



State of New Hampshire

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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JEFFREY A. MEYERS
COMMISSIONER

August 1, 2016

The Honorable Chuck Morse
Senate President
State House, Room 302
107 North Main Street
Concord, NH 03301

The Honorable Shawn Jasper
House Speaker
State House, 107 North Main Street
Concord, NH 03301

The Honorable David Watters
County-State Finance Commission
Legislative Office Building, Room 101-A
33 North State Street
Concord, NH 03301

The Honorable Kenneth Weyler
County-State Finance Commission
State House, 107 North Main Street
Concord, NH 03301

Re: SB 553, relative to implementation of the Medicaid managed care program

Dear Senate President Morse, House Speaker Jasper, and County-State Finance Commission:

In accordance with SB 553, Chapter 204 Laws of 2016, enclosed please find the Department's initial draft legislative changes to long term care statutes related to the incorporation of nursing facility and choices for independence (CFI) waiver services into managed care.

As mandated by SB 553, the draft changes contained herein reflect the Department's initial understanding of what may be necessary in order to pay for nursing facility services and CFI services to abide by federal payment requirements. This initial draft is intended to further discussion and is not intended for legislative drafting. The Department has convened a working group pursuant to SB 553 and is committed to working collaboratively with the legislature and participating stakeholders to craft legislation that not only ensures the transition to managed care complies with federal requirements but also that providers are efficiently and effectively compensated for offering these essential services. As such, the Department is looking forward to receiving feedback on the draft language.

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It is also important to highlight that the enclosed language does not address rates for nursing or CFI services. Rates for these services will be established in the future based on the plan for implementation of services that is now the subject of the working group and a consultative process between stakeholders and the Department and its actuaries. All rates developed for managed care service must be actuarially sound in order to insure access to services.

The Department looks forward to working with the legislature, the Governor and all stakeholders in the process of developing value based nursing and CFI services for the people we serve.

Sincerely,



Jeffrey A. Meyers
Commissioner

Enclosure

cc: Her Excellency, Governor Margaret Wood Hassan
SB 553 Stakeholder Workgroup

CHAPTER 84-C

NURSING FACILITY QUALITY ASSESSMENT

Comment [R1]: Chapter 84-C contains DRA related statutes. DRA is amenable to the proposed changes below.

Section 84-C:4

84-C:4 Returns. – Every nursing facility shall on or before the tenth day of the month following the expiration of the assessment period make a return to the commissioner and to the commissioner of the department of health and human services. The commissioner shall adopt rules, pursuant to RSA 541-A, relative to the form of such return and the date which it must contain for the correct computation of facility net patient services revenues and the assessment upon such amount. All returns shall be signed by the authorized representative of the nursing facility, subject to the pains and penalties of perjury. If such return shows an overpayment of the assessment due, the commissioner shall ~~refund or~~ credit the overpayment to the nursing facility~~[-] on the next quarterly return.~~

Source. 2003, 223:9. 2004, 260:13, eff. June 16, 2004.

Comment [R2]: DRA is unable to process refunds and this language is designed to make it clearer to providers how overpayments are handled. Further, there is a conflicting Statute (151-E 15) that requires all monies (NFQA or Bed Tax from DRA) transferred to DHHS has to be paid out to NF's, leaving no money available for a refund. However, DRA's form allows for prior period adjustments to the next quarterly return to account for errors and/or audit adjustments.

Section 84-C:5

84-C:5 Collection and Deposit of Assessment. –

I. Except as provided in RSA 84-C:5-a, the payments required by RSA 84-C:3 shall be made by electronic transfer of moneys to the state treasurer and ~~deposited~~ *transferred to the department of health and human services for the purpose of reimbursement of Medicaid expenditures incurred by public and private nursing facilities for the state's long-term care population.*~~[to the nursing facility trust fund established by RSA 151-E:14.]~~

II. ~~The state treasurer is authorized to establish an account or accounts and to take all steps necessary to facilitate the transfer of moneys required in paragraph I.~~

Source. 2003, 223:9. 2008, 253:3, eff. June 26, 2008.

