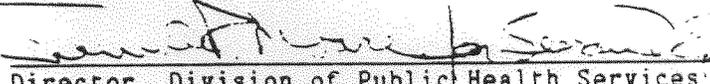
Director, Division of Human Services

6/14/91
Date



Director, Division of Mental Health and
Developmental Services

8/10
Date



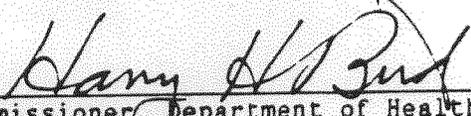
Director, Division of Public Health Services

7/10/91
Date



Medicaid Program Coordinator, Department
of Health and Human Services

7/11/91
Date

Approved by: 

Commissioner, Department of Health and
Human Services

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Appendix A

1. DPHS will contact the designated staff person at DMHDS, at least one week prior to the scheduled on-site visit of each ICF/MR-CP and request a list of Medicaid recipients to be reviewed at the facility.
2. On the first day of the on-site, the DPHS Inspection of Care Team will advise DMHDS of any discrepancies between the facility's Medicaid census and the list provided by DMHDS and establish the appropriate list of residents to be reviewed.
3. DMHDS will advise DPHS of any additional Medicaid recipients regarding review, that enter the facility during the on-site visit.
4. DPHS will send a list of names of those recipients reviewed for Inspection of Care during the last month of each quarter to DMHDS within five working days after the end of the quarter.
5. DMHDS will verify that all appropriate recipients were reviewed by DPHS and will conduct reviews for any that were missed by the DPHS team.
6. DMHDS will reimburse DPHS/BHFA for Inspection of Care reviews in accordance with budget agreements reviewed and approved by the Commissioner's Office.

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JOINT PLANNING, COORDINATION AND IMPROVEMENT OF HEALTH PROGRAMS
COORDINATION AGREEMENT

UNDER TITLE V, TITLE X, TITLE XIX AND WIC/CSFP

I. HISTORY

When Title XIX was enacted in 1965, it included a requirement for the development of cooperative arrangements between the state health agency administering Title V Maternal and Child Health programs and the Medicaid agency. In 1970, the enactment of Title X included a requirement for the development of a written agreement between the Family Planning Program and Title XIX. Subsequent amendments to the Social Security Act made the relationship between these two agencies more explicit requiring provisions for Medicaid reimbursement of Title V services, coordination of services, and interagency collaboration. The Omnibus Reconciliation Act of 1989 (P.L. 101-239) expanded and further defined this relationship. The 1990 Title V Maternal and Child Health Services Block Grant emphasized the need to identify children with disabilities and provide them with benefits and coordinated services through existing agencies and funding streams.

The WIC Program's statutory mandate, Public Law 101-11147, the Child Nutrition Act of 1989, requires adjunct income eligibility and coordination of services for WIC applicants who are recipients of Food Stamps, AFDC or Medicaid. In addition, WIC regulations, 264.4(a)(B) and pending CSFP regulations, require the coordination of program operations.

Accordingly, this cooperative agreement has been developed for the following purpose:

II. PURPOSE

The purpose of this agreement shall be to:

- A. Promote the joint planning, development, coordination, monitoring and evaluation of a comprehensive N.H. health care system for women, children and families administered under Title V, Title X, Title XIX, and WIC/CSFP.
- B. Identify and reduce duplication of services, implement innovative solutions to health care issues, share data, resources and provide clear statements of responsibilities and mutual objectives.
- C. Develop and implement strategies to assure compliance with federal and state statutes and the efficient and effective use of federal and state resources.
- D. Simplify the Title V application and referral process and improve child and family access to and utilization of health services.
- E. Develop and implement procedures for making interagency decisions and for planning, developing and coordinating policies.
- F. Promote the collaboration, development and implementation of health standards.

III. OBJECTIVES

- A. Improve the planning, coordination and accountability of health care services for N.H. women, children and children with special

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health care needs by providing accurate and timely information regarding changes in programs, policies and procedures.

- B. Improve Title V, Title X, Title XIX and WIC/CSFP health services programs by simplifying the application and referral process and by eliminating barriers to health services. Assure that all Medicaid-eligible children and women have access to the full range of assessment, diagnostic and treatment services, including those funded by Title V, Title XIX, WIC/CSFP and Title X.
- C. Improve data collection and utilization of management information systems by coordinating data collection and reporting activities required under the Social Security Act, or as necessary for program management and operation.
- D. Improve program planning, coordination and operations by establishing formal interagency linkages, defining mutual responsibilities, collaborating in data gathering analysis, reporting and planning on projects of mutual benefit.
- E. Improve the delivery of health services by participating in joint training, technical assistance and educational activities.
- F. Improve interagency and interprogram coordination, resource and information sharing through formal standing committees and work groups.

IV. RESPONSIBILITIES

- A. The Division of Public Health Services and the Division of Human Services shall:
 - 1. Designate one or more staff persons to assume responsibilities of liaison and coordination of activities between the Division of Human Services and the division of Public Health Services.
 - 2. Participate in joint training education, and technical assistance activities to maintain and improve services and coordination of programs.
 - 3. Establish a schedule of periodic meetings as may be required to achieve mutual objectives and activities, improve coordination and ensure proper execution of this agreement.
- B. Pursuant to P.L. 101-239, the Division of Human Services shall be responsible for providing the following information to the Division of Public Health Services on an annual basis:
 - 1. Unduplicated total number of women provided prenatal, delivery, or postpartum care.
 - 2. Unduplicated total number of infants, birth to one year of age provided services.
 - 3. Total number of service recipients ages 0-21.
 - 4. Total number of special health care needs services recipients ages 0-21.
 - 5. Total number of SSI recipients under age 16.
 - 6. Total number enrolled in Medicaid and CHAP/EPSDT ages 0-21

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C. The Office of the Commissioner shall be the Medicaid liaison with federal and state officials, and shall provide verbal and written interpretation between HCFA and DPHS concerning Title V, X and WIC/CSFP.

V. ACTIVITIES FOR ENHANCING INTERAGENCY PLANNING AND COORDINATION

To promote and support the provision of interagency coordination, planning and delivery of quality health services for children and families, both agencies shall:

1. Exchange information regarding changes in programs, policies, and procedures.
2. Develop and implement policies and procedures for making interagency decision and resolving problems.
3. Identify and eliminate gaps in necessary resources, reduce duplication and identify and eliminate barriers to health services.
4. Collaborate on fee setting for EPSDT visits by Medicaid eligible children, data analysis and rate setting for family planning programs.
5. Share guidance materials, information on new programs and projects of mutual benefit.
6. Collaborate in the development of policies and standards for specialty health services to assure the provision of comprehensive health system.
7. Develop and implement joint outreach activities, including making printed materials available to DHHS District Office personnel.
8. Plan, coordinate and participate in joint training, education and technical assistance activities.
9. Communicate timely information regarding training, education and technical assistance opportunities and resources.
10. Exchange practitioner-specific information, including Medicaid provider status, as required to identify areas with reduced access to health care, and such exchanges for the purpose of requesting federal or state designation of an area as being medically underserved or as a health professional shortage area.

VI. ATTACHMENTS

Attachment A is a description of 1991-1993 DPHS and DHS cooperative agreement activities undertaken to enhance services funded by title V, X, XIX, and U.S.D.A.

Attachment B is a description of the 1993-1994 DPHS and DHS cooperative agreement activities which will be undertaken to enhance services funded by Title V, X, XIX, and U.S.D.A.

-4-

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VII. TERMS AND CONDITIONS

A. Agreement Period

The term of this agreement shall begin on the first day of September, 1993, and will continue thereafter until termination by either party upon 30 days written advance notice to the other.

B. This agreement pertains to all Medicaid State Plan services that are provided by the Division of Public Health Services or by contract agencies.

