

**RULEMAKING NOTICE FORM**

Notice Number 2015-198 Rule Number He-W 512

<p>1. Agency Name &amp; Address:</p> <p><b>NH Dept. of Health &amp; Human Services Office of Medicaid Business and Policy 129 Pleasant Street Concord, NH 03301</b></p>	<p>2. RSA Authority: <b>RSA 126-A:5, XXIV(f); RSA 126-A:5,XXV(f); RSA 161:4-a, X</b></p> <hr/> <p>3. Federal Authority: <b>42 U.S.C. 1396u-7</b></p> <hr/> <p>4. Type of Action:</p> <p>Adoption _____</p> <p>Amendment _____</p> <p>Repeal _____</p> <p>Readoption _____</p> <p>Readoption w/amendment <u>X</u></p>
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5. Short Title: **Alternative Benefit Plan and Premium Assistance Program**

6. (a) Summary of what the rule says and of any proposed amendments:

**Chapter 3, Laws of 2014 (SB 413) directs the NH Department of Health and Human services to establish the NH Health Protection Program (NHHPP), which expands Medicaid eligibility as allowed under the Affordable Care Act (ACA). The ACA requires that this expanded population receive Alternative Benefit Plan (ABP) benefits in accordance with Section 1937 of the Social Security Act (also referred to as Medicaid Benchmark or Benchmark Equivalent Plans).**

**He-W 512 establishes the ABP provided through NH Medicaid to newly eligible adults in accordance with Chapter 3, Laws of 2014 (SB 413). Newly eligible adults are those who are 19–64 years old, with incomes up to 138 percent of the federal poverty level, who are not pregnant at the time of application, are not eligible for or enrolled in Medicare, and are not eligible for Medicaid through any other existing Medicaid eligibility category. The proposal describes the rules governing the Premium Assistance Program (PAP), which is the next phase of the NHHPP, and includes requirements for enrollment, exemptions, benefits, appeals, and cost sharing. Note that this proposal is the same in substance as INT 2015-16 and it will replace that rule.**

**The PAP is a requirement in state law and under a federal waiver that newly eligible individuals who are in the NHHPP must get coverage from a Qualified Health Plan (QHP) under the PAP in 2016. Chapter 3, Laws of 2014 (SB 413) requires that adults eligible for medical assistance under 42 U.S.C. §1396(a)(10)(A)(i)(VIII) enroll in a cost-effective QHP certified for sale on the N.H. federally facilitated Marketplace and requires the Department to submit a §1115(a) Research and Demonstration waiver application to the Centers of Medicare and Medicaid Services (CMS) to implement the PAP. The Department received approval of its §1115(a) Research and Demonstration waiver, #11-W-00298/1, from CMS on March 4, 2015. The waiver allows the implementation of the requirements of SB 413, as noted above. Coverage under the PAP begins January 1, 2016, and ends December 31, 2016, unless authorized to operate longer by the General Court of New Hampshire.**

**NHHPP individuals who are enrolled with a Medicaid Managed Care Organization (MCO) with a comparable, cost-effective QHP will be auto-assigned into that QHP, and given one 30-day opportunity to select a different QHP. NHHPP individuals who are enrolled in a MCO without a comparable, cost-effective QHP will have 30 days to select a QHP. If they fail to select a QHP during that period, they will be auto-assigned to a QHP based on the following: family affiliation with a MCO, family affiliation with a QHP, affiliation with a primary care provider enrolled with a QHP, or, in the event those criteria cannot be met, auto-assignment will be equally distributed among the available QHPs.**

**Individuals who identify as medically frail will have the choice of state plan Medicaid benefits or ABP benefits delivered by a MCO. Individuals who are Native American or Alaskan Native can voluntarily opt out of the PAP and, if so, will receive their ABP benefits from a MCO. NHHPP individuals identifying as pregnant after their Medicaid application can choose between receiving state plan Medicaid benefits or ABP benefits from an MCO.**

**PAP participants will receive the ABP benefits covered by the QHP and will receive wrap benefits under state plan Medicaid for non-emergency medical transportation, EPSDT for 19- and 20-year olds, family planning services, adult dental in accordance with He-W 566.04(e), and adult vision services in accordance with He-W 530.03(g).**

