

Table of Contents

State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: 21-0039

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

November 12, 2021

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

RE: New Hampshire 21-0039

Dear Commissioner Shabinette:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 21-0039. Effective July 1, 2021, this amendment continues the suspension of the direct graduate medical education, indirect graduate medical education, and catastrophic aid hospital payments for state fiscal years ending 2022 and 2023.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 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 21-0039 is approved effective July 1, 2021. The CMS-179 and the amended plan page(s) are attached.

Please note that 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. CMS may still have questions on the funding structure in determining it's consistent with sections 1902(a)(2), 1903(a), and 1903(w) of the Act as implemented by 42 CFR §433.54. 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. On April 2, 2021, CMS issued a letter on the New Hampshire Granite Advantage Health Care Trust Fund, in companion to the approval of New Hampshire's Medicaid managed care state directed payment preprints. The letter requested additional information to allow CMS to further review the state's sources of non-federal share financing of the Medicaid adult expansion population. The state responded to the letter on May 28, 2021, and CMS will continue to review the funding structure in question based on the state's response. The result of the review may also be applicable to the expenditures related to the payments authorized in this SPA.

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,



Rory Howe
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER 21-0039	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 July 1, 2021
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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 Section 1923 of the Social Security Act and 42 CFR Part 447	7. FEDERAL BUDGET IMPACT Remainder of FFY 2021: \$0 FFY 2022: \$0
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19-A, Page 2 Attachment 4.19-A, Page 3 Attachment 4.19-A, Page 4	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19-A, Page 2, TN 19-0009 Attachment 4.19-A, Page 3, TN 19-0009 Attachment 4.19-A, Page 4, TN 21-0005
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10. SUBJECT OF AMENDMENT


Continued Suspension of DME, IME, and Catastrophic Aid Payments

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 Janine Corbett Division of Medicaid Services/Brown Building Department of Health and Human Services 129 Pleasant Street Concord, NH 03301
13. TYPED NAME Ann H. Landry	
14. TITLE Associate Commissioner	
15. DATE SUBMITTED 9/21/21	

FOR REGIONAL OFFICE USE ONLY	
17. DATE RECEIVED September 21, 2021	18. DATE APPROVED November 12, 2021

PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2021	20. SIGNATURE OF REGIONAL OFFICIAL  For
21. TYPED NAME Rory Howe	22. TITLE Director, Financial Management Group

23. REMARKS

- (3) For in-state hospitals only, inpatient (physical) rehabilitative Medicaid discharges in Medicare certified DPU's or rehabilitation hospitals shall be paid only a flat rate (with no additional outlier payments) for the rehabilitation DRG's 945 and 946. The rate represents an average cost across such facilities.
 - (4) Neonatal care for Medicaid discharges assigned certain DRG's (DRG 789 through 794) shall be paid only a per diem rate (with no additional outlier payments) associated with the specific DRG. The rate shall be paid at 65% of the full per diem amount.
 - (5) In order to ensure recipient access to maternity-related labor and delivery services, critical access hospitals in Coos County in New Hampshire will be paid as a separate peer group at an enhanced rate for those services by applying a percentage multiplier of 300% to the DRG based payment.
- b. Certain costs over and above normal hospital operating costs shall be recognized and paid in addition to the DRG payments made under 3.a. above. These payments shall be made as pass-through payments to individual hospitals. Except where specifically noted otherwise, such payments shall apply to all hospitals—in-state, border, and out-of-state.
- (1) For in-state hospitals only, direct medical education costs shall be paid at a rate proportional to the Medicaid share, as calculated using Medicare principles, of actual hospital-specific costs and proportional to each hospital's share of the Medicaid annual budgeted amount. Such payments shall be made semi-annually, except that direct medical education payments shall be suspended for the period beginning July 1, 2021 and ending June 30, 2023.
 - (2) Day outliers shall be paid (except as specified in 3.a.(3) and (4)) for all DRG's for all facilities on a per diem basis, at 60% of the calculated per diem amount (see 3.d. for calculation), and outlier payments shall be added to the DRG payments. Payment shall be made for medically necessary days in excess of the trim point associated with a given DRG. Medicare trim points shall be used except where New Hampshire specific trim points have been established. However, day outlier payments shall be suspended beginning with March 1, 2010 discharge dates, except that this suspension shall not apply to claims for infants who have not attained the age of one year, and to claims for children who have not attained the age of six years.
 - (3) The Medicare deductible amount for patients who are Medicare/Medicaid (dually) eligible shall be recognized and paid.