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AGREEMENT BETWEEN THE
NEW HAMPSHIRE DIVISION OF PUBLIC HEALTH SERVICES
AND THE
NEW HAMPSHIRE DIVISION OF HUMAN SERVICES
RELATIVE TO
JOINT PLANNING AND
COORDINATION OF HEALTH PROGRAMS UNDER TITLE V, TITLE X, TITLE XIX AND WIC/CSFP

Whereas the Division of Public Health Services and the Division Human Services share a common responsibility in the delivery of quality comprehensive cost-effective health services to women, children and children with special health care needs and low income families; and in consideration of the mutual promises herein contained, the parties have agreed and do hereby enter into this cooperative agreement according to the provision set out herein.

This agreement is entered into and supported by the following staff of the operating agencies:

9/17/93
Date [Signature]
Director, Division of Public Health Services

9/27/93
Date [Signature]
Director, Division of Human Services

9/27/93
Date [Signature]
Commissioner, Department of Health and Human Services

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ATTACHMENT A

1991 - 1993

SUMMARY OF JOINT AGENCY ACTIVITIES

This attachment summarizes existing collaborative activities as well as activities planned or in process. At the Division level, the Medicaid Medical Care Advisory Committee includes three representatives from DPHS as permanent members, and the Department's Policy Coordination Committee includes one representative from DPHS.

The following collaborative activities are listed by DPHS programmatic unit.

BUREAU OF MATERNAL AND CHILD HEALTH (BMCH)

- Periodicity schedule for screening services to children ages 0-6: MCH child health programs and the EPSDT program known as the Child Health Assurance Program in New Hampshire (CHAP) utilize essentially similar periodicity schedules.
- Extended Prenatal Care: Effective January 1990, Medicaid approved an extended care reimbursement schedule for Public Health-funded prenatal clinics for services, including case management, to Medicaid eligible clients. Services are provided in accordance with policy developed by the Medicaid agency, public health, and prenatal clinics. During 1992, smoking cessation counselling was added.
- Public Information "Caring for Tomorrow's Children:" Public Health, Medicaid, Concord Hospital, and Blue Cross collaborated on a multi-media public information campaign and telephone hot line designed to increase the number of women seeking prenatal care in their first trimester. The campaign was implemented in October 1990.
- Uniform Eligibility: Discussion is ongoing on the concept of a uniform eligibility level as a standard for Medicaid and MCH programs serving women and children.
- Referrals: Discussions are ongoing with respect to the quality of referrals to the local DHH District Offices by local child health programs. Fact sheets developed by the Bureau of Special Medical Services and the Office of Economic Services for families will be adapted to assist agencies. A training session was done to assist in this process.
- Rate Setting: The BMCH collaborated with the Medicaid agency on program development and rate setting for state family planning programs by facilitating meetings between family planning agencies and the Medicaid program.
- The BMCH and Medicaid also collaborated on fee setting for EPSDT visits by Medicaid eligible children who attend local agency child health programs. Discussions are ongoing with respect to rates and procedure codes for other local child health program services such as home visits.

-7-

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ATTACHMENT A (Continued)

BUREAU OF SPECIAL MEDICAL SERVICES

(BSMS - Programs for Children With Special Health Care Needs)

- **Program Information and Dissemination:** Fact sheets about various medical assistance programs have been developed for use within the Bureau of Special Medical Services to counsel families about financial assistance available through Medicaid and disseminated to well-child clinics, area agencies, family support coordinators and other human services agencies. These are updated as Medicaid eligibility changes occur. In service training about Medicaid has been conducted by the Chief, Bureau of Special Medical Services. An insider's guide about Medicaid is in the planning phase.
- **Model Demonstration Project - Outreach Efforts:** Since February 1989, a Case Technician trained in economic services eligibility has been jointly funded by Medicaid and DPHS. Stationed at the Bureau of Special Medical Services' Concord Office, this individual provides enhanced access, outreach and follow-up of referrals of Title V recipients to DHHS District Offices.
- **Care Management:** Case Management under the Bureau of Special Medical Services means long-term coordination and/or the provision of specialty health care services to include: (1) periodic evaluation to determine the child's specialty health care needs; (2) recommendations for treatment/interventions to facilitate meeting identified needs of the child and family; and (3) family support services defined as information and referral linkages to community resources, flexible financing options and parent-to-parent supports. Currently, families with Medicaid-eligible children under the care of the Bureau of Special Medical Services as well as persons with AIDS on Medicaid receive care management services. Beginning FY 94, new positions will be made available through shared funding.
- **Joint Medical Review Team:** The Bureau of Special Medical Services recruits and funds a pediatrician to be a member of the Joint Medical Review Team for HC-CSD and CSD eligibility determination. Additionally, for those children not determined Medicaid eligible, the Bureau of Special Medical Services provides linkages to other community resources including Title V, and information and referral to assist families in accessing specialty care for their child(ren.)
- **Provider Relations:** A common problem experienced by Medicaid clients is the inability to access specialty health care from a provider due to the choices of some practices to limit the number of Medicaid-eligible children seen at their offices. For Medicaid eligible children receiving care coordination from the Bureau of Special Medical Services, these children have been able to gain access via Bureau providers. Discussion continues on the development of consistent policies and standards for the provision of specialty health services by providers participating in Medicaid and Title V including health systems development to ensure the provision of all necessary services from outreach to referral through assessment, treatment and follow-through care.
- **Durable Medical Equipment Authorization (DME):** BSMS has been delegated the authority to approve and preauthorize medically necessary DME items on behalf of Medicaid recipients participating in CSI and CV programs.
- **Problem Resolution:** There is a need to establish a joint interdepartmental work group to problem solve around "system failures" due to continued categorical eligibility criteria and services.

-8-

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ATTACHMENT A (Continued)

BUREAU OF WIC NUTRITION SERVICES (BWNS)

- **Program Information-Sharing and Referrals:** BWNS staff have attended CHAP staff meetings upon request to provide training in the Supplemental Food Program for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program CSFP eligibility and services. CHAP staff have attended WIC Nutrition in-services to discuss their program also.
- **Documentation of Referrals:** Local WIC agencies code the Medicaid status (enrolled, not enrolled, referred) of every WIC participant at each recertification. Monthly reports are available on the number/percentage of participants for each program by local agency.
- **Immunization Reminders:** The BWNS and DPHS Immunization Program, along with the Medicaid Program have developed a reminder system which is sent to the parent of each WIC child participant at approximately 14 months of age, and costs for this activity are shared by programs. This system may be expanded in coordination with Immunization Program funds.
- **Information Distribution:** The WIC and CSFP Programs are under legislative mandate to distribute information regarding Medicaid and other Division of Human Services programs to each WIC participant or adult caretaker. The Bureau of WIC Nutrition Services has developed a fact sheet on DPHS and DHS Programs for distribution to each WIC/CSFP participant or adult caretaker.
- **Joint Application:** Agency discussion is needed on the concept of a joint WIC/CSFP, Title V MCH, Title X, and Title XIX application and protocols for accepting verification of common eligibility criteria (birth certificate, income, residence) performed by another of these programs.
- **Information-Sharing for Outreach:** Agency discussion is needed on the concept of developing protocols for forwarding names and contact information on prospective clients referred between the subject programs.
- **Reimbursement Issues for Nutritional Services:** Discussions have been held concerning Medicaid reimbursement of special infant formulas in amounts not covered by WIC; rental and purchase of electric breastpumps for premature or hospitalized infants; printing and mailing costs for immunization postcard reminders to WIC participants and nutritional assessment and counseling to medically high risk women or children.

