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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #:13-015

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3) Superseding Pages:
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    b. Attachment 3.1-A, page 2-a, TN 13-008
    c. Attachment 3.1-A, page 3-b, TN 11-009
    d. Attachment 3.1-B, page 2-a, TN 12-009
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

December 13, 2013

Nicholas A. Toumpas, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

Re: New Hampshire SPA TN 13-015

Dear Commissioner Toumpas,

We are pleased to enclose a copy of approved New Hampshire State Plan Amendment (SPA) No. 13-015 with an effective date of July 1, 2013. This SPA transmitted a proposed amendment to your approved Title XIX State plan to reflect changes related to the outpatient hospital service limits.

If there are questions, please contact Joyce Butterworth at (617) 565-1220 or by e-mail at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

cc: Kathleen Dunn, State Medicaid Director
Diane Peterson, Medicaid Business and Policy

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 13-015

2. STATE: NH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.20, 42 CFR 440.50, 42 CFR 440.60, 42 CFR 230(d)

7. FEDERAL BUDGET IMPACT:
FFY 2013 and 2014: 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

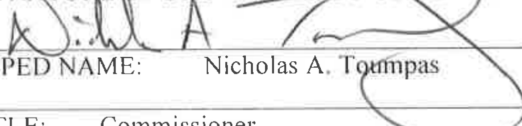
Attch 3.1-A, page 1-a and 2-a
Attch 3.1-A, page 3-b and 3-b.1
Attch 3.1-B, page 2-a, 2-c, and 3-a
Attch 3.1-B, page 3-b and 3-b.1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attch 3.1-A, page 1-a, TN 12-009; 2-a, TN 13-008 pending
Attch 3.1-A, page 3-b,TN 11-009
Attch. 3.1-B, page 2-a, TN 12-009; 2-c and 3-a, both TN 11-009
Attch 3.1-B, page 3-b, TN 11-009

10. SUBJECT OF AMENDMENT:
Outpatient Hospital and Related Limits

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: comments, if any, will follow

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME: Nicholas A. Toumpas

14. TITLE: Commissioner

15. DATE SUBMITTED:
September 27, 2013

16. RETURN TO:

Dawn Landry
Division of Family Assistance/Brown Building
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 27, 2013

18. DATE APPROVED:
December 13, 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2013

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME:
Richard R. McGreal

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Operations, Boston, MA

23. REMARKS:

No Pen & Ink Change Requests

1. Inpatient Hospital Services

Payment for inpatient hospital services is limited to medically necessary days only. Medically necessary days are days of stay approved by the State agency responsible for utilization review, or its designee, i.e., the Quality Improvement Organization (QIO), which evaluates the quality, necessity, and appropriateness of care and renders length of stay determinations.

All accommodations and ancillary services are paid for each approved, medically necessary day. The day(s) of discharge does not count toward the limit. No payment is made for days of stay beyond the determination of medical necessity.

Coverage of organ transplantation is limited as per Attachment 3.1-E.

Prior authorization is required for inpatient hospitalizations at out of state hospitals, excluding border facilities and emergency hospitalizations.

2. a. Outpatient Hospital

Payment for outpatient hospital services is limited to twelve (12) visits per recipient per state fiscal year. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity. Visits to Urgent Care or the Emergency Department (ED) are not limited. The services associated with the outpatient hospital visit, and that may be performed by various practitioners, are also limited to twelve. This is a combination limit meaning that the services of physicians, ARNP's, clinical psychologists and pastoral counselors count in combination toward a limit of 12 when provided in the outpatient hospital setting. This limit may be exceeded in conjunction with the outpatient hospital limit if prior authorization is granted by the Department based on medical necessity.

b. Rural Health Clinic (RHC) Services – Hospital Based (HB) and Non-Hospital Based (NHB) - are provided as defined in Section 1905(a)(2)(B) of the Social Security Act. RHC services include services provided by physicians (to include physician assistants under the supervision and direction of a physician in accordance with NH RSA 328-D:1), nurse practitioners, certified nurse midwives, clinical psychologists, clinical social workers, visiting nurses and other ambulatory services included in the NH Title XIX State Plan. RHC services also include services and supplies that are furnished incident to professional services furnished by a physician (to include a physician assistant under the supervision and direction of the physician), nurse practitioner, certified nurse midwife, and for visiting nurse care, medical supplies, other than drugs and biologicals. "Other ambulatory services" that are included in the NH Title XIX State Plan and covered as RHC services are covered according to the applicable descriptions, service limitations, and payment provisions described elsewhere in this Title XIX State Plan. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity

4a. Nursing Facility Services

Payment for nursing facility care is available to both categorically and medically needy recipients in need of such care. Payment is made for a non-private room. Determination of need for nursing facility care and authorization of payment for nursing facility care is made by the Bureau of Elderly and Adult Services.

