

Table of Contents

State/Territory Name: NH

State Plan Amendment (SPA) #: 17-0006

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 AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850



Financial Management Group

AUG 14 2017

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

RE: New Hampshire SPA 17-0006

Dear Commissioner Meyers:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 17-0006. This amendment revises the fiscal year 2017 pool amounts for Disproportionate share hospital (DSH) and supplemental access payments for uncompensated care costs.

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. We are pleased to inform you that Medicaid State plan amendment 17-0006 is approved effective May 31, 2017. We are enclosing the CMS-179 and the amended plan pages.

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

Sincerely,



Kristin Fan
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 17-0006	2. STATE NH
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		4. PROPOSED EFFECTIVE DATE May 31, 2017	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES			
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: SSA 1923 and 42 CFR Part 447		7. FEDERAL BUDGET IMPACT: FFY 2017: \$4,792,686	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19A, page 5b, 5c, and 5d		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19A, page 5b, 5c, and 5d, TN 06-0011	
10. SUBJECT OF AMENDMENT: DSH Payment Adjustments and Supplemental Access Payments			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: comments, if any, will follow <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO COMMENTS ENCLOSED			
12. SIGNATURE: [Redacted]		16. RETURN TO: Dawn Landry Office of Medicaid Business and Policy/Brown Building Department of Health and Human Services 129 Pleasant Street Concord, NH 03301	
13. TYPED NAME: Jeffrey A. Meyers			
14. TITLE: Commissioner			
15. DATE SUBMITTED: 6/23/2017			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: AUG 14 2017	
PLAN APPROVED -- ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: MAY 31 2017		20. SIGNATURE OF REGIONAL OFFICIAL: [Redacted]	
21. TYPED NAME: Kristin Fan		22. TITLE: Director, FMCO	
23. REMARKS:			

Disproportionate Share – Payment Adjustment
(continued)

2. **Critical Access Hospitals:** Each Critical Access Hospital (CAH) that is not a specialty hospital for rehabilitation and that participates in the provider network of the NH Medicaid Care Management program shall receive a DSH payment equal to 75% of the hospital's uncompensated care costs, except as further adjusted where applicable under the provisions of paragraph 4 below. "Uncompensated care costs" are calculated in accordance with the federal requirements of 42 U.S.C. 1396r-4(g) and any federal regulations promulgated by the federal oversight agency, the Centers for Medicare and Medicaid Services (CMS), further defining or interpreting such federal statutory requirements; and shall take into account any Supplemental Access or enhanced Medicaid rate payments received under Attachment 4.19-A. This payment amount is reconciled in a subsequent year to account for variances identified between projected uncompensated care costs and actual uncompensated care costs as determined by the independent certified audit performed pursuant to 42 CFR, Part 455, Subpart D.

3. **Other DSH Qualifying, Non-Public Hospitals:** Each DSH qualifying hospital that is not a critical access hospital or a specialty hospital for rehabilitation, but which does participate in the provider network of the NH Medicaid Care Management program shall receive a DSH payment adjustment in an amount proportional to, but not greater than, each such hospital's total allowable uncompensated care costs. For each hospital that meets the eligibility criteria under this paragraph 3, the funding and payment amounts shall be as follows, except as further adjusted pursuant to paragraph 4 below:

(A) Funding for State Fiscal and State Plan Year 2015 shall be \$34,355,739; each qualifying hospital under paragraph 3 shall receive a pro rata share of this funding in proportion to its total allowable uncompensated care costs.

(B) For State Fiscal and State Plan Years 2016 and 2017, each such hospital shall be paid 50% of its uncompensated care costs.

(C) For State Fiscal and State Plan Year 2018 and 2019, and thereafter, each such hospital shall be paid 55% of its uncompensated care costs.

4. Notwithstanding the provisions of paragraphs 1, 2, or 3 above:

(A) if in any Fiscal Year 2016, 2017, 2018 or 2019, and thereafter, qualifying hospitals' total aggregate uncompensated care costs, as reported to the NH Department of Health and Human Services, is less than \$350 million, the State shall pay such hospitals not less than \$175 million in DSH payments, shared among such hospitals in proportion to the amount of uncompensated care costs incurred by each such hospital relative to the total; provided that New Hampshire hospitals with a critical access designation shall continue to receive reimbursements of no less than 75% of each such hospital's uncompensated care costs; and

(B) total statewide DSH payments to hospitals qualifying under this second type of DSH payment adjustment shall not exceed \$207,184,916 in Fiscal Year 2016 and \$217,271,699 in Fiscal Year 2017, and shall not exceed \$241.9 million in Fiscal Years 2018 and 2019.

Supplemental Access Payment

The NH Department of Health and Human Services will make a Supplemental Access payment annually to those hospitals with critical access designation by the Centers for Medicare and Medicaid Services that also meet the “qualifying criteria” of this section as a Type I or Type II Access Hospital. Such access payments shall be made in addition to any other non-DSH Medicaid rate payments available to such qualifying hospitals under the provisions of Attachment 4.19-A of the NH State Plan. Hospitals receiving a Supplemental Access Payment under this section in any fiscal year shall not be qualified to receive a Disproportionate Share Hospital (DSH) payment in the same fiscal year unless such hospital meets the criteria for a Deemed DSH payment and said payment would not result in payments in excess of the hospital-specific DSH limit under 42 USC 1396r-4(g).

I. Type I - Essential Critical Access Hospital

A. Qualifying criteria for the Essential Critical Access Hospital, Type I:

- 1) The hospital is designated as a critical access hospital (CAH) in accordance with criteria established by the Centers for Medicare and Medicaid Services;
- 2) The hospital is the smallest CAH located in Coos County, as measured by net inpatient service revenue in fiscal year 2012;
- 3) The hospital has the highest ratio of Medicaid and uninsured charges to total charges in the state for state fiscal year 2012, as determined by the Department; and
- 4) The hospital has the highest ratio of uncompensated care costs to total operating costs in Coos County for state fiscal year 2012, as determined by the Department.

B. The Type I Supplemental Critical Access payment shall be made during the last fiscal quarter of each state fiscal year and shall reimburse 100% of the qualifying hospital’s estimated uncompensated care costs incurred in each state fiscal year, as determined by the state using the best available data at the time of the payment. For State Fiscal Year 2017, the amount of the Type I payment shall be \$1,938,410.

TN No: 17-0006
Supersedes
TN No: 16-0011

Approval Date: AUG 14 2017

Effective Date: 5/31/2017

Supplemental Access Payment
(continued)

II. Type II - Essential Maternity Access Hospital

A. Qualifying criteria for the Essential Maternity Access Hospital, Type II:

- 1) The hospital qualifies for the enhanced payments for maternity-related labor and delivery services payment under paragraph 3.a(5) at page 2 of Attachment 4.19-A in a fiscal year; and
- 2) The hospital has critical access designation by the Centers for Medicare and Medicaid Services.

B. The Type II Supplemental Access Payment shall be made once annually during the last fiscal quarter of each state fiscal year. For State Fiscal Year 2017, the amount of the Type II payment shall be \$5,462,125.

All Type I and Type II Supplemental Access Payments made under this section shall be included in the determination of total Medicaid payments made to the eligible hospital for purposes of determining the hospital's DSH limit, as defined by federal law at 42 USC 1396r-4(g). The State of New Hampshire will ensure that no hospital participating in the Medicaid program shall receive any DSH payment in excess of such federal limit.

TN No: 17-0006
Supersedes
TN No: 16-0011

Approval Date: AUG 14 2017

Effective Date: 5/31/17