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ATTACHMENT B

1993-1994

PLANNED COOPERATIVE ACTIVITIES

1. Establish minimum interagency health care standards for child and family health programs.
2. Develop and implement procedures for making interagency decisions, and resolving problems.
3. Develop policy and procedures which will authorize prenatal clinics to be "Qualified Providers" to enable them to expedite prenatal Medicaid eligibility determinations.
4. Improve the child health programs referral system.
5. Establish an enhanced care service component of child health programs, including Medicaid coverage of the provision of health care support and other services to improve childrens health status and function within the family and community.
6. Develop a CHAP Plus-Enhance EPSDT service plan.
Establish a reimbursement schedule for family planning counseling/education services.
8. Continue the discussion and work regarding a uniform eligibility level as a standard for Medicaid and MCH programs serving women and children.
9. Develop a multi-program health services application form, and referral process and follow-up protocols for services offered through Title V, WIC-CSFP, Title X and Medicaid.
10. Establish nursing coordinators for HC-CSD/AIDS/SSI/Medicaid clients.
11. Continue the work and discussions regarding revisions to the administrative rules for HC-CSD/CSD eligibility.
12. Develop an insider's guide to Medicaid.
13. Improve notification to Medicaid recipients of the availability of services provided by the Family Planning Program by participating in joint outreach activities.
14. Provide Medicaid with a listing of health clinics and satellite sites which will participate as providers of Medicaid services. Notify Medicaid of new clinics and name changes when appropriate.
15. Improve access to and utilization of maternal and child health services for uninsured, low-income pregnant women and children by:
 - a. expanding Medicaid eligibility,
 - b. establishing procedures in the medical assistance program for improved outreach and enrollment for pregnant women and children,
 - c. establishing procedures for improved coordination of the Medicaid program for pregnant women and children with other publicly funded health programs serving mothers and children
 - d. instituting an aggressive public education campaign regarding the availability of Medicaid coverage for maternal and child health services, the existence of other publicly-funded health programs

12/1/93

- ...serving mothers and children, and the advantage of preventive health care,
- e. instituting a newborn home visiting program whereby a licensed health professional makes a home visit to targeted households with Medicaid covered newborns within 60 days after birth to encourage families to participate in the EPSDT program, conduct a health screen, and to better ensure continued Medicaid coverage of the infant,
 - f. providing for the receipt and initial processing of initial Medicaid applications from individuals at locations which are other than HHS District Offices and which include providers of Title V MCH services and Child Health Services, Title X Family Planning Services, WIC/CSFP, and Early Intervention program sites, as well as those required under 42 U.S.C. 1396 a (a) (55),
 - g. instituting a formal procedure for taking maternity-related medical assistance applications at the offices of "qualified providers" including the providers listed in RSA 167:68, and non-district office sites,
 - h. instituting a formal procedure of making Medicaid services available to a pregnant woman during a "presumptive eligibility period" as provided in 42 U.S.C. 1396 r-1 and
 - i. continuing rulemaking and other measures designed to make Medicaid reimbursement available to these publicly funded health programs for medically necessary case management and care coordination services provided by these agencies to Medicaid eligible pregnant women and children.

Office

TN 93-020

Title XIX-NH

PCO 11-81-17-a

Attachment 4.16-A

Page 5 Page 2j

STATE New Hampshire

~~the appropriate fee schedule. In addition, the Bureau of Dental Health is responsible for prior authorization review of crippling malocclusion, and Maternal and Child Health Program shall determine which Home Health/Visiting Nurse agencies are capable of providing services in accordance with the screening protocol and periodicity schedule and notify the Medicaid agency in writing.~~

IV. Agreement with Division of Vocational Rehabilitation (VR)

The objectives of this agreement are: (1) to enable the eligible client population of both agencies to benefit from services available through both programs; (2) to promote the exchange of relevant information about mutual clients; (3) to state agency service goals and clarify associated agency policies.

The agreement provides for (1) referral of all Medicaid applicants/recipients to VR and screening by VR; (2) exchange of medical, social and vocational data on mutual clients with client release of information; (3) provision and payment for services for eligible clients by each agency within the scope of each program; (4) delineation of individual responsibilities in certain mutual service areas; (5) designation of staff in each agency responsible for liaison, coordination and other identified responsibilities; (6) mutual agreement prior to delivery of service before any commitment for payment on behalf of a client by one agency becomes binding on the other; (7) annual review of the agreement; (8) written notification by one agency to the other of changes in policy or provision of client services that would affect the substance of the agreement.

TN# 93-020

Supersedes TN 81-17-a Approval Date 12/1/93 Effective Date 7/1/93

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: NEW HAMPSHIRE

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home.

The department abides by the recommendation of the institutionalized individual's physician, who signs the level of care form. If the physician indicates that the admission is to be "indefinite," the department considers that the admission will be permanent.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):
- signed affidavit from the son or daughter who have provided care to the individual;
 - letter from the individual's physician attesting to the fact that the son or daughter provided care; or
 - other documentation as necessary.
3. The State defines the terms below as follows:
- estate means, for the purpose of recovering the costs of medical assistance, all assets subject to probate, the contents of revocable trusts that have been established on or after 01/01/1999, and all property, real or personal, which at the time of a recipient's death was held by the recipient in joint tenancy with rights of survivorship, tenancy in common, life estate, or living trust, without regard to the date that such title or interest was established, remaining balance of certain annuities, and life insurance policies in which the State is the beneficiary.
 - individual's home means real property which is owned and occupied or formerly occupied as the place of residence by the assistance group, consisting of the house, mobile home, condominium or townhouse and any adjoining land or buildings necessary to its maintenance, including land that is contiguous to the lot on which the house rests, and adjoining land that is divided by a road or the boundary of a political subdivision. (Assistance group means the individuals living together with or without benefit of a dwelling, whose needs, income, and/or resources are considered and combined together when determining benefits for financial or medical assistance.)
 - equity interest in the home is one held by virtue of equitable title or claimant on equitable grounds, e.g., a trust beneficiary has equitable interest in trust residence. Equitable title is one of beneficial character and gives the holder the right to acquire the formal legal title. Legal title evidences apparent ownership but may fall short of full and complete title.
 - residing in the home for at least one or two years on a continuous basis means the individual must have used that property as sole residence for the requisite period. Prolonged absences from the property, except for normal vacation or recreation, may discredit the claim of continuous residency. Individuals must have had intent to remain in that property and make it their domicile.
 - lawfully residing means residing in the home under color of law with express permission of the owner.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: NEW HAMPSHIRE

LIENS AND ADJUSTMENTS OR RECOVERIES

4. The State defines undue hardship as follows:

Undue hardship, for the purposes of liens, adjustments and recovery, means circumstances that would make application of the department's right to recovery unfair and which results in the department waiving its right to recover for medical assistance correctly paid on behalf of the deceased Medicaid recipient.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

(a) The department shall waive recovery on the basis of undue hardship as provided below:

- (i) Where the estate includes real property on which a business or farm is located and:
 - o The business or farm has been in operation as the primary residence of the heir for at least 12 months preceding the death of the decedent;
 - o The business or farm produces more than 50% of the heir's livelihood; and
 - o The recovery of the claim would directly result in the loss of the livelihood of the heir;
- (ii) Where the estate includes income-producing property and:
 - o The heir has used his/her own personal resources for the past 12 months to maintain the income-producing property;
 - o The property produces more than 50% of the heir's livelihood; and
 - o The recovery of the claim would directly result in the loss of the livelihood of the heir;
- (iii) Where the estate includes only personal property and recovery by the department would directly result in the heir becoming eligible for public assistance;

TN No. 05-007
Supersedes
TN No. _____

Approval Date 05-20-09

Effective Date 10/01/2005

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: NEW HAMPSHIRE

LIENS AND ADJUSTMENTS OR RECOVERIES

-
- (iv) Where the estate includes the home of the Medicaid recipient upon which the department placed a lien and;
- The applicant for the waiver is an adult child of the deceased Medicaid recipient;
 - The applicant for the waiver resided in the home of the deceased Medicaid recipient for a period of at least 2 years immediately before the date of the deceased Medicaid recipient's admission to the medical institution;

 - The applicant for the waiver establishes that he or she provided uncompensated care daily to the deceased Medicaid recipient for at least 2 years immediately before the date of the deceased Medicaid recipient's admission to the medical institution which permitted the deceased Medicaid recipient to reside at home rather than in a medical institution, including but not limited to any or all of the following activities:
 - Bathing;
 - Dressing;
 - Administering medication;
 - Shopping;
 - Cooking;
 - Feeding;
 - House cleaning;
 - Money management;
 - Driving; or
 - Other care specific to the condition of the deceased Medicaid recipient; and
 - The applicant for the waiver is lawfully residing in the home of the deceased Medicaid recipient and has lawfully resided in such home on a continuous basis since the date of the deceased Medicaid recipient's admission to the medical institution; or
- (v) Where the estate includes the home of the Medicaid recipient and;
- The applicant is a sibling of the deceased Medicaid recipient;
 - The applicant resided in the home of the deceased Medicaid recipient for a period of at least one year immediately before the date of the deceased Medicaid recipient's admission to the medical institution; and
 - The applicant is lawfully residing in the home of the deceased Medicaid recipient and has lawfully resided in such home on a continuous basis since the date of the deceased Medicaid recipient's admission to the medical institution.