4b. Early and Periodic Screening. Diagnosis. and Treatment

Limited to federal requirements for the categorically needy. Any limits to services provided in Attachment 3.1-A do not apply to individuals under EPSDT as long as medical necessity criteria as determined by the Office of Medicaid Business and Policy have been met.

4c. Family Planning Services

4c. (i) Family planning services include those services described in Section 1905(a)(4)(C).

4c. (ii) Family planning-related services provided under the state eligibility option at Attachment 2.2-A, B, are those medical diagnosis and treatment services provided in a family planning setting as part of, or as follow-up to, a family planning visit pursuant to Section 1902(a)(IO)(G)(XVI). Family planning-related services that are covered in NH include: (1) services to treat adverse reactions to, or medical complications of, family planning procedures, services, treatment, or therapies (e.g., treatment of perforated uterus due to intrauterine device insertion, treatment of severe menstrual bleeding caused by Depo-Provera injection); (2) drugs (as well as follow-up visits and re-screens based on CDC guidelines) for the treatment of STD's, except for HIV/AIDS and hepatitis, when the STD is identified or diagnosed during a routine or periodic family planning visit; (3) drugs and other treatment (as well as follow-up visit) for lower genital tract and genital skin infections/disorders, and urinary tract infections, when identified/diagnosed during a routine/periodic family planning visit; and (4) vaccinations to prevent cervical cancer routinely provided pursuant to a family planning service in a family planning setting.

5a. Physician Services

Coverage for physician services is unlimited except for those physician services affiliated with outpatient hospital visits, which are limited (in combination with ARNP, clinical psychologist, and pastoral counselor services- 6d) to 12 per recipient per state fiscal year, except for emergency department (ED) and urgent care visits, which are not limited. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity. Laboratory tests and diagnostic x-rays are not counted against the outpatient physician visit limit.

Except for kidney and tissue transplants, to include corneas, bone grafts, and skin transplants, which are covered without prior authorization, prior authorization is required for the coverage of physician services for organ transplants which include bone marrow, liver, heart, lung, heart-lung, pancreas, and pancreas-kidney. (See Attachment 3.1-E for specific details.) Certain surgical procedures to include bariatric surgery, breast reduction, blepharoplasty, panniculectomy, septoplasty and rhinoplasty also require prior authorization.

Non-covered organ transplantation and procurement services include physician services for the surgery, inpatient hospital services for the surgical admission(s), and organ procurement related to the following types of transplants: any type of organ or tissue transplant not specified above (including hairplasty) or more than two transplants of the same type of organ per recipient per lifetime.

In accordance with federal law, coverage for induced abortions is provided when the physician certifies that the pregnancy was the result of rape or incest or the woman suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

6b. Optometrist Services

Payment to state licensed optometrists or ophthalmologists for refraction is limited to one (1) per recipient per state fiscal year whether the provider is a licensed optometrist or ophthalmologist.

6c. Chiropractor Services

Not covered

6d. Clinical Psychologist

Treatment provided by a licensed clinical psychologist, who is not on the staff of a community mental health center, is limited to 18 visits per recipient per state fiscal year for adults (age 21 and over) and 24 visits per recipient per state fiscal year for children (under age 21). Such visits are to be counted toward the 18 visit adult/24 visit child psychotherapy cap for all non-physician practitioners. Clinical psychologist services (in combination with ARNP and pastoral counselor services in 6d, and physician services in 5a) that are affiliated with outpatient hospital visits are limited to 12 per recipient per state fiscal year, except for emergency department (ED) and urgent care visits, which are not limited. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

