

Attachment 4.19D

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MEDICAL ASSISTANCE		SR	90-32
NURSING HOME REIMBURSEMENT			

POLICY
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Purpose, Scope
and Effective
Date
9999.1

a. Purpose:

The purpose of these regulations is to define the items of expense which will be taken into account or excluded in the calculation of reasonable costs, and the methods and standards for reimbursement on a reasonable cost related basis for long-term care facilities under Title XIX of the Social Security Act.

b. Scope:

Except where indicated, these regulations apply to all long-term care facilities providing services to Medicaid patients in the State of New Hampshire. These regulations do not apply to Intermediate Care Facilities/Mentally Retarded-Community Programs (ICF/MR-CP's) (15 beds or less) or state-operated facilities. The manual includes the policies and principles applicable to Nursing Facilities as well as methods and standards for reimbursement for nursing care.

Reasonable
Cost
Principles
9999.2

The following are the principles underlying cost or cost-related reimbursement:

Any questions concerning the reasonableness of any cost should be resolved to the extent possible by references to the regulations in effect for Medicare and Medicaid.

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Reimbursement
Based on Actual
Allowable Costs
9999.2

- (a) To be allowable, 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 MAM 9999, 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:
- i. 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;
 - ii. Costs resulting from unnecessary or luxurious care, such as purchasing a luxury sedan when a utilitarian sedan would suffice for the transportation of residents;
 - iii. 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
 - iv. Costs or financial transactions conceived for the purpose of circumventing the provisions of MAM 9999, 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 percent of time for which the service is actually provided;

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Reimbursement
Based on Actual
Allowable Costs

- 9999.2 (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 MAM 9999.7.

Annual Cost
Reports
9999.3

- (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;

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Annual Cost
Reports
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- (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
129 Pleasant Street
Concord, NH 03301-3843

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- (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 (ac) below.
- (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) below.
 - (m) NF's 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.

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- (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 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.

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- (5) The commissioner of the department shall have the discretion to wave the penalties as stated above.

(r) 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 (s) below.

- (s) A field audit shall be conducted as part of the review of the annual cost report in accordance with MAM 9999.6 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.
- (t) Based on the desk review or field audit, the department shall determine allowable costs and facility compliance in accordance with the provisions of MAM 9999.
- (u) 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 (s) above; and
 - (2) The provider's right to a reconsideration and an administrative appeal in accordance with MAM 9999.11.
- (v) 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.
- (w) The department shall reopen cost reports only as a result of field adjustments by department staff or in the case of fraud.
- (x) 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.
- (y) 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.

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- (Z) 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 NF's 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) Where a Health 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.
- (aa) 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.
- (ab) There shall be no retroactive settlement of the initial prospective per diem rate described in (a) and (b) above.
- (ac) 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.

Accounting
Principals
9999.4

The following accounting principles shall apply:

- (a) The allowable costs shown in all annual cost reports shall follow 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.

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Record
Keeping
Requirements
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- (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.

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Auditing
Procedures
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The following auditing procedures shall apply:

- (a) The department shall conduct on-site audits of the financial and statistical records of participating NF's, pursuant to the requirements of 42 CFR 447.202 and 42 CFR 447.253(g);
- (b) The on-site audit as described in (a) above shall be to ascertain whether the cost report submitted by the NF provider meets the requirements as outlined in MAM 9999; and
- (c) For out-of-state NF's, 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.

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Guidelines
For Allowable/
Non-Allowable
Costs
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(a) Routine Services

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.

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(b) 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:

(1) The depreciation shall be:

- (a) Identifiable and recorded in the NF provider's accounting records;
- (b) Based on the historical cost of the asset or fair market value at the time of donation in the case of donated assets; and
- (c) Prorated over the estimated useful life of the asset using the straight line method and the guideline lives specified in the American Hospital Association "Useful Lives of Depreciable Hospital Assets" -, 2004 edition.

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- (2) Recording of the depreciation pursuant to (a)(1) above shall encompass:
- (a) The identification of the depreciable asset in use;
 - (b) The asset's historical cost;
 - (c) The method of depreciation;
 - (d) The estimated useful life of the asset; and
 - (e) The asset's accumulated depreciation;
- (3) 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:
- (a) 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;
 - (b) 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;
 - (c) 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;
 - (d) The recapture provisions shall apply regardless of the seller's Medicaid provider enrollment status at the time of the gain;
 - (f) For recapture purposes, the transfer of stock or shares shall be recognized as a change in ownership except in the following circumstances:
 1. The number of shares transferred does not exceed 25 percent of the total number of shares in any one class of stock; -or
 2. The transferred stock or shares are those of a publicly traded corporation;
 3. The transfer has been made solely as a method of financing, not as a method of transferring management or control; and;

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

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

(5) For recapture or depreciation, the department shall charge the NF provider interest when an 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.

(c) Leased Facility and Equipment.