TN No: 21-0039
Supersedes
TN No: 19-0009

Approval Date 11/12/2021

Effective Date: 07/01/2021

- (4) For only in-state hospitals with approved graduate medical education programs, indirect medical education costs (IME) shall be recognized and paid on a per discharge basis using the Medicare methodology at 42 CFR 412.105 to determine the amount of payment. Such payment shall be added to the DRG payment, except that IME payments shall be suspended for the state fiscal year 2022-2023 biennium.
- (5) There shall be a reserve "catastrophic" fund equal to 3.3 percent of the projected annual Medicaid inpatient hospital expenditures.

This fund shall be used to provide for payments for inpatient hospital services outside the DRG system where (a) the DRG payment plus third party liability is below 25% of hospital charges, (b) the claim is for a DRG weight greater than 4.0, (c) the claim involves an inpatient stay in excess of 30 days, and (d) the hospital requests additional funding.

Reimbursement for each request shall be limited to 65% of charges reduced by prior payments, DRG allowed amounts and third party liabilities. Hospitals shall submit claims by December 15 and June 15 in order to be considered for payment for the six-month period ending, respectively, December 31 and June 30 of each year. The state shall expend half of the catastrophic fund no later than December 31 of each year and the second half no later than June 30 of each year. However, catastrophic payments will be suspended for the state fiscal year 2022-2023 biennium. Payment of eligible claims shall be determined by computing the total dollar amount of all hospitals' requests, determining each requesting hospital's total dollars requested as a percent of all requests, and applying that percent to the amount of money in the catastrophic fund in order to calculate payment to that hospital. No claims or portions of claims shall be carried over into the subsequent six-month period, nor shall any excess funds be carried over into the subsequent six-month period.

- c. The calculation for the price for a DRG with a relative weight equal to one (1.0000), to be used for all DRG's except those specified above for psychiatric, rehabilitation and neonatal services shall be as follows:
 - (1) Beginning October 1, 1999, and each year thereafter, take the current DRG price per point(s) and inflate each by the same percent as the Medicare market basket estimated increase for prospective payment hospitals minus any Medicare or state Medicaid defined budget neutrality factors and other generally applied Medicare adjustments appropriate to Medicaid.

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d. Other relevant calculations:

(1) The Department separates inpatient hospital providers into peer groups according to the intensity of care provided in each. The peer groups are set up for general acute care, critical access hospitals (CAH), distinct part units for psychiatric care, Psych Atypical distinct part unit, Designated Receiving Facility (DRF), rehabilitative care and maternity care in the northern county. The Department sets a base rate (Price per Point) for each peer group. The Price per Point values for hospital peer groups are accessible at: <http://www.nhmmis.nh.gov> (go to “documents and forms” under the “documentation” tab)

(2) The current Price per Point rates are as follows:

Acute Care	=	\$ 3,011.21
CAH	=	\$ 3,345.79
Psych DPU	=	\$ 3,310.07
Psych Atypical DPU	=	\$6,134.00
Psych DRF	=	\$14,400.00
Rehab	=	\$ 15,428.86
Maternity	=	\$ 3,345.79

(3) Psych Atypical DPU price per point rate is for psychiatric distinct part unit stays that will have a relative weight of 1.2 or greater due to the higher acuity level of care required based on the ICD Diagnosis. Psych DPU price per point rate is for psychiatric distinct part unit stays that have a relative weight under 1.2 with a lower acuity Diagnosis. DRF price per point rate is for DRGs billed by psychiatric designated receiving facilities.

(4) DRG reimbursement is calculated by multiplying the Price per Point for the appropriate peer group times the relative weight assigned to the DRG.

(5) The DRG amount determined above is multiplied by the reimbursement percentage assigned to the provider. The reimbursement percent is 100% except for maternity which is a 300% multiplier effective 7/1/09 as specified in item 3.a.(5) above.

(6) The per diem price associated with a given DRG shall be calculated by dividing the price for that DRG by the geometric mean length of stay associated with that DRG.

4. Direct medical education costs shall be allowed as a pass through payment in accordance with Department guidelines which shall be based on Medicare guidelines established at 42 CFR 412.2, except that direct medical education pass through payments shall be suspended for the period beginning July 1, 2021 and ending June 30, 2023.
5. Day outliers shall be reimbursed on a per diem DRG payment unless payment is suspended in accordance with 3.b.(2). Cost outliers shall not be recognized nor reimbursed. (also, see 3.b.(2) and 3.d. for day outliers.)
6. Periodic interim payments as made under the Medicare Program shall not be made by the Medicaid Program.
7. Pricing shall be prospective and payment shall be retrospective.
8. Payment rates shall be based on the relative weights and payment rates in effect at the time of discharge, taking into account the requirement to pay the lesser of the usual and customary charge or the computed rate, in accordance with 42 CFR 447.271 and RSA 126-A:3.
9. Providers of hospital services shall make quarterly refunds of Medicaid payments that are in excess of the Medicaid allowed amounts.