DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services (CMCS)

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

FEB 11 2013

RE: New Hampshire SPA 12-007

Dear Mr. Toumpas:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 12-007. This amendment modifies the reimbursement methodology for inpatient hospital services. Specifically, this state plan amendment (SPA) allows for the implementation of a higher rate of reimbursement per an agreement between New Hampshire's DHHS and Children's Hospital Boston (CHB) for High Acuity, out-of-state Pediatric Specialty Hospital Inpatient Services that are not otherwise provided by NH providers.

We evaluated your submitted for consistency with all of the requirements of the Social Security Act, with particular attention to the requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 and the implementing Federal regulations at 42 CFR 447. We are pleased to inform you that Medicaid State plan amendment 12-006 is approved effective May 25, 2012. We are enclosing the CMS-179 and the amended plan pages.

We are enclosing the CMS-179 and the following amended plan page.

- Attachment 4.19A, Page 4.2

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,
/ s /

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 12-007

2. STATE: NH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~April 1, 2012~~ May 24, 2012

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:
SSA 1902 and 42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
($1,950,000) - FFY 2012
($3,900,000) – FFY 2013

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, page ~~4 (TBD)~~ 4.2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A, page New ~~tbd (pending rai's)~~

10. SUBJECT OF AMENDMENT:
Reimbursement of "High Acuity, Out-of-State Pediatric Specialty Hospital Inpatient Services"

11. 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: comments, if any, will follow

12. SIGNATURE OF ~~STATE AGENCY OFFICIAL~~:
/s/

13. TYPED NAME: [redacted]

14. TITLE: ~~Commissioner~~

15. DATE SUBMITTED: 6/27/12

16. RETURN TO:
Dawn Landry
Division of Family Assistance/Brown Building
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: FEB 11 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: MAY 24 2012

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: [redacted]

22. TITLE: DEP. DIRECTOR, CMCS

23. REMARKS:

Per request from State, changes were made to Sections 4, 8 & 9.

FORM HCFA-179 (07-92)

11) Payment for high acuity, out-of-state pediatric specialty hospital inpatient services: When inpatient hospital services are provided to a New Hampshire Medicaid recipient in connection with a transfer or high acuity admission; *i.e.,* at a level of 5.0 or greater on the 3M All-Payer Refined Grouper version 26, to an out-of-state, non-Prospective Payment System (PPS) pediatric specialty hospital that (i) has entered into a Medicaid Provider Enrollment Agreement Addendum with the New Hampshire Department of Health and Human Services to provide tertiary and quaternary hospital care not otherwise sufficiently available within the State of New Hampshire, and (ii) had 200 or more hospital admissions of New Hampshire Medicaid recipients during hospital fiscal year 2011, such transfer or high acuity inpatient hospital services and the services associated with the transfer or high acuity inpatient episode of care, shall be reimbursed at a rate that approximates the cost of the service(s) rendered as follows:

a. Rates shall be calculated by multiplying billed charges on qualifying claims, as set forth in the hospital or its physician organization's charge master (the standard charges established by any given hospital and/or associated physician organization for any particular service and presented to all payors), by a cost to charge ratio (CCR) of 61.9% which is determined from the Massachusetts Medicaid Cost Report.

b. The costs associated with services eligible for high acuity payments are determined by the Department through utilization of charge data submitted by the provider as related to the provider's transfer and high acuity admissions.

c. Providers will first be paid in accordance with the methodologies used to reimburse New Hampshire in-state acute care hospitals (as previously detailed in this Attachment 4.19-A). On a quarterly basis, the Department and the provider(s) shall identify and reconcile those services that are eligible to be reimbursed at a rate as determined by applying the cost to charge ratio of 61.9%. Providers shall have at least one full quarterly reconciliation period (90 days) following the date the initial claim was paid by the MMIS system to submit the necessary documentation to support the request for the high acuity payment. The Department will review the claim and pay providers the variance between actual MMIS payments and payments calculated by applying the CCR to actual charges as described above.

d. "Transfer admission" means an admission of a New Hampshire Medicaid recipient transferred by ambulance or other emergency transportation from another in-state or out-of-state hospital.