Leasing arrangements for property shall be an allowable cost pursuant to the following conditions:

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

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

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

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(2) Lease - Purchase Arrangements

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

- (a) The rental charge exceeds rental charges of comparable equipment in the area;
- (b) The term of the lease is less than the useful life of the equipment;
- (c) The NF provider has the option to renew the lease at a reduced rental; and
- (d) 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 acquisition by the provider is permitted;

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

- (a) 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;
- (b) 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;
- (c) 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
- (d) 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

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- (4) Sale and leaseback agreements for property – rental charges
Sale and leaseback agreements for property shall be allowable costs subject to the following conditions:
- (a) Rental costs specified in sale and leaseback agreements, incurred by NF's 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
 - (b) 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.

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(d.) Interest Expense

- (1) Interest shall be an allowable cost subject to (2) through (7) below:
- (2) Necessary interest and proper interest on both current and capital indebtedness shall be an allowed cost as defined in (3) below.
- (3) Definitions
 - (a) Interest
Interest is the cost incurred for the use of borrowed funds.
 - (b) Necessary
Necessary requires that the interest:
 - i. Be incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments would not be considered necessary.
 - ii. Be incurred for a purpose reasonably related to recipient patient care.
 - (c) Proper
Proper requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in an arm's length transaction in the money market, existing at the time the loan was made.
- (4) 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;
- (5) Interest expense shall be reduced by interest income.
- (6) 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.
- (7) The imputed interest described in (6) above shall not be calculated on disallowed borrowing.

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(e.) Bad debts, charity and courtesy allowances

(1) Bad debts, charity and courtesy allowances shall not be included as allowable costs.

(2) Definitions

(a) Bad debts

Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services.

(b) Charity allowances

Charity allowances are reductions in charges made by the provider of services because of the indigence of the patient.

(c) Courtesy Allowances

Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider.

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(f.) Cost of educational activities

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

(a) Definitions

(i) Approved educational activities

Approved educational activities means formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of patient care in a facility or to improve the administration of the facility. These activities must be licensed where required by state law.

(ii) Net Cost

The net cost means the cost of approved educational activities less any reimbursement from grants, tuition and specific donations.

- (2) Orientation, on-the-job training and in-service programs shall not be considered to be approved educational activities for reporting purposes.
- (3) The activities listed in (2) above shall be recognized as allowable costs in accordance with the provisions of MAM 9999.

(g.) Research costs

Costs incurred for research purposes shall not be included as allowable costs.

(h.) 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.

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(i.) Discounts, Trade Discounts and Refunds of Expenses

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

(a) Definitions

(i) Discounts

Discounts, in general, are reductions in the cost of purchases classified as cash, trade or quantity discounts. Cash discounts are reductions granted for the settlement of debts within a stipulated period before they become due. Trade discounts are reductions from list prices granted to a certain class of customers before consideration of credit terms. Quantity discounts are defined as reductions from list prices granted because of the size of individual or aggregate purchase transactions.

(ii) Allowances

Allowances are deductions granted for damage, delay, shortage, imperfection, or other causes, excluding discounts and returns.

(iii) Refunds

Refunds are amounts paid back, or a credit allowed on account of an over collection.

- (2) 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.
- (3) Refunds of previous expense payments shall be reductions of the related expense

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(j.) Administration Functions

(1) 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.

(2) Definitions

(a) Compensation

Compensation means the total benefit provided for the administration services rendered to the provider. It includes:

Fees, salaries, wages, payroll taxes, fringe benefits, and other increments paid to, or for the benefit of, those providing the administration services.

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(3) Administrators' 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 MAM 9999.2 a-e.

(4) 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.

(5) Owners, Operators, or Their Relatives

- (a) For reimbursement purposes, NF's 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:
 - (i) Any individual or organization with any equity interest in the NF's operation;
 - (ii) Any member of such individual's family or his/her spouse's family;
 - (iii) Partners and all stockholders in the provider's operation, and
 - (iv) 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.

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(6) 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.

(k.) Advertising Expenses

- (1) 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.
- (2) Reasonable and necessary expense of newspaper or other public media advertisement for legal notices required by local, state and federal government shall be an allowable cost.
- (3) No other advertising expenses shall be allowed.

(l.) Motor Vehicle Expense

- (1) The cost of operating a motor vehicle shall be an allowable cost if the vehicle is used solely for the provision of resident care.
- (2) Motor vehicle expenses shall include:
 - (a) Mileage payments;
 - (b) Repairs;
 - (c) Excise taxes; and
 - (d) Sales taxes and other related expenses, including interest charges, insurance and depreciation.

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(m.) Services to Individuals Other Than Residents.

- (1) Employee meals consumed on premises during regular working hours from the NF kitchen or food supply shall be allowable costs.
- (2) If individuals other than residents are provided rooms, such services shall not be allowable costs.
- (3) Shared services provided to individuals who are not NF residents shall be properly allocated. This would included but not be limited to staffing and space within the facility used for other reimbursed programs such as assisted living or adult day care programs.

(n.) Ancillary Service Costs

- (1) The costs of ancillary services provided by the facility, except for prescribed drugs, shall be included in the NF rate determination.
- (2) Ancillary services shall include, but not be limited to:
 - (a) Occupational therapy;
 - (b) Physical therapy;
 - (c) Speech therapy;
 - (d) Inhalation therapy, including oxygen costs;
 - (e) Laboratory; and
 - (f) Radiology.
- (3) The net cost of Medicaid ancillary services not previously reimbursed by another payor source shall be included in the NF rate determination, provided that NF's maintain revenue and cost data of all ancillary services provided to Medicaid residents of the facility separately from all other ancillary services and costs.

