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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: 22-0051

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

February 24, 2023

Lori A. Weaver
Interim Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

Re: New Hampshire State Plan Amendment (SPA) 22-0051

Dear Interim Commissioner Weaver:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 22-0051. This amendment proposes to provide a comprehensive adult dental benefit that includes diagnostic, preventive, limited periodontal, restorative, and oral surgery services for all Medicaid eligible adults age 21 and older.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations 42 CFR §440.100. This letter is to inform you that New Hampshire's Medicaid SPA Transmittal Number 22-0051 is approved on February 23, 2023, with an effective date of April 1, 2023.

If you have any questions, please contact Joyce Butterworth at (857) 357-6375 or via email at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
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February 24, 2023

Lori A. Weaver
Interim Commissioner
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

Re: New Hampshire State Plan Amendment (SPA) Transmittal Number NH-22-0051.

Dear Interim Commissioner Weaver:

This letter is being sent as a companion to the Centers for Medicare & Medicaid (CMS) approval of New Hampshire's State Plan Amendment (SPA) Transmittal Number 22-0051, which made changes to the New Hampshire Medicaid State Plan regarding dental services. This amendment was submitted on December 27, 2022, with an effective date of April 01, 2023. The SPA clarifies coverage and reimbursement of dental services for beneficiaries under the age of 21.

As a part of the review of the proposed changes to the 10 Dental Services coverage page, Supplement to Attachment 3.1-A, Page 4a, and Supplement to Attachment 3.1-B, Pages 4a, CMS included an analysis of the 9 Clinic Services coverage pages on the same pages. Based on our review, CMS identified language on the 4a. Clinic Services coverage pages on the Supplements to Attachment 3.1-A and Attachment 3.1-B do not comply with current federal regulations or statutes. This language is not integral to the approval of SPA NH-22-0051. Still, additional changes are required to the New Hampshire Medicaid State Plan's coverage of the Clinic Services benefit as specified below.

Regulations at 42 Code of Federal Regulations (CFR) 430.10 require that the State Plan be a comprehensive written statement describing the nature and scope of the State's Medicaid program. It should contain all information necessary for CMS to determine whether the Plan can be approved and whether the State program is eligible for Federal Financial Participation (FFP).

The content described on the coverage pages for 9. Clinic Service in the Supplements to Attachment 3.1-A and Attachment 3.1-B, Pages 4a, outlines that "Out-of-state clinic services require prior authorization from the Department. Such payment authorization may be given only if substantiated by the attending physician's statement of medical necessity." The language reflected on the coverage page does not comply with federal Medicaid statute or policy, as outlined, as it does not include sufficient detail regarding coverage of clinic services. Currently, the State Plan does not describe the types of clinics that the State covers, and it is not clear if there are limitations on the amount, duration, and scope outside of out-of-state services. These descriptions must be added to the State Plan. For additional information about the clinic services benefit, please refer to the State Medicaid Manual in Chapter 4, Section 4320, Clinic Services. Please note that information about whether they can be exceeded based on a medical necessity review should be included when describing any limitations. If limits cannot be exceeded (have a hard cap), a response to sufficiency questions should accompany the State Plan submission. CMS will then ascertain whether such limitations are sufficient to meet the purpose of the clinic benefit. Please see

the December 16, 2014, Associate Regional Administrators Memo "Sufficiency of Mandatory and Optional Services" for more information on the sufficiency of mandatory and optional services.

Additionally, the language regarding out-of-state coverage of services is not currently compliant with the requirements found at 42 CFR 431.52, indicating that "A State Plan must provide that the State will pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a beneficiary who is a resident of the State, and any of the following conditions are met:

> (1) Medical services are needed because of a medical emergency;
> (2) Medical services are needed, and the beneficiary's health would be endangered if he were required to travel to his State of residence;
> (3) The State determines, based on medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other State;
> (4) It is general practice for beneficiaries in a particular locality to use medical resources in another State."

