CHAPTER He-E 800 MEDICAL ASSISTANCE

PART He-E 806 NURSING FACILITY REIMBURSEMENT

He-E 806.01 Definitions.

(a) "Accrual method of accounting" means revenues are reported in the period when they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(b) "Administration function" means those duties which are necessary to the general supervision and direction of the current operations of the facility.

(c) "Allowances" means the deductions granted for damage, delay, shortage, imperfection, or other causes, excluding discounts and returns.

(d) "Approved educational activities" means formally organized or planned programs of study engaged in by a nursing facility (NF) provider and his or her staff in order to enhance the quality of resident care in a facility or to improve the administration of the facility.

(e) "Arm's length transaction" means a transaction in which one party is not associated with, affiliated with, or controlled by the other party.

(f) "Bad debts" means the amounts considered to be uncollectable from accounts and notes receivable which were created or acquired in providing services.

(g) "Bed day" means any paid day of care at a nursing facility regardless of the payer.

(h) "Centers for Medicare and Medicaid Services (CMS)" means the federal agency responsible for administering the Medicare and Medicaid programs, formerly known as the Health Care Financing Administration or HCFA.

(i) "Chain operation" means an organization which consists of a group of 2 or more health care facilities which are owned, leased or controlled by a home office.

(j) "Charity allowances" means the reductions in charges made by the provider of services because of the indigence of the resident.

(k) "Compensation" means the total benefit provided for the services rendered to the NF provider. It includes fees, salaries, wages, payroll taxes, fringe benefits, and other increments paid to, or for the benefit of, those providing the services.

(l) "Cost center" means an organizational unit, generally a department or its subunit, having a common functional purpose for which direct and indirect costs are accumulated, allocated and apportioned.

(m) "Courtesy allowances" means reductions in charges in the form of allowances to physicians, clergy, members of religious orders, or others as approved by the governing body of the facility, for services received from the NF provider.

(n) "Department" means the New Hampshire department of health and human services.

(o) "Discounts" means reductions in the cost of purchases classified as cash, trade or quantity discounts.

(p) "Fair market value" means the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

(q) "Generally accepted accounting principles (GAAP)" means accounting principles approved by the American Institute of Certified Public Accountants or the Institute of Management Accountants.

(r) "Hill-Burton funds" means federal funds made available through the Hill-Burton Act, Title VI of the Public Health Service Act, for building or remodeling.

(s) "Historical cost" means the cost incurred by the present owner in acquiring the asset, subject to the limitations specified in 42 CFR 413.134(j).

(t) "Home office" means the controlling organization of a chain operation which furnishes central management and administrative services such as accounting, purchasing, and personnel services, but is not an NF provider.

(u) "Home office costs" means costs of a home office to furnish services to its related organizations.

(v) "Intermediate care facility mentally retarded (ICF-MR)" means a nursing care facility certified to provide long term care for the mentally retarded and/or individuals with related conditions, such as cerebral palsy.

(w) "Luxurious" means the aspect of any item or service which provides comfort, pleasure or enjoyment but is not essential for resident care.

(x) "Necessary interest" means interest, other than working capital interest or interest on lines of credit, which are incurred:

(1) On a loan made to satisfy a financial need of the NF provider for a purpose reasonably related to resident care; and

(2) On a loan repaid in payments over a period of time not to exceed the estimated useful life of the asset purchased with the loan.

(y) "Net cost" means the cost of approved activities less any reimbursement from grants, tuition and specific donations.

(z) "Nursing facility (NF)" means an institution or a distinct part of an institution, including ICF-MRs that provide one or more of the following as defined in Section 1919(a) of the Social Security Act and is not primarily for the care and treatment of mental diseases:

(1) Skilled nursing care and related services for residents who require medical or nursing care;

(2) Rehabilitation services for the rehabilitation of injured, disabled or sick individuals; or

(3) On a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services above the level of room and board which can be made available to them only through an institution.

(aa) "Nursing facility rate" means the Medicaid per diem for each certified NF as set by the department.

(ab) "Picture date" means the date on which resident data is gathered from all facilities to be used to calculate the Medicaid rate.

(ac) "Proper interest" means that interest is incurred at a rate not in excess of what a prudent borrower would have had to pay in an arm's length transaction at the time the loan was made.

(ad) "Prospective per diem rate" means a per diem amount calculated using a historical cost period as a basis and inflated forward.

(ae) "Quantity discounts" mean reductions from list prices granted because of the size of individual or aggregate purchase transactions.

(af) "Related organizations" means organizations that are associated or affiliated with, have control over, or are controlled by, each other.

(ag) "Related parties" means parties that are associated or affiliated with, have control over, or are controlled by, each other.

(ah) "Reserved bed day" means a 24-hour period, midnight to midnight, when the resident of a NF is not present during the midnight census at the conclusion of the day, and that is chargeable to Medicaid.

(ai) "Routine services" means regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities.

(aj) "State owned and operated institutions" means the Glencliff Home for the Elderly.

(ak) "Straight-line method of depreciation" means that the cost or other basis less its estimated salvage value, if any, is determined first, and then this amount is distributed in equal amounts over the period of the estimated useful life of the asset.

(al) "Trade discounts" mean reductions from list prices granted to a certain class of customers before consideration of credit terms.

Source. #8547, eff 1-24-06 (formerly He-W 593.01); ss by #9623, eff 12-24-09

He-E 806.02 Annual Cost Reports.

(a) Each NF, with the exception of state-owned and operated facilities, shall submit:

(1) An annual cost report of the costs of their operations utilizing the "Medicaid Annual Cost Report" form described in (b) below;

(2) Financial statements for the reporting period;

(3) Any certifications, opinions or notes that are a part of (2) above;

(4) Copies of federal income tax statements pertaining to the operation of the NF only if requested by the department; and

(5) Copies of all signed lease agreements for property, buildings and equipment unless they have previously been submitted and are unchanged.

(b) NF providers shall submit the following statements and schedules as part of the "Medicaid Annual Cost Report" described in (a)(1) above:

(1) A signed statement certifying that the information provided on the report, whether filed by paper or electronically, is true, accurate and complete and acknowledging that penalties for any false statement or misrepresentation of material fact include fine or imprisonment;

(2) Resident census statistics which shall include the numbers of residents within each level of care and revenue source for each level of care;

(3) Expenses as described in He-E 806.06 through He-E 806.30 and cost center allocations such as support services, resident care and capital costs;

(4) Reclassification of expenses, as needed, from one cost center to another;

(5) Adjustments to expenses due to activity such as refunds, discounts, or sale of merchandise or supplies;

(6) Allocation statistics which provide information regarding square footage of the facility, meals served by the facility, pounds of laundry done and the cost centers relevant to each;

(7) Building and general information which shall include information regarding ownership or rental of the facility;

(8) Fixed assets and depreciation which shall include a listing of land, buildings, major movable equipment, and motor vehicles owned by the provider or related parties and the depreciation on these assets;

(9) Debt and interest which shall include a listing of NF debt, related party capital debt, and the necessary interest on these debts;

(10) Rental expense detail which shall include rental costs for buildings, fixed equipment, other equipment, and motor vehicles;

(11) Owner and officer compensation which shall include a statement of compensation and other payments to owners, officers, directors, and trustees including their ownership interest, and average hours per week of work provided to the facility;

(12) A financial statement which shall include a balance sheet listing current assets, current liabilities, total equity and changes in equity, cash flow from operating, investing, and financing activities, revenues from inpatient and other operating activities, and a statement of expense and profit or loss;

(13) Funded depreciation detail which shall include a listing of fund income and payments;

(14) Resident fund which shall include a listing of resident funds received and disbursed, interest earned, and remaining balance; and

(15) Staffing pattern which shall include a listing of facility staff, consultants and contract staff, hours worked by position, and total salaries or other compensation paid.