**PAP participants will be required to exhaust the private market appeal process for appeals related to a QHP covered service before seeking a state fair hearing. The private market appeals process includes internal review conducted by the QHP under RSA 420-J:5 and RSA 420-J:5-a through 5-e with respect to medical necessity and coverage issues, and an option for an additional independent external review conducted by an independent review organization under RSA 420-J:5 with respect to medical necessity issues. PAP participants will have the right to a state fair hearing when they have exhausted the private market process and must request a hearing in accordance with He-C 200.**

**All NHHPP individuals will be subject to co-payments as follows:**

- \$8.00 for each specialty drug prescription and refill dispensed;**
- \$3.00 for each primary care provider visit to treat illness or injury;**
- \$125 for each inpatient mental health admission, inpatient substance use disorder treatment admission or hospital admission, excluding maternity admissions;**
- \$35 for high-cost imaging such as CT/PET scans, and MRIs;**
- \$3.00 for each mental health outpatient visit;**
- \$3.00 for each substance use disorder outpatient visit;**
- \$3.00 for each physical therapy visit;**
- \$3.00 for each occupational therapy visit;**
- \$8.00 for each speech therapy visit;**
- \$3.00 for each chiropractor visit;**
- \$8.00 for each specialty physician visit; and**
- \$3.00 for each visit to other medical professionals such as an advanced practice registered nurse or a physician's assistant.**

**In addition, the proposal also changes the co-payment amounts for each brand preferred and non-preferred prescription drug from \$4.00 to \$8.00 and the co-payment for each generic prescription drug from \$1.00 to \$4.00.**

**6. (b) Brief description of the groups affected:**

**The proposal affects New Hampshire Medicaid recipients who are newly eligible adults. Newly eligible adults are those who are 19–64 years old, with incomes up to 138 percent of the federal poverty level, who are not pregnant at the time of application, are not eligible for or enrolled in Medicare, and are not eligible for Medicaid through any other existing Medicaid eligibility category. The rule also affects NH Medicaid providers who serve the newly eligible adults, as well as the Managed Care Organizations under contract with the Department to serve the Medicaid population.**

6. (c) Specific section or sections of state statute or federal statute or regulation which the rule is intended to implement:

<b>Rule</b>	<b>Federal Reg./RSA</b>
He-W 512.01	RSA 126-A:5, XXIV; 42 U.S.C. 1396u-7
He-W 512.02	RSA 126-A:5, XXIV; 42 U.S.C. 1396u-7
He-W 512.03	RSA 126-A:5, XXIV; 42 U.S.C. 1396u-7
He-W 512.04	RSA 126-A:5, XXIV; 42 U.S.C. 1396u-7; RSA 420-J:5
He-W 512.05	RSA 126-A:5, XXIV; 42 U.S.C. 1396u-7
He-W 512.06	RSA 126-A:5, XXIV; 42 U.S.C. 1396u-7
He-W 512.07	RSA 126-A:5, XXIV; 42 U.S.C. 1396u-7; RSA 420-J:5
He-W 512.08	RSA 126-A:5, XXIV; 42 CFR 433.139
He-W 512.09	RSA 126-A:5, XXIV; 42 CFR 455; and 42 CFR 456

7. Contact person for copies and questions including requests to accommodate persons with disabilities:

Name: **Michael Holt** Title: **Rules Coordinator**  
 Address: **Dept. of Health and Human Services** Phone #: **271-9234**  
**Administrative Rules Unit** Fax#: **271-5590**  
**129 Pleasant St.** E-mail: [michael.holt@dhhs.state.nh.us](mailto:michael.holt@dhhs.state.nh.us)  
**Concord, NH 03301**

TTY/TDD Access: Relay NH 1-800-735-2964 or dial 711 (in NH)

**The proposed rules may be viewed and downloaded at:**

<http://www.dhhs.nh.gov/oos/aru/comment.htm>

8. Deadline for submission of materials in writing or, if practicable for the agency, in the electronic format specified: **Thursday, January 14, 2016**

Fax  E-mail  Other format (specify):

9. Public hearing scheduled for:

Date and Time: **Thursday, January 7, 2016 at 10:30 AM**

Place: [\*\*DHHS Brown Bldg., Auditorium, 129 Pleasant St., Concord, NH\*\*](#)

10. Fiscal Impact Statement (Prepared by Legislative Budget Assistant)

FIS # 15:216, dated 12/07/15

**1. Comparison of the costs of the proposed rule(s) to the existing rule(s):**

There is no difference in cost when comparing proposed rules He-W 512.01-512.03, 512.05, and 512.08-512.09 to the existing rules. Proposed rule He-W 512.06 will increase costs for state citizens, to the extent they are Medicaid recipients subject to the copayments imposed by the rule. Proposed rules He-W 512.04 and He-W 512.07 are new rules.

