

## **Table of Contents**

**State Territory Name: New Hampshire**

**State Plan Amendment (SPA) #: 26-0007**

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  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



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**Financial Management Group**

June 16, 2026

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

RE: New Hampshire State Plan Amendment Transmittal Number 26-0007

Dear Commissioner Weaver:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed New Hampshire state plan amendment (SPA) to Attachment 4.19-D NH-26-0007, which was submitted to CMS on March 30, 2026. This plan amendment titled, "Nursing Facility MQIP for Dates of Service January through March 2026" updates the quarterly pool amount and total Medicaid day count (used in the distribution formula) for New Hampshire's nursing facility supplemental payment, also known as MQIP, for both private and non-state government owned and operated facilities.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 1, 2026. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Diana Dinh at 410-786-0744 or via email at [diana.dinh@cms.hhs.gov](mailto:diana.dinh@cms.hhs.gov).

Sincerely,



Rory Howe  
Director

Enclosures

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

1. TRANSMITTAL NUMBER

2 6 — 0 0 0 7

2. STATE

NH

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT



XIX



XXI

TO: CENTER DIRECTOR  
CENTERS FOR MEDICAID & CHIP SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

January 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION

Section 1902(a)(13) of the Social Security Act and 42 CFR Part 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY 2026 \$ 11,774,090 ~~12,041,840~~

b. FFY \_\_\_\_\_ \$ \_\_\_\_\_

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-D, Page 31(d.8)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

Attachment 4.19-D, Page 31(d.8), TN 25-0010

9. SUBJECT OF AMENDMENT

Nursing Facility MQIP for Dates of Service January through March 2026

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL

[Redacted Signature]

12. TYPED NAME

Ann Landry

13. TITLE

Associate Commissioner

14. DATE SUBMITTED

March 30, 2026

15. RETURN TO

Sara Morris  
Division of Medicaid Services - Brown Building  
129 Pleasant Street  
Concord, NH 03301

**FOR CMS USE ONLY**

16. DATE RECEIVED

March 30, 2026

17. DATE APPROVED

June 16, 2026

**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL

January 1, 2026

19. SIGNATURE OF APPROVING OFFICIAL

[Redacted Signature]

20. TYPED NAME OF APPROVING OFFICIAL

Rory Howe

21. TITLE OF APPROVING OFFICIAL

Director, FMG

22. REMARKS

Governor comments, if any, will follow.

Pen-and-ink change to Box 6 by CMS with state concurrence

Attachment 4.19D		ITEM B	PAGE 31(d.8)
MEDICAL ASSISTANCE	SUBJECT NURSING FACILITY REIMBURSEMENT		DATE SR

Policy  
(Continued)  
9999.8

f(1). Supplemental Medicaid Nursing Home Payment

Licensed CMS nursing facilities, both private and county operated, which provide Medicaid nursing home services shall be eligible to receive a supplemental nursing home payment. Payments are made quarterly in the quarter following the service quarter. Payments are based on the applicable Medicaid dates of service paid in the prior quarter. The purpose of the supplemental payment is to eliminate or reduce to the maximum extent possible the difference between the facility's allowable Medicaid costs and the per diem payments made to such facility which are derived from the nursing facility Medicaid acuity rate setting system multiplied by the budget adjustment factor in Section 9999.8, page 29(f), item 8 b.

The quarterly payment methodology is as follows:

1. The Department will allocate the supplemental pool quarterly among the eligible licensed nursing facilities. The pool for service quarter of January through March 2026 payment is \$24,083,680.80. On a quarterly basis, the Department shall furnish to the facilities, before supplemental payments are processed, a calculation exhibit which identifies each facility's calculated rate and supplemental payment for that quarter.
2. The supplemental pool shall be distributed based on each nursing facility's relative share of total Medicaid paid nursing home days as calculated by the NH Medicaid Management Information System (MMIS). The total paid Medicaid nursing home days for the service quarter of January through March 2026 payment is 312,180. Relative share shall equal each facility's total paid Medicaid nursing home days per the MMIS divided by the total of all nursing home paid Medicaid days (per the MMIS) for all facilities. (Facility total paid Medicaid nursing home days divided by total Medicaid nursing home paid days = relative share) x (supplemental pool \$\$) = supplemental payment.

TN No: 26-0007  
Supersedes  
TN No: 25-0010

Approval Date: June 16, 2026  
Effective Date: 01/01/2026