

## **Table of Contents**

**State/Territory Name: New Hampshire**

**State Plan Amendment (SPA) #: 20-0006**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services

Center for Medicaid & CHIP Services

233 North Michigan Ave., Suite 600

Chicago, Illinois 60601



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**Financial Management Group**

April 10, 2020

Jeffrey A. Meyers, Commissioner  
Department of Health and Human Services  
129 Pleasant Street  
Concord, NH 03301

RE: TN 20-0006

Dear Commissioner Meyers:

We have reviewed the proposed New Hampshire (NH) State Plan Amendment (SPA) to Attachment 4.19-B, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on February 07, 2020. This plan amendment updates the allowance for a 3.1% increase in the outpatient hospital rates.

Based upon the information provided by the State, we have approved the amendment with an effective date of January 01, 2020. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

Please note that our approval relates only to the requested change in payment methodology and CMS may still have questions on the funding structure in determining its consistent with section 1902(a)(2) and 1903(a) of the Act as implemented by 42 CFR § 433.54. Therefore, our approval relates only to the requested change in payment methodology and that the resultant rates and related expenditures are consistent with section 1902(a)(30)(A) of the Act. Approval of the subject SPA does not relieve the State of its responsibility to comply with federal laws and regulations, and to ensure that claims for federal funding are consistent with all applicable requirements.

If you have any additional questions or need further assistance, please contact James Moreth at 206-615-2043 or [James.Moreth@cms.hhs.gov](mailto:James.Moreth@cms.hhs.gov).

Sincerely,

A solid black rectangular box used to redact the signature of Todd McMillion.

Todd McMillion  
Director  
**Division of Reimbursement Review**

Enclosures

cc: Henry Lipman, State Medicaid Director  
Diane Peterson, Medicaid Business and Policy  
Joyce Butterworth, CMS Boston Regional Office

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <b>20-0006</b>	2. STATE <b>NH</b>
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE <b>January 1, 2020</b>	

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

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 FFY 2020: \$145,968 FFY 2021: \$194,622
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19B, Page 1	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19B, Page 1, TN 11-007

10. SUBJECT OF AMENDMENT  
**Outpatient Hospital Reimbursement - NH 2020 Budget Increase**

11. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
comments, if any, will follow

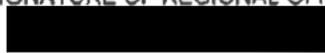
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO Dawn Landry Division of Medicaid Services/Brown Building Department of Health and Human Services 129 Pleasant Street Concord, NH 03301
13. TYPED NAME    Lori A. Shibinette	
14. TITLE    Commissioner	
15. DATE SUBMITTED <b>02-07-2020</b>	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED <b>02/07/2020</b>	18. DATE APPROVED <b>04/10/2020</b>
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**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL <b>01/01/2020</b>	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME <b>Todd McMillion</b>	22. TITLE <b>Director, Division of Reimbursement Review</b>

23. REMARKS

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

1. Outpatient Hospital Services –An interim payment shall be made based on a percent of charges. Final payment is made in accordance with a percent of costs. An audit of each hospital’s actual costs eligible for reimbursement shall be performed by the fiscal intermediary in accordance with federal Medicare requirements. The Department shall determine the percent of actual costs to be reimbursed, and then payments made to the hospital shall be cost settled using the percent determined by the Department and the actual cost data audited by the fiscal intermediary. Laboratory services provided as part of an outpatient hospital visit are reimbursed through an add-on fee and are paid in addition to the percentage of cost payment for the outpatient visit.

The interim rate established for each hospital is set as a Ratio of Cost to Charges (RCC) derived from the last settlement processed. Each hospital shall, after the close of its own unique fiscal period, submit the Medicare Cost Report (CMS Form 2552) as required by Medicare, which is subsequently audited by the Medicare Fiscal Intermediary according to the Medicare auditing schedule and principles of reimbursement. Allowable costs are allocated to the outpatient services rendered to NH Medicaid recipients on Worksheet E-3, Part III. The current reimbursable amount of the costs is at 55.72% for acute care non-critical access hospitals and 94.10% for critical access hospitals and rehabilitation hospitals. The actual interim payments made during the cost period are compared to the reimbursable costs determined by audit and the difference is the settlement payable to the hospital or to the Department. The results of this review are reported by the fiscal intermediary to the Department and to each hospital. Settlements due to the hospitals are paid in accordance with the timely claims payment requirements of 42 CFR 447.45.

TN No: 20-0006  
Supersedes  
TN No: 11-0007

Approval Date 04/10/20

Effective Date: 01/01/2020