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State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: NH-23-0016

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

September 5, 2023

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

RE: New Hampshire State Plan Amendment 23-0016

Dear Commissioner Weaver:

We have reviewed the proposed amendment to Attachments 3.1-A, 3.1-B, 4.19-A, 4.19-B, and 4.19-C of your Medicaid State plan submitted under transmittal number (TN) 23-0016. Effective May 30, 2023, this amendment provides for coverage and reimbursement for psychiatric residential treatment facility (PRTF) services.

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 23-0016 is approved effective May 30, 2023. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Joyce Butterworth at (857) 357-6375 or joyce.butterworth@cms.hhs.gov, or 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 <u>2 3 — 0 0 1 6</u>	2. STATE <u>NH</u>
	3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE May 30, 2023	
5. FEDERAL STATUTE/REGULATION CITATION 42 CFR 440.160; 42 CFR 447	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>2023</u> \$ <u>745,513</u> b. FFY <u>2024</u> \$ <u>2,212,294</u>	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 3.1-A Page 7-a Attachment 3.1-B Page 6a Attachment 4.19-A Page 7-8 Attachment 4.19-B Page 4 and Attachment 4.19-C Page 1 & 2 & 3	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 3.1-A Page 7-a, (TN 97-09) Attachment 3.1-B Page 6a, (TN 97-09) Attachment 4.19-A Page 7-8, (N/A New Pages) Attachment 4.19-B Page 4, (TN 22-0028) Attachment 4.19-C Page 1, (TN 05-002) & 2 (New Page)	

9. SUBJECT OF AMENDMENT
Psychiatric Residential Treatment Facilities (PRTFs)

10. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED.

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

11. SIGNATURE OF STATE AGENCY OFFICIAL 	15. RETURN TO Jody Farwell Division of Medicaid Services/Brown Building Department of Health and Human Service 129 Pleasant Street Concord, NH 03301
12. TYPED NAME Ann Landry	
13. TITLE Associate Commissioner	
14. DATE SUBMITTED	

FOR CMS USE ONLY

16. DATE RECEIVED June 26, 2023	17. DATE APPROVED September 5, 2023
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PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL May 30, 2023	19. SIGNATURE OF APPROVING OFFICIAL
20. TYPED NAME OF APPROVING OFFICIAL Rory Howe	21. TITLE OF APPROVING OFFICIAL Director, Financial Management Group

22. REMARKS
Pen-and-ink changes made to Boxes 7 and 8 by CMS with state concurrence.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED

15a. and 15b. Intermediate Care Facilities

Payment for nursing facility care is available to both categorically and medically needy recipients in need of such care. Payment for nursing facility care must be prior authorized for a specified period of time based on the amount and length of care recommended by the recipient's physician. Payment is made for a non-private room. Determination of need for nursing facility care and authorization of payment for nursing facility care is made by the Office of Long Term Care.

Medicaid-only certified beds in which nursing facility services are provided shall be at or about 5,146 beds statewide. However, the Department of Health and Human Services does not intend to attain this number of beds unless there is a need for the beds to ensure access to services. Furthermore, the Commissioner and his/her designee shall approve certification of additional Medicaid-only nursing facility beds if needed to ensure access to nursing facility services.

16. Inpatient Psychiatric Facility Services for Individuals Under 21 Years of Age

Inpatient psychiatric services for individuals under age 21 must be:

- Provided under the direction of a physician;
- Provided by:
 - A psychiatric hospital that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital as specified in 42 CFR 482.60, or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS; or
 - A hospital with an inpatient psychiatric program that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital, as specified in 42 CFR part 482, or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS; or
 - A psychiatric facility that is not a hospital (defined as a Psychiatric Residential Treatment Facility (PRTF) in 42 CFR 483.352) that is accredited by the Joint Commission on Accreditation of Healthcare Organizations (TJC), the Council on Accreditation for Families and Children, the Commission on Accreditation of Rehabilitation Facilities (CARF), or by any other accrediting organization, with comparable standards, that is recognized by the State.
- Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reaches age 21, before the earlier of the following:
 - The date the individual no longer required the services; or
 - The date the individual reaches 22; and
- Certified in writing to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances in accordance with 42 CFR 441.152).

The State assures that it meets all requirements in 42 CFR 440.160, 42 CFR 441 Subpart D, and 42 CFR 483 Subpart G.

17. Nurse Midwife Services

Nurse midwife services are provided in accordance with 42 CFR 440.165. These services are performed by certified nurse midwives in accordance with state law.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED

14c. Payment for intermediate care services in institutions for mental disease is available to categorically and medically needy recipients in need of such care. Payment for intermediate care services in institutions for mental disease must be prior authorized for a specified period of time based on the amount and length of care recommended by the recipient's physician. Determination of need for, and authorization of payment for, intermediate care services in institutions for mental disease is made by the Office of Long Term Care.