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(o.) Drugs

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 [See Section 4.19-B of State Plan].

(p.) General County Government Costs

- (1) Indirect costs associated with general county government such as, but not limited to, interest and depreciation, shall not be allowable.
- (2) For county-owned and operated nursing facilities, the costs of general county government shall not be allowable costs.
- (3) Costs described in (2) above shall include, but not be limited to:
 - (a) County commissioners;
 - (b) Treasurers; and
 - (c) Attorneys and other administrative and support staff

(q.) Barber and Beauty Services

- (1) The direct costs of barber and beauty services shall be non-allowable for purposes of Medicaid reimbursement.
- (2) The fixed costs for space and equipment related to providing the services described in (a) above shall be allowable.

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(r.) Social Workers

The cost of a social worker(s) shall be an allowable cost

(s.) Home Office Costs

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

- (a) Payroll and benefit services;
- (b) Personnel services, including hiring of additional personnel;
- (c) Data processing;
- (d) Credit and collections;
- (e) Accounting; and
- (f) Legal services.

(2) 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 MAM 9999.3(p).

(3) If a home office cost report is not submitted or an extension is not granted as in (2) above, then home office costs shall not be allowable costs.

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

- (a) The costs are reasonable, as defined in MAM 9999.2 (a);
- (b) The costs are related to resident care; and
- (c) The costs meet all reimbursement criteria set forth in MAM 9999.

(5) 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 MAM 9999, 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.

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

- (a) The allowable cost if the cost was properly allocated to the NF provider; or
- (b) 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.

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- (7) A NF's "Medicaid Annual Cost Report" shall not include both home office cost expense and management fees.
- (8) 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 MAM 9999.

t. Other Non-Allowable Costs

(1) The following costs shall not be allowed:

- (a) 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;
- (b) Duplicative functions or services;
- (c) Expenditures in excess of approved cost controls;
- (d) Political contributions or lobbying costs;
- (e) Membership costs in social or fraternal organizations; and
- (f) Fees and interest charged for untimely payments.

(2) NF's 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.

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Rate Setting & Payment
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Per Diem Rates and Payment for Nursing Care

An 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.

Payment rates shall be pursuant to the provisions of MAM 9999.

(a) Bed Days

- (1) Bed days mean the actual total bed days of the year. A day begins at midnight and ends twenty-four (24) hours later. The midnight-to-midnight census keeping method must be used even if the provider uses a different definition of a patient day for its statistical or other purposes. The census taking hour is midnight.
- (2) Bed days shall include the day of admission, but not the day of discharge.
- (3) If admission and discharge occur on the same day, one bed day shall be allowed. However, where a patient admitted is transferred from one participating provider to another participating provider before midnight of the same day, the day is not included in either the Medicaid days or total patient days of the transfer provider.
- (4) Where the patient occupies a bed in more than one patient care area in one day, the inpatient day should be counted only in the patient care area in which the patient was located at the census-taking hour.
- (5) The Day of Admission is the day when a person is admitted to an Extended Care Facility for bed occupancy for purposes of receiving inpatient nursing services and counts as one inpatient day. If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day.
- (6) Under the Medicaid cost reimbursement form the Day of Discharge for a recipient is not counted as a day of patient care, except as noted above.

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b. Per Diem-Rate-General Nursing Care

1. Rate Setting

- (a) Except for certain ICF-MR's, each facility will receive a prospectively determined general nursing care per diem rate. The general nursing care per diem rate is comprised of five components of cost: administrative; other support; plant maintenance; capital; and patient care.
- (b) Each facility's general nursing care per diem rate will be determined by the Finance Unit of the NH Department of Health and Human Services from the provider's most recently desk reviewed or field audited cost reports and from Minimum Data Set (MDS) 3.0, currently specified for use by the Centers for Medicare and Medicaid Services (CMS), information periodically submitted by each facility to the Department of Health and Human Services.
- (c) If a facility qualifies to be an atypical (special needs) facility, its rate will be determined as indicated in Section 9999.8 c.
- (d) Rate calculation work sheets are maintained by the Department and are available for inspections on the premises by contacting the Department of Health and Human Services.

2. Prospective Rate Determination

- (a) The New Hampshire Acuity-Based Nursing Facility Reimbursement System was implemented effective February 1, 1999. New Hampshire nursing facilities are paid a prospective rate which links each facility's per diem rate to the level of services required by its resident mix.

TN No: 17-0005
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TN No: 01-005

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- (b) The New Hampshire Acuity-Based Nursing Facility System resident classifications will be derived from the 48-group of the most current Version of RUG IV classification system from CMS when calculated by the the third party Medicaid vendor.
- (c) Atypical (special needs) residents are excluded from this classification methodology. The cost of atypical (special needs) care is determined according to Section 9999.8 c.

3. Retrospective Rates

Prospective rates are used for nursing facilities rather than retrospective rates.