**2. Cite the Federal mandate. Identify the impact of state funds:**

Section 1937 of the Social Security Act is the federal standard for the medicaid population. Under the Affordable Care Act (ACA), states that decide to implement Medicaid expansion must provide services to the newly-eligible population through an Alternative Benefit Plan (ABP) which includes 10 essential health benefits. Section 1902(a)(17) of the Social Security Act requires comparability with respect to cost sharing among similarly-situated Medicaid enrollees. As a result, in order to be in compliance, the

cost-sharing copayments required by this proposed rule and applied to Premium Assistance Plan enrollees are required to be applied to similarly-situated adults in standard Medicaid who have incomes above 100% of the federal poverty level (FPL) and are not otherwise exempt from co-payments, to be applied later in 2016.

**3. Cost and benefits of the proposed rule(s):**

With the exception of the copayments described in (B) below, any cost or benefit associated with the proposed rules, including the proposed new rules He-W 512.04 and He-W 512.07, is attributable to Chapter 3, Laws of 2014, which directed the Department of Health and Human Services to establish the New Hampshire Health Protection Program (NHHPP), expanding Medicaid Eligibility as allowed under the ACA. As noted in (2) above, the ACA requires that this expanded population receive ABP benefits (also known as Medicaid Benchmark or Benchmark Equivalent Plans). In addition, the Premium Assistance Program is a requirement in state law and under a federal waiver that newly-eligible individuals in the NHHPP must get coverage from a Qualified Health Plan under the Premium Assistance Program beginning in 2016. The proposed rule describes the rules governing the Premium Assistance Program including enrollment, exemptions, benefits, appeals, and cost sharing.

**A. To State general or State special funds:**

None.

**B. To State citizens and political subdivisions:**

The proposed rule He-W 512.06 will increase costs for state citizens to the extent they are Medicaid recipients subject to the copayments imposed by proposed rule. These proposed copayments amounts were determined by an actuary to meet federal regulations which require a 94.6% actuarial value in order to be approved for sale on the federal marketplace in New Hampshire. One-third of the newly eligible population will be subject to the proposed copayments, which are as follows:

- \$8 for each specialty drug prescription and refill dispensed;
  
- \$3 for each primary care provider visit to treat illness or injury;
- \$125 for each inpatient mental health admission, inpatient substance use disorder treatment admission or hospital admission, excluding maternity admissions;
- \$35 for high-cost imaging such as CT/PET scans and MRIs;
- \$3 for each mental health outpatient visit;
- \$3 for each substance use disorder outpatient visit;
- \$3 for each physical therapy visit;
- \$3 for each occupational therapy visit;
- \$8 for each speech therapy visit;
- \$3 for each chiropractor visit;
- \$8 for each specialty physician visit; and
- \$3 for each visit to other medical professionals such as an advanced practice registered nurse or a physician's assistant.

**C. To independently owned businesses:**

None.

11. Statement Relative to Part I, Article 28-a of the N.H. Constitution:

**The proposal modifies an existing program or responsibility, but does not mandate any fees, duties or expenditures on the political subdivisions of the state, and therefore does not violate Part I, Article 28-a of the N.H. Constitution.**

**Readopt with amendment He-W 512, effective 8/15/14 (Document #10656), cited and to read as follows:**

CHAPTER He-W 500 MEDICAL ASSISTANCE

PART He-W 512 ALTERNATIVE BENEFIT PLAN (ABP) AND PREMIUM ASSISTANCE PROGRAM

He-W 512.01 Purpose. The purpose of this part is to describe the alternative benefit plan (ABP) services and the premium assistance program (PAP) available through the medicaid program to the newly eligible population in accordance New Hampshire Health Protection Plan, RSA 126-A:5, XXIV.

He-W 512.02 Definitions.

