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

1. Outpatient Hospital Services - An interim payment shall be made based on a percent of charges. Final payment is made in accordance with a percent of costs. An audit of each hospital’s actual costs eligible for reimbursement shall be performed by the fiscal intermediary in accordance with federal Medicare requirements. The Department shall determine the percent of actual costs to be reimbursed, and then payments made to the hospital shall be cost settled using the percent determined by the Department and the actual cost data audited by the fiscal intermediary. Laboratory services provided as part of an outpatient hospital visit are reimbursed through an add-on fee and are paid in addition to the percentage of cost payment for the outpatient visit.

The interim rate established for each hospital is set as a Ratio of Cost to Charges (RCC) derived from the last settlement processed. Each hospital shall, after the close of its own unique fiscal period, submit the Medicare Cost Report (CMS Form 2552) as required by Medicare, which is subsequently audited by the Medicare Fiscal Intermediary according to the Medicare auditing schedule and principles of reimbursement. Allowable costs are allocated to the outpatient services rendered to NH Medicaid recipients on Worksheet E-3, Part III. The current reimbursable amount of the costs is at 54.04% for acute care non-critical access hospitals and 91.27% for critical access hospitals and rehabilitation hospitals. The actual interim payments made during the cost period are compared to the reimbursable costs determined by audit and the difference is the settlement payable to the hospital or to the Department. The results of this review are reported by the fiscal intermediary to the Department and to each hospital. Settlements due to the hospitals are paid in accordance with the timely claims payment requirements of 42 CFR 447.45.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

1. Outpatient Hospital Services (continued)

1 (b) Services associated with a transfer or high acuity inpatient admission to a qualifying out-of-state pediatric specialty hospital, as described on page 4.2 of Attachment 4.19-A of the NH Title XIX State Plan:

These outpatient services shall be reimbursed at a rate that approximates the cost of the service(s) rendered, where the rate is calculated by applying a cost-to-charge ratio (CCR) of 61.9% determined from the Massachusetts Medicaid Cost Report, to the charges billed by the qualifying facility, and where “services associated with” such transfer and high acuity admissions to a qualifying out-of-state pediatric hospital include all of the outpatient hospital, ancillary and professional services related to the preparation for such a high acuity admission provided by the qualifying hospital or the hospital’s physician organization up to 30 days prior to such admission date, during the admission, or rendered as follow-up care during the 90 days following the transfer or high acuity discharge date."

Services rendered shall first be reimbursed in accordance with the methodologies used to reimburse New Hampshire acute care hospitals; physicians and other practitioners; and other ancillary services (as detailed in the applicable sections of this state plan Attachment 4.19-B). 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 shall 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, provided that reconciliation payments will be further adjusted, if needed, to ensure that laboratory services are not paid in excess of the Medicare laboratory services fee schedule.

For services that do not qualify for payment under 1(b), payment will be made in accordance with (i) the outpatient hospital service payment provisions of 1(a) for outpatient hospital services, and (ii) for other services, payment provisions described elsewhere in this Attachment 4.19-B are applied, i.e., other professional (such as physician, APRN) and ancillary services (such as x-rays, labs, drugs, and therapy services).
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

2. **A) Freestanding Laboratory Services**: Payment is made in accordance with a fee schedule established by the Department pursuant to NH RSA 161:4, VI. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the lesser of (a) the applicable fee schedule amount, or (b) the provider's usual and customary charge. Payment is made based upon laboratory CPT codes and the fee schedule. The laboratory fee schedule can be accessed at [www.nhmedicaid.com/downloads/procedurecodes.html](http://www.nhmedicaid.com/downloads/procedurecodes.html) and is applicable to all public and private providers of freestanding laboratory services.

B) **Freestanding X-Ray Services**: Payment is made in accordance with a fee schedule established by the Department pursuant to NH RSA 161:4, VI. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the lesser of (a) the applicable fee schedule amount, or (b) the provider's usual and customary charge. Payment is made based upon radiological CPT codes and modifiers, and the fee schedule. The x-ray fee schedule can be accessed at [www.nhmedicaid.com/downloads/procedurecodes.html](http://www.nhmedicaid.com/downloads/procedurecodes.html) and is applicable to all public and private providers of freestanding x-ray services.

3. **Early and Periodic Screening, Diagnosis and Treatment**: Payment is made in accordance with the methodology and time frames established for the particular service being rendered as described elsewhere in this attachment. For example, a laboratory service provided to an EPSDT recipient would be reimbursed as per the above. All fee schedules are accessible at [www.nhmedicaid.com/downloads/procedurecodes.html](http://www.nhmedicaid.com/downloads/procedurecodes.html) and are applicable to all public and private providers.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

4. Family Planning Services – Payment for these services is provided in accordance with the same principles of reimbursement developed for the specific types of practitioners and/or services described elsewhere in the state plan which are considered to qualify as family planning services. For example, those types of individual practitioner’s services which qualify as family planning services are paid in accordance with #5 and #6 below. 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.

5. Physician Services – Payment is made in accordance with a fee schedule established by the department. Rates were set as of July 1, 2016, and are effective for services provided on or after that date. No provider shall bill or charge the department more than the provider's usual and customary charge. 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.

6. Services of Other Licensed Practitioners – Payment for all types of other licensed practitioners is made in accordance with a fee schedule established by the department. Rates were set as of July 1, 2016, and are effective for services provided on or after that date. No provider shall bill or charge the department more than the provider's usual and customary charge. 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.

Note: When it is stated that "rates were set as of," this indicates the most recent date rates were changed on one or more codes for the type of service/practitioner in question. It is not meant to imply that all of the codes pertaining to the type of service/practitioner in question were changed or reviewed.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

4.d Tobacco Cessation Counseling Services for Pregnant Women – Payment for these services is provided in accordance with the same principles of reimbursement developed for the specific types of practitioners described elsewhere in the state plan, i.e., physicians and other licensed practitioners. 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.

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

7. **Home Health Care Services** – Payment rates for nursing and home health aide services are established in accordance with state statute. A unit means a 15 minute unit. Skilled nursing services are reimbursed a flat rate per visit. Home health aide visits composed of fewer than 8 units of direct care time are reimbursed a flat rate per visit. Home health aide visits composed of eight or more units of direct care time are reimbursed a flat rate per unit of direct care time. The agency’s rates were set on April 1, 2010 and are effective for services provided on or after that date. Physical, occupational, and speech therapy/audiology services are reimbursed a per unit rate set by the department and in accordance with #11 below. Medical supplies, equipment and appliances are reimbursed at rates set by the department. No provider shall bill or charge the department more than the provider's usual and customary charge. The fee schedule, which is applicable to all public and private providers of home health care services, can be accessed at [www.nhmmis.nh.gov](http://www.nhmmis.nh.gov), under the “documents and forms” tab under “documentation.” For equipment which is prior authorized, the approved reimbursement amount, which is based upon the provider's acquisition and retail costs and other individualized circumstances of the request such as rental/trial periods, accessories, etc., is provided on the prior authorization approval notice which is sent to the provider. For those supplies, equipment and appliances which are not individually priced based on the above circumstances, rates were set on January 1, 2019, and are effective for services provided on or after that date.