4. Rate Components

- (a) A single facility-wide prospective rate will be paid to each facility. This prospective rate is comprised of five components of cost determined from nursing facility cost reports submitted to the Department. The five components of costs are as follows:
- (1) Administrative costs are those costs incurred in the general management and support of the facility. They include, but are not limited to, compensation for owners, administrators and consultants, management fees, accounting, legal, travel, working capital interest, and other similar costs. In the base year, costs were inflated from the midpoint of the cost report period to the midpoint of the rate period using the CMS Prospective Payment System (PPS) Skilled Nursing Facility Input Price Index by Expenses Category index.

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- (2) Other Support costs are those allowable costs in the Support group, except for plant maintenance-related costs. Other support costs include housekeeping, laundry, dietary, central supply, pharmacy, medical records, social service, and recreation. In the base year, costs were inflated from the midpoint of the cost report period to the midpoint of the rate period using the CMS (Centers for Medicare and Medicaid Services) Prospective Payment System (PPS) Skilled Nursing Facility Input Price Index by Expenses Category index.
- (3) Plant maintenance costs are those allowable costs in the support group related to plant maintenance. Plant maintenance costs include plant maintenance salaries and benefits, supplies, utilities, property taxes, as well as other costs. From the base year, costs were inflated from the midpoint of the cost report to the midpoint of the rate period using the CMS (Centers for Medicare and Medicaid Services) Prospective Payment System (PPS) Skilled Nursing Facility Input Price Index by Expenses Category index.
- (4) Capital costs are depreciation and interest costs that include, but are not limited to, interest on mortgages and long-term notes and depreciation. Depreciation and interest costs are not inflated.
- (5) Patient care costs are those costs incurred in the direct care of residents. They include, but are not limited to, salaries of RNs, LPNs and Aides, nursing supplies, and ancillaries, including therapy services. In the base year, costs were inflated from the midpoint of the cost report period to the midpoint of the rate period using the CMS (Centers for Medicare and Medicaid Services) Prospective Payment System (PPS) Skilled Nursing Facility Input Price Index by Expenses Category index.
- a. Physical, occupational and speech therapy costs included in the patient care cost component are subject to a ceiling. The ceiling is 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. These rates were inflated for the August 1, 2006, rate-setting period.

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(b) For each of the components of cost, inflated costs per diem are adjusted by a factor to remove costs incurred by residents with atypical (special needs) needs that are determined according to Section 9999.8c of this Plan. The atypical (special needs) factor is calculated by multiplying the atypical (special needs) rate in effect by actual atypical (special needs) days to actual total atypical (special needs) costs. To calculate the number of atypical (special needs) days, the number of atypical (special needs) residents in each facility as of a date specified by the Department of Health and Human Services was multiplied by 365. The atypical payments are then divided by total Medicaid costs for each facility to develop a ratio of atypical (special needs) costs to total costs. Each cost component per diem is then reduced by this ratio to remove the costs of treating an atypical (special needs) resident.

5. Classification of Residents Using MDS 3.0 and RUG-IV of the most current Version Grouper and Calculation of Relative Weights

- (a) CMS STRIVE (Staff Time and Resource Intensity Verification) wage weighted staff time nursing minutes are combined with New Hampshire nursing costs derived from the facilities' base year cost reports to determine New Hampshire facility-specific direct care nursing costs per day for each classification.
- (b) To calculate the relative weight for each of the 48 classifications, the CMS STRIVE raw national nursing minutes per day for each classification are "smoothed" by a ratio of smoothed to unsmoothed mean nursing wage weighted staff time, then are multiplied times the New Hampshire nursing wages per minute to yield the average wages per day for each classification. The total wages per day for each classification are then divided by the sum of the nursing wages per day for all classifications to obtain the relative weight.
- (c) Using the MDS Data 3.0, submitted quarterly, the assessment types used will be CMS required MDS (OBRA and PPS) assessments including admission, annual, significant change, quarterlies and PPS-only assessments. The applicable date on the MDS used to determine inclusion in the Picture Data draw is the last day of the fifth month prior to the Medicaid rate date. These assessments shall be either an admission assessment with a Date of Entry 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 five days past the picture date. All applicable assessments should be transmitted and accepted at the state database on or before the 20th of the month following the picture date, for inclusion in the Picture Date Case Mix Index data collection process by all New Hampshire nursing facilities for all residents. Each resident is then classified into 1 of 48 resident classifications using the most current version of the RUG-IV Grouper when calculated by the third party Medicaid vendor.

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(d) The 48 RUG-IV classifications are described as "State of New Hampshire Acuity Group Classifications." Relative weights for each classification are then calculated based on the weighted average relative weight of the 48 RUG-IV classifications (weighted based on the number of residents in each of the 48 RUG-IV classifications).

6. Calculation of the Facility All-Payor Case Mix Index

An all-payor case-mix index for each facility is determined by multiplying the number of residents times the relative weight for each of the 48 classifications. The values across each resident grouping are summed and divided by the total number of residents. The all payor case mix index shall be updated to synchronize the all payor case mix index with the Medicaid cost report year.