(a) “Alternative benefit plan (ABP)” means the medicaid benchmark or benchmark equivalent coverage described in section 1937 of the Social Security Act.

(b) “Department” means the New Hampshire department of health and human services.

(c) “Medicaid” means the Title XIX and Title XXI programs administered by the department, which makes medical assistance available to eligible individuals.

(d) “Medically frail” means a newly eligible individual who is exempt from mandatory enrollment in the ABP or PAP in accordance with the conditions set forth in 42 CFR § 440.315(f).

(e) “Newly eligible adult” means adults who are eligible for medicaid under the New Hampshire health protection program and the provision of section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of 1935 as amended, 42 USC §1396a(a)(10)(A)(i)(VIII).

(f) “Premium Assistance Program (PAP)” means the Marketplace Premium Assistance Program, established by SB 413 (Chapter 3, Laws 2014) which requires that adults eligible for medical assistance under 42 USC § 1396a(a)(10)(A)(i)(VIII) enroll in a cost-effective Qualified Health Plan offered on New Hampshire’s federally facilitated Marketplace, authorized through the Section 1115(a) research and demonstration waiver, # 11-W-00298/1 by the Centers for Medicare and Medicaid Services on March 4, 2015.

(g) “Qualified Health Plan (QHP)” means an individual health insurance policy certified by Centers for Medicare and Medicaid Services (CMS) for sale through New Hampshire’s individual health insurance Marketplace.

(h) “Subluxation” means an incomplete dislocation, off centering, misalignment, fixation, or abnormal spacing of the vertebrae.

(i) “Title XIX” means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the department.

(j) “Title XXI” means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department.

(k) “Wrap benefits” means:

(1) Non-emergency medical transportation;

(2) Early Periodic Screening Diagnosis and Treatment (EPSDT) services as described in He-W 546, for individuals who are under the age of 21; and

(3) Family planning services and supplies from a medicaid enrolled provider, and adult dental in accordance with He-W 566.04(e) and adult vision services in accordance with He-W 530.03(g).

He-W 512.03 Eligibility.

(a) All newly eligible individuals shall receive services under the ABP, unless they are medically frail or identify as pregnant after application and opt to receive Medicaid state plan services.

(b) Beginning January 1, 2016, individuals who are eligible for medicaid through the New Hampshire Health Protection Plan (NHHPP) shall be in the PAP unless the individual is exempt or voluntary as described in He-W 512.04(b) and (c) below.

He-W 512.04 Enrollment.

(a) For individuals who are eligible for PAP, enrollment in a QHP shall be mandatory in calendar year 2016 unless the individual is determined to be exempt as described in (b) below or voluntary as described in (c) below.

(b) Individuals who are determined to be medically frail as defined in 42 CFR § 440.315(f) shall be exempt from mandatory enrollment with a QHP.

(c) The following individuals shall be voluntary for enrollment with a QHP:

(1) Individuals who are members of a federally recognized Indian tribe or Alaskan natives; and

(2) Individuals who are enrolled in PAP who identify as pregnant after the point of application for medicaid.

(d) The department shall send a notice of QHP plan selection to all individuals eligible for PAP enrollment as indicated in (a) above except those who are exempted from enrollment.

(e) PAP participants shall have 30 days from the date of the QHP plan selection notice in (d) above to select a QHP and to respond to the department's notice, by using the on-line portal NH Electronic Application System (NH EASY), calling via telephone, or contacting the department in person.

(f) PAP participants who fail to select a QHP within 30 days from the date of the notice in (e) above shall be auto-assigned to a QHP.

(g) Auto-assignments with a QHP shall be based on the following criteria:

(1) Personal or family affiliation to a QHP or medicaid managed care organization (MCO), if the MCO offers a complementary QHP;

(2) Primary care provider affiliation to a QHP; or

(3) If no assignment can be made utilizing (1)-(2) above, assignment shall be equally distributed among the available QHPs.

(h) PAP participants may request to change the QHP selection without cause, by making a written or oral request to the department at any of the following times:

(1) During the first 30 days following the date of the member's initial selection of or the auto-assignment to the QHP, or the date the department sends the member confirmation of the individual's selection or auto-assignment, whichever is later;

(2) Within 60 days of the occurrence of one of the following events:

a. PAP participant loses access to the QHP he or she is currently enrolled in because of a permanent move to a county where that QHP is not available;

b. PAP participant gains or becomes a dependent through marriage, birth, adoption, foster care, child support order, or court order;

c. PAP participant loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if the enrollee's dependent dies;

d. PAP participant demonstrates to the department that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the PAP participant; or

e. PAP participant's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the department, its instrumentalities, or a non-departmental entity providing enrollment assistance or conducting enrollment activities; and

(3) During open enrollment every 12 months.

