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State/Territory Name: NH

State Plan Amendment (SPA) #: 19-0009

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 S2-26-12
Baltimore, Maryland 21244-1850

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

Financial Management Group

October 30, 2019

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

RE: New Hampshire SPA 19-0009

Dear Commissioner Meyers:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 19-0009. Effective July 1, 2019, this amendment continues suspension of direct and indirect medical education (DME/IME) payments and catastrophic aid to inpatient hospitals for the biennium ending June 30, 2021.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 19-0009 is approved effective July 1, 2019. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,

[redacted]

Kristin Fan
Director

cc:
Avery Stahlecker
Novena James-Hailey

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: 19-0009
2. STATE: NH
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2019

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 1923 and 42 CFR Part 447

7. FEDERAL BUDGET IMPACT
0 remainder of FFY 2019
0 - FFY 2020

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19A, page 1
Attachment 4.19A, page 2
Attachment 4.19A, page 3
Attachment 4.19A, page 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19A, page 1, TN 10-004
Attachment 4.19A, page 2, TN 17-0007
Attachment 4.19A,page 3, TN 17-007
Attachment 4.19A, page 4, TN 17-0007

10. SUBJECT OF AMENDMENT

Continued Suspension of DME, IME, and Catastrophic Aid Payments

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ OTHER, AS SPECIFIED: comments, if any, will follow
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGN [redacted]L

13. TYPED NAME: Jeffrey A. Meyers

14. TITLE: Commissioner

15. DATE SUBMITTED: 8/28/2019

16. RETURN TO

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED: OCT 30 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2019

20. SIGNATURE OF REGIONAL OFFICIAL [redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS

FORM CMS-179 (07/92)

PAYMENT FOR INPATIENT HOSPITAL SERVICES

The New Hampshire Department of Health and Human Services (the Department) shall make payment for inpatient hospital services, with the exception of governmental psychiatric hospital services, as follows:

1. A diagnosis related group (DRG) method of payment shall be used for all inpatient hospital services, except that in-state hospital pass through payments for capital costs shall not be paid.

2. The DRG relative weights shall be based on the Centers for Medicare and Medicaid Services (CMS) weights and grouper software published annually or periodically for Medicare in accordance with the requirements of 42 CFR 412.60, except that CMS weights shall not be used in the computations in 3 a (3) & (4) below.

3. Reimbursement shall be based on rates and amounts established by the Department in accordance with the following methodology:

   a. Normal hospital operating costs shall be recognized and paid on a per discharge basis, and these payments shall be considered payment in full for such operating costs. Except where specifically noted otherwise, such payments shall apply to all hospitals—in-state, border, and out-of-state.

      (1) Inpatient acute care services shall be paid a pre-determined price (in relation to a DRG with a relative weight equal to one; see 3.c. for calculation) associated with the DRG assigned by the Department, to each Medicaid hospital discharge, and this rate shall be uniformly applied, except as specified in (2), (3), (4), and (5) below.

      (2) For in-state hospitals only, inpatient psychiatric care services shall be paid a pre-determined price associated with the applicable psychiatric DRG as assigned to each Medicaid discharge, but the price shall differ by the DPU or DRF peer group in which the facility is placed based upon severity of care.

(3) For in-state hospitals only, inpatient (physical) rehabilitative Medicaid discharges in Medicare certified DPU's or rehabilitation hospitals shall be paid only a flat rate (with no additional outlier payments) for the rehabilitation DRG's 945 and 946. The rate represents an average cost across such facilities.

(4) Neonatal care for Medicaid discharges assigned certain DRG's (DRG 789 through 794) shall be paid only a per diem rate (with no additional outlier payments) associated with the specific DRG. The rate shall be paid at 65% of the full per diem amount.

(5) In order to ensure recipient access to maternity-related labor and delivery services, critical access hospitals in Coos County in New Hampshire will be paid as a separate peer group at an enhanced rate for those services by applying a percentage multiplier of 300% to the DRG based payment.

b. Certain costs over and above normal hospital operating costs shall be recognized and paid in addition to the DRG payments made under 3.a. above. These payments shall be made as pass-through payments to individual hospitals. Except where specifically noted otherwise, such payments shall apply to all hospitals—in-state, border, and out-of-state.

(1) For in-state hospitals only, direct medical education costs shall be paid at a rate proportional to the Medicaid share, as calculated using Medicare principles, of actual hospital-specific costs and proportional to each hospital's share of the Medicaid annual budgeted amount. Such payments shall be made semi-annually, except that direct medical education payments shall be suspended for the period beginning July 1, 2019 and ending June 30, 2021.

