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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: 22-0030

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

April 29, 2022

Lori Shibinette RN, MBA, NHA
Commissioner
Department of Health and Human Services
Pleasant St.
Concord, NH 03301

Re: New Hampshire State Plan Amendment (SPA) 22-0030

Dear Commissioner Shibinette:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0030. This amendment proposes to revise the provisions governing third party liability in order to clarify language around preventive pediatric services, child support enforcement, and prenatal services, as well as to update policies and procedures.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR 139(b)(3)(i) and (ii), 42 CFR 433.139(f)(2) and (3), 42 CFR 447.15, 42 CFR 447 20, and Section 1902(a)(25)(E) and (F) of the Act. This letter is to inform you that New Hampshire's Medicaid SPA Transmittal Number 22-0030 was approved on April 28, 2022 with an effective date of January 1, 2022.

If you have any questions, please contact Joyce Butterworth at 857-338-0554 or via email at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

[redacted]

Ruth A. Hughes, Acting
Director Division of Program
Operations

cc: Henry Lipman, State Medicaid Director
Dawn Landry, Medicaid Business and Policy

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22 — 0030
2. STATE: NH

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
1/1/2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 139(b)(3)(i) and (ii); 42 CFR 433.139(f)(2) and (3); 42 CFR 447.15; 42 CFR 447.20; Section 1902(a)(25)(E) and (F) of the Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 0
b. FFY 2023 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Section 4, page 69a
Attachment 4.22-A, Pages 1-4
Attachment 4.22-B, Pages 1-2

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Section 4, page 69a (TN 94-17)
Attachment 4.22-A, Pages 1-4 (TN 87-9)
Attachment 4.22-B, Page 1 (TN 01-008)

9. SUBJECT OF AMENDMENT
TPL Clarification

10. 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:
Any comments received will be forwarded

[redacted]TATE AGENCY OFFICIAL

12. TYPED NAME
Ann H. Landry

13. TITLE
Associate Commissioner

14. DATE SUBMITTED March 15, 2022

15. RETURN TO

Janine Corbett
Division of Medicaid Services/Brown Building
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

FOR CMS USE ONLY

16. DATE RECEIVED
March 15, 2022

17. DATE APPROVED
April 28, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2022

[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Ruth A. Hughes

Acting Director, Division of Program Operations

22. REMARKS

Instructions on Back

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

State/Territory: New Hampshire

Citation		
42 CFR 433.139 (b)(3)(i)	(c)	The State will make payment for pediatric preventive services, including early and periodic screening, diagnosis, and treatment services, without regard to third party liability and seek reimbursement from any liable third party to the extent of such legal liability, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days. Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
	(d)	ATTACHMENT 4.22-B specifies the following:
42 CFR 433.139(b)(3)(ii)(A)	(1)	The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).
42 CFR 433.139(f)(2)	(2)	The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
42 CFR 433.139(f)(3)	(3)	The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20 42 CFR 447.15	(e)	The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

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/JVA

(b) (1) • Frequency (433.13)(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 sent to the MMIS nightly and 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 that there is a Workers Compensation case from the Medicaid recipient, the information is entered into the MMIS Recovery Case and verified with the third party carrier and/or Workers Compensation Department. Workers Compensation cases are managed as accident cases as noted below.

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, a letter is sent to the Medicaid recipient requesting accident and insurance information. If the Medicaid recipient does not respond, then the service provider is contacted for insurance information and any additional claims related to the accident are pended until insurance information is obtained. The accident, insurance, and attorney, if applicable, are entered into the MMIS Recovery case and all claims are manually reviewed to determine if they are related to the accident. Lien reports are sent to either the insurance company or the representing attorney for recovery.

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

Within 10 days of receipt of the suspected accident claim information, the data is entered into the MMIS Recovery Case and notifications are sent. A lien report is sent within 30 days, once insurance or representative attorney is determined.

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 date is entered into the eligibility case file and sent nightly to the MMIS. The information is verified and utilized in processing claims in accordance with (433.139)(b) through (f).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Requirements for Third Party Liability -
Identifying Liable Resources

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EXCHANGES

(b) (4) DIAGNOSIS AND TRAUMA CODE EDITS

• Identification (433.138)(e)

The MMIS has indicators for all Accident and Trauma ICD-10 diagnosis codes and accident indicators. When a claim is processed with one of the codes or indicators, the claim is suspended for manual review. If the claim is determined to be a potential Recovery case, the claim is processed. For minor children, the claim is paid; for adults, the claim remains suspended. A letter is sent to the Medicaid recipient or guardian for more information and liable third party. For adults, if the letter is not returned within 30 days, the claims are denied. Once the letter is returned and there is a third party liable, a recovery case is established in the MMIS. All claims within the timeframe for the Medicaid recipient are automatically entered into the recovery case. Each claim is manually reviewed to determine if it is related to the accident or injury. A lien report is generated and sent to the insurance company or attorney representing the Medicaid recipient. A updated lien report is generated every time requested by the insurance company or attorney.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