7. Calculation of Prospective Per Diem Rates-Component Amounts

A facility-specific prospective per diem rate is calculated by summing five rate components: administrative costs, other support costs, plant maintenance, capital, and patient care costs. Each component's per diem amount is calculated as follows:

(b) The patient care cost component is based on the lower of each facility's case-mix adjusted direct care cost per diem amount, or the statewide median value. The case mix adjusted direct care cost per diem for each facility is 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. The resulting amount is then divided by the all payor case-mix index to determine the case-mix adjusted patient care cost component per diem amount. Facility-specific amounts are arrayed, and the statewide median is determined.

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- (b) The Department will periodically review acuity-based rates for possible adjustment at least every six months, using the most recently available MDS data submitted by the facilities after review and validation.
- (c) The administrative cost component of the prospective per diem rate is based on the statewide median value. Facility-specific cost per diem amounts are 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. Facility-specific amounts are arrayed, and the statewide median value is determined.
- (d) The other support cost component of the prospective per diem rate is based on the statewide median value. Facility-specific cost per diem amounts are 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. Facility-specific amounts are arrayed, and the statewide median value is determined.
- (e) The plant maintenance component of the prospective per diem rate is based on the statewide median value. Facility-specific cost per diem amounts are 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. Facility-specific amounts are arrayed, and the statewide median value is determined.

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- (f) The capital cost component of the prospective per diem rate is 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.
- (g) Administrative, other support, and plant maintenance cost components are reimbursed at the statewide median value, based on data included in the most recently desk reviewed and/or field audited cost reports.

8. Calculation of Facility-Specific Per Diem Rate

- (a) The per diem cost components are summed to obtain the total facility rate per day for each resident in the nursing facility as of a date specified by the Department of Health and Human Services.
- (b) The rate determined in (a) above shall be reduced by a budget adjustment factor (BAF) equal to 26.82%.

9. Rate Limitation

- (a) In no case may payment exceed the provider's customary charges to the general public for such services or the Medicare upper limit of reimbursement.
- (b) 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. When a rate limitation is applied as a condition of the certificate of need, a provider may, if aggrieved, appeal such limitation.

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10. Semi-Annual Updating

Acuity-based rates will be reviewed and updated every six months using the most recently reviewed and validated MDS data submitted by the facilities for an effective date of July 1 and January 1. The rates determined shall be subject to the budget adjustment factor in 8(b) above.

11. Rebasing

The Department will review rates and will rebase nursing facility rates at least every five years. In between rebase years, cost components are inflated in accordance with sections 7 (a) - (g). The resulting rate is also subject to the BAF as defined above.

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13. Return on Equity

The Division of Human Resources does not recognize return on equity for reimbursement purposes.

c. Per Diem-Atypical Care

- (1) 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 NF's for the purpose of calculating and applying cost and/or occupancy limits.
- (2) Examples of such care described in (a) above shall include services for:
 - (a) Children with severe physical or mental disabilities;
 - (b) Brain/spinal injured patients;
 - (c) Ventilator dependent patients; or
 - (d) Other specialized services.
- (3) 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.
- (4) The rate described in (c) above shall:
 - (a) Include routine care costs, ancillary costs and capital costs;
 - (b) Take into consideration any additional amount necessary to assure access to necessary and appropriate services for NH Medicaid residents with specialized care needs; and
 - (c) Be exempt from comparative cost and occupancy limits.

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

- (a) Requests to be considered a provider of atypical care;
- (b) Describes the care or services to be provided; and
- (c) Documents the costs of such care.

(6) 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.

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

d. Payment of Rates

1. The NH Department of Health and Human Services will determine and pay rates for long term nursing care based on the principles and procedures contained in the Title XIX State Plan.
2. The Department will reimburse at the rates set by out-of-state Medicaid agencies for services rendered to NH Medicaid patients in those states.
3. However, where out-of-state Medicaid rate does not exist, or is not sufficient to allow access of the New Hampshire patients in need of services, a rate will be determined by the Division of Elderly & Adult Services on the basis of cost data and cost finding as described in Section 9999.7 and 8.

e. Proportionate Share Incentive Adjustment

No payment shall be made under this section for any period after state fiscal year 2005.

1. The NH Department of Health and Human Services recognizes that non-State operated governmental (county) nursing facilities provide care to many severely medically involved patients requiring an extraordinary intensive and costly level of care and have a very high Medicaid proportion of their patient census.
2. The Department will insure continued access to this level of care through proportionate share incentive adjustment payments to each non-State operated governmental nursing facility.

TN No. 06-003
Supersedes
TN No. 03-002

Approval Date NOV - 7 2006

Effective Date 02/01/06

MEDICAL ASSISTANCE	SUBJECT NURSING FACILITY REIMBURSEMENT	DATE SR
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3. The proportionate share incentive adjustment shall be made in one payment at the end of each State Fiscal Year. The payment shall be based upon the actual Medicare rates for ten months and the estimated Medicare rates for two months as estimated by the fiscal intermediary. The payment to each facility is in proportion to the facility's Medicaid days, during the cost reporting period used to set its current rates, relative to the sum of Medicaid days for all eligible facilities. The total funds for incentive adjustment payments shall be established each State Fiscal Year subject to the anticipated level of all nursing facility payments within the year and to the payment limits of 42 CFR 447.272. The calculation of the payment limit of 42 CFR 447.272 is computed as follows:

The calculation shall be a comparison of the rates Medicare would pay for these facilities using the Medicare ratesetting methodology and the rates New Hampshire Medicaid actually is paying these facilities. The variance in the per diem rates is calculated per facility, an average variance determined and that variance applied to the total Medicaid days.