Comment [R3]: Under federal managed care regulations, a capitation rate is established for the population covered. Once LTC goes into managed care, rate cells for NF and HCBC will be established. As a result of LTC utilizing a capitation payment, monies will all be within one Medicaid accounting unit. The capitation payment will also reflect ProShare and MQIP as applicable.

Section 84-C:6

84-C:6 Additional Returns. – When the commissioner has reason to believe that a nursing facility has failed to file a return or to include any part of its net patient services revenue in a filed return, the commissioner may require the nursing facility *to file additional information, as the commissioner prescribes, on the next quarterly return.* ~~[to file a return or a supplementary return showing such additional information as the commissioner prescribes.]~~ Upon the receipt of *the requested information* ~~[the supplementary return]~~, or if none is received ~~[within the time set by the commissioner]~~, the commissioner may find and assess the amount due upon the information that is available. The ~~[making of such]~~ *filing of the additional information on the next quarterly return* does not relieve the nursing facility of any penalty for failure to make a

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correct original return or relieve it from liability for interest imposed under RSA 21-J:28 or any other additional charges imposed by the commissioner. This section shall not be construed to modify the statute of limitations provided in RSA 21-J:29.

Source. 2003, 223:9. 2004, 260:14, eff. June 16, 2004.

Comment [R4]: This change compliments changes to RSA 84-C:4. DRA has a form that allows for prior period adjustments to the next quarterly return to account for errors and/or audit adjustments and the goal is to provide clarity to the process of correcting quarterly returns.

Section 84-C:11

84-C:11 Contingencies. –

I. The nursing facility quality assessment imposed by this chapter shall not be assessed, and no return shall be required to be made, upon the occurrence of any of the following events:

(a) ~~Aggregate medicaid reimbursement for nursing facilities through accounting unit 05-01-10-04-01 class 90 is reduced below the level in effect as of February 1, 2003, increased by the funds expended from the nursing facility trust fund established under RSA 151-E:14 and matched by corresponding federal funds.]~~

(b) Federal approval of the nursing facility quality assessment established under this chapter, or of any related state plan amendments or waivers is withdrawn.

(c) Collection of the assessment is rendered invalid by the decision of any court or administrative agency.

(d) ~~[Any proceeds collected from nursing facilities as defined in RSA 84-C:1, V(a), from the nursing facility quality assessment established in this chapter are expended by the state or any state agency for any purpose other than funding nursing facility expenditures through the nursing facility trust fund under RSA 151-E:14.]~~

(e) [Repealed.]

II. The commissioner of health and human services shall notify the commissioner of revenue administration of the occurrence of any of the contingencies in paragraph I.

III. ~~[The nursing facility quality assessment under this chapter shall not be assessed or collected and payments from the nursing facility trust fund authorized by RSA 151-E:14 shall not be made until after the commissioner of health and human services certifies to the commissioner that the department of health and human services has obtained all necessary federal approvals. Payments under RSA 151-E:15 shall be effective for the period beginning May 1, 2003.]~~

Source. 2003, 223:9. 2004, 260:15-17, 21, I. 2008, 253:5, eff. June 26, 2008.

2012, 247:3, eff. Aug. 17, 2012.

Comment [R5]: Capitation rates will be established and include Proportionate Share and MQIP. Rates are fixed, subject to actuarial determination and will reflect a specific amount to be paid per person to facilities.

TITLE V TAXATION

CHAPTER 84-D ICF QUALITY ASSESSMENT

Section 84-D:4

84-D:4 Returns. – Every ICF shall on or before the 10th day of the month following the expiration of the assessment period make a return to the commissioner and to the commissioner of the department of health and human services. The commissioner shall adopt rules, pursuant to RSA 541-A, relative to the form of such return and the date which it must contain for the correct computation of facility net patient services revenues and the assessment upon such amount. All returns shall be signed by the authorized representative of the ICF, subject to the pains and penalties of perjury. If such return shows an overpayment of the assessment due, the commissioner shall ~~refund or~~ credit the overpayment to the ICF ~~[-]~~ *on the next quarterly return.*

Source. 2008, 253:8, eff. July 1, 2008; 253:12, eff. July 11, 2008.

