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State/Territory Name: NH

State Plan Amendment (SPA) #: 21-0045

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

January 25, 2022

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

RE: New Hampshire 21-0045

Dear Commissioner Shibinette:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 21-0045. Effective October 1, 2021, this amendment updates the nursing facility reimbursement rate budget adjustment factor.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment TN 21-0045 is approved effective October 1, 2021. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Mark Wong at (415) 744-3561 or mark.wong@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

Enclosures

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: 21-0045

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
October 1, 2021

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:
SSA 1902(a)(13) and 42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
Remainder of FFY 2022: No fiscal impact

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19D, page 29 (f)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19D, page 29 (f), TN 21-0033

10. SUBJECT OF AMENDMENT:
Nursing Facility Reimbursement - Change to Budget Adjustment Factor (BAF)

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:
[redacted]

13. TYPED NAME: Ann H. Landry

14. TITLE: Associate Commissioner

15. DATE SUBMITTED: 11/22/21

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
November 22, 2021

18. DATE APPROVED:
January 25, 2022

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2021

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Rory Howe

22. TITLE:
Director, Financial Management Group

23. REMARKS:

FORM HCFA-179 (07-92)

Policy
(Continued)
9999.8

(f) The capital cost component of the prospective per diem rate is based on the actual facility cost, taken from the most recently desk reviewed and/or field audited cost reports, subject to an aggregate 85th percentile ceiling.

(g) Administrative, other support, and plant maintenance cost components are reimbursed at the statewide median value, based on data included in the most recently desk reviewed and/or field audited cost reports.

8. Calculation of Facility-Specific Per Diem Rate

(a) The per diem cost components are summed to obtain the total facility rate per day for each resident in the nursing facility as of a date specified by the Department of Health and Human Services.

(b) The rate determined in (a) above shall be reduced by a budget adjustment factor (BAF) equal to 23.62%.

(c) After the close of the state fiscal year, all monies remaining in the nursing facility account, after the budget adjustment factor is reconciled, are paid in the month of July to nursing facilities based on their pro rata share of total Medicaid fee for service nursing facility per diem expenditures. The balance remaining in the nursing facility account each state fiscal year is computed by subtracting the total expended Medicaid fee-for-service nursing facility per diem payments from the budget total in the account (i.e., class line 504).

For the state fiscal year ending June 30, 2022, the total computable budget amount allocated to class line 504 is $222,124,804.

9. Rate Limitation

(a) In no case may payment exceed the provider's customary charges to the general public for such services or the Medicare upper limit of reimbursement.

(b) Payment shall be made at the lesser rate when an established rate is a condition to a certificate of need approval and that rate differs from the Medicaid rate established by the Department. When a rate limitation is applied as a condition of the certificate of need, a provider may, if aggrieved, appeal such limitation.