8. **Private Duty Nursing Services** – Payment is made at a fee per hour in accordance with a fee schedule established by the department, with such fee schedule assigning fees based on day/ evening hours, or night and weekend hours, or a more intensive level of care. Rates were set as of April 1, 2016, and are effective for services provided on or after that date. No provider shall bill or charge the department more than the provider's usual and customary charge. All fee schedules are accessible at [www.nhmmis.nh.gov](http://www.nhmmis.nh.gov), under the “documents and forms” tab under “documentation,” and are applicable to all public and private providers.

9. **Clinic Services** – The individual practitioners who practice in the clinics are reimbursed according to the methodologies described in various entries in the state plan for the various types of practitioners providing the service. All fee schedules are accessible at [www.nhmmis.nh.gov](http://www.nhmmis.nh.gov), under the “documents and forms” tab under “documentation,” and are applicable to all public and private providers.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

10. Dental Services -- Payment is made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. The department's rates are reviewed biennially in accordance with RSA 126-A:18-b. Rates were set as of June 1, 2011, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider’s usual and customary charge. All fee schedules are accessible at www.nhmedicaid.com/Downloads/procedurecodes.html and are applicable to all public and private providers.

Effective June 1, 2011, interceptive orthodontia will be paid in one payment, inclusive of records. Also effective June 1, 2011, comprehensive orthodontia will be paid in three payments, inclusive of records: at banding, no sooner than 12 months after banding, and when evidence confirms that the case is completed. "Inclusive of records" means inclusive of the casts/models and various types of x-rays such as panorex and cephalometric x-rays that are required as part of the orthodontic consultation.

11. Physical Therapy and Related Services (Occupational and Speech Therapy) -- Payment for physical, occupational and speech therapy services is based upon a 15 minute unit of service, unless the CPT code is defined otherwise, and made in accordance with a fee schedule established by the department pursuant to NH RSA 161:4, VI. The department's rates are reviewed biennially in accordance with RSA 126-A:18-b. Rates were set as of October 1, 2008, and are effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. All fee schedules are accessible at www.nhmedicaid.com/Downloads/procedurecodes.html and are applicable to all public and private providers.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

12. Prescribed Drugs

DEFINITIONS:

Actual Acquisition Cost (AAC): The AAC equals the National Average Drug Acquisition Cost (NADAC) when available. When the NADAC is not available for select NDC’s, the back-up ingredient cost benchmark is the wholesale acquisition cost (WAC).

Professional Dispensing Fee: The professional dispensing fee for all drugs is $10.47.

FOR RETAIL COMMUNITY PHARMACIES:
- Payment for brand and generic, legend and non-legend drugs (including compound drugs), is based on the lesser of (a) the Actual Acquisition Cost (AAC) plus the applicable professional dispensing fee, (b) the wholesale acquisition cost (WAC) plus the applicable professional dispensing fee, (c) a New Hampshire Maximum Allowable Cost (NH MAC) plus the applicable professional dispensing fee, (d) the Federal Upper Limit (FUL) plus the applicable professional dispensing fee, or (e) the usual and customary charge to the general public.

FOR SPECIALTY DRUGS THAT ARE DISTRIBUTED BY A NON-RETAIL PHARMACY:
- Payment is at the lesser of (a) the Actual Acquisition Cost (AAC) plus the applicable professional dispensing fee, (b) the wholesale acquisition cost (WAC) plus the applicable professional dispensing fee, (c) a New Hampshire Maximum Allowable Cost (NH MAC) plus the applicable professional dispensing fee, (d) the Federal Upper Limit (FUL) plus the applicable professional dispensing fee, or (e) the usual and customary charge to the general public.

- Clotting factors are paid at the lesser of (a) the Actual Acquisition Cost (AAC) plus the applicable professional dispensing fee, (b) the wholesale acquisition cost (WAC) plus the applicable professional dispensing fee, (c) a New Hampshire Maximum Allowable Cost (NH MAC) plus the applicable professional dispensing fee, (d) the Federal Upper Limit (FUL) plus the applicable professional dispensing fee, or (e) the usual and customary charge to the general public.

- Investigational drugs are not covered by NH Medicaid.

DRUGS NOT DISTRIBUTED BY A RETAIL COMMUNITY PHARMACY SUCH AS IN LONG TERM CARE FACILITIES:
- Payment is at the lesser of (a) the Actual Acquisition Cost (AAC) plus the applicable professional dispensing fee, (b) the wholesale acquisition cost (WAC) plus the applicable professional dispensing fee, (c) a New Hampshire Maximum Allowable Cost (NH MAC) plus the applicable professional dispensing fee, (d) the Federal Upper Limit (FUL) plus the applicable professional dispensing fee, or (e) the usual and customary charge to the general public.

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

12. Prescribed Drugs (continued):

FOR PHYSICIAN ADMINISTERED DRUGS:
- Payment is set at the WAC, as listed on the published fee schedule available on the NH Medicaid provider website.

340 B DRUGS:
- 340B drugs purchased by 340B covered entities are not allowed to be billed to Medicaid. However, family planning providers are exempt from this billing prohibition because the Department has determined that it is more cost effective to allow family planning providers to bill 340B drugs.
- Drugs acquired by participating 340B covered entities will be reimbursed no more than AAC for drugs purchased through the 340B program.
- Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

FEDERAL SUPPLY SCHEDULE DRUGS:
- Drugs acquired at the Federal Supply Schedule (FSS) will be reimbursed at the AAC plus the professional dispensing fee.

DRUGS ACQUIRED AT NOMINAL PRICE:
- Drugs acquired at a nominal price will be paid at the AAC plus the professional dispensing fee.

FUL INFORMATION:

For multiple source drugs which meet requirements set by the Secretary, payment will not exceed, in the aggregate, upper limits established by the Secretary. The state intends to meet this requirement through its lesser of logic. The NH MAC is an aggressive pricing methodology which is updated weekly and is often less than the FUL. NH also does a monthly update of the FUL upon its publication. Because of these timely updates and the above noted lesser of logic, payment will not exceed, in the aggregate, the upper limits established by the Secretary.
13. **Prosthetic Devices and Durable Medical Equipment and Supplies** – Payment for some prosthetic devices and durable medical equipment (DME) and supplies is made in accordance with a fee schedule established by the department. Rates were set as of January 1, 2020, and are effective for services provided on or after that date. No provider shall bill or charge the department more than the provider’s usual and customary charge. All fee schedules are accessible at [www.nhmmis.nh.gov](http://www.nhmmis.nh.gov), under the “documents and forms” tab under “documentation,” and are applicable to all public and private providers. For DME which is prior authorized, the approved reimbursement amount, which is based upon the provider’s acquisition and retail costs and other individualized circumstances of the request such as rental/trial periods, accessories, etc., is provided on the prior authorization approval notice which is sent to the provider. For prosthetic devices that are manually priced, reimbursement is made at 85% of the amount billed. For medical supplies that are manually priced, reimbursement is made at 25% over invoice for enterals and specialty foods and at 40% over invoice for other medical supplies.