Section 84-D:5

84-D:5 Collection and Deposit of Assessment. – ~~[There is hereby established a nonlapsing ICF separate account in the office of the state treasurer.]~~ All funds collected under this chapter and any federal financial participation received by the state as a result of expenditures funded by the ICF quality assessments ~~[-and the interest thereon;]~~ shall be ~~deposited~~ *transferred to the department of health and human services for the purpose of Medicaid expenditures incurred by an ICF for the state's long-term care population.* ~~[this account. Moneys from the account shall not be expended by the state or any state agency for any purpose other than funding ICF expenditures as provided in RSA 151-E:15 a.]~~

Source. 2008, 253:8, eff. July 1, 2008; 253:12, eff. July 11, 2008.

Section 84-D:6

84-D:6 Additional Returns. – When the commissioner has reason to believe that an ICF has failed to file a return or to include any part of its net patient services revenue in a

Comment [R6]: Chapter 84-D contains DRA related statutes. DRA is amenable to the proposed changes below.

Comment [R7]: DRA is unable to process refunds and this language is designed to make it clearer to providers how overpayments are handled. Further, there is a conflicting Statute (151-E:15-a) that requires all monies (ICF QA or Bed Tax from DRA) transferred to DHHS has to be used to fund ICF Medicaid expenditures, leaving no money available for a refund. However, DRA's form allows for prior period adjustments to the next quarterly return to account for errors and/or audit adjustments.

Comment [R8]: Under federal managed care regulations, a capitation rate is established for the population covered. Once LTC goes into managed care, rate cells for NF and HCBC will be established. As a result of LTC utilizing a capitation payment, monies will all be within one Medicaid accounting unit. The capitation payment will also reflect ProShare and MQIP as applicable.

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filed return, the commissioner may require the ICF to file *additional information, as the commissioner prescribes, on the next quarterly return.* ~~[a return or a supplementary return showing such additional information as the commissioner prescribes.]~~ Upon the receipt of the *requested information* ~~[supplementary return,]~~ or if none is received ~~[within the time set by the commissioner],~~ the commissioner may find and assess the amount due upon the information that is available. The *filing of the* ~~[making of such]~~ *additional information on the next quarterly return* does not relieve the ICF of any penalty for failure to make a correct original return or relieve it from liability for interest imposed under RSA 21-J:28 or any other additional charges imposed by the commissioner. This section shall not be construed to modify the statute of limitations provided in RSA 21-J:29.

Source. 2008, 253:8, eff. July 1, 2008; 253:12, eff. July 11, 2008.

Comment [R9]: This language compliments the proposed changes to 84-D 4. DRA has a form that allows for prior period adjustments to the next quarterly return to account for errors and/or audit adjustments and the goal is to provide clarity to the process of correcting quarterly returns.

Section 84-D:11

84-D:11 Contingencies. –

I. The ICF quality assessment imposed by this chapter shall not be assessed, and no return shall be required to be made, upon the occurrence of any of the following events:

(a) Federal approval of the ICF quality assessment established under this chapter or of any related state plan amendments or waivers is withdrawn.

(b) Collection of the assessment is rendered invalid by the decision of any court or administrative agency.

(c) ~~[Any proceeds from the ICF quality assessment established in this chapter are expended by the state or any state agency for any purpose other than funding ICF expenditures.]~~

II. The commissioner of health and human services shall notify the commissioner of revenue administration of the occurrence of any of the contingencies in paragraph I.

III. ~~[The ICF quality assessment under this chapter shall not be assessed or collected and payments authorized shall not be made until after the commissioner of health and human services certifies to the commissioner that the department of health and human services has obtained all necessary federal approvals.]~~

Source. 2008, 253:8, eff. July 1, 2008; 253:12, eff. July 11, 2008.

Comment [R10]: Capitation rates will be established and include Proportionate Share and MQIP. Rates are fixed, subject to actuarial determination and will reflect a specific amount to be paid per person to facilities. A consultative process on rate development will be established.

TITLE XI

HOSPITALS AND SANITARIA

CHAPTER 151-E

LONG-TERM CARE

Section 151-E:6

151-E:6 Acuity-Based Reimbursement System. –

I. The department shall pursue as expeditiously as possible the development and implementation of a reimbursement system for nursing facility services based primarily on the acuity level of patients consistent with state and federal law and all appropriate notice requirements. All nursing facilities shall use best efforts to provide all information and data requested by the department in the course of its development of such a system and to assist the department in any manner reasonably requested by the department.