(c) The “Medicaid Annual Cost Report” and all accompanying documents shall bear original signatures of the NF administrator or owner, and paid third party preparer. All accompanying documents and original signatures shall be mailed when the Medicaid Annual Cost Report is filed electronically.

(d) One signed copy of the “Medicaid Annual Cost Report” form and one duplicate copy shall be submitted to: NH Department of Health and Human Services:

Bureau of Elderly and Adult Services
Rate Setting and Audit Unit
Brown Building
129 Pleasant Street
Concord, NH 03301-3843

(e) A complete annual cost report shall be submitted:

(1) No later than 3 months after the end of the facility's fiscal year, unless an extension has been granted by the department as described in (p) below. Home office costs shall be documented by the submission to the department of HCFA Form 287-92, Chain Home Office Cost Statement, no later than 5 months after the end of the home office fiscal year, unless an extension has been granted by the department as described in (p) below; or

(2) By the former owner of the NF within 90 calendar days of the sale of the NF when a change of ownership occurs and a new rate shall be determined by the department in accordance with He-E 806.32(d).

(f) Home office costs shall be documented by the submission to the department of HCFA Form 287-92, Chain Home Office Cost Statement and necessary schedules as requested, no later than 5 months after the end of the home office fiscal year, unless an extension has been granted by the department as described in (p) below.

(g) The department shall consider that an annual cost report is complete unless the cost report is missing information of a material nature so as to render the document unusable for the purpose of determining a per diem rate.

(h) Any facility which submits an incomplete annual cost report shall be subject to penalties described in (q) below, unless an extension has been granted as described in (o) below.

(i) An acceptable cost report shall reflect the most recent desk audit or field audit adjustments made to the previous year’s cost report, if applicable, with the exception of items still under appeal that have not been resolved.

(j) The department shall notify the NF by registered mail of an incomplete annual cost report within 30 days of receipt of the report.

(k) The time frame for submitting a complete cost report as described in He-E 806.03 shall not change due to an incomplete report submitted by an NF.

(l) Failure to submit an annual cost report or a complete annual cost report as required shall result in penalties as stated in (q) below, unless an extension has been granted by the department as described in (o)-(p) below.

(m) NFs which have separate arrangements for caring for residents with different levels of care needs shall segregate their operational costs on the same annual cost report form.

(n) NF providers with facilities in more than one location shall submit separate balance sheets for each location.

(o) Requests for extensions for filing the annual cost report beyond the prescribed deadline shall:

(1) Be in writing;

(2) Be submitted to the department at least 10 working days prior to the due date of the annual cost report, unless one of the circumstances identified in (p) below occurs during the 10 working days prior to the due date, in which case the request shall be made by telephone within 10 working days of the occurrence;

(3) Clearly explain the necessity for the extension; and

(4) Specify the date on which the report will be submitted.

(p) Approval of extensions shall be made only if it is determined that the delay is caused by circumstances beyond the NF provider's control or events over which the NF provider cannot exercise influence over its occurrence, such as, but not limited to:

(1) Flood;

(2) Fire;

(3) Strikes by employees necessary for the preparation of the cost report;

(4) Earthquakes; or

(5) The death of an owner or administrator.

(q) Failure to submit the annual cost report or a complete report as required shall result in the following penalties, unless an extension has been granted by the department:

(1) The per diem rate currently in effect shall be reduced by 25% effective on the first day of the month following the due date for filing of the completed annual cost report, and for each successive month of delinquency in filing the completed annual cost report;

(2) There shall be no retroactive restoration of penalty payments or reimbursement of related working capital interest costs upon the submission of a completed cost report;

(3) No determination of a new rate for the next payment period shall be made until an acceptable cost report as described in (a) – (e) above is received; and

(4) Reinstatement of the pre-existing rate or the determination of a new rate of payment shall be made subsequent to the receipt of an acceptable annual cost report, but retroactive only to the date of receipt by the department of said report.

(r) The commissioner of the department shall not impose the penalties in (q) above if it is determined that the reason for the NF provider not meeting the timeframes in (o)(2) above meets the criteria in (p) above.

(s) When a complete annual cost report has been submitted by the NF provider, the department shall conduct a desk review of the report and conduct a field audit as well if the NF meets one of the conditions for a field audit as described in (t) below.

(t) A field audit shall be conducted as part of the review of the annual cost report in accordance with He-E 806.30 if the NF meets one or more of the following conditions:

(1) The NF has been newly constructed or has had major capital improvements in the past year;

(2) There are items on the annual cost report which need further clarification or investigation as determined by the department; or

(3) A field audit has not been conducted on the NF during the previous 5 state fiscal years.

(u) Based on the desk review or field audit, the department shall determine allowable costs and facility compliance in accordance with the provisions of He-E 806.

(v) The department shall send a notice to the NF provider of the result of the desk review or field audit which shall include:

(1) A listing of all adjustments to submitted costs on the cost report, if any, as determined by the department as described in (t) above; and

(2) The provider's right to a reconsideration and an administrative appeal in accordance with He-E 806.40 and He-E 806.41.

(w) The department shall reopen cost reports for a period of 6 years following the date of submission of the cost report to the department for instances where changes in costs incurred by a facility have occurred which could result in a required rate adjustment.

(x) The department shall reopen cost reports only as a result of field adjustments by department staff or in the case of fraud.

(y) Cost reports shall be reopened at the request of the provider in the case of an error of a material nature until a rate has been set based on that submitted cost report.

(z) For an out-of-state provider or an out-of-state home office, any reopening by the home state or appropriate fiscal agent shall be considered a reopening for the NH Medicaid Program.

Source. #8547, eff 1-24-06 (formerly He-W 593.03); ss by #9623, eff 12-24-09

He-E 806.03 Record Keeping Requirements.

(a) A NF provider shall maintain accurate financial and statistical records, which substantiate the cost reports, for a period of 6 years.

