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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: NH-24-0011

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

April 2, 2024

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 24-0011

Dear Commissioner Weaver:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 24-0011. Effective January 1, 2024, 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 24-0011 is approved effective January 1, 2024. 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,

[redacted]

Rory Howe
Director

Enclosures

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: 24 — 0011

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, 2024

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 2024 $ ~~7,016,969~~ --- 4,377,635
b. FFY 2025 $ ~~9,355,958~~ --- 5,836,846

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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 23-0035

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
DocuSigned by:
[redacted]

12. TYPED NAME
Ann H. Landry

13. TITLE
Associate Commissioner

14. DATE SUBMITTED
March 13, 2024

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

FOR CMS USE ONLY

16. DATE RECEIVED
March 13, 2024

17. DATE APPROVED
April 2, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

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.

Instructions on Back

(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 25%.

(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 $252,331,168.

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.