14. **Eyeglasses** – Payment for eyeglasses is made in accordance with a fee schedules established by the department. Rates were set as of January 1, 2020, and are effective for services provided on or after that date. No provider shall bill or charge the department more than the provider’s usual and customary charge. All fee schedules are accessible at [www.nhmmis.nh.gov](http://www.nhmmis.nh.gov), under the “documents and forms” tab under “documentation,” and are applicable to all public and private providers.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

15. Other Diagnostic, Screening, Preventative, and Rehabilitation Services (Continued)—

Payment for community mental health services is made in accordance with a fee schedule established by the department. Rates were set as of January 1 2020, and are effective for services provided on or after that date. No provider shall bill or charge the department more than the provider’s usual and customary charge. 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.

Note: When it is stated that “rates were set as of” this indicates the most recent date rates were changed on one or more codes for the type of service/practitioner in question. It is not meant to imply that all of the codes pertaining to the type of service/practitioner in question were changed or reviewed.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

15) Other Diagnostic, Screening, Preventive and Rehabilitative Services (continued)

Substance Use Disorder (SUD) Treatment and Recovery Support Services – New Hampshire's Medicaid state plan specifies the reimbursement methodology in Attachment 4.19-A and Attachment 4.19-B for some of the services that are rendered for the treatment of substance use disorders. Please refer to the appropriate, existing Attachments for these services as follows:

Attachment 4.19-A – Inpatient Hospital Reimbursement
- Inpatient Hospital Acute Care Services for Substance Use Disorders
- Inpatient Governmental Psychiatric Hospital

Attachment 4.19-B – Payment for All Types of Care Other Than Inpatient Hospital, Skilled Nursing, or Intermediate Nursing Care Services
- Outpatient Hospital Services, except when providing outpatient or comprehensive SUD services, which are reimbursed as per the below
- Physician Services
- Services of Other Licensed Practitioners
- Clinic Services
- EPSDT
- Prescribed Drugs
- Extended Services to Pregnant Women
- Federally Qualified Health Center (FQHC) and FQHC Look-A-Like Services

Some SUD services under the rehabilitative section 13d of Attachment 3.1-A and 3.1-B can also be billed by outpatient and comprehensive SUD programs. Payment under these two programs is made as follows:

a. Screenings: Payment for screenings shall be made in accordance with a fee schedule established by the Department. Rates were set as of July 1, 2016, and are effective for services provided on or after that date. No provider shall bill or charge the Department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

b. Individual, Group, or Family Treatment: Payment for individual, group, or family treatment shall be made in accordance with a fee schedule established by the Department. Rates were set as of July 1, 2016, and are effective for services provided on or after that date. No provider shall bill or charge the Department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

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15) Other Diagnostic, Screening, Preventive and Rehabilitative Services (continued)

Substance Use Disorder (SUD) Treatment and Recovery Support Services (continued)

c. Crisis Intervention: Payment for crisis intervention shall be made in accordance with a fee schedule established by the Department. Rates were set as of July 1, 2016, and are effective for services provided on or after that date. No provider shall bill or charge the Department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

d. Peer Recovery Support: Payment for peer recovery support shall be made in accordance with a fee schedule established by the Department. Rates were set as of July 1, 2016, and are effective for services provided on or after that date. No provider shall bill or charge the Department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

In addition to billings by outpatient and comprehensive SUD programs, peer recovery support services may also be billed by peer recovery programs accredited by the Council on Accreditation of Peer Recovery Support Services (CAPRSS) or that are under contract with the department.

e. Non-Peer Recovery Support: Payment for non-peer recovery support shall be made in accordance with a fee schedule established by the Department. Rates were set as of July 1, 2016, and are effective for services provided on or after that date. No provider shall bill or charge the Department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

f. Continuous Recovery Monitoring: Payment for continuous recovery monitoring shall be made in accordance with a fee schedule established by the Department. Rates were set as of July 1, 2016, and are effective for services provided on or after that date. No provider shall bill or charge the Department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.

g. Evaluation: Payment for evaluations shall be made in accordance with a fee schedule established by the Department. Rates were set as of July 1, 2016, and are effective for services provided on or after that date. No provider shall bill or charge the Department more than the provider's usual and customary charge. Medicaid payment shall be made at the lesser of Medicaid's applicable fee schedule amount or the provider's usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov (go to "documents and forms" under the "documentation" tab) and are applicable to all public and private providers.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

15) Other Diagnostic, Screening, Preventive and Rehabilitative Services (continued)

Substance Use Disorder (SUD) Treatment and Recovery Support Services (continued)

h. Intensive Outpatient SUD Services: Payment for intensive outpatient SUD services shall be made at a per diem rate established by the Department. Rates were set as of July 1, 2016, and are effective for services provided on or after that date. Intensive outpatient SUD services are comprised of a combination of individual and group treatment services for 3 hours/day, 3 days/week for recipients age 21 and over and 2 hours/day, 3 days/week for recipients under age 21 and includes a range of outpatient treatment services and other ancillary and/or other drug services. The service is similar to the current Medicaid behavioral health service of 1/2 day of behavioral health partial hospitalization (H0035) and was, therefore, priced at the same rate, and also mirrors the rate established in 2014 for the alternative benefit plan (ABP) intensive outpatient SUD service. All fee schedules are accessible at www.nhmmis.nh.gov (go to “documents and forms” under the “documentation” tab) and are applicable to all public and private providers.

i. Partial Hospitalization: Payment for partial hospitalization shall be made at a per diem rate established by the Department. Rates were set as of July 1, 2016, and are effective for services provided on or after that date. Partial hospitalization is comprised of a combination of a range of group and individual outpatient treatment services that are provided at least 20 hours/week. It was determined that this level and intensity of service was similar to the current Medicaid covered full day of behavioral health partial hospitalization (S0201) and thus, this service was priced at the same rate. It also mirrors the rate established in 2014 for the alternative benefit plan (ABP) partial hospitalization service. All fee schedules are accessible at www.nhmmis.nh.gov (go to “documents and forms” under the “documentation” tab) and are applicable to all public and private providers.

j. Medically Monitored Outpatient Withdrawal Management: Payment for medically monitored outpatient withdrawal management shall be made at a per visit rate established by the Department. Rates were set as of July 1, 2016, and are effective for services provided on or after that date. These services must be supervised by a physician and include such things as physician assessment for withdrawal, vitals, and physician management of any elevated levels. This service typically takes place over the course of 3-10 days. Due to the nature of the service, it was compared to a physician visit for ratesetting purposes. It was determined that it was best compared to an established patient office visit, which is defined as requiring 2 of 3 components (detailed history, detailed exam, medical decisions of moderate complexity). It was therefore priced equivalent to Medicaid’s current rate for the office visit code of 99214. It also mirrors the rate established in 2014 for the alternative benefit plan (ABP) medically monitored outpatient withdrawal management service. All fee schedules are accessible at www.nhmmis.nh.gov (go to “documents and forms” under the “documentation” tab) and are applicable to all public and private providers.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