TN No. 05-007
Supersedes
TN No. _____

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Effective Date 10/01/2005

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: NEW HAMPSHIRE

LIENS AND ADJUSTMENTS OR RECOVERIES

(b) A request for an undue hardship waiver shall be in writing and include the following information:

- (i) The deceased Medicaid recipient's name;
- (ii) The deceased Medicaid recipient's last street address;
- (iii) The applicant's name;
- (iv) The applicant's relationship to the deceased Medicaid recipient;
- (v) The reason(s) for the undue hardship waiver request; and
- (vi) Documentation to support the undue hardship waiver request, including, but not limited to:
 - o Mortgage note;
 - o Real property deed;
 - o IRS forms, including business, personal or farm deduction forms;
 - o Proof of residency such as a copy of the heir's driver's license or W-2;
 - o Canceled checks relating to the income producing property or business;
 - o City or town tax assessor bills;
 - o A copy of the deceased Medicaid recipient's death certificate;
 - o Estate paperwork filed with the probate court;
 - o An affidavit from the applicant describing the kind and quality of care provided the deceased Medicaid recipient including dates the care was provided; and
 - o Affidavits from at least 2 medical professionals who cared for the deceased Medicaid recipient prior to admission to the medical institution stating that the applicant provided the kind and quality of care necessary to maintain the Medicaid recipient at home rather than in a medical institution for at least 2 years immediately before the Medicaid recipient's admission to the medical institution.

(c) The undue hardship waiver request shall be reviewed as follows:

- (i) A request for a hardship waiver must be filed with the department within 30 days from the Medicaid recipient's death or within 30 days from the date of the filing of the department's claim with the probate court, whichever is later.
- (ii) The request must contain a written statement of the circumstances constituting the hardship and supporting documentation.
- (iii) The department determines whether the undue hardship exists within 90 days from the date of the hardship waiver request.
- (iv) A written notice of decision is sent to the person making the request, informing the person that the waiver has been granted or denied, and, if denied, the amount of the State's claim.
- (v) All notices include a statement informing the applicant that he/she may appeal the department's decision and request an administrative hearing if requested within 30 days of the date of the decision.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: NEW HAMPSHIRE

LIENS AND ADJUSTMENTS OR RECOVERIES

(d) Administrative Hearings:

- (i) The waiver of recovery decision shall be final unless within 30 calendar days of the date of decision, a request is submitted for an administrative hearing.
- (ii) If the department's administrative hearing process finds in favor of the applicant, the department shall withdraw its claim for recovery from probate court.

(6) The State defines cost-effective as follows (including methodology/thresholds used to determine cost-effectiveness):

No claims are made against estates if the value of the estate is less than \$200. Some case-by-case review occurs balancing complexity of issues with likelihood of recovery and the amounts of the potential recovery.

(7) The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

- (a) Liens on real property – notice of intent to place a lien is sent to all known owners who may request appeal. If they prove of the limitations on lien placement applies (i.e., recipient resides in the house), no lien will be filed.
- (b) Claims against estates of deceased recipients made by filing timely notice of claim and appearance with Probate Court of jurisdiction. State statute sets priority of payment out of the estate.
- (c) The Department holds several promissory notes and mortgages.
- (d) Occasional small claims are filed when a person defaults on agreed payment.

TN No. 05-007
Supersedes
TN No. _____

Approval Date 05-30-09

Effective Date 10/01/2005

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Hampshire

Attachment 4.18-A, Page 2 - to be
removed from state plan, supersedes 85-12

TN No. 14-0006
Supersedes
TN No. 85-12

Approval Date 07/01/2014

Effective Date 07/01/14

HCFA ID: 0053C/0061E

Revision: HCFA-PM-85-14 (BERC)
SEPTEMBER 1985

Attachment 4.18-A
Page 3
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Hampshire

Attachment 4.18-A, Page 3 - to be removed from
state plan, supersedes 85-12

TN No. 14-0006
Supersedes
TN No. 85-12

Approval Date 07/01/2014

Effective Date 07/01/14

HCFA ID: 0053C/0061E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Hampshire

A. The following charges are imposed on the medically needy for services:

Service	Deduct. Coins.	Type of Charge Copay.	Amount and Basis for Determination
Prescribed Drugs: each Medicaid covered prescription and refill		X	The co-payment amount of \$1.00 per generic Medicaid covered prescription and refill and \$2.00 per compounded product or brand name Medicaid covered prescription and refill is based on the agency's average payment per prescription which was \$50.79 for state fiscal year 2003.

OFFICIAL

IN No. 04-002
Supersedes
IN No. 87-8

Approval Date 06/16/2004

Effective Date 03/01/2004

HCFA ID: 0053C/0061E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Hampshire

Attachment 4.18-C, Page 2 - to be removed
from state plan, supersedes 85-12

TN No. 14-0006
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TN No. 85-12

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HCFA ID: 0053C/0061E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: New Hampshire

Attachment 4.18-C, Page 3 - to be removed from state plan,
supersedes 85-12

TN No. 14-0006
Supersedes
TN No. 85-12

Approval Date 07/01/2014

Effective Date 07/01/14

HCFA ID: 0053C/0061E

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

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

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B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

TN No. 91-23
Supersedes - - - Approval Date 11/27/92 Effective Date 11/01/91
TN No. - - -
HCFA ID: 7986E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

C. State or local funds under other programs are used to pay for premiums:

Yes No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

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*Description provided on attachment.

TN No. 91-23
Supersedes - - - Approval Date 11/27/92 Effective Date 11/01/91
TN No. - - -

HCFA ID: 7986E

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

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

- A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

OFFICIAL

- B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

TN No. 91-23
Supersedes - - - Approval Date 11/27/92 Effective Date 11/01/91
TN No. - - - HCFA ID: 7986E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

C. State or local funds under other programs are used to pay for premiums:

Yes No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

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*Description provided on attachment.

TN No. 91-23
Supersedes - - - Approval Date 11/27/92 Effective Date 11/01/91
TN No. - - -

HCFA ID: 7986E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: New Hampshire

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Deductible	Type of Charge Coinsurance Copayment	Amount and Basis for Determination

Attachment 4.18-C, Page 1 - to be removed from state plan, supersedes 04-002

TN No. 14-0006
 Supersedes
 TN No. 04-002

Approval Date 07/01/2014

Effective Date: 07/01/2014

HCFA ID: 0053C/0061E

RESERVED BED DAYS

A reserved bed day means:

up to a 24 hour period, midnight to midnight, chargeable to Medicaid, during which a recipient is not present in an inpatient facility (an ICF-MR) serving persons with a mental retardation and/or developmental disability during the midnight census.

Payment is made to reserve a bed during a recipient's temporary absence from a facility under the following conditions.

The Division of Community Based Care Services shall allow up to fifty-two (52) days per recipient, per state fiscal year, as chargeable days to reserve a bed in an inpatient facility (as defined above) if the following criteria are met:

- a) Such days must be specified in the recipient's plan of care;
- b) The recipient's plan of care must describe any plans for continuity of care during the recipient's absence from the facility; and
- c) Such days must not be for hospitalization or for transferring to another facility.