(b) The records of the NF provider described in (a) above shall include, but not be limited to, information regarding:

(1) Provider ownership, organization, operation, fiscal and other record keeping systems;

(2) Federal and state income tax information related to the operation of the facility;

(3) Asset acquisition, lease, sale or other action;

(4) Franchise or management arrangement;

(5) Patient service charge schedule;

(6) Information regarding cost of operation and amounts of income received; and

(7) Flow of funds and working capital.

(c) When the department determines that a provider is not maintaining records as required in He-E 806.03 (a) and (b) above, the department shall send a written notice to the provider of its intent to suspend payments in 30 days, together with an explanation of the deficiencies.

(d) If the provider disagrees with the department's decision, the provider may request an appeal pursuant to He-E 806.41.

(e) Payments shall remain suspended until adequate records are maintained as specified in (a)-(b) above, or until an appeal decision is rendered pursuant to He-E 806.41.

(f) Payments shall be reinstated at the full rate retroactive to the beginning of the suspension period once the NF provider maintains adequate records in accordance with He-E 806 or if an appeal decision is rendered pursuant to He-E 806.41 in favor of the NF provider.

(g) Providers shall make the records described in (a)-(b) above available upon request to representatives of the department or the US Department of Health and Human Services, subject to the penalties described in (e) above.

Source. #8547, eff 1-24-06 (formerly He-W 593.06); ss by #10474, eff 1-24-14

He-E 806.04 Accounting Principles for Annual Cost Reports. The following accounting principles shall apply:

(a) The allowable costs shown in all annual cost reports shall follow the Generally Accepted Accounting Principles (GAAP) and the accrual method of accounting; and

(b) If a NF maintains its records on a cash basis, then it shall record such accruals as adjustments.

Source. #8547, eff 1-24-06 (formerly He-W 593.05); ss by #10474, eff 1-24-14

He-E 806.05 Reimbursement Based on Actual Allowable Costs. The department shall reimburse NFs based on actual allowable costs as follows:

(a) To be allowable, the costs, including compensation, shall be reasonable and necessary for services related to resident care and pertinent to the operation of the NF as described below:

(1) To be reasonable, the compensation shall be such as would ordinarily be paid for comparable services by comparable facilities, for example, facilities of similar size and level of care; and

(2) To be necessary, the service shall be such that had the individual not rendered the services, another person would have had to have been employed to perform the same services;

(b) Allowable costs for services and items directly related to resident care, pursuant to He-E 802, shall be included in the per diem rate unless the service or item is reimbursable under Medicare or covered by the drug rebate program through the department;

(c) The following costs shall not be allowable:

(1) Costs that are a result of inefficient operations, such as the hiring of a consultant to assist in daily operations due to management practices which could or did result in the loss of the facility's license to operate;

(2) Costs resulting from unnecessary or luxurious care, such as purchasing a luxury sedan when a utilitarian sedan would suffice for the transportation of residents;

(3) Costs related to activities not common and accepted in a NF, as determined by the department, in comparison to other facilities, such as purchasing an airplane; and

(4) Costs or financial transactions conceived for the purpose of circumventing the provisions of He-E 806, such as listing an employee with a job title that would be reimbursable under Medicaid, but the job duties actually performed by the employee are not reimbursable under Medicaid;

(d) To be an allowable cost of compensation, services shall actually be performed by the individual and paid in full to the individual by the NF provider;

(e) If services are provided on a less than full-time basis, as determined by the NF, allowable compensation shall be based on the percentage of time for which the service is actually provided;

(f) Costs incurred to comply with changes in federal or state laws, rules or regulations for enhanced direct and indirect resident care services and improved facilities administration shall be considered allowable costs; and

(g) Allowable or non-allowable costs for specific services or items shall be determined as described in He-E 806.06 through He-E 806.30.

Source. #8547, eff 1-24-06 (formerly He-W 593.08); ss by #10474, eff 1-24-14

He-E 806.06 Routine Services.

(a) Allowable costs for routine services and items directly related to resident care shall include but not be limited to:

(1) All general nursing services including, but not limited to, administration of oxygen and related medications, hand feeding, incontinency care, and tray service;

(2) Items furnished routinely and commonly to most or all residents, such as resident gowns, water pitchers, and basins;

(3) Routine personal hygiene and grooming supplies such as deodorant, lotion, shampoo, soap and toothpaste;

(4) Medical supplies, pharmaceutical items, and non-legend drugs, that is, drugs prescribed by a licensed practitioner that are normally purchased over the counter, which are stocked at nursing stations or on the floor in gross supply and distributed individually in small quantities;

(5) Laundry services for routine NF requirements and residents' personal clothing; and

(6) Routine and emergency dental services defined by the Medicaid State Plan rendered to NF residents.

Source. #8547, eff 1-24-06 (formerly He-W 593.09); ss by #10474, eff 1-24-14

He-E 806.07 Physician Services, Psychologist Services and Pharmacist Consultant Services.

(a) The cost of physician or psychologist services performed in rendering direct resident care shall not be allowable in the per diem rate.

(b) The cost of indirect services performed in an administrative or advisory capacity, such as the cost of a medical director or a consultant psychologist, or the cost of a pharmacist consultant rendering administrative services and drug reviews shall be included in the per diem rate.

Source. #8547, eff 1-24-06 (formerly He-W 593.22); ss by #10474, eff 1-24-14

He-E 806.08 Ancillary Services.

(a) The costs of ancillary services provided by the facility, except for prescribed drugs, shall be included in the NF rate determination.

(b) Ancillary services shall include, but not be limited to:

(1) Occupational therapy;

(2) Physical therapy;

(3) Speech therapy;

(4) Inhalation therapy, including oxygen costs;

(5) Laboratory; and

(6) Radiology.

(c) The net cost of Medicaid ancillary services not previously reimbursed by another payor source shall be included in the NF rate determination, provided that NFs maintain revenue and cost data of all ancillary services provided to Medicaid residents of the facility separately from all other ancillary services and costs.

Source. #8547, eff 1-24-06 (formerly He-W 593.27); ss by #10474, eff 1-24-14

He-E 806.09 Drugs and Institutional Pharmacy Costs. The cost of operating an institutional pharmacy and the cost or charges of prescribed legend drugs shall not be an allowable cost in the per diem rate as the NH Medicaid program reimburses these costs to the provider of these services through a direct billing process on a fee for service basis in accordance with He-W 570 Pharmacy Services.

Source. #8547, eff 1-24-06 (formerly He-W 593.28); ss by #10474, eff 1-24-14

He-E 806.10 Barber and Beauty Services.

(a) The direct costs of barber and beauty services shall be non-allowable for purposes of Medicaid reimbursement.

(b) The fixed costs for space and equipment related to providing the services described in (a) above shall be allowable.

Source. #8547, eff 1-24-06 (formerly He-W 593.31); ss by #10474, eff 1-24-14

He-E 806.11 Motor Vehicle Expense.

(a) The cost of operating a motor vehicle shall be an allowable cost if the vehicle is used solely for the provision of resident care.