II. Unless otherwise required by state or federal law, the acuity-based reimbursement system developed by the department ~~[shall not]~~ *may* create separate classifications for county and non-county facilities ~~[and shall be based on the concept of the cost of operating an efficient facility rather than actual costs]~~ when determining rates.

III. ~~[Repealed.]~~

Source. 1998, 388:1, eff. Nov. 25, 1998. 2012, 264:2, II, eff. Aug. 17, 2012.

Section 151-E:6-b

~~151-E:6-b Memorandum of Agreement. – [The department of health and human services shall establish, by means of a memorandum of agreement with the New Hampshire Association of Counties, a mechanism for the receipt of input from the Association of Counties regarding the type, cost, utilization, and procedures relative to payments which the counties are obligated to make pursuant to RSA 167:18 a. The memorandum of agreement shall be reviewed annually and amended as may be determined to be necessary by the parties.]~~

Source. 2001, 198:2, eff. July 5, 2001. 2007, 263:15, eff. July 1, 2008.

Repeal and re-enact after RSA 151-E:6-c as follows:

Comment [R11]: DHHS will create separate classifications for county and non-county facilities. As an example, counties may be receiving the Medicare rate under managed care. Currently, all facilities have to be treated the same when calculating Acuity Rates. ProShare is a separate supplemental payment made only to counties; however, no payments outside of the capitation payment can be paid under Managed care. Therefore, in order for the counties to receive additional funding there needs to be different classifications.

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151-E:6-d Consultation; Information for Determining Medicaid Capitation Rates. – The department of health and human services shall, in consultation with the New Hampshire Association of Counties, New Hampshire Health Care Association and any stakeholder in the acuity-based reimbursement system, develop a process by which these entities will be able to provide information to the actuary utilized by the department for the purpose of assisting with determining Medicaid capitation rates as well as receive draft rate reports for the purpose of providing comments to the department prior to the rate becoming final.

Comment [J12]: This language is aligned with the provisions of SB 553 (2016) to include key stakeholders from county and private nursing facilities to collect and provide information to be used in determining Medicaid capitation rates.

Section 151-E:6-c

151-E:6-c Payment System for Nursing Facilities. – [The payment system for nursing facility level of care shall be as follows:

I. Rate calculation worksheets for all providers will be provided at least 30 days prior to the effective date of any rate changes.

II. Acuity levels must be updated at least [semi] annually, on a regular, predictable basis using the latest available data.

III. The commissioner of the department of health and human services shall continue to evaluate the effectiveness of the acuity-based payment system for medicaid payments for nursing facility care. The commissioner shall determine if any changes in the payment system are appropriate.

IV. [Repealed.]

V. Any rate changes due to the updating of acuity or cost data shall occur only with proper prior notification and explanation to affected providers and the affected beneficiary population.

Source. 2001, 198:2, eff. July 5, 2001. 2012, 264:2, III, eff. Aug. 17, 2012.

Comment [R13]: Capitation rates are to be determined on an annual basis and are approved by Governor and Executive Council through a contract amendment with the MCOs. Rates must be determined to be actuarially sound and sufficient in order to ensure access to services.

Section 151-E:11

151-E:11 Program Management and Cost Controls. –

[I. The department shall designate in its operating budget requests specific class lines for nursing facility, mid-level, and home-based care provided for in this chapter. These class lines shall reflect, and the requesting documentation shall include, the anticipated number of persons to receive services. The department shall not increase expenditures in approved budgets for these class lines or the number of persons to receive mid-level or home care services without the approval of the legislative fiscal committee, and the prior review of the county-state finance commission. The medicaid rates paid for nursing facility services, mid-level care services, and home and community-based care services shall not be reduced below those levels in effect on the last day of the previous biennium. No transfers may be made from the nursing facility medicaid quality incentive program and all funding derived from that program shall be paid to nursing facilities.