Additionally, "The plan must provide that the State will establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan."

In sum, the New Hampshire Medicaid State Plan must be revised to include information about the types of clinics the State covers and any limitations on amount, duration, or scope, indicate whether limits can be exceeded with a medical necessity review, and a revision of the out-of-state services language limitations to comply with 42 CFR 431.52. Procedure code detail should not be included.

The State has 90 days from the date of this letter to respond to the issues described above. Within that period, the State may submit a SPA to address the inconsistencies or submit a corrective action plan describing in detail how the State will resolve the issues identified above in a timely manner.

Failure to respond may result in the initiation of a formal compliance process. During the 90 days, CMS will provide technical assistance as needed or required.

If you have any questions, please contact Joyce Butterworth at (857) 357-6375 or via email at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

James G. Scott, Director
Division of Program Operations

cc: Henry Lipman, State Medicaid Director
Dawn Tierney, 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: 22-0051

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
April 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 440.100; 42 CFR 440.120; 42 CFR Part 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 9,748
b. FFY 2024 $ 19,496

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-A: Page 4a; Page 5; Page 5a(6)

Attachment 3.1-B: Page 4a; Page 4; Page 4h

Attachment 4.19-B: Page 2a; Page 2c.1

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Att. 3.1-A: Page 4a (14-014); Page 5(86-2b); Page 5a(6) (N/A, new page) 86-8
Att. 3.1-B: Page 4a (14-014); Page 4 (~~86-6~~); Page 4h (N/A, new page)
Att. 4.19-B: Page 2a (21-0010); Page 2c.1 (N/A, new page)

9. SUBJECT OF AMENDMENT
Adult Dental Benefit for those Excluded from the Prepaid Ambulatory Health Plan (PAHP)

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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Christine Santaniello

13. TITLE
Associate Commissioner

14. DATE SUBMITTED 12-27-22

15. RETURN TO
Janine Corbett
Division of Medicaid Services - Brown Building
129 Pleasant Street
Concord, NH 03301

FOR CMS USE ONLY

16. DATE RECEIVED December 27, 2022

17. DATE APPROVED February 23, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
April 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director, Division of Program Operations

22. REMARKS
Pen & ink change to Box 8 correcting superseded page number.

Comments, if any, will follow.

FORM CMS-179 (09/24)

Instructions on Back

9. Clinic Services

Out-of-state clinic services require prior authorization from the Department. Such payment authorization may be given only if substantiated by the attending physician's statement of medical necessity.

10. Dental Services

Recipients under age 21

Treatment covered for recipients under 21 includes: (a) prophylaxis every 150 days, (b) restorative treatment, (c) periodic examinations, no more frequently than every 150 days, unless they are medically necessary to diagnose an illness or condition, (d) vital pulpotomy, (e) extractions of symptomatic teeth associated with diagnosed pathology as documented in the provider's treatment record, (f) extractions of asymptomatic teeth subject to prior authorization, with the exception of third molars , (g) extractions of third molars associated with diagnosed pathology as documented in the provider's treatment record, and subjectto prior authorization, (h) general anesthesia and nitrous oxide analgesia (i) orthodontic therapy subject to prior authorization, (j) x-rays including complete or panoramic every 5 years, bitewings every 12 months if medically necessary, and all types regardless of limits if required to complete a differential diagnosis, (k) palliative treatment, (l) topical fluoride treatment two times/year, (m) endodontia, including root canal therapy, (n) crowns, (o) periodontic treatment limited to prophylaxis, scaling, and root planning, (p) sealants for permanent and deciduous molars every 5 years, (q) surgical periodontal treatment subject to prior authorization, and (r) any other services that meet EPSDT medical necessity criteria as determined by the Department. Any limits to services do not apply to EPSDT recipients as long as medical necessity criteria as determined by the Department have been met.