15) Other Diagnostic, Screening, Preventive and Rehabilitative Services (continued)

Substance Use Disorder (SUD) Treatment and Recovery Support Services (continued)

Comprehensive SUD Program:

a. Medically Monitored Residential Withdrawal Management: Payment for medically monitored residential withdrawal management provided in a residential treatment and rehabilitation facility shall be made at a per diem rate established by the Department. Rates were set as of July 1, 2019, and are effective for services provided on or after that date. Medically monitored residential withdrawal management includes medical service components such as monitoring of vital signs and managing medications for withdrawal from alcohol and other drug substances. The rate was set after an analysis of rates paid by other states for similar services. All fee schedules are accessible at www.nhmmis.nh.gov (go to “documents and forms” under the “documentation” tab) and are applicable to all public and private providers.

b. Rehabilitative Services in a Residential Treatment and Rehabilitation Facility: Payment for services in a residential treatment and rehabilitation facility shall be made at per diem rates established by the Department based on the appropriate level of intensity (low, medium, high, or specialty care such as extended services to pregnant women and children) in accordance with the American Society of Addiction Medicine (ASAM) Criteria. Rates were set as of January 1, 2019, and are effective for services provided on or after that date. The per diem rates were established based on rates paid by Medicaid or on a contract basis by various divisions for similar services, rates paid by other states for similar services, and based on clinical determinations of similarities of service delivery, practitioner involvement, and intensity. Payment does not include room and board.

A clinical determination was made that the low level intensity service for adults should be priced at the current Medicaid rate for therapeutic behavioral health services (H2020) which is a per diem rate of $120.00. By their nature, adolescent services are more involved than adult services at the low level of intensity. These adolescent services were priced at a per diem rate of $128.00.

The rate for high level intensity services for adults was priced at $247.82 based on an assessment of in-state services and rates, as well as rates paid by other states for similar services. The comparable medium level intensity services for adolescents are priced at a per diem rate of $170.00. This rate was based on the current Medicaid rate ($170.00) for a similar adolescent facility under the division for children, youth and families.

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15) Other Diagnostic, Screening, Preventive and Rehabilitative Services (continued)

Substance Use Disorder (SUD) Treatment and Recovery Support Services (continued)

1. Rehabilitative Services in a Residential Treatment and Rehabilitation Facility (continued):

High intensity specialty care, which encompasses the extended services to pregnant women substance use programs, was priced using the current program’s price of $162.60 as a basis. This Medicaid rate was set about 20 years ago based on cost reporting and contract prices that were then reviewed and substantiated a year after the program was launched. Based on this information, and in comparison to the proposed adult high intensity rate of $162.60, a rate of $230 has been set for the high intensity specialty level of care for pregnant and postpartum women in substance use treatment programs. This rate takes into account that the $162.60 rate has not been increased in over 20 years with such proposed increase being equivalent to less than a 2% inflation factor over each of 18 years. It also takes into consideration the complexities of specialty care for this population such as ensuring access to obstetrical care and active participation in pre-natal care and parenting.

Once the above rates were calculated, they were compared to the average per diem rate for a rehabilitation hospital stay to ensure that they were reasonable; rates were found to be substantially and acceptably less than the average per diem rate of $847.59. These rates also mirror the rates established in 2014 for the alternative benefit plan (ABP) residential treatment and rehabilitation facility service. All fee schedules are accessible at www.nhmmis.nh.gov (go to “documents and forms” under the “documentation” tab) and are applicable to all public and private providers.
NEW HAMPSHIRE DIVISION OF HUMAN SERVICES

FINDING AND ASSURANCE STATEMENT

AS REQUIRED BY 42 CFR 447.333

In accordance with 42 CFR 447.333(b)(2), the New Hampshire Medicaid Program assures that effective February 1, 1996, it has met the requirements set forth in 42 CFR 447.331 and 447.332 concerning upper limits. Additionally, the New Hampshire Medicaid Program assures that effective February 1, 1996, and in accordance with 42 CFR 447.333(b)(1), that the agency has made the following separate and distinct findings:

1. In the aggregate, Medicaid expenditures for multiple source drugs identified and listed in accordance with 447.332(a) are in accordance with the upper limits specified in 447.332(b).

2. In the aggregate, Medicaid expenditures for all other drugs are in accordance with 447.331.

New Hampshire has also reviewed the State Medicaid Manual requirements which relate to these regulations and assures that effective February 1, 1996, it also meets the requirements at Sections 6305.1 and 6305.2. In accordance with Section 6305.2E, the agency assures that it pays no more than the upper limits described in Section 6305.1, in accordance with 42 CFR 447.304(a).
NH Title XIX State Plan Amendment #96-01
Supporting Documentation

Reasonable Dispensing Fee

Effective February 1, 1996, a reasonable dispensing fee of $2.50 has been established for each prescription drug dispensed. This dispensing fee was determined to be reasonable based on the following:

1. A June, 1995, proposal prepared for NH by Express Scripts recommended a $2.50 dispensing fee for the state. Express Scripts is a Pharmacy Benefit Manager (PBM) and bases its recommendations on statewide data. Currently, of those pharmacies in NH already involved with Express Scripts in other capacities, approximately 70% are Medicaid providers, thus indicating an acceptance by the provider community of a dispensing fee in the range of $2.50.

2. The prescription drug plan of Blue Cross/Blue Shield of NH (BC/BS-NH) is managed through PCS Health Systems Inc., another PBM, and was implemented March 1, 1995. This plan, which has NH provider acceptance, also utilizes a $2.50 dispensing fee.

3. As part of the work done by the Department of Health and Human Services regarding passage of House Bill 32 which contained many cost savings incentives for the Department, the Commissioner and Assistant Commissioner of the Department of Health and Human Services met with the NH Pharmacists Association President and a representative of their Executive Committee to discuss feasibility of the $2.50 dispensing fee.

Estimated Acquisition Cost (EAC)

Effective February 1, 1996, a 12 percent discount is applied to the Average Wholesale Price (AWP) in order to arrive at an EAC. This discount was arrived at by utilizing the same resources as used to support the dispensing fee.

1. The proposal prepared by Express Scripts recommended a 12 percent discount be applied to the AWP.

2. The BC/BS-NH plan through PCS Health Systems, Inc. applies a 13 percent discount to the AWP.

3. Again, the Commissioner of the Department of Health and Human Services discussed the discount with the NH Pharmacists Association.