(b) Motor vehicle expenses shall include:

(1) Mileage payments;

(2) Repairs;

(3) Excise taxes; and

(4) Sales taxes and other related expenses, including interest charges, insurance and depreciation.

Source. #8547, eff 1-24-06 (formerly He-W 593.24); ss by #10474, eff 1-24-14

He-E 806.12 Depreciation of Equipment and Property. Depreciation of equipment and property which has a purchase price of over $500.00 shall be an allowable cost pursuant to the following conditions:

(a) The depreciation shall be:

(1) Identifiable and recorded in the NF provider's accounting records;

(2) Based on the historical cost of the asset or fair market value at the time of donation in the case of donated assets; and

(3) Prorated over the estimated useful life of the asset using the straight line method and the guidelines specified in the American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets" (Revised 2013 Edition), available as noted in Appendix A;

(b) Recording of the depreciation pursuant to (a)(1) above shall encompass:

(1) The identification of the depreciable asset in use;

(2) The asset's historical cost;

(3) The method of depreciation;

(4) The estimated useful life of the asset; and

(5) The asset's accumulated depreciation;

(c) Depreciation shall be allowed on assets financed with Hill-Burton or other federal or public funds;

(d) If an asset for which depreciation had been allowed in Medicaid reimbursement is sold at a gain, such reimbursement shall be subject to recapture as follows:

(1) Gain shall be determined to be the difference between net book value, that is, historical cost less accumulated straight line depreciation recognized for Medicaid reimbursement purposes, and the selling price;

(2) Gain shall be calculated in the aggregate without adjustment or offset for gain attributed to return on equity, inflationary increases in the market value of the remaining assets, or for increases in value due to supply and demand for the assets in the market place;

(3) Recapture shall be calculated as the depreciation paid by the program to the facility for the asset, but recapture shall not exceed the amount of the gain;

(4) The recapture provisions shall apply regardless of the seller's Medicaid provider enrollment status at the time of the gain;

(5) For recapture purposes, the transfer of stock or shares shall be recognized as a change in ownership except in the following circumstances:

a. The number of shares transferred does not exceed 25 percent of the total number of shares in any one class of stock;

b. The transferred stock or shares are those of a publicly traded corporation; or

c. The transfer has been made solely as a method of financing, not as a method of transferring management or control; and

(6) The transfer of an asset shall not be subject to recapture if the transfer occurs between family members or other related parties; and

(e) For recapture or depreciation, the department shall charge the NF provider interest when a NF provider does not pay in a timely manner or in the case of a dispute on the amount of recapture owed and the department prevails at an administrative hearing. The amount of the interest charged shall be payable to the department at the highest rate paid by the seller on loans for the facility.

Source. #8547, eff 1-24-06 (formerly He-W 593.10); ss by #10474, eff 1-24-14

He-E 806.13 Leased Facility and Equipment. Leasing arrangements for property shall be an allowable cost pursuant to the following conditions:

(a) Rent expense on facilities and equipment leased from a related organization shall be limited by substituting the lower of the following:

(1) The actual interest, depreciation, and taxes incurred for the year under review; or

(2) The price of comparable services or facilities purchased elsewhere;

(b) The existence of the following conditions shall establish that a lease is a virtual purchase:

(1) The rental charge exceeds rental charges of comparable equipment in the area;

(2) The term of the lease is less than the useful life of the equipment;

(3) The NF provider has the option to renew the lease at a reduced rental; and

(4) The NF provider has the right to purchase the equipment at a price which appears to be less than what the fair market value of the equipment would be at the time of acquisition by the provider is permitted;

(c) When a lease is a virtual purchase, as described in (b) above, allowable costs shall be subject to the following limitations:

(1) The rental charge shall be allowable only to the extent that it does not exceed the amount which would have been an allowable cost had the asset been purchased;

(2) The difference between the amount of rent paid and the amount of rent allowed as rental expense shall be considered as a deferred charge and capitalized as part of the historical costs of the asset when the asset is purchased;

(3) If the asset is returned to the owner, instead of purchased, the deferred charge shall be recorded as an expense in the year the asset is returned; and

(4) If the asset continues to be rented after the due date for the purchase, and rental has been reduced, the deferred charge shall be recorded as an expense to the extent of increasing the reduced rental to a fair market rental value; and

(d) Sale and leaseback agreements for property shall be allowable costs subject to the following conditions:

(1) Rental costs specified in sale and leaseback agreements, incurred by NFs through selling equipment, but not real property, to a purchaser not connected with or related to the NF provider, and concurrently leasing back the same equipment shall be an allowable cost if the rental charges are as specified in 42 CFR 413.134(h); and

(2) Rental charges in sale and leaseback agreements shall be allowable only to the extent that they do not exceed the amount which would have been an allowable cost had ownership of the asset been retained.

Source. #8547, eff 1-24-06 (formerly He-W 593.11); ss by #10474, eff 1-24-14

He-E 806.14 Administrator Salaries. For reimbursement purposes, administrators' salaries shall be limited to an amount that is comparable for facilities of similar size and level of care, as determined by the department, in accordance with the provisions of He-E 806.

Source. #8547, eff 1-24-06 (formerly He-W 593.19); ss by #10474, eff 1-24-14

He-E 806.15 Assistant Administrator Salaries.

(a) For facilities of 100 or more beds, assistant administrators' salaries shall be an allowable cost at the rate of one assistant for each 100 beds.

(b) The allowable cost for the salary of the assistant administrator described in (a) above shall not exceed 70% of the allowable salary of the administrator.

(c) For facilities of fewer than 100 beds, assistant administrator salary shall not be an allowable cost.

Source. #8547, eff 1-24-06 (formerly He-W 593.20); ss by #10474, eff 1-24-14

He-E 806.16 Social Workers. The cost of a social worker(s) shall be an allowable cost.

Source. #8547, eff 1-24-06 (formerly He-W 593.32); ss by #10474, eff 1-24-14

He-E 806.17 Owners, Operators, or Their Relatives.

(a) For reimbursement purposes, NFs which have a full-time, that is, 40 hours per week minimum, administrator shall not otherwise be allowed compensation for owners, operators or their relatives except in circumstances specified in (c) below, when the facility has a licensed capacity of more than 99 beds.

(b) Owners shall include:

(1) Any individual or organization with any equity interest in the NF's operation;

(2) Any member of such individual's family or his/her spouse's family;

(3) Partners and all stockholders in the provider's operation; and

(4) All partners and stockholders in organizations which have an equity interest in the operation.

(c) The amount allowable for owner's compensation shall be pursuant to all applicable Medicare policies identified in Section 700 and 900 of the Provider Reimbursement Manual, Part I, HCFA-Pub. 15-1 in effect at the time.

Source. #8547, eff 1-24-06 (formerly He-W 593.21); ss by #10474, eff 1-24-14

He-E 806.18 Non-Paid Workers. If a worker does not receive remuneration for services which he/she provides on behalf of the NF, any costs to the employer such as meals and uniforms for the worker, shall be an allowable cost.