The actual Medicare rates per facility for each Resource Utilization Groups (RUGS) Category as calculated by the Medicare fiscal intermediary are obtained for New Hampshire Medicare providers. Medicaid providers that do not use the Medicare fiscal intermediary or are not Medicare providers have Medicare rates calculated for them consistent with the current Medicare methodology and rates as calculated by the fiscal intermediary.

The RUGS Category is determined for each New Hampshire Medicaid patient, and the corresponding Medicare rates are averaged for the state fiscal year and compared to the average rates New Hampshire Medicaid actually is paying these facilities.

To allow comparison of like costs, to this rate is added the actual Medicaid patient cost of drugs, lab, x-ray, outpatient and therapies as determined by Medicaid. The variance between that calculated total Medicare rate and the actual New Hampshire Medicaid rate, including the additional expenses, is then calculated as a per diem, and an aggregate variance calculated.

TN No. 03-002
Supersedes
TN No. 96-6

Approval Date FEB - 9 2004

Effective Date 02/17/03

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f. Proportionate Share Incentive Adjustment 1

The below payment methodology will end on June 30, 2019.

Only nursing facilities owned or operated by Belknap County, Hillsborough County or Sullivan County shall receive payment under this section according to the following conditions.

1. The NH Department of Health and Human Services recognizes that non-State operated governmental (county) nursing facilities provide care to many severely medically involved patients requiring an extraordinarily intensive and costly level of care and have a very high Medicaid proportion of their patient census.
2. The Department will ensure continued access to this level of care through proportionate share incentive adjustment payments to each of the above noted non-State operated governmental nursing facilities.
3. The Proportionate Share Incentive Adjustment 1 shall be made to the facilities noted above in one payment by the end of each State Fiscal Year. The payment shall be based upon the actual Medicare rates, to coincide with the state's fiscal year, for nine months and the actual Medicare rates for three months. The payment to each facility shall be no more than the amount attributable to it in the Medicare UPL demonstration for the year to which the payment is attributed.

TN No: 18-0006
Supersedes
TN No: 03-0002

Approval Date: JUN 28 2018

Effective Date: 01/01/18

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g. Proportionate Share Incentive Adjustment 2

Effective January 1, 2018, all non-State operated governmental (county) nursing facilities other than those facilities owned or operated by Belknap County, Hillsborough County or Sullivan County (referred to as "qualifying non-State operated governmental nursing facilities" or "qualifying nursing facilities") shall receive payments under this section according to the following conditions:

1. The Department recognizes that non-State operated governmental (county) nursing facilities provide care to many severely medically involved patients requiring an extraordinarily intensive and costly level of care and have a very high Medicaid proportion of their patient census.
2. The Department will ensure continued access to this level of care through proportionate share incentive adjustment payments to non-State operated governmental nursing facilities.
3. The Proportionate Share Incentive Adjustment 2 shall be made to all qualifying non-State operated governmental nursing facilities in one payment by the end of each State Fiscal Year. The payment shall be calculated individually for each qualifying nursing facility by certifying all Medicaid allowable costs as reflected on the most recent final audited Medicaid cost report that is available for all qualifying nursing facilities, including the portion of the Nursing Facility Quality Assessment allocable to Medicaid (referred to as "Medicaid Costs") and all payments received by the nursing facility for Medicaid enrollees, including any Medicaid Quality Incentive Program Payments (to the extent applicable) (referred to as "Medicaid Payments"). The Proportionate Share Incentive Adjustment 2 shall be no more than the difference between Medicaid Costs and Medicaid Payments.
4. All qualifying nursing facilities shall certify public expenditures as the non-federal share of Proportionate Share Incentive Adjustment 2 based on the following process.

TN No: 18-0006
Supersedes
TN No: ncw page

Approval Date: **JUN 28 2018**

Effective Date: 01/01/2018

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g. Proportionate Share Incentive Adjustment 2 (continued)

- **Interim Rates:** The Department will develop and pay interim rates to qualifying facilities based on cost reports from the most recent period for which such information is available, adjusted by inflation to the current payment period. The interim rates will be provisional in nature and subject to reconciliation after the completion of cost reconciliation and settlement.
- **Cost Methodology:** In determining Medicaid allowable costs for providing services at each facility, the Department will certify all Medicaid allowable costs as reflected on the most recent final audited Medicaid cost report that is available for all qualifying nursing facilities, including the portion of the Nursing Facility Quality Assessment allocable to Medicaid.
- **Settlement:** Within 24 months of the end of a reporting period, subject to state reporting/audit, the Department will compare its interim rates for the period with final certified costs. If the interim rates exceed the audited costs, the Department will return the federal share of the overpayments to the federal government pursuant to 42 CR 433, Subpart P. If the final certified costs exceed the interim rates, the Department will submit claims to the federal government for the underpayment.
- **Audit:** All supporting accounting records, statistical data and all other records related to the provision of services by the qualifying facilities shall be subject to audit. If an audit discloses discrepancies in the accuracy and/or allowances of costs or data submitted for a qualifying facility, the payment rate for the period in question shall be subject to adjustment.
- **Cost Reports:** Final reimbursement for services provided by each qualifying facility will be based on a certified cost report provided by the facility to the Department. The Department will review and audit the data before finalizing the certified cost report. The CPE certification statement will be incorporated into the state's cost reporting package.