When a recipient is on reserved bed day status, the Department of Health and Human services shall not pay separately for any services, or any similar services, typically covered as part of the facility's rate.

A reserved bed day means:

up to a 24 hour period, midnight to midnight, chargeable to Medicaid, during which a recipient is not present in an inpatient facility (a nursing facility or an ICF-IMD) serving the frail, elderly or other people who qualify for nursing facility care during the midnight census.

Payment is made to reserve a bed during a recipient's temporary absence from a facility under the following conditions.

The Division of Community Based Care Services shall allow up to thirty (30) days per recipient, per state fiscal year, as chargeable days to reserve a bed in an inpatient facility (as defined above) if the following criteria are met:

- a) Such days must be specified in the recipient's plan of care;
- b) The recipient's plan of care must describe any plans for continuity of care during the recipient's absence from the facility; and
- c) Such days must not be for hospitalization or for transferring to another facility.

When a recipient is on reserved bed day status, the Department of Health and Human services shall not pay separately for any services, or any similar services, typically covered as part of the facility's rate.

TN No: 05-002
Supersedes
TN No: 92-8

Approval Date

5/24/05

Effective Date: 01/01/05

OFFICIAL

Attachment 4.19-E

STATE New Hampshire

79-11

For All Types of Service

For the purposes of meeting requirements for Timely Payment of Claims, a claim is defined as a line item of service.

N. Hamp. 10/11/79 Incorp. 11/5/79 Effective 8/23/79

79-11
NH HCFA-PCO-11 #
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OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

Requirements for Third Party Liability -
Identifying Liable Resources

Cross Reference
To Page 69

EXCHANGES

SWICA/IVA

- (b) (1) • Frequency (433.138)(f)

The data matches are performed at the time of initial application, re-determinations and quarterly.

- (b) (2) • Follow-up Method (433.138)(g)(1)(II)

The data exchange information is obtained prior to the initial or re-determination interviews. Within 30 days from identification or receipt of verification of a third party resource, the information is entered into the eligibility case file. This data is utilized in processing medical service claims in accordance with (433.139)(b) through (f).

WORKERS COMPENSATION

- (b) (1) • Frequency (433.138)(f)

The data exchanges are done as needed.

- (b) (2) • Follow-up Method (433.138)(g)(2)(II)

Within 60 days from receipt of third party information from the Workers Compensation Department, the information is entered into the eligibility case file and third party files or verified with the third party carrier. Verified data is entered into the eligibility case file and third party files within 60 days from receipt of the verified data.

TN No. 87-9
Supersedes
TN No. --

Approval Date 11/22/87

Effective Date 10/1/87

HCFA ID:1076P/0019P

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

Requirements for Third Party Liability -
Identifying Liable Resources

Cross Reference
To Page 69

EXCHANGES

MOTOR VEHICLE/ACCIDENT FILES

- (b) (1) • Frequency (433.138)(f)

The data exchanges are done as needed.

- (b) (3) • Follow-up Method (433.138)(g)(3)(i)

If determined that possible liability exists due to an automobile accident, insurance/liability information is requested from our Motor Vehicle Department. Upon receipt of the information, verification is made with the insurance agency if needed. The insurance/liability information is entered into the third party case file and exception indicator/edit is set within the claims processing system. This edit suspends all claims for review by the Third Party Liability (TPL) Unit. TPL staff determine whether or not the service is related to the accident. If the service is related, the claim is denied for accident related third party resources available. Service claims which are not accident related are approved for payment. Payments made for accident related claims, prior to identification are recovered from the liable third party.

- Timeframe For Incorporation of the Information (433.138)(g)(3)(iii)

Within 30 days of receipt of the requested information, the data is entered into the TPL files. If verification is needed, the data is entered into the TPL files within 30 days from receipt of the verified information.

HEALTH INSURANCE INFORMATION

- (b) (2) • Follow-up Method (433.138)(g)(2)(ii)

Health insurance information is obtained at the initial and re-determination interview. Within 60 days from identification of third party liability, the data is entered into the eligibility case file. This data is utilized in processing medical service claims in accordance with (433.139)(b) through (f).

TN No. 87-9
Supersedes
TN No. --

Approval Date

[Signature]

Effective Date 10/1/87

HCFA ID:1076P/0019P

OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

Requirements for Third Party Liability -
Identifying Liable Resources

Cross Reference
To Page 69

EXCHANGES

(b) (4) DIAGNOSIS AND TRAUMA CODE EDITS

• Identification (433.138)(e)

Medical Management Information System (MMIS) generates a report, HML R330D, which lists paid claims consisting of a primary or secondary diagnosis code in the range of 800 through 999 inclusive.

Two exceptions to this report:

1. diagnosis code 994.6, motion sickness, is not considered accident/trauma related and is not reviewed (Exception allowed by Federal Regulation).
2. paid claims, previously edited for accident edits (cost avoidance) and approved for payment are not reviewed in the post payment procedure. (This State identifies accident related liable third parties prior to payment and cost avoids all claims for related services. The cost avoidance process and the post payment review include the same procedures.)

• Data Elements, Accident/Trauma Report

(header) recipient name & identification number
claim number (TCN) and paid date
provider number
diagnosis codes
amount billed and paid
other insurance amount

(detail) service dates
detail diagnosis
procedure codes
detail paid amount

TN No. 87-9
Supersedes
TN No. --

Approval Date 11/22/87

Effective Date 10/1/87

HCFA ID:1076P/0019P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

Requirements for Third Party Liability -
Identifying Liable Resources

Cross Reference
To Page 69

EXCHANGES

OFFICIAL

(b) (4) • Frequency (433.138)(f)

The Accident/Trauma Report is generated monthly and reviewed within 30 days from the report run date.

• Follow-up Procedures (methods) (433.138)(g)

Determining Third Party Liability (TPL)

1. review all data elements of report to identify the possibility of TPL
2. research additional information, such as, recipient birth date, recipient Medicaid eligibility and related claims history

Question of possible liability

1. Inquiry is sent to the recipient
Timeframe: within 30 days of report review date

Identified TPL

1. Third party resource information is incorporated into Third Party Files for recovery.
Timeframe: within 30 days of receipt of information or verification
2. Eligibility case file and MMIS is edited for cost avoidance.
Timeframe: within 30 from receipt of information or verification.
3. In recording our accounts receivable and cost avoidance savings, the diagnosis code is recorded for the purpose of identifying those codes which yield the highest dollar savings and giving priority to those codes.

TN No. 87-9
Supersedes
TN No. --

Approval Date

1/22/87

Effective Date 10/1/87

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEW HAMPSHIRE

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

TN No: 08-002
Supersedes
TN No: N/A

Approval Date 11/20/08

Effective Date: 09/05/2008

Official

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

Requirements for Third Party Liability – Payment of Claims

Processes by which reimbursement from liable third parties is sought vary in accordance with type of recovery being pursued.

In casualty cases identified by the Recovery Unit, Medicaid payment on every related claim dating to the date of the injury/accident is included in the dollar amount for reimbursement. Should the total dollar amount due the Title XIX Program (including anticipated related claims) be less than \$250.00, recovery efforts will not be continued.

For health insurance cases, providers are required to pursue collections from third party resources prior to billing the Medicaid Program.

When a recipient has expanded coverage such as a major medical contract, claims are accumulated for up to a one year period. Should the total dollar amount in these situations be less than \$150.00, further recovery efforts will not be undertaken since these types of policies have a \$100 deductible.

In health insurance cases where potential third party resources other than the above expanded coverages are identified following Title XIX payment, recovery will be pursued when the total amount due the Title XIX Program (including anticipated related claims) is greater than \$50.00.

Compliance with the requirement that providers wait 30 days from the date of furnishing a service to bill Medicaid, if they have billed a third party, is determined by manual review of claims with hard copy documentation attached during claims processing.

The method of assuring provider compliance with 42 CFR 447.20 is:

1. The Medicaid Provider Agreement requires it.
2. Providers have been given specific notice.
3. Client services in MAB receives and resolves recipient complaints relating to provider collections.