(i) PAP participants shall be dis-enrolled from the PAP program if they identify as medically frail after they were previously determined eligible.

(j) Medically frail individuals shall have the option to enroll with a medicaid managed care organization to receive the ABP benefit or the state plan medicaid benefit.

(k) Individuals who are voluntary as described in (c) above shall be enrolled as follows:

(1) Individuals who are enrolled in PAP and identify as pregnant after the point of application for medicaid shall elect to receive either state plan medicaid benefits delivered through a medicaid MCO or remain enrolled in the PAP with a QHP; and

(2) Individuals who are members of a federally recognized Indian tribe or an Alaskan natives who elect to dis-enroll from their QHP shall receive ABP benefits delivered through a medicaid MCO.

(l) For PAP participants eligible for medicaid after October 1, 2015, the PAP participant shall receive coverage through fee-for-service medicaid from the date of the eligibility determination until the individual's enrollment in the QHP becomes effective. PAP participants who are enrolled with a medicaid MCO prior to or on October 1, 2015 shall receive coverage through the MCO until January 1, 2016 if there is no change to the participant's eligibility status.

(m) If a PAP participant selects or is auto-assigned to a QHP on or before the 15<sup>th</sup> of the month, coverage in the QHP shall be begin the first day of the month following the month in which the selection or auto-assignment was made.

(n) If a PAP participant selects or is auto-assigned to a QHP any time after the 15<sup>th</sup> of the month, coverage in the QHP shall be begin the first day of the second month following the month in which the selection or auto-assignment was made.

He-W 512.0405 ~~Alternate Benefit Plan Services~~ Covered Services.

(a) ABP services for NHHP participants who are medically frail or identify as members of federally recognized Indian tribes or Alaskan natives who choose to opt-out of the PAP shall include the following:

~~(a)~~(1) Services described in He-W 506.04(a) and (b);

~~(b)~~(2) Substance use disorder (SUD) services as described in He-W 513; and

~~(c)~~(3) Chiropractor services, which shall be provided as follows:

~~(1)~~a. Chiropractic services shall consist of spinal manipulation and manual medical intervention services, including:

~~a.~~1. Office visits for:

~~1.~~(i) Assessment;

~~2.~~(ii) Evaluation;

~~3.~~(iii) Spinal adjustments;

~~4.~~(iv) Manipulation; and

~~5.~~(v) Physiological therapy before or in conjunction with spinal adjustments; and

~~b.~~2. Medically necessary diagnostic laboratory and x-ray tests;

~~(2)~~b. Chiropractic services shall not include wellness care; and

~~(3)~~c. Chiropractic services shall be limited to 12 visits per recipient, per state fiscal year.

(b) Covered services for PAP participants enrolled with a QHP shall include the following categories of services from a QHP:

- (1) Ambulatory patient services;
- (2) Emergency services;
- (3) Hospitalization;
- (4) Maternity and newborn care;
- (5) Mental health and substance use disorder services, including behavioral health treatment;
- (6) Prescription drugs;
- (7) Rehabilitative and habilitate services and devices;
- (8) Laboratory services;
- (9) Preventive and wellness services and chronic disease management; and
- (10) Pediatric services including oral and vision care.

(c) PAP participants shall receive benefits described in (b) above from a QHP, and shall be restricted to using the QHP provider networks except that PAP participants shall not be restricted in their choice of family planning providers if the family planning provider is enrolled with medicaid.

(d) PAP participants shall receive fee-for service wrap benefits as defined in He-W 512.01(k) above.

He-W 512.0506 Co-payments.

