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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: NH 21-0030

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



September 03, 2021

Lori Shibinette RN, MBA, NHA
Commissioner
Department of Health and Human Services
129 Pleasant St.
Concord, NH 03301

Re: New Hampshire State Plan Amendment (SPA) 21-0030

Dear Commissioner Shibinette:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) 21-0030. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.*), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The State of New Hampshire also requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the SPA submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(1)(C) of the Act, CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

These waivers or modifications of the requirements related to SPA submission timelines, public notice, and tribal consultation apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that New Hampshire Medicaid SPA Transmittal Number 21-0030 is approved effective May 17, 2021. This SPA is in addition to the Disaster Relief SPA #1 NH 20-0034 approved on May 22, 2020, Disaster Relief SPA #2 NH 20-0032 approved on June 2, 2020, Disaster Relief SPA #3 NH 20-0036 approved on July 15, 2020, Disaster Relief SPA #4 NH 21-0003 approved on April 9, 2021 and Disaster Relief SPA #5 NH 21-0031 approved on July 21, 2021 and does not supersede anything approved in those SPAs

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Joyce Butterworth at (857) 338-0554 or by email at Joyce.Butterworth@cms.hhs.gov if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of New Hampshire and the health care community.

Sincerely,

Alissa M.
Deboy -S

Digitally signed by Alissa
M. Deboy -S
Date: 2021.09.03
07 27:53 -04'00'

Alissa Mooney DeBoy
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

Enclosures

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

1. TRANSMITTAL NUMBER
21-0030

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
~~May 15, 2021~~ May 17, 2021

5. TYPE OF PLAN MATERIAL (Check One)
 NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN 181 AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION
Title 19 of the Social Security Act and
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT
FFY 2021: ~~\$259,180.56~~ 255,424.32
FFY 2022: ~~\$426,333.24~~ 430,089.48

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Section 7.4 (Payments Section), pages ~~52-53~~, 1135 waivers
Pages 53-63

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
NIA- new pages

10. SUBJECT OF AMENDMENT
Specialized COVID-19 Behavioral Health Long-Term Care Beds Rate

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 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL



16. RETURN TO
Jantne Corbett
Division of Medicaid Services/Brown Building
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

15. DATE SUBMITTED
12/21

FOR REGIONAL OFFICE USE ONLY
17. DATE RECEIVED June 24, 2021 118. DATE APPROVED September 03, 2021

PLAN APPROVED- ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
May 17, 2021

20. SIGNATURE OF REGIONAL ADMINISTRATOR
Alissa M. Deboy -S
Digitally signed by Alissa M. Deboy -S
Date: 2021.09.03 07:28:26 -04'00'

21. TYPED NAME Alissa Mooney DeBoy

22. TITLE On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

23. REMARKS
Permission obtained from NH to make pen & ink changes to Box 4, 7, and 8 to correct effective date, Federal budget impact, and page numbers.

Section 7 – General Provisions**7.4. Medicaid Disaster Relief for the COVID-19 National Emergency**

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NH requests this SPA to be effective from May 17, 2021 to May 16, 2022, or to the end of the PHE if earlier. NH plans to submit a non-disaster SPA prior to the end of the PHE.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

 x The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. x Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These

TN: 21-0030

Approval Date: 9-03-21

Supersedes TN: N/A

Effective Date: 5-17-21

This SPA is in addition to the Disaster Relief SPA #1 NH 20-0034 approved on May 22, 2020, Disaster Relief SPA #2 NH 20-0032 approved on June 2, 2020, Disaster Relief SPA #3 NH 20-0036 approved on July 15, 2020, Disaster Relief SPA #4 NH 21-0003 approved on April 9, 2021 and Disaster Relief SPA #5 NH 21-0031 approved on July 21, 2021 and does not supersede anything approved in those SPAs

requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c. _____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

- 1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

- 2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

- 3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

TN: 21-0030

Supersedes TN: N/A

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Effective Date: 5-17-21

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[Empty box]

Less restrictive resource methodologies:

[Empty box]

4. ____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. ____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

[Empty box]

6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. ____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

[Empty box]