15a. and 15b. Intermediate Care Facilities

Payment for nursing facility care is available to both categorically and medically needy recipients in need of such care. Payment for nursing facility care must be prior authorized for a specified period of time based on the amount and length of care recommended by the recipient's physician. Payment is made for a non-private room. Determination of need for nursing facility care and authorization of payment for nursing facility care is made by the Office of Long Term Care.

Medicaid-only certified beds in which nursing facility services are provided shall be at or about 5,146 beds statewide. However, the Department of Health and Human Services does not intend to attain this number of beds unless there is a need for the beds to ensure access to services. Furthermore, the Commissioner and his/her designee shall approve certification of additional Medicaid-only nursing facility beds if needed to ensure access to nursing facility services.

16. Inpatient Psychiatric Facility Services for Individuals Under 21 Years of Age

Inpatient psychiatric services for individuals under age 21 must be:

- Provided under the direction of a physician;
- Provided by:
 - A psychiatric hospital that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a psychiatric hospital as specified in 42 CFR 482.60, or is accredited by a national organization whose psychiatric hospital accrediting program has been approved by CMS; or
 - A hospital with an inpatient psychiatric program that undergoes a State survey to determine whether the hospital meets the requirements for participation in Medicare as a hospital, as specified in 42 CFR part 482, or is accredited by a national accrediting organization whose hospital accrediting program has been approved by CMS; or
 - A psychiatric facility that is not a hospital (defined as a Psychiatric Residential Treatment Facility (PRTF) in 42 CFR 483.352) that is accredited by the Joint Commission on Accreditation of Healthcare Organizations (TJC), the Council on Accreditation for Families and Children, the Commission on Accreditation of Rehabilitation Facilities (CARF), or by any other accrediting organization, with comparable standards, that is recognized by the State.
- Provided before the individual reaches age 21, or, if the individual was receiving the services immediately before he or she reaches age 21, before the earlier of the following:
 - The date the individual no longer required the services; or
 - The date the individual reaches 22; and
- Certified in writing to be necessary in the setting in which the services will be provided (or are being provided in emergency circumstances in accordance with 42 CFR 441.152).

The State assures that it meets all requirements in 42 CFR 440.160, 42 CFR 441 Subpart D, and 42 CFR 483 Subpart G.

Psychiatric Residential Treatment Facilities (PRTFs)

The Psychiatric Residential Treatment Facility (PRTF) statewide per diem rate is a prospective payment model for 24-hour treatment for services within a PRTF delivered to Medicaid recipients under age 21 (or under age 22 for those receiving services immediately before turning 21, and not exceeding the date the recipient reaches the age of 22). The PRTF per diem payment is for services provided to a PRTF resident, as described in paragraph b below.

Payment of PRTF per diem rates do not include costs of providing any non-coverable services or educational services, or for transitional case management services provided by an entity other than the PRTF to support transition back to the community. Payment may not be duplicative of services for which payment is included in the PRTF's per diem rate. PRTF payment will not exceed the provider's usual and customary charge.

a. The sources used to develop the PRTF statewide per diem rate include:

- a. 1. Budget forecasts and financial statements from private providers approved for contracted residential services within New Hampshire;
- a. 2. Direct service providers' compensation benchmarking statewide data from the Bureau of Labor Statistics; and
- a. 3. A projected increase or decrease in the CMS Market Basket index for Inpatient Psychiatric Facility was calculated for the 24 months between the mid-point of the base period and the midpoint of the rate year.

b. The PRTF statewide per diem rate is determined to reimburse for the following three categories:

- b. 1. Child maintenance services, including 24-hour care; room and board; and administrative services;
- b. 2. Medical and Rehabilitative services to meet the child's health and rehabilitative needs to address their physical, intellectual, medical and emotional needs.
 - Occupational therapy, including evaluations, treatments or consultations necessary to implement a program of activities to develop or maintain skills necessary to achieve adequate and appropriate physical and mental functioning of a child
 - Psychiatric services when necessary for the evaluation, diagnosis, and treatment of psychiatric problems;
 - Rehabilitative services, including:
 - . Assistance with communication;
 - . Behavior management;
 - . Nutrition counseling;
 - . Medication management and training;
 - . Hygiene and personal care training;
 - . Coordination of medical care; and
 - . Development and implementation of individual treatment plans.
 - In addition to the psychiatric and psychological services referenced within this paragraph b.2, behavioral health services shall be provided when necessary, which shall include at a minimum:
 - . Behavior management;
 - . Individual, group, and/or family counseling;
 - . Substance use disorder counseling; and
 - . Crisis intervention and stabilization.
 - Any other remedial services as are necessary for the maximum reduction of a child's physical, intellectual, or behavioral disabilities, excluding classroom instruction and academic tutoring.
 - Any evaluations, treatments, staff training, or consultations that are necessary for the child to be safely cared for;
 - Administration of medication;
 - Observation of children with chronic or acute illnesses in order to assure that medical needs are being appropriately identified, addressed and monitored; and
 - Other services allowed under their individual identified scope of practice for nursing services.
 - Psychological services when necessary for the evaluation, diagnosis, and treatment of emotional or behavioral problems or disturbances;