TN No: 18-0006
Supersedes
TN No: new page

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Effective Date: 01/01/2018

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g. Proportionate Share Incentive Adjustment 2 (continued)

- Cost Reports (continued): The cost reports used are from the applicable claiming period for which such information is utilized in the final settlement calculation of the Proportionate Share Incentive Adjustment 2 (ProShare 2). The calculation of ProShare 2 is performed as follows:
 - All Medicaid payments are retrieved directly from the NH MMIS Health Enterprise Portal (NH MMIS).

The state-developed Medicaid cost report summarizes the financial and statistical data to correspond to the nursing facility reimbursement methodology, including the grouping of expenditures into the cost components used to determine reimbursement. The summary page of each cost report review or audit summarizes the nursing facility's allowable expenditures by line item, which are grouped and subtotaled by cost component.

Medicaid Cost Report Schedule A

- Nursing Facility Costs are transferred from the Medicare 2540 cost report Worksheet A to the NH Medicaid Cost Report on Schedule A, Column 2 and then mapped to the corresponding cost center sections as on the Medicare cost report.
 - Capital Group Cost Centers, Lines 1-7
 - Support Group Cost Centers, Lines 8-129 (including Plant, Housekeeping, Laundry, Dietary, Central Supply, Pharmacy, Medical Records, Social Service, Recreation, and Barber and Beauty staff and supply costs)
 - Patient Care Group Cost Centers, Lines 131- 266 (including Nursing Administration, Laboratory, Radiology, Inhalation, IV Therapy, EKG, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Supplies Charged to Patients, Drugs Charged to Patients, and Inpatient Nursing SNF and/or ICF costs)
 - Non Reimbursable Group Cost Centers, Lines 269-283 (including gift shop, ambulance and staff physician expenses)

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g. Proportionate Share Incentive Adjustment 2 (continued)

Medicaid Cost Report Schedule A (continued)

- o Administration Cost Centers, Lines 287-368 (including salaries, legal expenses, advertising expenses, corporate taxes, subscriptions, accounting and audit services, and the Nursing Facility Quality Assessment tax)
- o Provider Reclassifications – Providers will reclassify items that were assigned to the incorrect cost center or are shared costs between cost centers in Column 3. These reclassifications are detailed in the Reclassifications Schedule A-1 which includes explanations for each reclassification.
- o Provider Adjustments – Providers will make adjustments to remove unallowable costs relating to other County organizations (i.e. jail), non-patient meals, allowable financial costs allocated from County Finance offices, and other minor adjustments in Column 4. These adjustments are detailed in the Adjustment Schedule A-2 which includes explanations for each adjustment.
- o Medicaid Reclassifications – Medicaid auditors will reclassify items that were assigned to the incorrect cost center or are shared costs between cost centers in Column 4a. These reclassifications are detailed in the Reclassifications Schedule C5-1 which includes an explanation and the authority for each reclassification.
- o Medicaid Adjustments – Medicaid auditors will make adjustments to remove unallowable costs, (i.e. miscellaneous revenue, depreciation and purchased services) in Column 4b. These adjustments are detailed in the Adjustment Schedule C5-1 which includes an explanation and the authority for each reclassification.
- o Adjusted Total – General ledger costs from Column 2 are adjusted based on reclassifications and adjustments made by both the Provider and the Medicaid auditor and summed in Column 5.
- o Allocation – Costs – Reimbursable and non-reimbursable - Medicaid costs in Columns 6, 7, 8 and 9 are calculated by multiplying the costs in each column by the identified statistics in Columns 10, 11, 12 and 13.

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Supersedes
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g. Proportionate Share Incentive Adjustment 2 (continued)

Medicaid Cost Report Schedule A (continued)

- Allocation - Statistics – Columns 10, 11, 12 and 13 identify the statistical information to be used in identifying reimbursable and non-reimbursable -. As outlined in the “Instructions for Completing Form 356, Medicaid Annual Report for Nursing Facilities” (SR 06-17, page 7) each cost center must use either a primary or alternative basis for statistics. For example, capital costs must use square footage as the allocation statistic where laundry could use either pounds of laundry or patient days as the allocation statistic. The Administration cost center uses cumulative costs as the allocation statistic from the Capital cost center through the non-reimbursable cost center to allocate costs as either reimbursable or non-reimbursable.