(a) Except as prohibited by 42 USC § 1396o-1(b)(3)(B), newly eligible individuals who have an income greater than 100% percent of the FPL shall be subject to the following co-payments:

- (1) A co-payment in the amount of \$84.00 for each ~~preferred and non-preferred brand name prescription drug prescription, each compound product prescription,~~ and each refill of a brand name ~~or compound product~~ prescription dispensed; ~~and~~
- (2) A co-payment in the amount of \$41.00 for each generic ~~prescription drug~~ prescription and refill dispensed;:-
- (3) A co-payment in the amount of \$8.00 for each specialty drug prescription and refill dispensed;
- (4) A co-payment in the amount of \$3.00 for each primary care provider visit to treat illness or injury;
- (5) A co-payment in the amount of \$125.00 for each inpatient mental health admission, inpatient substance use disorder treatment admission or hospital admission, excluding maternity admissions;
- (6) A co-payment in the amount of \$35.00 for high-cost imaging such as CT/PET scans, and MRIs;

- (7) A co-payment in the amount of \$3.00 for each mental health outpatient visit;
- (8) A copayment in the amount of \$3.00 for each substance use disorder outpatient visit;
- (9) A co-payment in the amount of \$3.00 for each physical therapy visit;
- (10) A co-payment in the amount of \$3.00 for each occupational therapy visit;
- (11) A co-payment in the amount of \$8.00 for each speech therapy visit;
- (12) A co-payment in the amount of \$3.00 for each chiropractor visit;
- (13) A co-payment in the amount of \$8.00 for each specialty physician visit; and
- (14) A co-payment in the amount of \$3.00 for each visit to other medical professionals such as an advanced practice registered nurse or a physician's assistant.

(b) Co-payment obligations shall be suspended for the remainder of the ~~calendar state fiscal~~ year ~~quarter~~ when the total co-payments made out of pocket by the newly eligible individual reaches 5 percent % of the individual's household income.

He-W 512.07 Appeals Process for the Premium Assistance Program.

(a) The appeal process for the PAP shall address PAP participants' requests for the appeal of any adverse decisions made by the QHP related to a PAP participant's QHP covered benefits and decisions made by the department related to eligibility or wrap benefits related to the PAP.

(b) PAP participants who want to appeal a decision made by the QHP regarding a QHP's covered benefits shall exhaust all private market appeals processes applicable under NH RSA 420-J:5 and NH RSA 420-J:5-a through 5-e prior to requesting a state fair hearing with the department. The private market appeal processes includes internal review conducted by the QHP under NH RSA 420-J:5 with respect to both medical necessity and coverage issues, and an independent external review conducted by an independent review organization (IRO) under NH RSA 420-J:5-a through 5-e with respect to medical necessity issues only.

(c) PAP participants shall have the right to a state fair hearing in accordance with (d) and (e) below when the enrollee has exhausted the private market appeals processes without having the issue under appeal resolved in his or her favor. PAP enrollees shall file a request for a fair hearing in accordance with He-C 200.

(d) PAP participants shall have the right to a state fair hearing for the following issues:

- (1) For medical necessity issues, at the conclusion of the external review process as provided in NH RSA 420-J:5-a – 5-e;
- (2) For issues not related to medical necessity, at the conclusion of a QHP internal review process as provided in NH RSA 420-J:5; and
- (3) For decisions related to eligibility for medicaid or decisions made regarding wrap benefits made by the department, without first exhausting any private market appeals processes.

(e) Requests for a department fair hearing shall be made in writing within 30 calendar days of the date of the notice of the resolution of the appeal through the private market appeals process.

(f) A PAP participant’s benefits shall be continued during a department fair hearing if:

(1) The individual requests a department fair hearing within 10 calendar days of the notice of the disposition of the private market appeals process or the notice of the department’s decision on eligibility or wrap benefits;

(2) The individual requests continuation of benefits; and

(3) The individual identifies a medicaid enrolled provider to provide the benefit requested.

(g) If the QHP’s adverse decision is upheld in a department fair hearing, the member shall be liable for the cost of continued benefits.

He-W 512.0608 Utilization Review and Control. The department’s provider program integrity unit shall monitor utilization of ABP services to identify, prevent, and correct potential occurrences of fraud, waste and abuse in accordance with in accordance with He-W 520, 42 CFR 455, and 42 CFR 456.

He-W 512.0709 Third Party Liability. All third party obligations shall be exhausted before claims shall be submitted to the department’s fiscal agent in accordance with 42 CFR 433.139.

**APPENDIX**

He-W 512.01	RSA 126-A:5, XXIV; 42 U.S.C. 1396u-7
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