In accordance with 42 CFR 447.204, we believe that payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent services are available to the general population. As indicated above, EAC and dispensing fees are based on data utilized by PBM’s operating in NH. These PBM’s handle benefit programs that are utilized by the general population. BC/BS-NH has more than 260,000 members covered under 6 major benefit plans served by PCS participating pharmacies in NH and across the nation. Express Script has a retail network of over 43,000 pharmacies which includes approximately 70 percent of the NH Medicaid participating pharmacies.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

1. Case Management Services - Payment rates for case management services provided to mentally ill persons by community mental health programs will be set by the Division of Mental Health and Developmental Services upon reasonable costs as submitted by community mental health programs.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN
INPATIENT HOSPITAL, SKILLED NURSING OR INTERMEDIATE NURSING CARE SERVICES

16. Inpatient Psychiatric Facility Services - Payment rates for inpatient psychiatric facility services provided to all Medicaid eligible clients will be established by the Commissioner based on reasonable costs as submitted by the providers.

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.

18. Case Management Services -

a. Payment rates for case management services provided to all Medicaid eligible adult clients by approved providers will be set by the Division of Human Services based on reasonable costs as submitted by the providers. Any third party liability health insurance must be billed for case management services prior to Medicaid payment.

b. Payment rates for CHAP Plus Care Coordination services shall be determined by the Office of Medical Services.

c. Payment for case management services provided to Division of Mental Health and Developmental Services (DMHDS) clients will be the lesser of the area agency’s/community mental health center’s charge or the Medicaid rates on file, set by DMHDS.

d. Case Management Services - Payment rates for case management services provided to mentally ill persons by community mental health programs will be set by the Division of Behavioral Health.

e. Case Management Services - Payment rates for case management services provided to all Division for Children, Youth and Families Medicaid eligible clients by approved providers will be set by the Division of Human Services based on reasonable costs as submitted by the providers. Before billing Medicaid, families must pay for these services as per any court orders. Additionally, any third party liability health insurance must be billed for these services prior to Medicaid payment.

TN No. 98-03
Supersedes
TN No. 96-12

Approval Date: 5/1/98
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PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

f. Reimbursement for case management of chronically ill children is paid via a monthly rate per eligible child, established by the Department of Health and Human Services.

g. Reimbursement for case management of advance care planning and directives is based on a 15 minute unit of service at a rate established by the Division of Elderly and Adult Services of the Department of Health and Human Services.

19. Medical Transportation - Payment for emergency and air ambulance service is made in accordance with the rates established by the Department. Rates were last reviewed as of January 1, 2016, with such review resulting in no changes to the rates, and are effective for services provided on or after that date. No provider shall bill or charge the department more than the provider’s usual and customary charge. 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.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

19. Case Management Services (continued):

b. Behavioral Health Case Management Services

Payment rates for case management services provided to adult Medicaid recipients with severe and persistent mental illness or Medicaid eligible children with severe emotional disturbances are made in accordance with a fee schedule established by the department. No provider shall bill or charge the department more than the provider’s usual and customary charge. The rate is applicable to all public and private providers.

Case management providers are paid a unit of service equivalent to a monthly rate per eligible recipient for services rendered. The rate for this service is $404.24/month.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

19. Case Management Services (continued):

b. Developmental Services Case Management Services

Payment rates for case management services provided to Medicaid recipients with developmental disabilities are made in accordance with a fee schedule established by the department. No provider shall bill or charge the department more than the provider's usual and customary charge. The rate is applicable to all public and private providers.

Case management providers are paid a unit of service equivalent to a monthly rate per eligible recipient and the rate may be billed only if services are actually provided in the month. The rate was set based on comparisons with other states and to applicable services and rates in NH. The rate for this service is $257.35/month.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

19. Case Management Services (continued):

b. Adults with Chronic Illnesses or Disabilities Case Management Services

Payment rates for case management services provided to Medicaid recipients who are adults with chronic illnesses or disabilities are made in accordance with a fee schedule established by the department. No provider shall bill or charge the department more than the provider’s usual and customary charge. The rate is applicable to all public and private providers.

Case management providers are paid using a day as a unit of service. The rate for the service is $8.52/day and is limited to 25 days/month. The rate was set based on comparisons with other states and to applicable services and rates in NH.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

19. Case Management Services (continued):

b. Chronically Ill Children Case Management Services

Payment rates for case management services provided to Medicaid recipients under the age of 21 and certified by a physician as having a chronic illness are made in accordance with a fee schedule established by the department. No provider shall bill or charge the department more than the provider’s usual and customary charge. The rate is applicable to all public and private providers.

Case management providers are paid a unit of service equivalent to a monthly rate per eligible child and the rate may only be billed if services are actually provided in the month. The rate was set based on comparisons with other states and to applicable services and rates in NH. The rate for this service is $331.50/month.

TN No: 08-012
Supersedes
TN No: new page

Approval Date: 04/27/2018

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

19. Case Management Services (continued):

b. Advance Care Planning and Directives Case Management Services

Payment rates for case management services provided to Medicaid recipients who have been diagnosed by a licensed physician as being severely ill are made in accordance with a fee schedule established by the department. No provider shall bill or charge the department more than the provider’s usual and customary charge. The rate is applicable to all public and private providers.

Case management providers are paid $35 per 15-minute unit of service from 6/12/2008 through 6/30/2010 when this service was replaced with “hospice care services” effective 7/1/2010 with reimbursement as detailed in Attachment 4.19-B, page 6, item #25.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

19. Case Management Services (continued):

f. EPSDT Case Management Services

Payment rates for case management services provided to Medicaid recipients under the age of 21 are made in accordance with a fee schedule established by the department. No provider shall bill or charge the department more than the provider’s usual and customary charge. The rate is applicable to all public and private providers.

Case management providers are paid a 1 unit rate per eligible child when case management is provided in conjunction with a well-child visit delivered in accordance with the Bright Futures/American Academy of Pediatrics periodicity schedule. The rate for this case management service is $12.00.
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

20. Extended Services to Pregnant Women—For extended services to pregnant women provided by agencies under contract with the Division of Public Health, e.g., "Home Visiting NH and Child/Family Health Care Support" and "Extended Services to Pregnant Women," payment is made in accordance with a fee schedule as determined by the Department of Health and Human Services (Department). Rates have not been updated since March, 2004. For the one residential treatment and rehabilitation facility of fewer than 17 beds for pregnant and post-partum women, payment is based on a rate as determined by the Department. The rate is $162.60 and does not include room and board. For all other providers, payment is made pursuant to the methodologies described in Attachment 4.19-B for the specific covered service or practitioner. Fee schedules are accessible at www.nhmmis.nh.gov under the "documents and forms" tab, and are applicable to all public and private providers.

21. a) Rural Health Clinics (RHC’s)-Non Hospital Based – Payment for non-hospital based RHC’s is made according to the same methodology used for Federally Qualified Health Centers (FQHC) and FQHC Look-A-Likes (LAL’s) as described on page 5a through 5f.**

b) Rural Health Clinics (RHC’s) – Hospital Based – Payment for hospital based RHC’s is made according to the methodology described on page 5g.**

22. Personal Care Services – Payment for personal care services is made in accordance with a fee schedule developed by the Department. Rates for services were set as of March 6, 2015 and are effective for services on or after that date. No provider shall bill or charge the Department more than the provider’s usual and customary charge. All fee schedules are accessible at www.nhmmis.nh.gov under the “documents and forms” tab, and are applicable to all public and private providers.