II. For the fiscal year beginning July 1, 2003, and each fiscal year thereafter the

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average annual cost for the provision of services to persons in the mid-level of care shall not exceed 60 percent of the average annual cost for the provision of services in a nursing facility. The average annual cost for the provision of services in home-based care shall not exceed 50 percent of the average annual cost for the provision of services to persons in a nursing facility. No person whose costs would be in excess of 80 percent of the average annual cost for the provision of services to a person in a nursing facility shall be approved for home-based or mid-level services without the prior approval of the commissioner of health and human services. The prior approval shall include a comparison of the mid-level or home-based care costs of the person with the costs of a facility qualified to provide any specialized services necessary for the proper care and treatment of the individual. The department shall provide a report semi-annually on the utilization of non-nursing home services to the county-state finance commission and the legislative fiscal committee.

III. (a) The methodology for determining the cost of care for recipients in the home and community-based care waiver program for the elderly and chronically ill shall include the cost of:

- (1) Waiver program services; and
- (2) Other medicaid long-term care services, including but not limited to personal care, home health services, physical therapy, occupational therapy, speech therapy, adult medical day program services, private duty nursing, and case management services.

(b) Such methodology shall not include services rendered for the treatment of an acute illness or injury.

IV. Pursuant to RSA 541-A, the commissioner of the department of health and human services, with prior reporting to the oversight committee on health and human services, shall adopt by rule:

(a) Methodologies for determining the cost and average annual cost of home-based care, mid-level care, and intermediate, skilled, or specialized nursing facility care, including:

- (1) Bases for the methodologies;
- (2) Identification of services considered in determining costs;
- (3) Average annual costs based on the annual average number of recipients in the setting;
- (4) The requirement that nursing facility care include both the initial Medicaid rate and supplemental rates paid through the Medicaid Quality Incentive Program; and
- (5) The requirement that the nursing facility will include the cost for transitional case management.

(b) A process to identify persons in home-based or mid-level care whose costs are expected to exceed 80 percent of the average annual cost for the provision of services to a person in a nursing facility.

(c) A standard of review and process for prior approval by the commissioner, in accordance with paragraph II of this section, for the cases identified through the process in subparagraph (b).

Comment [R14]: DHHS anticipates changes to this section in order to comply with federal law on cost controls for managed care. CMS input on cost controls must be sought.

Source. 1998, 388:1. 2003, 223:5, eff. July 1, 2003; 319:35, eff. July 1, 2003. 2005, 175:13, eff. Aug. 29, 2005. 2010, 112:1, 2, eff. Jan. 1, 2011.

Section 151-E:14

~~151-E:14 Nursing Facility Trust Fund Established.— [There is hereby established the nursing facility trust fund for the receipts from nursing facilities as defined in RSA 84-C:1, V(a), from the nursing facility quality assessment under RSA 84-C:3, any federal financial participation received by the state as a result of expenditures funded by these nursing facility quality assessments, and the interest thereon. All of these funds shall be credited to and for the purposes of the nursing facility trust fund and shall not be used for any other purposes.]~~

Source. 2003, 223:11, eff. July 1, 2003. 2008, 253:6, eff. June 26, 2008.

Comment [R15]: Capitation rates will be established and include Proportionate Share and MQIP. Rates are fixed, subject to actuarial determination and will reflect a specific amount to be paid per person to facilities.

Section 151-E:15

~~151-E:15 Expenditure of Funds [From Nursing Facility Trust Fund]. – Notwithstanding any other provision of law, moneys in the department's Medicaid fund [nursing facility trust fund] shall be expended on Medicaid expenditures incurred by public and private nursing facilities for the state's long-term care population. [in the following manner:]~~

~~I. All moneys in the fund shall be paid out no less frequently than on a quarterly basis and shall be disbursed as follows:~~

~~—(a) The moneys in the fund shall be used to eliminate or reduce to the maximum extent possible the difference between the allowable Medicaid costs, 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.~~

~~—(b) If after the disbursement required in subparagraph (a) there are still any moneys remaining in the fund, the nursing facility rate setting system shall be adjusted to insure that all moneys in the fund are expended for nursing facility care.~~

~~—II. The state treasurer shall transfer from the nursing facility trust fund to the general fund on the first business day of each quarter the amount necessary to fund the payments under paragraph I.~~

~~—III. The state treasurer shall transfer, and the commissioner of health and human services shall fund the full amount of the nursing facility trust fund in each quarter.~~

~~—IV. Notwithstanding the provisions of RSA 167:18-a, no county shall be required to make any contribution to the distribution under this section.]~~

Source. 2003, 223:11. 2004, 260:18, eff. June 16, 2004. 2007, 263:16, eff. July 1, 2008.