Source. #8547, eff 1-24-06 (formerly He-W 593.16); ss by #10474, eff 1-24-14

He-E 806.19 Administrative Expenses and Administrator Duties. The administration function shall be an allowable cost including, but not limited to, the following:

(a) Hiring and firing of personnel;

(b) Administrative supervision of the nursing, dietary and other personnel;

(c) Supervising the maintenance of resident records;

(d) Maintenance of payroll, bookkeeping and other records of the business;

(e) Supervising the maintenance and repairs of the facility; and

(f) Procuring necessary supplies and equipment.

Source. #8547, eff 1-24-06 (formerly He-W 593.18); ss by #10474, eff 1-24-14

He-E 806.20 General County Government Costs.

(a) Indirect costs associated with general county government such as, but not limited to, interest and depreciation, shall not be allowable.

(b) For county-owned and operated nursing facilities, the costs of general county government shall not be allowable costs.

(c) Costs described in (b) above shall include, but not be limited to:

(1) County commissioners;

(2) Treasurers; and

(3) Attorneys and other administrative and support staff.

Source. #8547, eff 1-24-06 (formerly He-W 593.29); ss by #10474, eff 1-24-14

He-E 806.21 Approved Educational Activities.

(a) The net cost of educational activities as approved by the entity, agency, or board having jurisdiction over the activity, shall be an allowable cost.

(b) Orientation, on-the-job training and in-service programs shall not be considered to be approved educational activities for reporting purposes.

(c) The activities listed in (b) above shall be recognized as allowable costs in accordance with the provisions of He-E 806.

Source. #8547, eff 1-24-06 (formerly He-W 593.14); ss by #10474, eff 1-24-14

He-E 806.22 Research Costs. Costs incurred for research purposes shall not be included as allowable costs.

Source. #8547, eff 1-24-06 (formerly He-W 593.15); ss by #10474, eff 1-24-14

He-E 806.23 Advertising Expense.

(a) Reasonable and necessary expense of newspaper or other public media advertisement for the purpose of securing necessary employees and volunteers shall be an allowable cost.

(b) Reasonable and necessary expense of newspaper or other public media advertisement required by local, state and federal government shall be an allowable cost.

(c) No other advertising expenses shall be allowed.

Source. #8547, eff 1-24-06 (formerly He-W 593.23); ss by #9623, eff 12-24-09

He-E 806.24 Home Office Costs.

(a) Home office costs shall include, but not be limited to, the following:

(1) Payroll and benefit services;

(2) Personnel services, including hiring of additional personnel;

(3) Data processing;

(4) Credit and collections;

(5) Accounting; and

(6) Legal services.

(b) Home office costs shall be documented by the submission to the department a copy of HCFA Form 287-92, Chain Home Office Cost Statement, no later than 5 months after the end of the home office fiscal year, unless an extension has been granted by the department as described in He-E 806.02 (p).

(c) If a home office cost report is not submitted or an extension is not granted as in (b) above, then home office costs shall not be allowable costs.

(d) Home office costs for chain operations shall be allowed if:

(1) The costs are reasonable, as defined in He-E 806.05 (a);

(2) The costs are related to resident care; and

(3) The costs meet all reimbursement criteria set forth in He-E 806.

(e) The amount of allowable home office expenses to be included in any year's administrative costs shall meet the criteria of allowable costs as outlined in He-E 806, and the combination of home office expenses and the expenses of related organizations shall be comparable to NF's that do not have a home office but are providing the same level of service.

(f) Home office costs shall be limited to the lower of:

(1) The allowable cost if the cost was properly allocated to the NF provider; or

(2) The price of comparable services, facilities or supplies that could be purchased elsewhere, taking into consideration the benefits of effective purchasing that would accrue to each member provider in the chain because of aggregate purchasing.

(g) A NF's "Medicaid Annual Cost Report" shall not include both home office cost expense and management fees.

(h) A home office cost shall not be allowed if the same cost, when incurred by a NF provider, would not be allowed as a cost pursuant to He-E 806

Source. #8547, eff 1-24-06; ss by #10474, eff 1-24-14

He-E 806.25 Services to Individuals Other Than Residents.

(a) Employee meals consumed on premises during regular working hours from the NF kitchen or food supply shall be allowable costs.

(b) If individuals other than residents are provided rooms, such services shall not be allowable costs.

(c) Shared services provided to individuals who are not NF residents shall be properly allocated.

Source. #8547, eff 1-24-06 (formerly He-W 593.26); ss by #10474, eff 1-24-14

He-E 806.26 Other Non-Allowable Costs.

(a) The following costs shall not be allowed:

(1) Expenditures made by a NF provider only for the protection, enhancement, or promotion of the provider's business interests, and not related to the provision of resident care;

(2) Duplicative functions or services;

(3) Expenditures in excess of approved cost controls;

(4) Political contributions or lobbying costs;

(5) Membership costs in social or fraternal organizations; and

(6) Fees and interest charged for untimely payments.

(b) NFs which include any such costs in the expenditure sections of the annual cost report shall exclude them on the appropriate schedules of the annual cost report.

Source. #8547, eff 1-24-06 (formerly He-W 593.33); ss by #10474, eff 1-24-14

He-E 806.27 Interest Expenses.

(a) Interest shall be an allowable cost subject to (b) through (e) below.

(b) Necessary interest and proper interest as defined in He-E 806.01 on both current and capital indebtedness shall be an allowed cost.

(c) To be allowable, interest expense shall be incurred on indebtedness to lenders or lending organizations not related through control, ownership, affiliation or any personal relationship to the borrower.

(d) Interest expense shall be reduced by interest income.

(e) With respect to loans receivable from an officer, related person, or organization, interest income shall include interest earned on such loan imputed at a rate equal to the highest rate payable on loans payable by the NF provider.

(f) The imputed interest described in (e) above shall not be calculated on disallowed borrowing.

Source. #8547, eff 1-24-06 (formerly He-W 593.12); ss by #10474, eff 1-24-14

He-E 806.28 Discounts, Trade Discounts and Refunds of Expenses.

(a) Discounts and allowances received on purchases of goods or services shall be reductions of the cost to which they relate.

(b) If a NF provider fails to take advantage of available discounts when able to do so, then the amount of the lost discount shall be disallowed.

(c) Refunds of previous expense payments shall be reductions of the related expense.

Source. #8547, eff 1-24-06 (formerly He-W 593.17); ss by #10474, eff 1-24-14

He-E 806.29 Bad Debts, Charity and Courtesy Allowances. Bad debts, charity and courtesy allowances shall not be included as allowable costs.

