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## Medicaid Care Management Nursing Facilities: Questions and Answers

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### **1. What are the services provided by the Nursing Facilities that are included in the per diem? What happens when the facility determines that a resident needs to be accompanied on a trip where non-emergency care is provided?**

See *Services Associated with the Nursing Facility Per Diem* for what is included in the per diem rate. The services included in the per diem are NOT part of Step 1.

These services are included in the per diem when they are provided by the facility. Not all facilities provide radiology or lab services, for example, so when these services are provided by another provider, that service provider is paid separately. This would then be the responsibility of the Health Plan.

If a facility determines that a resident must be accompanied during a non-emergency trip for medical care, the facility provides that staff person and the costs are in their rate.

### **2. What kind of inhalation therapy is included in the per diem?**

Nebulizers (machine and supplies) and ventilators (and related supplies) are included in the per diem.

NOTE: Ventilator care is included in the specialized per diem (Medicaid FFS) rate set for:

- Crotched Mountain
- Cedar Crest
- Edgewood
- Laconia Rehabilitation Center

### **3. Which party (DHHS or the Health Plans) will be responsible for ventilators in Step 2?**

The Health Plans will be financially responsible for ventilators in Nursing Facilities in Step 2.

### **4. What services are not included in the per diem and, therefore, are the responsibility of the Health Plans?**

The Health Plans are responsible for all services *not* included in the per diem (see *Services Associated with the Nursing Facility Per Diem*). Services *not* included in the per diem, include:

- Physician services and/or consultations
- Non-emergent or emergency transportation by ambulance
- Transportation by any vehicle not owned by the facility
- DME – for example, a specialized, customized wheelchair
- Prosthetics and orthotics
- Elective admission
- TPN/all infusion services
- Lab services – all lab services provided by a provider *other than* the facility
- Outpatient facility services
- Pharmacy
- All hospital services

### **5. Who is responsible for non-emergent transportation for enrolled Health Plan members?**

The Health Plans are responsible for non-emergent transportation for their members:

- Non-emergent transportation must be arranged through each Health Plan's vendor.
- Must provide 5-day notice to vendor to make arrangements.
- Can provide wheelchair van services.
- If an ambulance is needed for non-emergent transportation:
  - **Meridian Health Plan** call the Utilization Management Department at 855-291-5218.
  - **New Hampshire Healthy Families** call Access2Care at 866-769-3085 with 72-hour notice.
  - **Well Sense** call Coordinated Transportation Solutions (CTS) at 800-492-9923.

### **6. Who is responsible for Behavioral Health Services for enrolled Health Plan members?**

The Health Plans are responsible for all Behavioral Health Services for their members.

### **7. Who is responsible for hospice services for enrolled Health Plan members?**

The Health Plans are responsible for hospice services for their members.

**8. Do all nursing homes have Medical Directors?**

Yes. Some facilities have part-time directors. Most Medical Directors do not provide resident care.

**9. Are Nursing Facility residents subject to the radiology service limit?**

Yes.

**10. Does the Nursing Facility require approval from the Bureau of Elderly and Adult Services (BEAS) prior to payment?**

Yes, if the stay is Medicaid-covered. No, if the stay will be covered by Medicare.

**11. What are the Nursing Facility responsibilities during a planned temporary absence of a resident, other than when the resident is receiving treatment or care at another facility? This is addressed in the Nursing Facility Services administrative rule, He-E 802.**

He-E 802.15 Temporary Absence from the Nursing Facility

(a) A facility shall establish and follow a written policy regarding bed-hold periods which is consistent with RSA 151:25 and which indicates that when a facility has not received payment for a period of temporary absence or when the absence is longer than 10 days:

- (1) The resident shall have the option to return to the facility to the next available bed; and
- (2) If more than one person has a right of readmission, vacancies shall be allocated on a first request made, first request honored basis, and without regard to the source of payment.

(b) If a resident leaves the nursing facility for any reason and there is reason to believe that the resident might be absent during the next midnight census, then the following shall apply:

- (1) The facility shall provide to the resident and his/her legal representative the facility's written policy regarding bed-hold periods;
- (2) The nursing facility shall document the notification in the resident's record, along with the resident's and legal representative's written agreement to pay, or rejection of the option to pay, for the bed-hold period;
- (3) The nursing facility shall not charge an amount in excess of the Medicaid rate to hold a bed for a resident who is on Medicaid; and
- (4) If a nursing facility refuses to readmit a resident following an absence for medical treatment or therapeutic leave then a transfer or discharge will have been deemed to have occurred and the facility shall follow the transfer discharge requirements found in He-E 802.16.

(c) When a resident leaves the nursing facility for medical treatment, the facility shall communicate with the hospital or facility providing the medical treatment to the extent reasonably necessary in order to plan for the resident's safe and orderly transition back to the nursing facility.

(d) When a resident is absent from a nursing facility due to therapeutic leave, the facility may bill for reserved bed days pursuant to 42 CFR 447.40, subject to the following conditions:

- (1) Such days shall be specified in the resident's plan of care;
- (2) The plan of care shall describe provisions for continuity of care while the resident is out of the facility;
- (3) Such days shall not be for hospitalization or for transferring to another facility;
- (4) The facility may not bill for more than 30 reserved bed days per resident per state fiscal year; and
- (5) When a recipient is on reserved bed day status, the department shall not pay separately for any services covered as part of the facility's rate pursuant to He-E 806.