TN No: 01-008
Supersedes
TN No: 90-11

Approval Date 12/4/01

Effective Date: 07/01/01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

The Health Insurance Premium Payment (HIPP) Program, a program through which NH Medicaid pays health insurance premiums of employer group health plans for Medicaid individuals if cost effective, is a voluntary program for qualified Medicaid members. In accordance with Section 1906 of the Social Security Act (the Act), a group health plan is defined under Section 5000(b)(1) of the Internal Revenue Code as a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship, or their families. The employer must contribute to the employee premium in order for the Medicaid member to qualify for the NH HIPP program.

Cost Effectiveness Methodology

Purchasing or paying for employer group health insurance is deemed *not* cost-effective when:

- The member is enrolled or eligible for Medicare, Medicare Advantage Plans (Medicare Part C), or Medicare supplement policy plans;
- Insurance is a school-based plan for students while at school only;
- Insurance is an indemnity or catastrophic insurance plan that does not cover standard medical benefits;
- The insurance plan is through the Health Insurance Exchange (marketplace);
- The insurance is dental only, unless the dental is included in the employer group health insurance plan offered by the employer and the dental is not offered separately;
- A member is only eligible for Medicaid through in and out medical assistance.

TN No: 17-0004
Supersedes
TN No: 91-25

Approval Date 09/22/2017

Effective Date: 04/01/2017

HCFA ID: 7985E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

State Method on Cost Effectiveness of Employer-Based Group Health Plans

An individual's enrollment in an employer group health plan (ESI) is considered cost effective when the amount you pay for premiums, coinsurance, deductibles, other cost sharing obligations, and additional administrative costs is likely to be less than the Medicaid expenditures for an equivalent set of services. The methodology used by NH for determining cost-effectiveness authorized under Section 1906 of the Act is as follows:

(a) The cost-effective calculation elements are as follows:

1. Average Medicaid Cost: The average Medicaid cost is the rate associated with the Medicaid eligibility group for which the individual would be determined eligible, which will either be the managed care capitation payment or premiums associated with the New Hampshire Health Protection Program Premium Assistance at the time the HIPP application is received for the category of assistance, age, and gender of the Medicaid members in the employer group health plan.

Additional costs are added for specific conditions (see Table 1) for which NH Medicaid pays additional costs under fee for service or through additional managed care rates. These additional costs are updated when the managed care rates are adjusted, and fee for service is adjusted annually based on cost of services. The condition must be valid at the time of the HIPP application review.

2. Medicaid Cost for Included Services: The Medicaid cost for included services is the percent of the managed care capitation payment or premiums associated with the New Hampshire Health Protection Program Premium Assistance noted in (a) 1 above that is for Medicaid covered services that are included in the employer group health plan. A percentage of services not covered by the employer health plan will be determined by the actuarial company that determines the managed care rates.

3. Employer Group Health Plan Cost for Included Services: Employer group health plan cost is the adjustment factor to equalize Medicaid costs to employer group health plan costs. This is necessary because Medicaid typically pays less for services than employer group health plans do. The adjustment factor for HIPP is 1 times the figure calculated in step 2. This factor is used because NH Medicaid is using managed care or New Hampshire Health Protection Program Premium Assistance rates.

4. Adjustment for Coinsurance and Deductible Amounts: Adjustment of coinsurance and deductible is 30% of the figure derived in step 3.

5. Administrative Cost: Application of the administrative cost for administering the HIPP program.

(b) An employer group health plan will be considered cost effective when the cost of the employer group health plan is lower than the cost under Medicaid managed care or the New Hampshire Health Protection Program Premium Assistance program.

1. The employer group health plan cost is the employer's share of the premium plus the coinsurance and deductible amount calculated in (a)(4), plus the administrative cost in (a)(5).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

State Method on Cost Effectiveness of Employer-Based Group Health Plans

2. The Medicaid cost is determined by the managed care capitation payment or New Hampshire Health Protection Program Premium Assistance payment in (a)(2).

(c) A cost effectiveness redetermination is carried out as follows:

1. Cost effectiveness shall be redetermined annually concurrent with the member's policyholder's annual open enrollment in the employer group health plan, or any time there is a change in the employer group health plan or family status.

(d) ESI enrollment will be voluntary. Individuals enrolled in the state's Health Insurance Premium Payment (HIPP) program are afforded the same member protections provided to all other Medicaid enrollees.

1. The state will provide a benefits wrap to all services and benefits available under the Medicaid State Plan that are not provided through the ESI plan.

2. The state will provide a cost sharing wrap to any cost sharing amounts of a NH Medicaid covered service that exceeds the cost sharing limits described in the state plan, regardless of whether individuals enrolled in a Health Insurance Premium Payment (HIPP) program receive care from a Medicaid participating provider or a non-participating provider.

The state has a provider enrollment process for non-participating providers to ensure that providers that service Medicaid members can be enrolled and paid through the state Medicaid program for any and all cost sharing amounts that exceed the Medicaid permissible limits.

To effectuate the cost sharing wrap, the state will encourage non-participating providers to enroll by conducting targeted outreach to inform non-participating Medicaid providers on how to enroll in Medicaid for the purposes of receiving payment from the state for cost sharing amounts that exceed the Medicaid permissible limits.

3. The state will inform members regarding options available when the member obtains care from a non-participating provider, including, as applicable, reimbursement for out of pocket cost sharing costs from this provider.

TN No: 17-0004
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

State Method on Cost Effectiveness of Employer-Based Group Health Plans

Cost Effectiveness Methodology (continued)

TABLE 1

NH MEDICAID HIPP SPECIAL CONDITIONS
ADD-ON LIST

The Special Conditions list contains those costs to be added to the average Medicaid cost under the NH Medicaid HIPP cost effectiveness calculation in (a) 1.

These costs are added because they are additional payments for managed care services or because costs are covered by fee for service Medicaid and not included in the managed care or New Hampshire Health Protection Program Premium Assistance program. The amount of each special condition will be based on the managed care additional cost at the time of the HIPP application or the past fiscal year annualized cost for the condition. These additional Medicaid costs must be covered by the employer group health plan and are valid at the time of the HIPP application review. These are the only additional costs that can be added to the average Medicaid cost for the HIPP cost effectiveness calculation.

CODE IDENTIFIER	DESCRIPTION
D57/D66-68	Blood disorder (sickle cell, hemophilia)
B19.2	Hepatitis C
E72.2	Disorder of Urea Cycle Metabolism
T2025	Maternity Kick Payment
T2026	Newborn Kick Payment

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Official

State/Territory: New Hampshire

Citation

1902(y)(1),
1902(y)(2)(A),
and Section
1902(y)(3)
of the Act
(P.L. 101-508,
Section 4755(a)(2))

1902(y)(1)(A)
of the Act

1902(y)(1)(B)
of the Act

1902(y)(2)(A)
of the Act

Sanctions for Psychiatric Hospitals

- (a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
- (b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
- (c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:
1. terminate the hospital's participation under the State plan; or
 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or
 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
- (d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

1-1-93 or as required by Federal Law

TN No. 93-5
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Revision: HCFA-PM-86-9 (BERC)
May 1986

ATTACHMENT 4.32-A
Page 1
OMB No: 0938 -0193

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

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUEST TO OTHER STATE AGENCIES

In addition to the request for information required by 43 CFR 435.948(a), the State of New Hampshire requests income and eligibility information from the following:

VA Crossmatch

A report of all public assistance, medical assistance and food stamp recipients with veteran benefit income is provided to the Veterans Administration annually. The VA annotates the report with current eligibility and benefit information. The annotated report is provided to the eligibility workers for follow-up action as appropriate.

PARIS Datamatch

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 request 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.