23. Federally Qualified Health Centers (FQHC’s) and FQHC Look-A-Likes (LAL’s) – Payment for FQHC’s and FQHC LAL’s is made according to the methodology described on page 5a. **

**Addendum to 21a and 23 above, RHC’s and FQHC/FQHC-LAL’s:

X The payment methodology for RHC’s/FQHC’s/FQHC-LAL’s will conform to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

The payment methodology for RHC’s/FQHC’s/FQHC-LAL’s will conform to the BIPA 2000 requirements for a prospective payment system (PPS).

X The payment methodology for RHC’s/FQHC’s/FQHC-LAL’s will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

(1) is agreed to by the state and the center or clinic; and

(2) results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

(Addendum continued on next page)
OFFICIAL

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

**Addendum to 21 and 23 above, RHC’s, FQHC’s and FQHC-LAL’s (continued):

Description of Alternative Payment Methodology — RHC’s, FQHC’s and FQHC-LAL’s (21 and 23 above)

21a and 23. Rural Health Clinics - Non-Hospital Based (RHC-NHB), Federally Qualified Health Centers (FQHC’s) and FQHC Look-A-Likes (LAL’s)

a) General

Payment for RHC-NHB’s, FQHC’s, and FQHC-LAL’s conforms to Section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000. The NH Department of Health and Human Services (the Department) determines an encounter rate for primary, preventive care services using an Alternative Payment Methodology (APM) under SSA 1902(bb)(6). The encounter rate is an all-inclusive rate of payment for primary, preventive care covered services defined in 1905(a)(2)(B) and (C) of the Social Security Act and included in the NH Title XIX State Plan to eligible Medicaid recipients.

The Alternative Payment Methodology (APM) is calculated using the providers’ fiscal year 2011 cost-settled rates as the baseline for all subsequent years’ encounter rates trending forward using the Medicare Economic Index (MEI) published annually for each of those years. The cost settlement process applied to the 2011 baseline limited each provider to the lesser of their actual costs or 133% of the Medicare rate.

The Department also calculates an encounter rate using a Prospective Payment Methodology (PPS) and the formula established by BIPA 2000, using the average cost based rate per visit for provider fiscal years of 1999 and 2000, trended forward by the MEI.

The baseline rates for RHC-NHB’s, FQHC’s, and FQHC-LAL’s that did not have any reported costs in either the APM or PPS baseline will be set as an average of the rates for similar clinics or centers in the same urban or rural settings. The effective date for such rates is the effective Medicaid enrollment date for the provider.

Effective October 8, 2012, each provider will receive an encounter rate that is the greater of the APM or PPS. Only those providers that agree in writing to the proposed APM will receive the proposed APM. Thereafter, annually on July 1, each provider’s encounter rate will be trended forward by the MEI and adjusted for any approved change in scope of services (see below).

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Supersedes Approval Date 08/12/13
TN No: NEW Effective Date: 10/08/12
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

**Addendum to 21 and 23 above RHC’s, FQHC’s and FQHC-LAL’s (continued):

Description of Alternative Payment Methodology – RHC’s, FQHC’s and FQHC-LAL’s (21 and 23 above)

21a and 23. Rural Health Clinics - Non-Hospital Based (RHC-NHB), Federally Qualified Health Centers (FQHC’s) and FQHC Look-A-Likes (LAL’s) (continued)

b) Change of Scope in Service

A change of scope in service is recognized by the Department when there is a change in the type, intensity, duration and/or amount of services as a result of the following:

1. An increase in scope of service could result from the addition of a new professional staff member (i.e., contracted or employed) who is licensed to perform medical services that are approved RHC-NHB, FQHC, or FQHC-LAL benefits that no current professional staff is licensed to perform.

2. A decrease in scope of service could result when no current professional staff member is licensed to perform the medical services currently performed by a departing professional staff member.

An increase or decrease in scope of service does not necessarily result from any of the following (although some of these changes may occur in conjunction with a change of scope in service):

- an increase, decrease or change in number of staff working at the clinic except as noted above
- an increase, decrease or change in office hours
- an increase, decrease or change in office space or location
- the addition of a new site that provides the same set of services
- an increase, decrease or change in equipment or supplies
- an increase, decrease or change in the number or type of patients served

RHC-NHB’s, FQHC’s and FQHC-LAL’s may request a change of scope in service once a year for implementation on July 1. This will be concurrent with the effective date of the increase to the encounter rate. RHC-NHB’s, FQHC’s, and FQHC-LAL’s are required to submit requests in writing no later than March 31 in order to be effective July 1. The Department will review and analyze all requests to ensure compliance with the Medicare FQHC/RHC regulations relative to a change of scope in service.

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

**Addendum to 21 and 23 above RHC’s, FQHC’s and FQHC-LAL’s (continued):**

**Description of Alternative Payment Methodology – RHC’s, FQHC’s and FQHC-LAL’s (21 and 23 above)**

21a and 23. Rural Health Clinics - Non-Hospital Based (RHC-NHB), Federally Qualified Health Centers (FQHC’s) and FQHC Look-A-Likes (LAL’s) (continued)

b) Change of Scope in Service (continued)

1. All requests should be submitted in writing to the Department by the RHC-NHB, FQHC, or FQHC-LAL and should include:

   - a detailed explanation of each change of scope in services provided by the RHC-NHB, FQHC, or FQHC-LAL delineating how services were provided both before and after the change;
   - the effective date of each change of scope in services;
   - the Medicaid visits and total visits associated with each change of scope in services;
   - the total number of visits for all sites for the same time period that the RHC-NHB, FQHC, or FQHC-LAL submits the incremental costs;
   - the incremental increase or decrease in costs by expense category for each change of scope in services; and
   - the cumulative per visit dollar amount of the rate adjustment requested.

2. All requests should include, at a minimum, a detailed worksheet that delineates the total incremental difference in costs for each of the categories and subcategories of expenses associated with the change of scope in service.

3. A change in costs alone in and of itself will not be considered a change of scope in service unless it is a CMS approved change of scope in service and all of the following apply:

   - the increase or decrease in cost is attributable to an increase or decrease in the scope of the services defined above;
   - the cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413;
   - the change of scope in services is a change in the type, intensity, duration, or amount of services, or any combination thereof; and
   - the net change in costs in the RHC-NHB, FQHC, or FQHC-LAL’s must meet a minimum threshold of 5%.

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**Addendum to 21 and 23 above RHC’s, FQHC’s and FQHC-LAL’s (continued):**

**Description of Alternative Payment Methodology – RHC’s, FQHC’s and FQHC-LAL’s (21 and 23 above)**

**21a and 23. Rural Health Clinics - Non-Hospital Based (RHC-NHB), Federally Qualified Health Centers (FQHC’s) and FQHC Look-A-Likes (LAL’s) (continued)**

b) **Change of Scope in Service (continued)**

The RHC-NHB’s, FQHC’s, and FQHC-LAL’s shall submit supporting documentation for each amount included in the categories of expenses for both the prior period and the period where there is a change of scope in services following Medicare reasonable cost principles.