Advanced Registered Nurse Practitioners

Section 6405 of P.L. 101-239 (OBRA 1989) is met by ARNP. Treatment provided by advanced registered nurse practitioners (known as advanced practice registered nurses-APRN's-in NH) who meet state licensure requirements is unlimited except for psychotherapy treatment. Psychotherapy is limited to 18 visits per recipient per state fiscal year for adults (age 21 and over) and 24 visits per recipient per state fiscal year for children (under age 21). Such visits are to be counted toward the 18 visit adult/24 visit child psychotherapy cap for all non-physician practitioners. ARNP services (in combination with clinical psychologist and pastoral counselor services in 6d, and physician services in 5a) that are affiliated with outpatient hospital visits are limited to 12 per recipient per state fiscal year, except for emergency department (ED) and urgent care visits, which are not limited. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

Certified Midwives

Midwife services comprised of the necessary supervision, care, and advice provided to women during the pregnancy, labor and postpartum period, and including care of the newborn, shall be provided pursuant to RSA 326-D and by individuals certified to practice midwifery in New Hampshire pursuant to RSA 326-D:6. For purposes of this Title XIX state plan service, certified midwives shall be considered the equivalent of licensed practitioners per CMS.

Pastoral Counselors

Psychotherapy services provided by a licensed pastoral counselor, who is not on the staff of a community mental health center, are limited to 18 visits per recipient per state fiscal year for adults (age 21 and over) and 24 visits per recipient per state fiscal year for children (under age 21). Such visits are to be counted toward the 18 visit adult/24 visit child psychotherapy cap for all non-physician practitioners. Pastoral counselor services (in combination with clinical psychologist and ARNP services in 6d, and physician services in 5a) that are affiliated with outpatient hospital visits are limited to 12 per recipient per state fiscal year, except for emergency department (ED) and urgent care visits, which are not limited. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

Home Health Services

Home health services are provided in accordance with 42 CFR 440.70 and include the services specified in 7a-7d. Home health services are provided to a recipient on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days, except as specified in 42 CFR 440.70(b)(3). Medical supplies, equipment and appliances suitable for use in the home are provided in accordance with physician review as specified in 42 CFR 440.70(b)(3). Medicaid recipients do not have to be homebound in order to receive home health services.

Home health agencies must meet the Medicare conditions of participation in 42 CFR Part 484.

a. & b. Nursing and Home Health Aide

Services can only be provided in the patient's place of residence, not in a hospital, nursing facility, or ICF-MR, except as allowed at 42 CFR 440.70(c).

1. Inpatient Hospital Services

Payment for inpatient hospital services is limited to medically necessary days only. Medically necessary days are days of stay approved by the State agency responsible for utilization review, or its designee, i.e., the Quality Improvement Organization (QIO), which evaluates the quality, necessity, and appropriateness of care and renders length of stay determinations.

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In accordance with federal law, coverage for induced abortions is provided when the physician certifies that the pregnancy was the result of rape or incest or the woman suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

Physician laboratory and diagnostic radiology services are subject to the limit described under the Other Laboratory and X-ray service heading.

Services provided by licensed psychiatrists and ophthalmologists are included in the physician limits. Payment for refraction is limited to one (1) per recipient per state fiscal year, whether the provider is an optometrist or ophthalmologist.

5b. Medical and Dental Services

Services provided by a doctor of dental surgery or dental medicine which would otherwise be physician services are treated in the same manner as physicians in accordance with 5a.

6a. Podiatrists' Services

Payment for the services of licensed podiatrists is limited to four (4) visits per recipient per state fiscal year. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

Podiatrist services shall be covered for medical and surgical treatments of the foot and lower leg for pathological conditions of the foot due to localized illness, injury, or symptoms involving the foot. Prevention and reduction of corns, calluses, and warts are covered if by cutting or surgical means only. Other licensed podiatrist services include routine foot care and trimming and burring of nails, including mycotic nails, performed by a podiatrist provided that:

The recipient's primary health care provider has documented in the recipient's medical record the the recipient's current medical condition justifies the need for such foot care to be performed by a podiatrist; and

The primary health care provider has written a referral to a podiatrist for such care, and the referral is maintained in the recipient's record.

6b. Optometrists' Services

Payment to state licensed optometrists or ophthalmologists for refraction is limited to one (1) per recipient per state fiscal year whether the provider is a licensed optometrist or ophthalmologist.

