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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: NH-23-0035

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 S3-14-28
Baltimore, Maryland 21244-1850



Financial Management Group

October 24, 2023

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

RE: New Hampshire State Plan Amendment 23-0035

Dear Commissioner Weaver:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 23-0035. Effective July 1, 2023, this amendment updates the nursing facility reimbursement rate budget adjustment factor as well as the Class Line 504 amount.

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 23-0035 is approved effective July 1, 2023. 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,

A solid black rectangular box redacting the signature of the sender.

Rory Howe
Director

Enclosures

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

1. TRANSMITTAL NUMBER <u>2 3</u> — <u>0 0 3 5</u>	2. STATE <u>NH</u>
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	

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

4. PROPOSED EFFECTIVE DATE
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. Part 447 and Title XIX of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)

a. FFY <u>2023</u>	\$ (741,751)	\$409,680
b. FFY <u>2024</u>	\$ (2,967,005)	\$858,166

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, page 29(f)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
Attachment 4.19-D, page 29(f), TN 22-0040

9. SUBJECT OF AMENDMENT
Nursing Facility Reimbursement – Change to Budget Adjustment Factor (BAF)

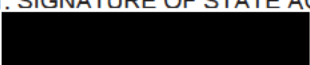
10. GOVERNOR'S REVIEW (Check One)

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


12. **Ann H. Landry**

13. TITLE
Associate Commissioner

14. DATE SUBMITTED
September 18, 2023

15. RETURN TO
**Jody Farwell
Division of Medicaid Services - Brown Building
129 Pleasant Street
Concord, NH 03301**


FOR CMS USE ONLY

16. DATE RECEIVED
September 18, 2023

17. DATE APPROVED
October 24, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL


20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS
Pen and ink change made to Box 6 by CMS with state concurrence.

	SUBJECT	DATE
MEDICAL ASSISTANCE	NURSING FACILITY REIMBURSEMENT	SR

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 21.82%.
- (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, 2024, the total computable budget amount allocated to class line 504 is \$233,619,252.

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.

TN No: 23-0035
Supersedes
TN No: 22-0040

Approval Date: October 24, 2023

Effective Date: 07/01/2023