TN No. 10-013
Supersedes TN# 90-11

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

The Division of Human Services follows the following procedures for issuing Medicaid cards to homeless individuals:

1. If the individual is able to identify an in-care-of address to which mail should be sent, the Medicaid card is sent to that address.
2. If the individual is unable to identify an in-care-of address, the local Division of Human Services District Office offers and arranges (with client approval) to have the Medicaid card mailed to the District Office. This procedure enables the individual to pick up the Medicaid card at a convenient location and time.

TN No. 87-5b
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TN No. -----

Approval Date 1/22/88

Effective Date 7/1/87

HCFA ID: 1080P/0020P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

see attached

OFFICIAL

TN No. 91-22
Supersedes Approval Date FEB 7 1992 Effective Date 12/01/91
TN No. -----

HCFA ID: 7982E

LIVING WILL

OFFICIAL

RSA 137-H, Living Wills, was amended by Chapter 239 of the Laws of 1991. This living will statute allows individuals to determine the course of life sustaining medical treatment through a living will document described in RSA 137-H:3 which is to be respected even though the individual can no longer participate in the decision making process due to a terminal condition or if the individual is permanently unconscious. A living will must be executed by a competent adult instructing his/her physician to provide, withhold or withdraw life sustaining medical procedures.

An attending physician must follow the dictates of the living will as closely as possible. An attending physician or other health care provider is generally immune from liability for making health care decisions in good faith pursuant to the directives of the living will. If the physician is unable to comply with the terms of the document due to personal beliefs or conscience, the physician must so inform the patient or the patient's family.

A health care facility or health care provider may not require a patient to draft a living will as a condition of receiving health care. Nor may health care be refused because a person has executed or not executed a living will.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

RSA 137-J, Durable Power of Attorney for Health Care, was enacted by Chapter 146 of the Laws of 1991. This statute allows individuals to maintain control over their medical care during periods of incapacity by prior designating another individual to make the decisions on his/her behalf. The designated party's authority shall be in effect when the attending physician has certified and placed the notation in the medical records, that the patient is unable to make health care decisions. When the patient regains the ability to make the decisions, it will be noted in the medical record. If the patient does not have an attending physician due to religious or moral beliefs, as specified in the document, then the designated party may certify in writing that the patient is incapable of making decisions. The designated party cannot decide to withdraw or withhold artificial nutrition and hydration unless specified in the document. A designated party cannot be the patient's health care provider, a non-relative who is an employee of the patient's health care provider, a resident care provider or a non-relative who is an employee of the patient's residential care provider. A durable power of attorney may be revoked, either orally or in writing, by executing a new durable power of attorney document or by filing an action for divorce when the spouse is the designated party.

The designated party may review and/or receive any information to assist in making a decision, and the provider is bound by the decision. If a decision is contrary to the health care provider's moral or ethical principles or other standards, the provider may transfer the patient to another facility.

A patient cannot be charged a different rate nor denied health care because of the existence or non-existence of a durable power of attorney.

OFFICIAL LIVING WILL

Declaration made this _____ day of _____ (month, year).

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition or a permanently unconscious condition by 2 physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized or that I will remain in a permanently unconscious condition and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary to provide me with comfort care. I realize that situations could arise in which the only way to allow me to die would be to discontinue artificial nutrition and hydration. In carrying out any instruction I have given under this section, I authorize that artificial nutrition and hydration not be started or, if started, be discontinued. (yes) (no) (Circle your choice and initial beneath it. If you do not choose "yes", artificial nutrition and hydration will be provided and will not be removed.)

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physicians as the final expression of my right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed _____

State of _____

_____ County

We, the [declarant and] following witnesses, being duly sworn each declare to the notary public or justice of the peace or other official signing below as follows:

1. The declarant signed the instrument as a free and voluntary act for the purposes expressed, or expressly directed another to sign for him.
2. Each witness signed at the request of the declarant, in his presence, and in the presence of the other witnesses.

TN No. 91-22
Supersedes _____
TN No. ----

Approval Date FEB 7 1991

Effective Date 12/01/91

OFFICIAL

3. To the best of my knowledge, at the time of the signing the declarant was at least 18 years of age, and was of sane mind and under no constraint or undue influence.

[_____ Declarant]

_____ Witness

_____ Witness

The affidavit shall be made before a notary public or justice of the peace or other official authorized to administer oaths in the place of execution, who shall not also serve as a witness, and who shall complete and sign a certificate in content and form substantially as follows:

Sworn to and signed before me by _____, declarant
_____ and _____, witnesses on

Signature

Official Capacity

TN No. 91-22
Supersedes
TN No. -----

Approval Date FEB 7 1992

Effective Date 12/01/91

OFFICIAL

INFORMATION CONCERNING THE DURABLE
POWER OF ATTORNEY FOR HEALTH CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you when you are no longer capable of making them yourself. "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your agent, therefore, can have the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent cannot consent or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy unless the failure to withhold the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this document any treatment you do not desire, except as stated above, or treatment you want to be sure you receive. Your agent's authority will begin when your doctor certifies that you lack the capacity to make health care decisions. If for moral or religious reasons you do not wish to be treated by a doctor or examined by a doctor for the certification that you lack capacity, you must say so in the document and name a person to be able to certify your lack of capacity. That person may not be your agent or alternate agent or any person ineligible to be your agent. You may attach additional pages if you need more space to complete your statement.

If you want to give your agent authority to withhold or withdraw the artificial providing of nutrition and fluids, your document must say so. Otherwise, your agent will not be able to direct that. Under no conditions will your agent be able to direct the withholding of food and drink for you to eat and drink normally.

Your agent will be obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent will have the same authority to make decisions about your health care as you would have had if made consistent with state law.

It is important that you discuss this document with your physician or other health care providers before you sign it to make sure that you understand the nature and range of decisions which may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

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TN No. -----

Approval Date FEB 7 1992

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Pursuant to RSA 137-J:15, Durable Power of Attorney: Form. The durable power of attorney shall be in substantially the following form:

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, hereby
appoint _____

of _____ as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document or as prohibited by law. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS REGARDING HEALTH CARE DECISIONS.

For your convenience in expressing your wishes, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. (Life-sustaining treatment is defined as procedures without which a person would die, such as but not limited to the following: cardiopulmonary resuscitation, mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions, and antibiotics.) There is also a section which allows you to set forth specific directions for these or other matters. If you wish you may indicate your agreement or disagreement with any of the following statements and give your agent power to act in those specific circumstances.

1. If I become permanently incompetent to make health care decisions, and if I am also suffering from a terminal illness, I authorize my agent to direct the life-sustaining treatment be discontinued. (YES) (NO) (Circle your choice and initial beneath it.)

2. Whether terminally ill or not, if I become permanently unconscious I authorize my agent to direct that life-sustaining treatment be discontinued. (YES) (NO) (Circle your choice and initial beneath it.)

3. I realize that situations could arise in which the only way to allow me to die would be to discontinue artificial feeding (artificial nutrition and hydration). In carrying out any instructions I have given above in #1 or #2 or any instructions I may write in #4 below, I authorize my agent to direct that (circle your choice of (a) or (b) and initial beside it):

(a) artificial nutrition and hydration not to be started or, if started, be discontinued,

or

TN No. 91-22
Supersedes
TN No. -----

Approval Date FEB 7 1991

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OFFICIAL

(b) although all other forms of life-sustaining treatment be withdrawn, artificial nutrition and hydration continue to be given to me. (If you fail to complete item 3, your agent will not have the power to direct the withdrawal of artificial nutrition and hydration.)

4. Here you may include any specific desires or limitations you deem appropriate, such as when or what life-sustaining treatment you would want used or withheld, or instructions about refusing any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. You may leave this question blank if you desire.

(attach additional pages as necessary)

In the event the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my health care agent, I hereby appoint _____ of _____ as alternate agent.

I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in the disclosure statement.