6c. Chiropractors' Services

Not provided

6d. Other Practitioners' Services

Clinical Psychologist

Treatment provided by a licensed clinical psychologist, who is not on the staff of a community mental health center, is limited to 18 visits per recipient per state fiscal year for adults (age 21 and over) and 24 visits per recipient per state fiscal year for children (under age 21). Such visits are to be counted toward the 18 visit adult/24 visit child psychotherapy cap for all non-physician practitioners. Clinical psychologist services (in combination with ARNP and pastoral counselor services in 6d, and physician services in 5a) that are affiliated with outpatient hospital visits are limited to 12 per recipient per state fiscal year, except for emergency department (ED) and urgent care visits, which are not limited. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

6d. Other Practitioner's Services (cont)

Advanced Registered Nurse Practitioners
Section 6405 of P.L. 101-239 (OBRA 1989) is met by ARNP. Treatment provided by advanced registered nurse practitioners (known as advanced practice registered nurses-APRN's-in NH) who meet state licensure requirements is unlimited except for psychotherapy treatment. Psychotherapy is limited to 18 visits per recipient per state fiscal year for adults (age 21 and over) and 24 visits per recipient per state fiscal year for children (under age 21). Such visits are to be counted toward the 18 visit adult/24 visit child psychotherapy cap for all non-physician practitioners. ARNP services (in combination with clinical psychologist and pastoral counselor services in 6d, and physician services in 5a) that are affiliated with outpatient hospital visits are limited to 12 per recipient per state fiscal year, except for emergency department (ED) and urgent care visits, which are not limited. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

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Midwife services comprised of the necessary supervision, care, and advice provided to women during the pregnancy, labor and postpartum period, and including care of the newborn, shall be provided pursuant to RSA 326-D and by individuals certified to practice midwifery in New Hampshire pursuant to RSA 326-D:6. For purposes of this Title XIX state plan service, certified midwives shall be considered the equivalent of licensed practitioners per CMS.

Pastoral Counselors
Psychotherapy services provided by a licensed pastoral counselor, who is not on the staff of a community mental health center, are limited to 18 visits per recipient per state fiscal year for adults (age 21 and over) and 24 visits per recipient per state fiscal year for children (under age 21). Such visits are to be counted toward the 18 visit adult/24 visit child psychotherapy cap for all non-physician practitioners. Pastoral counselor services (in combination with clinical psychologist and ARNP services in 6d, and physician services in 5a) that are affiliated with outpatient hospital visits are limited to 12 per recipient per state fiscal year, except for emergency department (ED) and urgent care visits, which are not limited. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

7. Home Health Services

Home health services are provided in accordance with 42 CFR 440.70 and include the services specified in 7a-7d. Home health services are provided to a recipient on his or her physician's orders as part of a written plan of care that the physician reviews every 60 days, except as specified in 42 CFR 440.70(b)(3). Medical supplies, equipment and appliances suitable for use in the home are provided in accordance with physician review as specified in 42 CFR 440.70(b)(3). Medicaid recipients do not have to be homebound in order to receive home health services.

Home health agencies must meet the Medicare conditions of participation in 42 CFR Part 484.

a. & b. Nursing and Home Health Aide

Services can only be provided in the patient's place of residence, not in a hospital, nursing facility, or ICF-MR, except as allowed at 42 CFR 440.70(c).

7c. Medical Supplies, Equipment and Appliances

Prior authorization is required for the purchase of most (prosthetics and orthotics which fall under DME in the department's rules, but under item #12 in the state plan, do not require prior authorization) durable medical equipment as detailed in the department's rules at He-W 571, as well as for modifications to manual or power wheelchairs. Repairs to power wheelchairs require prior authorization if the repairs total $800 or more.

Prior authorization is required for disposable diapers and related incontinence supplies for recipients 21 years of age and older. Other medical supplies do not require prior authorization.

7d. Physical and Occupational Therapy, Speech Pathology and Audiology Services

When provided by a home health agency, visiting nurse association or independent therapist, these services are limited to eighty (80), fifteen minute units per recipient per state fiscal year. The eighty (80) units may be used for one type of therapy or in any combination of therapies. Limits may be exceeded if prior authorization is granted by the Department based on medical necessity.

Physical, Occupational and Speech Pathology/Audiology Services are provided in accordance with the service and practitioner requirements of 42 CFR 440.110 and 42 CFR 440.70(b)(4).