Prior authorization from the Department is also required for (a) orthodontic therapy considered under theEPSDT medical necessity provisions, and (b) services not listed but identified in an EPSDT screening. Prior authorization for all orthodontic therapy is granted based upon substantiation of the meeting of conditions specified by the Department. Orthodontic therapy is covered only until the recipient reaches the age of 21.

Recipients age 21 and older

Treatment covered for recipients 21 and older includes: (a) diagnostic and preventive dental services, including an annual comprehensive oral examination, X-rays or other imaging, prophylaxis, topical fluoride, oral hygiene instruction, behavior management and smoking cessation counseling; (b) comprehensive restorative treatment; (c) oral surgery and treatment necessary to relieve pain, eliminate infection, or prevent imminent tooth loss. The individual benefit shall be capped at $1,500 per year, excluding preventive services. The $1,500 cap can be exceeded when additional services are medically necessary.

Dental services may require prior authorization and are approved when medically necessary.

11. Physical Therapy and Related Services (Occupational and Speech Therapy)

When provided by a home health agency, visiting nurse association, outpatient hospital (to include rehabilitation center), or independent therapist, these services are limited to eighty (80) 15-minute unitsper recipient per state fiscal year. The eighty (80) units may be used for one type of therapy or in any combination of therapies in an outpatient setting. The limits may be exceeded if prior authorization is granted from the Department based on medical necessity.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ **Provided:** / / **No limitations** /X/ **With limitations***
/ / **Not provided.**

b. Dentures.

/X/ **Provided:** / / **No limitations** /X/ **With limitations***
/ / **Not provided.**

c. Prosthetic devices.

/X/ **Provided:** / / **No limitations** /X/ **With limitations***
/ / **Not provided.**

d. Eyeglasses.

/X/ **Provided:** / / **No limitations** /X/ **With limitations***
/ / **Not provided.**

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services-

/X/ **Provided:** / / **No limitations** /X/ **With limitations***
/ / **Not provided.**

***Description provided on attachment.**

12b. Dentures

Coverage for removable prosthetic replacement of permanent teeth is limited to recipients under age 21 and must meet EPSDT medical necessity criteria as determined by the Department; coverage is subject to prior authorization.

State/Territory: New Hampshire

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

8. Private duty nursing services.

/X/ Provided / / No limitation /X/ With limitations*

9. Clinic services.

/X/ Provided / / No limitation /X/ With limitations*

10. Dental services.

/X/ Provided / / No limitation /X/ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided / / No limitation /X/ With limitations*

b. Occupational therapy.

/X/ Provided / / No limitation /X/ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/X/ Provided / / No limitation /X/ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided / / No limitation /X/ With limitations*

b. Dentures.

/X/ Provided / / No limitation /X/ With limitations*

*Description provided on attachment.

8. Private Duty Nursing Services

Private duty nursing services which are covered are those provided by a registered or licensed practical nurse under the order and general direction of the patient's physician to a patient only in his place of residence, not a long term care facility. Prior authorization is required every sixty (60) days from the Department.

9. Clinic Services

Out-of-state clinic services require prior authorization from the Department. Such payment authorization may be given only if substantiated by the attending physician's statement of medical necessity.

10. Dental Services

Recipients under age 21

Treatment covered for recipients under 21 includes: (a) prophylaxis every 150 days, (b) restorative treatment, (c) periodic examinations, no more frequently than every 150 days, unless they are medically necessary to diagnose an illness or condition, (d) vital pulpotomy, (e) extractions of symptomatic teeth associated with diagnosed pathology as documented in the provider's treatment record, (f) extractions of asymptomatic teeth subject to prior authorization, with the exception of third molars , (g) extractions of third molars associated with diagnosed pathology as documented in the provider's treatment record, and subjectto prior authorization, (h) general anesthesia and nitrous oxide analgesia (i) orthodontic therapy subject to prior authorization, (j) x-rays including complete or panographic every 5 years, bitewings every 12 months if medically necessary, and all types regardless of limits if required to complete a differential diagnosis, (k) palliative treatment, (l) topical fluoride treatment two times/year, (m) endodontia, including root canal therapy, (n) crowns, (o) periodontic treatment limited to prophylaxis, scaling, and root planing, (p) sealants for permanent and deciduous molars every 5 years, (q) surgical periodontal treatment subject to prior authorization, and (r) any other services that meet EPSDT medical necessity criteria as determined by the Department. Any limits to services do not apply to EPSDT recipients as long as medical necessity criteria as determined by the Department have been met.