(2) Day outliers shall be paid (except as specified in 3.a.(3) and (4)) for all DRG's for all facilities on a per diem basis, at 60% of the calculated per diem amount (see 3.d. for calculation), and outlier payments shall be added to the DRG payments. Payment shall be made for medically necessary days in excess of the trim point associated with a given DRG. Medicare trim points shall be used except where New Hampshire specific trim points have been established. However, day outlier payments shall be suspended beginning with March 1, 2010 discharge dates, except that this suspension shall not apply to claims for infants who have not attained the age of one year, and to claims for children who have not attained the age of six years.

(3) The Medicare deductible amount for patients who are Medicare/Medicaid (dually) eligible shall be recognized and paid.

(4) For only in-state hospitals with approved graduate medical education programs, indirect medical education costs (IME) shall be recognized and paid on a per discharge basis using the Medicare methodology at 42 CFR 412.105 to determine the amount of payment. Such payment shall be added to the DRG payment, except that IME payments shall be suspended for the state fiscal year 2020-2021 biennium.

(5) There shall be a reserve "catastrophic" fund equal to 3.3 percent of the projected annual Medicaid inpatient hospital expenditures.

This fund shall be used to provide for payments for inpatient hospital services outside the DRG system where (a) the DRG payment plus third party liability is below 25% of hospital charges, (b) the claim is for a DRG weight greater than 4.0, (c) the claim involves an inpatient stay in excess of 30 days, and (d) the hospital requests additional funding.

Reimbursement for each request shall be limited to 65% of charges reduced by prior payments, DRG allowed amounts and third party liabilities. Hospitals shall submit claims by December 15 and June 15 in order to be considered for payment for the six-month period ending, respectively, December 31 and June 30 of each year. The state shall expend half of the catastrophic fund no later than December 31 of each year and the second half no later than June 30 of each year. However, catastrophic payments will be suspended for the state fiscal year 2020-2021 biennium. Payment of eligible claims shall be determined by computing the total dollar amount of all hospitals' requests, determining each requesting hospital's total dollars requested as a percent of all requests, and applying that percent to the amount of money in the catastrophic fund in order to calculate payment to that hospital. No claims or portions of claims shall be carried over into the subsequent six-month period, nor shall any excess funds be carried over into the subsequent six-month period.

c. The calculation for the price for a DRG with a relative weight equal to one (1.0000), to be used for all DRG's except those specified above for psychiatric, rehabilitation and neonatal services shall be as follows:

(1) Beginning October 1, 1999, and each year thereafter, take the current DRG price per point(s) and inflate each by the same percent as the Medicare market basket estimated increase for prospective payment hospitals minus any Medicare or state Medicaid defined budget neutrality factors and other generally applied Medicare adjustments appropriate to Medicaid.

d. Other relevant calculations:

(1) The Department separates inpatient hospital providers into peer groups according to the intensity of care provided in each. The peer groups are set up for general acute care, critical access hospitals (CAH), distinct part units for psychiatric care, rehabilitative care and maternity care in the northern county. The Department sets a base rate (Price per Point) for each peer group. The Price per Point values for hospital peer groups are accessible at:

http://www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab)

(2) The current Price per Point rates are as follows:

Acute Care	= $2,832.85
CAH	= $3,147.61
Psych DPU	= $3,114.01
Psych DRF	= $7,200.00
Rehab	= $14,514.98
Maternity	= $3,147.61

(3) DRG reimbursement is calculated by multiplying the Price per Point for the appropriate peer group times the relative weight assigned to the DRG.

(4) The DRG amount determined above is multiplied by the reimbursement percentage assigned to the provider. The reimbursement percent is 100% except for maternity which is a 300% multiplier effective 7/1/09 as specified in item 3.a.(5) above.

(5) The per diem price associated with a given DRG shall be calculated by dividing the price for that DRG by the geometric mean length of stay associated with that DRG.

4. Direct medical education costs shall be allowed as a pass through payment in accordance with Department guidelines which shall be based on Medicare guidelines established at 42 CFR 412.2, except that direct medical education pass through payments shall be suspended for the period beginning July 1, 2019 and ending June 30, 2021.

5. Day outliers shall be reimbursed on a per diem DRG payment unless payment is suspended in accordance with 3. b. (2). Cost outliers shall not be recognized nor reimbursed. (also, see 3.b.(2) and 3.d. for day outliers.)

6. Periodic interim payments as made under the Medicare Program shall not be made by the Medicaid Program.

7. Pricing shall be prospective and payment shall be retrospective.

8. Payment rates shall be based on the relative weights and payment rates in effect at the time of discharge, taking into account the requirement to pay the lesser of the usual and customary charge or the computed rate, in accordance with 42 CFR 447.271 and RSA 126-A:3.

9. Providers of hospital services shall make quarterly refunds of Medicaid payments that are in excess of the Medicaid allowed amounts.