The Department will review the documentation submitted by the RHC-NHB’s, FQHC’s, and FQHC-LAL’s and will notify them as to whether the rate adjustment is approved.

The Department reserves the right to adjust the encounter rate for any change of scope in service that comes to its attention.

The following formula will be used by DHHS to determine the new rate:

\[
NR = \frac{(R \times PV) + C}{PV + CV}
\]

Where:
- “NR” represents the new reimbursement rate adjusted for the increase/decrease in the scope of service;
- “R” represents the present Medicaid rate;
- “PV” represents the present number of total visits, which is the total number of visits for the RHC-NHB, FQHC, or FQHC-LAL during the 12-month time period prior to the change of scope in service;
- “C” represents the expected change in costs due to the change of scope in service; and
- “CV” represents the expected change in the number of visits due to the change of scope in service.

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

**Addendum to 21 and 23 above RHC’s, FQHC’s and FQHC-LAL’s (continued):

Description of Alternative Payment Methodology – RHC’s, FQHC’s and FQHC-LAL’s (21 and 23 above)

21a and 23. Rural Health Clinics - Non-Hospital Based (RHC-NHB), Federally Qualified Health Centers (FQHC’s) and FQHC Look-A-Likes (LAL’s) (continued)

b) Change of Scope in Service (continued)

Example:
Assume the provider notified the department in writing of a change of scope in service offered prior to the July 1 implementation and the provider submitted the documentation and information necessary for the Department to make a determination. In addition, assume the RHC-NHB, FQHC, or FQHC-LAL has a present Medicaid reimbursement rate of $100 per visit with 10,000 visits per year.
A new professional staff member is added to provide services with 1,000 additional visits per year expected at an increase in cost of $140,000.

\[
NR = (Rx \ PV) + C \\
(\ PV + CV)
\]

\[
NR = ($100 \times 10,000) + $140,000 \\
(10,000 + 1,000)
\]

\[
NR = $1,140,000 \\
11,000
\]

\[
NR = $103.64
\]

c) Encounter Payments

Payment of the encounter rate will be allowed for medical and behavioral health visits. Only one medical and one behavioral health encounter claim may be submitted per date of service, unless a service authorization has been approved for two specific exceptions: (1) subsequent to the first encounter, the patient suffers an illness or injury with a different diagnosis, or (2) subsequent to the first encounter, the patient received a different treatment at a different time of the same day.

Medical nutrition therapy/diabetes education are not stand-alone services under the NH Title XIX State Plan and, therefore, will not be paid as a separate encounter payment amount but through the established medical encounter rate.

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

**Addendum to 21 and 23 above RHC’s, FQHC’s and FQHC-LAL’s (continued):

Description of Alternative Payment Methodology – RHC’s, FQHC’s and FQHC-LAL’s (21 and 23 above)

21a and 23. Rural Health Clinics - Non-Hospital Based (RHC-NHB), Federally Qualified Health Centers (FQHC’s) and FQHC Look-A-Likes (LAL’s) (continued)

d) Other Payments

With the exception of behavioral health visits which are paid a separate encounter rate (see page 5e, Item c, “Encounter Payments”), reimbursement for “other ambulatory services” (as defined in 1905(a)(2)(B) and (C) of the Social Security Act), that are covered under the NH Title XIX State Plan, will be made according to the Medicaid fee schedule, as these services are not included in the encounter rate. Examples of ambulatory services that are not included in the encounter rate but that will be paid according to the fee schedule rates specified in the NH Title XIX State Plan include dental and podiatry services; physician services rendered in the inpatient and outpatient hospital setting; radiology; pharmacy; vision and hearing services, other than routine screenings; non-routine laboratory services; vaccine administration for adults and children if not part of or incidental to an encounter; the actual vaccine for adults age 19 and over regardless of whether the administration of such vaccine is part of the encounter or reimbursed separately; family planning devices; physical therapy; occupational therapy; speech therapy; and medical transportation.

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Approval Date 08/12/13
Effective Date: 10/08/12
**Addendum to 21 and 23 above RHC’s, FQHC’s and FQHC-LAL’s (continued):**

**Description of Alternative Payment Methodology — RHC’s, FQHC’s and FQHC-LAL’s (21 and 23 above)**

21b. Rural Health Clinics (RHC’s) – Hospital Based

Hospital-based RHC’s are reimbursed a percent of costs. Each hospital, after the close of its own unique fiscal period, submits the Medicare Cost Report (CMS Form 2552) as required by Medicare, which is subsequently audited by the Medicare Fiscal Intermediary according to the Medicare auditing schedule and principles of reimbursement. Allowable costs are allocated to the hospital-based RHC services rendered to NH Medicaid recipients on Worksheet M-3. Effective for services on and after October 8, 2012, the current reimbursable amount of the costs is 91.27%. The reimbursable costs based on the audit are then compared to interim payments that were made during the unique cost period for that hospital, and the difference is the settlement that is payable to the hospital-based RHC or to the Department. Based on the settlement, the interim rate is also established for the hospital's next cost period by taking a Ratio of Cost to Charges (RCC) derived from the last settlement processed. This is an ongoing process that occurs as hospitals submit cost reports when their unique fiscal years end.

Laboratory services provided as part of a hospital based RHC encounter are reimbursed through an add-on fee which is paid in addition to the percentage of cost payment for the encounter. The add-on fee is the same laboratory fee-for-service fee schedule used for all laboratory services reimbursement effective as noted in the NH Title XIX State Plan, Attachment 4.19-B, page 1-1, and is the same fee schedule used for both governmental and private providers. The fee schedule can be found at www.nhmmis.nh.gov (see "documents and forms" under the documentation tab).

Vaccine administration is paid as part of the encounter. However, if vaccine is not administered as part of or incidental to an encounter, the vaccine administration can be billed separately and will be reimbursed at the interim rate and cost settled as per above. The actual vaccine is reimbursed for adults age 19 and older regardless of whether the administration of such vaccine is part of the encounter or billed separately and is billed with a pharmacy revenue code and paid an interim rate which is subsequently cost settled as per above.