Prior authorization from the Department is also required for (a) orthodontic therapy considered under theEPSDT medical necessity provisions, and (b) services not listed but identified in an EPSDT screening. Prior authorization for all orthodontic therapy is granted based upon substantiation of the meeting of conditions specified by the Department. Orthodontic therapy is covered only until the recipient reaches the age of 21.

Recipients age 21 and older

Treatment covered for recipients 21 and older includes: (a) diagnostic and preventive dental services, including an annual comprehensive oral examination, X-rays or other imaging, prophylaxis, topical fluoride, oral hygiene instruction, behavior management and smoking cessation counseling (b) comprehensive restorative treatment; (c) oral surgery and treatment necessary to relieve pain, eliminate infection, or prevent imminent tooth loss. The individual benefit shall be capped at $1,500 per year, excluding preventive services. The $1,500 cap can be exceeded when additional services are medically necessary.

Dental services may require prior authorization and are approved when medically necessary.

12b. Dentures

Coverage for removable prosthetic replacement of permanent teeth is limited to recipients under age 21 and must meet EPSDT medical necessity criteria as determined by the Department; coverage is subject to prior authorization.

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

10. Dental Services -

Recipients under age 21
Payment is made in accordance with a fee schedule established by the Department. As of April 1, 2023, there are separate fee schedules for the children's dental benefit and for the adult dental benefit. Children's dental benefit rates were set as of January 1, 2021, and are effective for services provided on or after that date. No provider shall bill or charge the Department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov under the "documents and forms" tab under "documentation," and are applicable to all public and private providers.

Effective January 1, 2022, limited orthodontia will be paid in one payment, inclusive of records. Comprehensive orthodontia will be paid in three payments, inclusive of records: at banding; no sooner than 12 months after banding; and when evidence confirms that the case is completed. "Inclusive of records" means inclusive of the casts/models and various types of X-rays, such as panorex and cephalometric X-rays, that are required as part of the orthodontic consultation.

Recipients age 21 and older
Payment is made in accordance with a fee schedule established by the Department. As of April 1, 2023, there are separate fee schedules for the children's dental benefit and for the adult dental benefit. Adult dental benefit rates were set as of April 1, 2023 and are effective for services provided on or after that date. No provider shall bill or charge the Department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov under the "documents and forms" tab under "documentation," and are applicable to all public and private providers.

11. Physical Therapy and Related Services (Occupational and Speech Therapy) - Payment for physical, occupational, and speech therapy services is based upon a 15 minute unit of service, unless the CPT code is defined otherwise, and made in accordance with a fee schedule established by the Department. Rates were set as of January 1, 2021, and are effective for services provided on or after that date. No provider shall bill or charge the Department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov under the "documents and forms" tab under "documentation," and are applicable to all public and private providers.

Note: When it is stated that "rates were set as of," this indicates the most recent date rates were changed on one or more codes for the type of service/practitioner in question. It is not meant to imply that all of the codes pertaining to the type of service/practitioner in question were changed or reviewed.

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

12b. Dentures – Payment for dentures, as provided for under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for beneficiaries under age 21, is made in accordance with a fee schedule established by the Department. Rates were set as of April 1, 2023 and are effective for services provided on or after that date. No provider shall bill or charge the Department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov, under the "documents and forms" tab under "documentation," and are applicable to all public and private providers.