Source. #8547, eff 1-24-06 (formerly He-W 593.13); ss by #10474, eff 1-24-14

He-E 806.30 Audit Procedures. The following auditing procedures shall apply:

(a) The department shall conduct on-site audits of the financial and statistical records of participating NFs, pursuant to the requirements of 42 CFR 447.202 and 42 CFR 447.253(g);

(b) The on-site audits as described in (a) above shall be performed to ascertain whether the cost report submitted by the NF provider meets the requirements as outlined in He-E 806; and

(c) For out-of-state NFs, the department shall accept the audit findings and adjustments of out-of-state Medicaid agencies developed in conjunction with their respective cost-related reimbursement plans.

Source. #8547, eff 1-24-06 (formerly He-W 593.07); ss by #10474, eff 1-24-14

He-E 806.31 Methodology for Determining the Per Diem Rate.

(a) A single facility-wide prospective rate shall be paid to each facility and comprised of 5 components of cost determined from nursing facility cost reports submitted to the department.

(b) The 5 components of costs shall be:

(1) Administrative costs incurred in the general management and support of the facility, including the following:

a. Compensation for owners, administrators and consultants;

b. Management fees;

c. Accounting;

d. Legal;

e. Travel; and

f. Other similar costs;

(2) Other support costs allowable in the support group, except for plant maintenance-related costs, to include the following:

a. Housekeeping;

b. Laundry;

c. Dietary;

d. Central supply;

e. Pharmacy;

f. Medical records;

g. Social service; and

h. Recreation;

(3) Plant maintenance costs allowable in the support group related to plant maintenance, including but not limited to:

a. Plant maintenance salaries and benefits;

b. Supplies;

c. Utilities; and

d. Property taxes, as well as other plant maintenance costs;

(4) Capital costs, which are depreciation and interest costs that include, but are not limited to, interest on mortgages and long-term notes and depreciation, of which depreciation and interest costs shall not be inflated; and

(5) Patient care costs, as follows:

a. Patient care costs shall be those costs incurred in the direct care of residents treated and include but are not limited to:

1. Salaries of RNs, LPNs and aides;

2. Nursing supplies; and

3. Ancillaries, including therapy services; and

b. Physical, occupational and speech therapy costs included in the patient care cost component shall be subject to a ceiling calculated based on the 85th percentile of the combined physical, occupational and speech therapy portion of the patient care component of nursing facility rates that were effective October 1, 1998, inflated to August 1, 2006.

(c) For each of the components of cost, inflated costs per diem shall be adjusted by a factor to remove costs incurred by residents with atypical needs calculated as follows:

(1) The atypical factor shall be calculated by multiplying the atypical rate in effect by estimated atypical days to estimated total atypical costs;

(2) The number of atypical days shall be calculated by multiplying by 365 the number of atypical residents in each facility as of a date specified by the department;

(3) The atypical payments shall then be divided by total medicaid costs for each facility to develop a ratio of atypical costs to total costs; and

(4) Each cost component per diem shall then be reduced by this ratio to remove the costs of treating an atypical resident.

(d) Costs listed in (b)(1), (2), (3), and (5) above shall be calculated by inflating costs in the base year from the midpoint of the cost report to the midpoint of the rate period using the CMS prospective payment (PPS) skilled nursing facility input price index by expenses category index.

(e) Resident acuity shall be classified using the minimum data set (MDS) version 2.0 and the 34 RUG-III, version 5.12 grouper classification system, when calculated by the bureau of elderly and adult services, or derived from the 34 RUG-III, version 5.20 grouper classification system when calculated by the third party Medicaid vendor, and relative weights assigned as described below:

(1) National M3PI standardized nursing minutes shall be combined with New Hampshire nursing costs derived from the facilities' base year cost reports to determine facility-specific direct care nursing costs per day for each classification;

(2) The national nursing minutes per day for each classification shall be multiplied by the New Hampshire nursing wages per minute to yield the average wages per day for each classification;

(3) Total wages per day for each classification shall then be divided by the sum of the nursing wages per day for all classifications to obtain the relative weight;

(4) The assessment types used shall be CMS required MDS (OBRA and PPS) assessments including admission, annual, significant change, quarterlies and PPS-only assessments according to the following:

a. The applicable date on the MDS used to determine inclusion shall be the last day of the fifth month prior to the Medicaid rate date;

b. These assessments shall be either an admission assessment with a date of entry (AB1) on or before the picture date depending on the adjustment period or the most recent quarterly, annual, or significant change assessment with an assessment reference date no later than 5 days past the picture date;

c. To insure inclusion in the acuity-based rate, a facility shall transmit all applicable assessments on or before the 20th of the month following the picture date, for inclusion in the data collection process; and

d. Each resident shall then be classified into one of 34 resident classifications using the 34 RUG-III, version 5.12 grouper classification system, when calculated by the bureau of elderly and adult services, or derived from the 34 RUG-III, version 5.20 grouper classification system when calculated by the third party Medicaid vendor, and relative weights assigned as described below;

(5) The 34 RUG-III classifications shall be described as "State of New Hampshire acuity group classifications;" and

(6) Relative weights for each classification shall then be calculated based on the weighted average relative weight of the 34 RUG-III classifications and weighted based on the number of residents in each of the 34 RUG-III classifications.

(f) The facility all-payor case mix index for each facility shall be calculated as follows:

(1) By multiplying the number of residents by the relative weight for each of the 34 classifications; and

(2) Dividing the sum of the values across each resident grouping by the total number of residents.

(g) The all-payor case mix index shall be updated to synchronize the all-payor case mix index with the medicaid cost report year.

(h) The prospective per diem rates-component amounts shall be calculated as follows:

(1) A facility-specific prospective per diem rate shall be calculated by summing 5 rate components:

a. Administrative costs;

b. Other support costs;

c. Plant maintenance;

d. Capital; and

e. Patient care costs; and

(2) Each component's per diem amount shall be calculated as follows:

a. The patient care cost component shall be based on:

1. The lower of each facility's case-mix adjusted direct care cost per diem amount; or

2. The statewide median value, as calculated below:

(i) The case mix adjusted direct care cost per diem for each facility shall be calculated by dividing total patient care costs including allowed physical, occupational and speech therapy costs from each facility's cost report by resident days, based on data included in the most recently desk reviewed and/or field audited cost reports, inflated to the mid point of the rate year in order to provide equity among providers with cost reports with different year end dates;

(ii) The resulting amount shall then be divided by the all payor case-mix index to determine the case-mix adjusted patient care cost component per diem amount; and

(iii) Facility-specific amounts shall be arrayed, and the statewide median determined;

b. The administrative cost component of the prospective per diem rate shall be based on the statewide median value, as calculated below:

1. Facility-specific cost per diem amounts shall be calculated by dividing the total administrative costs by resident days, based on data included in the most recently desk reviewed and/or field audited cost reports, inflated to the mid point of the rate year in order to provide equity among providers with cost reports with different year end dates; and

2. Facility-specific amounts are arrayed, and the statewide median value is determined;

c. The other support cost component of the prospective per diem rate shall be based on the statewide median value, as calculated below:

1. Facility-specific cost per diem amounts shall be calculated by dividing the total other support costs by resident days, based on data included in the most recently desk reviewed and/or field audited cost reports, inflated to the mid point of the rate year, in order to provide equity among providers with cost reports with different year end dates; and

2. Facility-specific amounts are arrayed, and the statewide median value is determined;

d. The plant maintenance component of the prospective per diem rate shall be based on the statewide median value, as calculated below:

1. Facility-specific cost per diem amounts shall be calculated by dividing the total plant maintenance costs by resident days, based on data included in the most recently desk reviewed and/or field audited cost reports, inflated to the mid point of the rate year in order to provide equity among providers with cost reports with different year end dates; and

2. Facility-specific amounts are arrayed, and the statewide median value is determined;

e. The capital cost component of the prospective per diem rate shall be based on the actual facility cost, taken from the most recently desk reviewed and/or field audited cost reports, subject to an aggregate 85th percentile ceiling; and

f. Administrative, other support, and plant maintenance cost components shall be reimbursed at the statewide median value, based on data included in the most recently desk reviewed and/or field audited cost reports.

(i) In addition to the requirements in (h)(2)a above, DHHS shall conduct a review of acuity-based rates at least every 6 months, using the most recently available MDS data submitted by the facilities after review validation.

(j) Facility-specific per diem rates shall be calculated as follows:

(1) The per diem cost components shall be summed to obtain the total facility rate per diem for each resident in the nursing facility as of a date specified by the department of health and human services;

(2) The resulting rate shall be paid to the nursing facility until rates are updated with new MDS data and/or upon rebasing, at which time the rates for all residents are summed and divided by the total number of residents in the facility; and

(3) These rates shall be subject to a budget neutrality provision, as defined in (p) below.

(k) Rates shall be limited in accordance with the following requirements stipulated below:

(1) In no case shall payment exceed the provider’s customary charges to the general public for such services or the Medicare upper limit of reimbursement; and

(2) Payment shall be made at the lesser rate when an established rate is a condition to a certificate of need approval and that rate differs from the Medicaid rate established by the department.

(l) When a rate limitation is applied as a condition of the certificate of need, a provider may, if aggrieved, appeal such limitation.

(m) Acuity-based rates shall be reviewed every 6 months for possible adjustment for acuity, using the most recently reviewed and validated MDS data submitted by the facilities.

(n) An acuity adjustment shall occur at least every 6 months.

(o) The department shall review rates, and rebase nursing facility rates at least every 5 years subject to the limitations given below:

(1) Only when rates are rebased shall costs be inflated;

(2) Costs shall be inflated to the mid point of the rate year, using the CMS prospective payment system (PPS) skilled nursing facility input price index by expenses category index; and

(3) The resulting rate shall be subject to budget neutrality, as defined in (p) below.

(p) The budget neutrality factor means the adjustment to rates made by the department to accommodate the difference between the allowable medicaid cost and acuity based rates, derived from the nursing facility Medicaid acuity rate setting system, which nursing facilities incur in providing care to Medicaid residents, and the amount which the state has budgeted in order to fund that care.

Source. #8547, eff 1-24-06 (formerly He-W 593.04); ss by #8769, EMERGENCY RULE, eff 12-1-06, EXPIRES: 5-30-07; ss by #8890, eff 5-25-07; ss by #9623, eff 12-24-09

He-E 806.32 Methodology for Determining the Per Diem Rate for New NF Providers, When Reconstruction Occurs, and When a Change in Ownership Occurs.

(a) The initial prospective per diem rate for new facilities which have completed and reported costs of operations for periods of time of less than 12 months at the time of rate setting, except when the condition exists solely as the result of a change in fiscal year end, shall be calculated as follows:

(1) The rate for variable operating costs shall be determined at a rate comparable to the most recently calculated rates for other NFs of a similar size, geographic region and level of care which have operated for a full year;

(2) The rate for fixed capital costs shall be determined at a rate based on allowable costs/statistics pursuant to RSA 151-C; and

(3) When a health services planning and review board review is not required as specified in RSA 151-C, the rate shall be based on the allowable costs/statistics submitted by the NF provider.

(b) The initial prospective per diem rate for facilities that are a reconstruction of an existing facility and which have completed and reported costs of operations for periods of time less than 6 months at the time of rate setting shall be calculated as described in (a)(1) through (3) above.

(c) There shall be no retroactive settlement of the initial prospective per diem rate described in (a) and (b) above.

(d) When a NF has changed ownership, the rate shall be a continuation of the old rate until such time as a new rate is set.

Source. #8547, eff 1-24-06 (formerly He-W 593.04); ss by #10474, 1-24-14

He-E 806.33 Per Diem Rates and Payment for Nursing Care.

(a) A NF shall be reimbursed for direct and indirect costs as determined by the bed days of care and the NF's prospective per diem rate.

(b) Payment rates shall be pursuant to the provisions of He-E 806.

Source. #8547, eff 1-24-06 (formerly He-W 593.35); ss by #10474, 1-24-14

He-E 806.34 Medicare Provider Reimbursement Manual. Decisions governing the allowability of costs not specifically detailed at He-E 806 shall be pursuant to the Medicare Provider Reimbursement Manual, Part I, HCFA-Pub 15-1 and Part II, HCFA-Pub 15-2 in effect at the time of such determination.

Source. #8547, eff 1-24-06 (formerly He-W 593.34); ss by #10474, 1-24-14

He-E 806.35 Rate Setting and Payment Limitations For General Nursing Facility Care.

(a) Rate setting and payment limitations for NF care shall be determined as specified in (b) through (f) below.

(b) Each facility's per diem rate shall be reviewed at least annually by the department pursuant to He-E 806 utilizing data submitted on the annual cost report.

(c) The per diem rate shall be calculated by dividing allowable costs by the greater of either:

(1) The actual days of service rendered, including reserved bed days; or

(2) The number of resident days computed at 85% of the certified bed capacity.

(d) In no case shall payment exceed the NF's customary charges to the general public for such services, or, where applicable, the Medicare rate of reimbursement, whichever is less.

(e) When a Medicaid per diem rate is established as a condition for a health services planning and review board approval, pursuant to RSA 151-C, and that rate differs from the Medicaid rate established by the department, payment shall be made at the lesser of the 2 rates.

(f) Where a rate limitation is applied as a health services planning and review board condition, a NF provider may, if aggrieved, appeal such limitation in accordance with He-C 200.

Source. #8547, eff 1-24-06 (formerly He-W 593.37); ss by #10474, 1-24-14

He-E 806.36 Rate Setting and Payment Limitations for Atypical Nursing Care.

(a) A provider of atypical care shall be a NF or a distinct part of a NF which possesses the physical characteristics and appropriate staffing for, and devotes its services exclusively to, highly specialized care, the nature of which renders that NF or unit incomparable to other NFs for the purpose of calculating and applying cost and/or occupancy limits.