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

25. Hospice Services - Payment for hospice services is at a per diem rate established in accordance with Medicare regulations at 42 CFR 418, Subpart G. Hospice payments for inpatient care are limited and paid in accordance with Medicare regulations at 42 CFR 418.302(f). Acquired Immunodeficiency Syndrome (AIDS) cases are included in the limitation calculation. The state does not apply the optional cap limitation on payments. The agency’s rates were set on July 1, 2010 and are effective for services provided on or after that date. The fee schedule, which is applicable to all public and private providers of hospice services, follows the Medicare fee schedule and is updated concurrent with Medicare updates. The fee schedule can be accessed on the Medicare hospice website at:


TN No: 10-007
Supersedes
TN No: n/a

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Effective Date: 07/01/2010
PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

28. Freestanding birth centers — Freestanding birth centers are paid a facility fee for a delivery performed at the center. Payment is in accordance with a fee schedule established by the Department pursuant to NH RSA 161:4, VI. The department's rates are reviewed biennially in accordance with RSA 126-A:18-b. The rate was set effective January 4, 2012 and is effective for services provided on or after that date. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the provider's usual and customary charge. All fee schedules can be accessed at www.nhmedicaid.com/Downloads/procedurecodes.html, and are applicable to all public and private providers.
5. Physician Services (continued from page 1a)

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting. New Hampshire has only one Medicare Geographic Practice Cost Index (GPCI). NH uses the Deloitte tool to develop the rates for each code. NH will not adjust its fee schedule to account for any changes in the Medicare rates.

☐ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:

**Method of Payment**

☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☒ quarterly

The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on the date of service as published in the agency’s fee schedule described in Attachment 4.19-B Page 1-a #5 Physician Services of the State Plan plus additional rates established for codes 99495 and 99496 added 1/1/2013 and the minimum payment required at 42 CFR 447.405.

**Primary Care Services Affected by this Payment Methodology**

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes):

99216, 99246, 99247, 99248, 99249, 99250, 99288, 99315, 99316, 99339, 99340, 99346, 99363, 99364, 99406, 99407, 99408, 99409, 99429, 99450, 99455, 99470, 99485, 99486, 99487, 99488, 99489, and 90461.

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(Primary Care Services Affected by this Payment Methodology – continued)

☒ The state will make payment under this SPA for the following codes, which have been added to the fee schedule since July 1, 2009 (specify code and date added):

99224 added 1/1/2011; 99225 added 1/1/2011; 99226 added 1/1/2011; 99495 added 1/1/2013; 99496 added 1/1/2013; 90460 added 1/1/2011 (vaccine); and 90460 U1 added 1/1/2011 (vaccine).

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect on 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect on 7/1/09 for code 90460 equals the rate in effect on 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12-month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: $3.68.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: ________________________________.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

______________________________

______________________________

______________________________

______________________________

______________________________

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Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending COB on 12/31/14, but not prior to December 31, 2014. All rates are published at:

- NHMedicaid.com (available until 4/1/13)
- NHMedicaidHealthEnterprise.com (available until at least 4/1/13)
- NHMMIS.nh.gov (available beginning 4/1/13)

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending COB on 12/13/14, but not prior to December 31, 2014. All rates are published at:

- NHMedicaid.com (available until 4/1/13)
- NHMedicaidHealthEnterprise.com (available until 4/1/13)
- NHMMIS.nh.gov (available beginning 4/1/13)

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 48 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
ACCESS SUPPLEMENT

INVESTIGATION OF ACCESS ISSUES AND Responsive ACTIONS

The State of New Hampshire monitors access to care and produces an access report on a quarterly basis under its monitoring plan. New Hampshire Medicaid will continue to review and revise the monitoring plan itself to ensure the continued relevance of the selected indicators and to expand it over time to include other Medicaid benefits, including behavioral health, long-term care services, and managed care. The access monitoring plan is based upon a two-tier detection system. The first detection method is based on the systematic, ongoing monitoring that is used to address access issues that develop gradually over time. The second method is the real-time and individualized detection of discrete access issues that are generally handled by the Medicaid Client Services Unit.

Surveillance through systematic, ongoing monitoring is one method of detecting an access issue. The following situation in systematic reporting will trigger the deployment of an Access Response Team:

- A data point above the upper control limit or below the lower control limit, depending on the measure; or
- The current period data for a given measure deviates to a degree that the confidence interval does not overlap with the prior period's confidence interval.

Should a systemic access issue be detected through New Hampshire's quarterly access monitoring report, New Hampshire Medicaid would activate an Access Response Team to research the specific cause(s) of the problem and make recommendations for responsive action. The members of the Access Response Team would be drawn from several of the following functional areas: client services, financial management and reimbursement, benefits management, provider network management, and data analytics. The Team would be responsible for determining the cause of the access issue, proposing responsive actions, including assessing the need to make modifications to the access monitoring systems. The Medical Care Advisory Committee (MCAC) will serve as a resource to engage stakeholders in this process of resolving any identified access issue. The Team would then submit a proposed response for the review and approval by the State Medicaid Director and the Department's Medicaid Executive Team. The timing and nature of any responsive action taken will necessarily depend upon the particular nature, complexity and magnitude of the access problem identified and the beneficiary population affected, but responsive action plans will set a target date for resolution of the identified access issue; and, in all cases, the target date will be set sometime within one year of the date that the responsive action plan was approved by the Medicaid Executive Team. Possible responsive actions may include, but are not limited to:

- Resolving provider administrative burdens, such as claims submission and payment issues;
- Assisting beneficiaries in obtaining necessary primary or specialty care services through provider referral, transportation assistance, or enrollment in Medicaid Managed Care;
- Assessing and realigning covered benefits so that additional resources can be directed toward a resource-challenged area;
- Incentivizing the expansion of health care providers in underserved areas in the State; or
- Restructuring rates and targeting them to address the particular underserved areas.
Surveillance by the Medicaid Client Services Unit is a second method of detecting any discrete events which create an access to care issue. This Unit manages a call center, providing ombudsman services to clients who need assistance, maintaining an up-to-date network reference guide, and offering referrals to providers upon request by any recipient or recipient representative, and providing transportation assistance and transportation reimbursement. The Unit is dedicated to resolving Medicaid recipient concerns on a real time, case-by-case basis. The client call tracking logs maintained on each of these individual responses to recipient concerns are a rich source of information about multiple discrete access issues; examination of these logs can assist in identifying indications of a trend across discrete access issues, which may require prompt intervention. New Hampshire has long had in place a toll free 800 number that beneficiaries can call for assistance. The phone number appears on the Medicaid member card, in the member welcome packet, and in all beneficiary communications and outreach materials. Should a discrete access issue be detected, NH would investigate facts directly from those providers implicated, analyze client impact, confirm alternative provider availability, and augment resources to the Client Services Unit to include additional staff and extended hours of operations if needed. Specific messaging to Medicaid beneficiaries potentially impacted would be issued as deemed necessary via media outlets, community network partners, and social media. A written synopsis of access issues identified in each quarter, if any, and New Hampshire Medicaid program's responses to them, is included in the following quarter's access monitoring report. Quarterly access monitoring reports are available under “Medicaid Access Monitoring” at www.dbhs.nh.gov/ombp/publications.htm.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ___ of this attachment (see 3. above).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State / Territory: NEW HAMPSHIRE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance *

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<td>Part B SP Deductibles</td>
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<td>SP Coinsurance</td>
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* For mental health claims subject to Medicare's 37.5% reduction, New Hampshire elects to also not pay any of the 37.5%.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New Hampshire

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

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