2. ____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

TN: 21-0030
Supersedes TN: N/A

Approval Date: 9-03-21
Effective Date: 5-17-21

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3. ____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. ____ The agency adopts a total of ____ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a. ____ The agency uses a simplified paper application.
 - b. ____ The agency uses a simplified online application.
 - c. ____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. ____ The agency suspends enrollment fees, premiums and similar charges for:
- a. ____ All beneficiaries
 - b. ____ The following eligibility groups or categorical populations:

TN: 21-0030

Approval Date: 9-03-21

Supersedes TN: N/AEffective Date: 5-17-21

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[Empty box]

- 3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

- 1. ____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

[Empty box]

- 2. ____ The agency makes the following adjustments to benefits currently covered in the state plan:

[Empty box]

- 3. ____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

- 4. ____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

TN: 21-0030

Supersedes TN: N/A

Approval Date: 9-03-21

Effective Date: 5-17-21

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Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state’s approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

TN: 21-0030

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Effective Date: 5-17-21

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a. Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

b. Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. The agency increases payment rates for the following services:

Please list all that apply.

a. Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: _____

Through a modification to published fee schedules –

TN: 21-0030

Supersedes TN: N/A

Approval Date: 9-03-21

Effective Date: 5-17-21

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Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

- a. _____ Are not otherwise paid under the Medicaid state plan;
- b. _____ Differ from payments for the same services when provided face to face;
- c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

- d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
 - i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
 - ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. X Other payment changes:

Please describe.

Specialized COVID-19 Behavioral Health Long-Term Care Beds Rate:

TN: 21-0030

Supersedes TN: N/A

Approval Date: 9-03-21

Effective Date: 5-17-21

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(1) Qualifying Nursing Facility. Effective May 17, 2021 for 365 days, or until the end of the PHE (whichever occurs first), qualifying nursing facilities will be able to receive a member-based per diem rate for residents with severe mental or neurological disorders who are receiving specialized services for such disorders. In order to qualify for this member-based per diem rate, a nursing facility must:

(a) as of May 17, 2021, provide nursing facility services, including the specialized rehabilitation services described in (1)(b) below, to residents with mental or neurological disorders, including residents with acquired brain injuries;

(b) provide the following specialized rehabilitation services for its residents:

1. an individualized therapeutic skill development plan for each member;
2. individual counseling;
3. group counseling (therapeutic and life skills groups), with group sessions offered multiple times each week to ensure access based on member needs and preferences (with flexibility to allow members to opt out of group counseling if they prefer individualized counseling);
4. sensory modulation and cognitive rehabilitation;
5. neuropsychological testing, evaluation, and intervention;
6. alcohol and substance abuse counseling and prevention;
7. all mental health services as indicated by each resident's PASSR Level II evaluation;
8. vocational programming; and
9. community re-integration.

(c) Maintain a program staff of specially trained professionals, including, but not limited to, a neuropsychiatrist, a neuropsychologist, licensed mental health counselors, vocational specialists, life skills counselors, certified brain injury specialists, substance abuse counselors, and therapeutic technicians. All such staff must be trained in behavior modification and de-escalation techniques.

(2) Per Diem Rate for Approved Admitted Members. Qualifying nursing facilities may receive a flat member-based per diem rate of \$289.12 for members with a mental or neurological disorder that severely affects the member's behavior who are admitted on or after May 17, 2021, provided that the qualifying nursing facility receives approval from NH DHHS prior to the member's admission that the member requires specialized rehabilitation services described in (1)(b) above and is therefore eligible for this enhanced rate. The specialized services program is designed to transition the member back to community-based care or less-restrictive placement, and such rate applies only during the time that the member has been approved by NH DHHS for the enhanced rate. If a facility's existing per diem rate is higher than the \$289.12 specialized per diem rate, the facility shall be paid at the higher per diem rate.

Qualifying facilities may also admit members without seeking approval from NH DHHS. In such circumstances, qualifying nursing facilities will receive the standard nursing facility rate

TN: 21-0030

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Approval Date: 9-03-21

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established under the NH State Plan, Attachment 4.19-D, *Nursing Home Reimbursement, Rate Setting & Payment, Section 9999.8*, with respect to those members.

Section F – Post-Eligibility Treatment of Income

1. ___ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
 - a. ___ The individual’s total income
 - b. ___ 300 percent of the SSI federal benefit rate
 - c. ___ Other reasonable amount: _____

2. ___ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

[Empty box for Section G information]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form,

TN: 21-0030

Approval Date: 9-03-21

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please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

TN: 21-0030

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