Comment [R16]: Under federal managed care regulations, DHHS is unable to direct funds specifically to NFs or HCBC but rather the entire population. There will now be one Medicaid accounting unit for budget purposes. More specifically, once LTC (NF & CFI) goes into managed care, NF's & HCBC will have rate cells within the capitation payment paid to the MCO's. As a result of LTC utilizing a capitation payment, monies will all be within one Medicaid accounting unit.

Section 151-E:15-a

151-E:15-a Expenditure of Funds From ICF Quality Assessment. –

Notwithstanding any other provision of law, moneys from the ICF quality assessment under RSA 84-D:3 and any federal financial participation received by the state as a result of expenditures funded by these ICF quality assessments, ~~and the interest thereon shall be paid out no less frequently than on a quarterly basis and~~ shall be *utilized for Medicaid expenditures incurred by an ICF for the state's long-term care population.* ~~[disbursed as follows:~~

~~—I. The moneys shall be used to eliminate or reduce to the maximum extent possible the difference between the allowable medicaid costs, derived from the ICF medicaid rate setting system, which ICFs incur in providing care to medicaid residents, and the amount which the state has budgeted in order to fund that care.~~

~~—II. If after the disbursement required in paragraph I there are still any moneys remaining from the ICF quality assessment and any federal financial participation and the interest thereon, the ICF rate setting system shall be adjusted to insure that all moneys are expended for ICF care.]~~

Source. 2008, 253:9, eff. July 1, 2008; 253:12, eff. July 11, 2008.

Comment [R17]: DHHS is unable to direct funds specifically to ICFs or HCBC but rather the entire population. There will only be one Medicaid accounting unit for budgeting purposes. More specifically, once LTC goes into Managed Care, ICFs & HCBC will have rate cells within the capitation payment paid to the MCO's. As a result of LTC being utilizing capitation payments, monies will all be within one Medicaid accounting unit.

Section 151-E:17

151-E:17 Availability of ~~[Targeted]~~ Conflict Free Case Management Services. –

The department shall make available to and advise all Medicaid recipients who require a nursing facility level of care or are at risk of needing such care and who are patients in hospitals, rehabilitation hospitals, or nursing facilities of the availability of ~~[targeted]~~ *conflict free* case management services provided by independent case managers, to explore the feasibility of transitioning to home and community-based care.

Source. 2007, 330:10, eff. Jan. 1, 2008.

Comment [R18]: Federal regulations, mandate that new waiver requests have provisions ensuring HCBC recipients receive conflict free case management as part of the person centered planning process.

Section 167:18-a

167:18-a County Reimbursement of Funds; Limitations on Payments. –

I. [These expenditures shall in the first instance be made by the state, but each county shall make monthly payments to the state for the amounts due under this section within 45 days from notice thereof.

(a) Counties shall reimburse the state for expenditures for recipients for whom such county is liable who are eligible for nursing home care and are receiving services from a licensed nursing home, or in another New Hampshire setting as an alternative to a licensed nursing home placement and are supported under the Medicaid home and community-based care waiver for the elderly and chronically ill, as such waiver may be amended from time to time, to the extent of 100 percent of the non-federal share of such

Comment [J19]: State payments for Long term Care will be made within a capitated payment that is determined to be actuarially sound. This statute will require further review in order to determine how to preserve the counties' limit on liability that is now established by the county cap.

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expenditures. Expenditures shall not include payments made for skilled care.

(b) Counties shall not be liable for Medicaid recipients in state institutions, the Crotched Mountain Rehabilitation Center, and intermediate care facilities (ICF) approved by the department of health and human services and servicing developmentally impaired persons.

II. (a) The total billings to all counties made pursuant to this section shall not exceed the amounts set forth below for state fiscal years 2014-2015:

(1) State fiscal year 2014, \$109,000,000.

(2) State fiscal year 2015, \$112,500,000.

(b) The caps on total billings for fiscal years after fiscal year 2015 shall be established by the legislature at least on a biennial basis.