(b) Examples of such care described in (a) above shall include services for:

(1) Children with severe physical or mental disabilities;

(2) Brain/spinal injured patients;

(3) Ventilator-dependent patients; or

(4) Other specialized services.

(c) The department shall determine the rate of reimbursement utilizing cost documentation submitted by the NF provider which clearly identifies the cost of the atypical care.

(d) The rate described in (c) above shall:

(1) Include routine care costs, ancillary costs and capital costs;

(2) Take into consideration any additional amount necessary to assure access to necessary and appropriate services for NH Medicaid residents with specialized care needs; and

(3) Be exempt from comparative cost and occupancy limits.

(e) In order to qualify as a provider of atypical care, a NF provider shall make application in writing which:

(1) Requests to be considered a provider of atypical care;

(2) Describes the care or services to be provided; and

(3) Documents the costs of such care.

(f) The department shall determine if a NF is qualified to provide and be paid for atypical care based on documentation submitted by the NF, and on whether there is a documented need for these services as determined by the availability of such services in the locality.

(g) Applications for approval of atypical care providers which have been denied may be appealed pursuant to He-E 806.41.

Source. #8547, eff 1-24-06 (formerly He-W 593.38); ss by #10474, 1-24-14

He-E 806.37 Reimbursement for Out-of-State Nursing Care. Reimbursement for out-of-state nursing care shall be made as follows:

(a) The department shall base the reimbursement rate on the rate set by the Medicaid agency of the state in which the out-of-state NF is located for services at that NF; and

(b) In cases where the out-of-state Medicaid rate does not exist or is not sufficient to allow access of NH residents in need of services, a rate shall be determined by the department as described in He-E 806.

Source. #8547, eff 1-24-06 (formerly He-W 593.39); ss by #10474, 1-24-14

He-E 806.38 Bed Days.

(a) Bed days shall include the day of admission, but not the day of discharge.

(b) If admission and discharge occur on the same day, one bed day shall be allowed.

Source. #8547, eff 1-24-06 (formerly He-W 593.36); ss by #10474, 1-24-14

He-E 806.39 Maintenance of Resident Funds.

(a) NFs shall maintain residents' personal funds such as, cash account funds and bank accounts.

(b) For cash account funds, pursuant to RSA 151, the NF shall determine the balance to be maintained as a source of ready cash for residents.

(c) The minimum monthly amount of cash retained per recipient shall be the amount cited at RSA 167:27-a.

(d) A receipt shall be obtained for all cash amounts given residents from this fund or any expenditures made on their behalf.

(e) Expenditures not related to residents' personal needs, such as the cashing of employee checks, shall be prohibited.

(f) All amounts of residents' personal funds in excess of the cash fund may be maintained in a bank in a variety of ways, such as checking, savings accounts and certificates of deposit.

(g) Residents' personal funds shall not be co-mingled with funds maintained for the general operations of the nursing facility.

(h) Interest accumulated by residents' personal funds accounts shall belong to those residents whose money generates the interest.

(i) Allocation of interest income shall be made at least quarterly.

(j) All disbursements made by the NF on behalf of residents shall be supported by receipts and invoices retained in the resident's personal needs file.

(k) Authorization by the resident or his/her authorized representative shall be obtained for all disbursements described in (j) above.

(l) Upon receipt of monthly bank statements, the residents' funds shall be reconciled to detail ledgers and equal the checking or savings and cash fund balance.

Source. #8547, eff 1-24-06 (formerly He-W 593.40); ss by #10474, 1-24-14

He-E 806.40 Reconsiderations for Cost Report Adjustments.

(a) There shall be 2 levels for appeal of cost report adjustments as described in He-E 806.02(s) and (t) as follows:

(1) A reconsideration by the department, through the bureau administrator of the bureau of elderly and adult services, or his/her designee, as described in (b) through (e) below; and

(2) An administrative appeal as specified in He-E 806.41.

(b) Providers may use either or both the reconsideration of cost reports adjustment as outlined in (a)(1) and the appeal process as outlined in (a)(2) above.

(c) A NF provider may request reconsideration of the proposed cost report adjustment(s) within 60 calendar days of the date of notification of the rate adjustments as described in He-E 806.02(t) by submitting a request for reconsideration to:

NH Department of Health and Human Services
Bureau Administrator
Bureau of Elderly and Adult Services
Brown Building
129 Pleasant Street
Concord, NH 03301-3843

(d) The NF provider shall submit a statement as to why the request for reconsideration is being made and may submit any new or additional information that he/she wishes the bureau administrator to consider.

(e) At the request of the NF provider, the reconsideration may be conducted by the bureau administrator or his/her designee as an informal meeting between the NF provider and the bureau administrator or his/her designee, or as a review by the bureau administrator or his/her designee of the information described in (f)(1) and (2) below.

(f) The bureau administrator or his/her designee shall make his/her decision on the reconsideration based on:

(1) A review of all information submitted by the NF provider; and

(2) A review of the cost report adjustments proposed by the department to determine the accuracy of the adjustments.

(g) The bureau administrator or his/her designee shall send a written decision of the reconsideration to the NF provider within 10 business days of the meeting.

(h) If the provider disagrees with the decision rendered by the bureau administrator or his/her designee, the provider may utilize the administrative appeals process in accordance with He-E 806.41.

Source. #8547, eff 1-24-06; ss by #9623, eff 12-24-09

He-E 806.41 Administrative Appeals.

(a) Requests for administrative appeals by NFs, with the exception of state owned and operated facilities, shall be directed to the department with a copy of the appeal sent to Bureau of Elderly and Adult Services, Rate Setting and Audit Unit.

(b) The written request for an appeal shall be received by the department within 30 calendar days of the date of the notice of the new Medicaid NF rates.

(c) Requests for appeals shall state the reason for the appeal.

(d) Appeals shall be held and heard in accordance with He-C 200.

(e) In accordance with 42 CFR 447.253(e), a provider shall request appeals:

(1) As specified in He-E 806; and

(2) Due to the action or inaction of the department relevant to He-E 806.

(f) A NF provider may request an appeal regarding a rate set by the department.

(g) A provider shall not request an appeal regarding:

(1) The department’s internal ratesetting methodology; or

(2) Federal or state constitutional law.

(h) The hearings officer shall deny any request for an appeal which is not as described in (e) or (f) above.

Source. #8547, eff 1-24-06 (formerly He-W 593.41); ss by #10474, 1-24-14

He-E 806.42 Incorrect Payments.

(a) If a NF was paid incorrectly, interest shall not be paid on underpayments nor collected on overpayments.

(b) If an appeal decision is in favor of the NF, the department shall make the appropriate rate adjustment(s) and payments, including any necessary retroactive payments.

(c) Any outstanding resident credit balances over 6 months shall be reported to the department on a quarterly basis.

Source. #8547, eff 1-24-06 (formerly He-W 593.42); ss by #10474, 1-24-14