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State/Territory Name: NH

State Plan Amendment (SPA) #: 18-0004

This file contains the following documents in the order listed:

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

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

MAY 23 2018

RE: New Hampshire SPA 18-0004

Dear Commissioner Meyers:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 18-0004. This amendment revises reimbursement for nursing facility services. Specifically, it changes the budget account factor (BAF), applied to the calculated nursing facility acuity rates, from 30% to 28.76% resulting in an increase in payments to providers.

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. We are pleased to inform you that Medicaid State plan amendment 18-0004 is approved effective January 1, 2018. 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,

[redacted]

Kristin Fan
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO.

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 18-0004

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
January 1, 2018

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(a)(13) and 42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
Remainder of FFY 2018: $830,200
FFY 2019: $1,660,401

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

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19D, page 29 (f), TN 17-0005

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

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:
[redacted]

13. TYPED NAME: Jeffrey A Meyers

14. TITLE: Commissioner

15. DATE SUBMITTED: 3/15/2018

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: MAY 23 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 1 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Deputy Director, FNP

23. REMARKS:

FORM HCFA-179 (07-92)

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 28.76%.

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.