III. (a) The counties shall have an aggregate credit of \$5,000,000 against amounts due under this section for each fiscal year beginning July 1, 2008. The credit shall be allocated as follows:

(1) For fiscal year 2009, \$4,000,000 shall be allocated among the counties based upon the proportion each paid for such expenditures in the prior fiscal year, and \$1,000,000 shall be allocated among the counties based upon their relative proportions of residents age 65 or older who are Medicaid recipients.

(2) For fiscal year 2010, \$2,000,000 shall be allocated among the counties based upon the proportion each paid for such expenditures in the prior fiscal year, and \$3,000,000 shall be allocated among the counties based upon their relative proportions of residents age 65 or older who are Medicaid recipients.

(3) For fiscal year 2011 and for each fiscal year thereafter, \$5,000,000 shall be allocated among the counties based upon their relative proportions of residents age 65 or older who are Medicaid recipients.

(b) The credit shall be made available as soon as possible after the start of the fiscal year. The department shall adopt county credit criteria in consultation with the county-state finance commission and in accordance with the provisions of RSA 541-A. The total aggregate obligation of the counties shall be reduced by the amount of the credit in each fiscal year.

IV. Notwithstanding the procedures of paragraphs I-III of this section, no county shall be liable for total billings in fiscal year 2009 or fiscal year 2010 in an amount which would be greater than the amount of liability projected for that fiscal year using the methodology for determining county payments in former RSA 167:18-a, 167:18-b, and 167:18-f prior to its repeal together with the amount of liability projected for that fiscal year using the repealed methodology for determining county payments in RSA 169-B, 169-C, and 169-D.

V. (a) Any shortfall between the state audited Medicaid allowances incurred by the state's county operated nursing homes and amounts otherwise reimbursed by federal 50 percent Medicaid matching funds or other income, shall be certified as a public expenditure and be eligible for additional federal funding match.

(b) The department of health and human services shall seek federal Medicaid assistance match for any state audited county nursing home Medicaid expense which is not fully reimbursed through rates. Any revenue realized through such a match shall be paid to the nursing homes which incurred the unreimbursed expense.]

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Source. 1973, 423:6. 1985, 380:33. 2007, 263:17. 2008, 52:10; 296:19, 20. 2009, 144:22. 2011, 224:21, 22. 2013, 144:8, eff. July 1, 2013

Re-enact as follows:

RSA 167:18-a County Reimbursement of Funds; Limitations on Payments. -

I. Counties shall be responsible for reimbursing the state for Medicaid expenditures on a fiscal year basis as set forth in the state operating budget for the respective biennium.

II. County cost share shall be allocated among the individual counties based upon the prior three (3) year rolling average of their relative proportions of the total number of residents who are Medicaid recipients.

III. Medicaid expenditures shall in the first instance be made by the state, but each county shall make monthly payments to the state for the amounts due under this section within 45 days from notice thereof.

Comment [R20]: County participation in funding LTC is vital. In addition, the County CAP will increase due to including the 50% ProShare participation with the current County CAP. In addition, the methodology for calculating each county's portion of the County CAP needs to be simplified, transparent & easier to understand & measure. The flexibility of the language as drafted would allow this to proceed as stand-alone legislation or via the budget process in HB 2.

Section 167:18-h

167:18-h County Nursing Homes; Proportionate Share Payments. -

~~[I. Proportionate share payments to county nursing homes shall be made each state fiscal year in an amount equal to the maximum permissible by federal regulations. All payments shall be apportioned to each facility in a percentage equal to that facility's proportion of total county nursing home medicaid utilization. If the federal government makes adjustments to any proportionate share payments that have been made by the state, the amounts due under this section shall be amended accordingly and adjusted payments shall be made to or from the state as necessary.~~

~~—II. Notwithstanding any provision of law to the contrary, each county government shall reimburse the state for 50 percent of the total cost of proportionate share payments made to the county pursuant to paragraph I.]~~

Source. 1998, 387:2. 2004, 260:7, eff. July 1, 2005.

Comment [R21]: Federal regulations do not allow supplemental payments in managed care. However, Proportionate Share payments will be contained within the capitation rate.

Effective Date. This act shall be effective contingent upon the requirements of SB 553 (2016) being met.