Requirements for Third Party Liability -
Identifying Liable Resources

Cross Reference

EXCHANGES

(b) (4)

- Frequency (433.138)(f)

The MMIS sends alerts to the TPL worker when new claims are paid and added to the recovery case. The recovery case is reviewed and updated on the request of the insurance company or attorney. Attorneys must request a final lien 30 days prior to settlement.

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

Claims with accident and trauma ICD-10 codes or accident indicators are suspended for manual review. Letters are sent within 10 days of the suspended claim to determine if there is a liable third party. If information is not received within 30 days, then claims are denied (adult-only claims). Service providers are contacted to determine if they have any additional information.

1. All claims for the case are automatically routed to the recovery case for review and inclusion in the case to generate the lien report. The MMIS maintains all case information, including all related claims, documents, case notes, follow up ticklers, etc.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

Requirements for Third Party Liability – Payment of Claims

(1) Providers are required to file a claim with the third party prior to filing with the Medicaid agency except in the following circumstances:

a) Claims for preventive pediatric services (including EPSDT services), and
b) Claims for covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program.

(2) Claims for preventive pediatric care, including EPSDT (Early and Periodic Screening, Diagnostic, and Treatment Services). The State pays claims for services and recovers such costs from the third party unless the State has made a determination related to cost effectiveness and access to care that warrants cost avoidance for up to 90 days.

(3) 42 CFR 433.139(b)(3)(ii). For services covered under the plan that are provided to an individual on whose behalf child support enforcement is being carried out by the State Title IV-D agency, the State will make payment for such services without regard to third party liability that is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by the State Title IV-D agency, and seek reimbursement from such liable third party to the extent of legal liability, under the following conditions:

a) The provider first bills the third party for the services.
b) Up to 100 days have elapsed since the date the provider initially billed the third party.
c) The provider has not received payment for the services.
d) The provider must submit the claim to the Medicaid agency's MMIS (Medicaid Management Information System) with documentation of the billing to the primary insurance.

(4) Section 53102(a)(1) of the Bipartisan Budget Act of 2018 amended section 1902(a)(25)(E) of the Act to require a state to use standard coordination of benefits cost avoidance when processing claims for prenatal services which now included labor and delivery and postpartum care claims. Therefore, these claims will be denied and be returned to the provider noting the third party that Medicaid believes to be legally responsible for payment. If, after the provider bills the liable third party and a balance remains or the claim is denied payment for a substantive reason, the provider can submit a claim to MMIS for payment of the balance, up to the maximum Medicaid payment amount established for the service in the State Plan.

(5) Claims for medical services are cost-avoided when a third party liability (TPL) policy exists within the MMIS that matches the benefit coverage-type and service date. Claims paid by the Agency prior to the TPL policy being entered into the MMIS and verified are pursued for recovery through an invoice submitted to the primary insurance carrier. This does not apply to exceptions for Good Cause or Confidential Services cases. Good Cause and Confidential Services cases include Title IV-D domestic violence cases. TPL billing is done monthly of all verified TPL policies entered in

the MMIS in the previous month. NH does not have a cost-effectiveness threshold to pursue recovery on a health insurance claim. However, any claims under $50 that are not paid by the primary carrier within 6 months may be closed as not recoverable.

Generally, casualty insurance claims are pursued for recovery. Casualty cases are determined by referral/inquiry from a provider, insurance carrier, Medicaid member, or attorney. Paid claims related to an accident/Injury on a Medicaid client are manually reviewed. MMIS automatically reviews the paid amount on an accident- or injury-related claim and initiates a Medical Service Questionnaire (MSQ) letter to the client if a case has not already been established. Casual cases are pursued regardless of amount, if it is determined recovery is probable.

(6) The Medicaid provider may not refuse covered services to an individual who is eligible for medical assistance under the plan on account of a third party's potential liability. The provider may not seek to collect from the Medicaid eligible individual (or any financially responsible relative or representative of that individual) if the total amount of the third party liability is equal to or greater than the amount payable under the State Plan (which includes, when applicable, approved cost-sharing payments.) When the total third party payment is less than the amount payable under the State Plan (which includes, when applicable, approved cost-sharing payments), the provider may collect from the individual (or any financially responsible relative or representative) an amount the lesser of any approved cost-sharing amount or the difference between the amount payable under the State Plan and the total third party payment.