The original of this document will be kept at _____ and the following persons and institutions will have signed copies:

In witness whereof, I have hereunto signed my name this _____ day of _____, 19 _____

Signature

TN No. 91-22
Supersedes _____
TN No. -----

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I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness: _____ Address: _____

Witness: _____ Address: _____

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing instrument was acknowledged before me this _____
day of _____, 19 _____, by _____

Notary Public/Justice of the Peace

My Commission Expires:

TN No. 91-22

Supersedes

TN No. -----

Approval Date FEB 7 1992

Effective Date 12/01/91

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

Not applicable.

TN No. 95-15
Supersedes
TN No. 90-11

Approval Date: 12/15/95

Effective Date: 7/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

CRITERIA FOR THE APPLICATION OF SPECIFIED REMEDIES FOR
SKILLED NURSING AND INTERMEDIATE CARE FACILITIES
(When and how each remedy is applied, the amounts of any fines,
and the severity of the remedies)

OFFICIAL

The following outlines the nursing facility remedy criteria:

1. Denial of payment for all Medicaid admissions will occur when the nursing facility has not corrected deficiency(s) with respect to certification requirements within the timeframe specified by the Bureau of Health Facilities, Division of Public Health Services; the nursing facility has been notified in writing by the state that payment will be denied and the effective date; and the state has notified the public through notice in a statewide newspaper.
2. Civil monetary penalties will be implemented when deficiency(s) is not corrected within three months from the original date of notification. The monetary penalties will be applied beginning the first day after the end of the three month period and will be \$5.00 per licensed bed per day; and interest at the rate of 5% per month commencing on the 1st day of the month following the month in which the penalty is first imposed.

The monetary penalties will be enforced only if the deficiencies do not affect the health and safety of the Medicaid recipients. Otherwise, the procedure for removing and relocating Medicaid recipients from the nursing home facility will be implemented.

3. The appointment of temporary management will occur when ordered by a court of a competent jurisdiction.
4. Medicaid recipients will be moved from one nursing facility to another in an emergency.
5. The remedy or remedies so applied will remain in effect until the requirement(s) which is failed to be met is subsequently met, provided that such remedy or remedies, except for 3 and 4 above will not be imposed during the pendency of an administrative appeal requested by the affected nursing facility.

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6/19/90

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and
notice requirements specified
in the regulation.)

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TN No. ---

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

OFFICIAL

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

ELIGIBILITY CONDITIONS AND REQUIREMENTS

OFFICIAL

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

Alternative Remedy

(Will use the criteria and notice requirements specified in the regulation.)

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

Not applicable.

TN No. 95-15

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

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

The State requires that 42 CFR 483.156(c)(1)(i) and (ii) must be included, i.e. "the individual's full name" and "information necessary to identify each individual."

OFFICIAL

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TN No. ---

Approval Date MAY 28 1992

Effective Date 1/1/92

HCFA ID:

Revision: HCFA-PM-93-1
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ATTACHMENT 4.39
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

DEFINITION OF SPECIALIZED SERVICES

TN No. 93-4 Approval Date 4/27/93 Effective Date 1/1/93
Supersedes _____
TN No. ---

Official

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

CATEGORICAL DETERMINATIONS

TN No. 93-4 Approval Date 4/27/93 Effective Date 1/1/93
Supersedes ---
TN No. ---

* U.S. G.P.O.:1993-342-239:80013

Officer's

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

New Hampshire has provided and will continue to provide informational mailings to facilities and residents to keep them informed about regulatory requirements. The state also provided speakers to facility resident council groups, provider groups and community organizations to provide information about regulatory requirements and the survey process. The state office has an open access policy to the public to facilitate dissemination of pertinent information. The MDS Coordinator may coordinate service programs in addition to ongoing survey and certification activities.

TN No. 92-15
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TN No. ---

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Effective
HCF

10/1/92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect
and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

The state has and follows a policy and procedure for expeditious handling of complaints related to allegations of resident abuse, neglect and misappropriation of resident property. The Ombudsmans office and the state agency have a working agreement to facilitate timely response to such complaints while reducing duplication of efforts. Subsequent to the investigation, a mechanism is in place for appropriate referral to the Board of Nursing for review of potential nurse aide certification or nurse licensure action.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

The state agency prepares schedules in a confidential manner. Scheduled inspections are varied in time to prevent prior knowledge by the provider. Information as to the proposed date of survey is available only to the Regional Office, the state agency management and the surveyors.

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HCFA 10/1/92

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The state agency reviews all deficiencies at the supervisory level to assure a regulatory basis, adherence to evidentiary support, and principles and practice of documentation. Any material which does not meet the above standards is utilized as a training tool to promote consistency of application among surveyors. Field supervision is utilized to monitor new surveyors and adherence to principles and practice of surveying on site.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

- (i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;
- (ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or
- (iii) the State has reason to question the compliance of the facility with such requirements.

The state agency conducts on site investigations of complaints either separately or during survey. On-site follow-ups monitor correction of deficiencies cited either as a result of a complaint investigation or survey. Continued on-site visits at the discretion of the survey agency until compliance with regulations is achieved.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New HampshireCompliance Oversight Methodology and Reassessment Frequency
False Claims Recovery Act EducationCompliance Oversight Methodology and Frequency

Annually/October-December: Information about the requirements of Section 6032 of the DRA of 2005 and Section 1902(a)(68) of the Social Security Act is posted on the fiscal agent's provider website as an important notice, and outlines the responsibilities of state-identified or self reported entities to comply. The notice will be updated every October-December, as applicable.

Annually/December: The above article will also be included annually in the provider December quarterly bulletin.

Annually/December: A "Proof of Compliance" Form will be posted on the website for use by self-reported entities, as well as those that are identified by the state as meeting the \$5M threshold. This form will also be included as an Appendix to the December quarterly bulletin.

Annually/October-December: Reports will be run by the state in order to identify those entities meeting the \$5M threshold. (Note: This does not release entities from the responsibility of self-reporting and complying with the applicable provisions if they know that they meet the threshold, e.g., if they are affiliated with other organizations that the state may not have identified as part of their "entity" and this results in their meeting the threshold).

Annually/October-December: A targeted notice will be sent to those entities that the state identifies as having met the \$5M threshold. This notice will reiterate the requirements contained in the general website and quarterly bulletin notice, and will specify that the targeted entity must comply as of January 1 as a condition of receiving payment. The "Proof of Compliance" Form will be included and the entity will be required to respond within 30 days from the date on the targeted notice. (See note on page 2 for 1/1/07 compliance details.)

Annually/January-March: The state will monitor the return of the "Proof of Compliance" Forms and will send out follow-up reminders as necessary. The follow-up reminder will indicate that the entity's funding is at risk, will specify a required response date, and will give an option of the state offering to work with the entity to come up with a compliance plan if they are having difficulties, particularly if the state determines that the loss of the entity would cause access problems for Medicaid recipients.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

**Compliance Oversight Methodology and Reassessment Frequency
False Claims Recovery Act Education**

Compliance Oversight Methodology and Frequency (continued)

Annually/April-June: Any entities who are not actively complying or working with the state as per the above will have their payments suspended and will receive another offer of assistance. Payments could be restored if requirements are met.

Annually/July: Disenrollment activities will begin for those entities who still have not complied after the above steps have been followed.

Note: The "Proof of Compliance" Form will request verification of compliance with the various components of the Act, as well as copies of documents or web addresses where such documents may be viewed. If employee handbooks exist, a copy of the cover page and the relevant pages will be requested.

In calendar year 2007 (for FFY ending 2006), a notice went out to all entities in June, 2007, informing them of the provisions of Section 6032 of the Deficit Reduction Act of 2005 and their responsibility to self identify and comply as soon as possible. Detailed information regarding the Act, as well as the Dear State Medicaid Director letter, was included so that entities could research and be fully informed of their legal obligations. Meanwhile, the state began running data reports and designing the above "Proof of Compliance" Form.

For the FFY 2006 time period, the state will, based upon the above data reports, send a targeted notice to those entities identified as meeting the \$5,000,000 annual threshold for FFY 2006 by October 1, 2007. Entities will be required to return their attestation of meeting the DRA requirements by completing and returning the "Proof of Compliance" Form by November 1, 2007.

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