Psychiatric Residential Treatment Facilities (PRTFs)

(continued)

b.3. Registered nurse (RN) staffing on-site 24 hours per day, 7 days per week (24/7 coverage).

c. Provider reimbursement:

The PRTF statewide per diem rate shall be payment in full for costs associated with daily care, administrative services, and room and board, as described above in section b.

Medically necessary services not otherwise included in the PRTF rate may be billed directly to Medicaid by providers delivering these services. Payment for necessary services not included in the PRTF statewide per diem rate is based on state-developed fee schedule rates, as applicable. All fee schedules are accessible at www.nhmmis.nh.gov, under the “documents and forms” tab under “documentation,” and are applicable to all public and private providers.

PRTF statewide per diem payments will be made to a PRTF provider for reserving a bed according to the methodology described in Attachment 4.19-C of the Medicaid State Plan.

Pursuant to 42 CFR § 431.52, PRTF services shall be provided in an out of state setting if medically necessary and if no suitable treatment option is found in New Hampshire. The reimbursement rate for PRTF services in out of state facilities will be negotiated between the New Hampshire Department of Health and Human Services (the Department) and the facility providing the services. When negotiating the rate, the Department will take into consideration the following:

- a) The Medicaid rate for the same or similar services in the state where the facility is located.
- b) When there is no Medicaid rate for the services within the located state, or a provider does not accept the Medicaid rate in the state where the facility is located, an average of contracted rates between that facility and others payers for the same service.

No provider shall bill or charge the department more than the provider’s usual and customary charge.

d. Payment rates:

Effective May 30, 2023, the PRTF statewide per diem rate is \$1,010.18 per day.

e. State government owned providers:

The statewide PRTF per diem rate as calculated shall be paid as an interim rate to state government owned PRTF providers. For a state government owned PRTF that is hospital-based and whose costs are reported in the hospital cost report, the reconciliation process of the interim rate shall be based on Medicare-audited costs from the Medicare cost report applied to the Medicaid Fee-for-Service (FFS) population. The total allowable costs for the inpatient routine service cost center PRTF sub provider (CMS-2552, Worksheet C, Part I, column 1) is applied to the Medicaid FFS days for the cost report year.

Medicaid claim days and payments for FFS days with dates of service in the cost report year are taken from the Medicaid Management Information System (MMIS). The allowable inpatient routine service cost is multiplied by the total MMIS Medicaid claim days divided by total days, resulting in the total allowable Medicaid FFS costs for the cost report year. The total payments made from the inpatient claims data, and any other payments made towards the applicable Medicaid service, including third party payments and patient cost sharing, is deducted from the total audited allowable Medicaid FFS costs for the cost report year to identify unreconciled inpatient costs.

Overpayments as a result of a lower audited cost compared to payments received shall be recouped from the provider as a financial transaction in MMIS. Underpayments shall be paid as a financial transaction in MMIS to the provider. Reconciliations of costs are performed within 90 days of Department receipt of the audited Medicare cost report.

PTRF payment will not exceed the provider’s usual and customary charge.

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN
INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

16. Inpatient Psychiatric Facility Services has been moved to Attachment 4.19-A, effective May 30, 2023.

17. Nurse-Midwife Services - Nurse-midwife services may be provided under the categories of physician, ARNP (other licensed providers), clinic, or rural health clinic services. Payment for nurse-midwife services is made based on the specific type of service provided. Payment is in accordance with the same principles of reimbursement developed for payment to the specific types of providers as described in #5, #6, and #9 herein.

RESERVED BED DAYS

For ICF-IID serving Individuals with Intellectual and/or Developmental Disabilities a reserved bed day means:

Up to a 24 hour period, midnight to midnight, chargeable to Medicaid, during which a recipient is not present in the ICF-IID facility during the midnight census.

Payment is made to reserve a bed during a recipient's temporary absence from a facility under the following conditions.

The Department of Health and Human Services (the Department) shall allow up to fifty two (52) days per recipient, per state fiscal year, as chargeable days to reserve a bed in an inpatient facility (as defined above) if the following criteria are met:

- a) Such days must be specified in the recipient's plan of care;
- b) The recipient's plan of care must describe any plans for continuity of care during the recipient's absence from the facility; and
- c) Such days must not be for hospitalization or for transferring to another facility.

When a recipient is on reserved bed day status, the Department shall not pay separately for any services, or any similar services, typically covered as part of the facility's rate.

For Nursing Facility services a reserved bed day means:

Up to a 24 hour period, midnight to midnight, chargeable to Medicaid, during which a recipient is not present in the facility during the midnight census.

Payment is made to reserve a bed during a recipient's temporary absence from a facility under the following conditions.

The Department shall allow up to thirty (30) days per recipient, per state fiscal year, as chargeable days to reserve a bed in an inpatient facility (as defined above) if the following criteria are met:

- a) Such days must be specified in the recipient's plan of care;
- b) The recipient's plan of care must describe any plans for continuity of care during the recipient's absence from the facility; and
- c) Such days must not be for hospitalization or for transferring to another facility.

When a recipient is on reserved bed day status, the Department shall not pay separately for any services, or any similar services, typically covered as part of the facility's rate.

Leave days are reimbursed at 100% of the facility's Medicaid per diem rate as described in Attachment 4.19-D.

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Effective Date: 5/30/2023

Supersedes

TN No: 05-002

RESERVED BED DAYS - continued

For a Psychiatric Residential Treatment Facility (PRTF) a reserved bed day means:

Up to a 24-hour period, midnight to midnight, chargeable to Medicaid, during which a recipient is not present in the PRTF during the midnight census, for any of the following reasons:

- a) Acute care hospital stay, which shall be when a recipient is temporarily absent from the PRTF during the midnight census due to an admission to an acute care hospital.
- b) State psychiatric hospital stay, private psychiatric hospital stay, or a psychiatric bed in an acute care hospital stay, which shall be when a recipient is temporarily absent from the PRTF during the midnight census due to receiving psychiatric treatment in a state psychiatric hospital, private psychiatric hospital, or psychiatric bed in an acute care hospital respectively.
- c) Therapeutic leave, which shall be when a recipient is temporarily absent from the PRTF during the midnight census for a therapeutic purpose that is:
 1. Provided for in the recipient's plan of care;
 2. A temporary stay outside of the PRTF in which the recipient is visiting with relative(s) or friend(s), attending camp days, for transitional discharge planning purposes, or for bereavement purposes; and is
 3. Approved by the recipient's treatment team.

Payment is made to reserve a bed during a recipient's temporary absence from a facility under the following conditions:

The Department shall allow a reserved bed day for an acute care hospital stay, a state psychiatric hospital stay, a private psychiatric hospital stay, or a psychiatric bed in an acute care hospital stay for a recipient's absence from the PRTF if the recipient:

- a) Is in Medicaid payment status in the PRTF;
- b) Has been in the PRTF overnight at least one (1) night;
- c) Is reasonably expected to return requiring PRTF care;
- d) The PRTF and hospital are not co-located and operated by the same agency; and

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RESERVED BED DAYS – continued

- e) Has not exceeded the bed reserve limit of 10 days per calendar year in aggregate for any combination of bed reserve days associated with an acute care hospital admission, a state psychiatric hospital admission, a private psychiatric hospital admission or an admission to a psychiatric bed in an acute care hospital.

Based on medical necessity, with a prior authorization, the ten (10) day limit may be extended.

When a recipient is on reserved bed day status, the Department shall not pay separately for any services, or any similar services, typically covered as part of the facility's rate.

The Department shall reimburse a reserved bed day for therapeutic leave for a recipient's absence from the PRTF if the recipient:

- a) Is in Medicaid payment status in the PRTF;
- b) Has been in the PRTF overnight at least one (1) night;
- c) Is reasonably expected to return requiring PRTF care; and
- d) Has not exceeded the bed reserve limit of 30 days for therapeutic leave per calendar year in aggregate for any combination of bed reserve days associated with therapeutic leave.

The Department shall allow a recipient to exceed the limit established if the Department determines that an additional therapeutic pass is in the best interest of the recipient.

When a recipient is on reserved bed day status, the Department shall not pay separately for any services, or any similar services, typically covered as part of the facility's rate.

The reimbursement to PRTFs for leave of absence days is 100 percent of the current applicable per diem rate as described in Attachment 4.19-A.

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