Medicaid Cost Report Summary

- Nursing Facility Costs are transferred from Schedule A to the Summary, schedule C3.
 - Provider Costs are summarized in sections I, II, III which are Provider Submitted Costs, Provider Adjustments and Provider Net Costs.
 - Medicaid Adjustments are summarized in section IV and Medicaid Reimbursable costs are identified in total in section V.
 - Medicaid Reimbursable Costs are allocated in summary to section VI, lines a, b, c, and d.
 - Total Reimbursable Costs Allocated are summarized in section VII.
- Reimbursable Costs to be used for calculating Medicaid Rates are summarized as follows:
 - Section A, Capital Costs, total reimbursable capital costs
 - Section B, Plant Costs, total reimbursable plant costs

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g. Proportionate Share Incentive Adjustment 2 (continued)

Medicaid Cost Report Summary

- Reimbursable Costs to be used for calculating Medicaid Rates (continued):
 - Section C, Support Costs less Plant Costs, total reimbursable support costs less reimbursable plant costs
 - Section D, Patient Care Costs less Therapy Costs (reimbursable therapy costs include Physical Therapy, Occupational Therapy and Speech Therapy), total reimbursable patient care costs less reimbursable therapy costs
 - Section E, Therapy Costs, total reimbursable therapy costs
 - Section F, Administrative Center Costs, total reimbursable administrative costs
 - Section G, Total Costs of A through F, grand total of all reimbursable costs, as identified above
 - Section H, Total Long Term Care Beds
 - Section I, Total Long Term Care Patient Days
 - Section J, Total Medicaid Patient Days
 - Section K, Long Term Care Patient Days at 85% Occupancy

Proportionate Share Incentive Adjustment 2 (ProShare 2)

- The cost reports used are from the applicable claiming period for which such information is utilized in the final settlement calculation of the Proportionate Share Incentive Adjustment 2 (ProShare 2). The calculation of ProShare 2 is performed as follows:
 - All Medicaid payments are retrieved directly from the NH MMIS Health Enterprise Portal (NH MMIS).
 - Total reimbursable costs are taken from the Medicaid Cost Report Summary, Section G.

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g. Proportionate Share Incentive Adjustment 2 (continued)

Proportionate Share Incentive Adjustment 2 (ProShare 2) (continued)

- o The amount of Nursing Facility Quality Assessment (NFQA) tax, included in Administrative costs as identified above, are reduced to allow only the portion allocable to Medicaid. This amount is calculated by multiplying the total amount of NFQA tax, times 1 minus the Medicaid percentage calculated by dividing the Medicaid census by the total All Payor census.
- o Net All Payor allowable costs is total reimbursable costs less the disallowed portion of the NFQA tax
- o The Medicaid census (patient) days are taken from the Medicaid Cost Report Summary, Section J.
- o Total All Payor census (patient) days are taken from Medicaid Cost Report Summary, Section I.
- o The percentage of Medicaid residents at the facility and is calculated by dividing the Medicaid census by the total All Payor census.
- o The allocable Medicaid costs are determined by multiplying the total costs by the Medicaid percentage calculated referenced immediately above.
- o A certification statement of total computable CPE is made by an officer of the governmental provider on a State provided form.
- o Reconciliation of interim payments on a facility specific basis is made based on audited cost reports (see attachment A). Interim payments, in this context, are defined as an initial estimate of final certified public expenditures based on the most recently submitted cost report for each facility.

Cost Settlement

- Within 24 months of the end of a reporting period, the Department will compare its interim rates for the period with final certified costs. If the interim payments exceed the audited costs, the Department will return the federal share of the overpayments to the federal government pursuant to 42 CR 433, Subpart P. If the final certified costs exceed the interim payments, the Department will submit claims to the federal government for the underpayment. Following the settlement of costs, if it is determined that the facility was overpaid, the Department would recoup those payments. If it is determined that the facility was underpaid, the Department would update the certified public expenditure claiming and make the additional payment to the facilities.

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Supersedes
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f(1). Supplemental Medicaid Nursing Home Payment

Licensed CMS nursing facilities, both private and county operated, which provide Medicaid nursing home services shall be eligible to receive a supplemental nursing home payment. Payments are made quarterly in the month following the quarter. Payments are made in July, October, January, and April, and are based on the prior three months of Medicaid paid dates of service applicable for that quarter. The purpose of the supplemental payment is to eliminate or reduce to the maximum extent possible the difference between the facility's allowable Medicaid costs and the per diem payments made to such facility which are derived from the nursing facility Medicaid acuity rate setting system multiplied by the budget adjustment factor in Section 9999.8, page 29(f), item 8 b.

The quarterly payment methodology is as follows:

1. The Department will allocate the supplemental pool quarterly among the eligible licensed nursing facilities. The pool for the July 2019 quarterly payment is \$23,383,255. On a quarterly basis, the Department shall furnish to the facilities, before supplemental payments are processed, a calculation exhibit which identifies each facility's calculated rate and supplemental payment for that quarter.
2. The supplemental pool shall be distributed based on each nursing facility's relative share of total Medicaid paid nursing home days as calculated by the NH Medicaid Management Information System (MMIS). The total paid Medicaid nursing home days for the July 2019 quarterly payment is 257,570. Relative share shall equal each facility's total paid Medicaid nursing home days per the MMIS divided by the total of all nursing home paid Medicaid days (per the MMIS) for all facilities. (Facility total paid Medicaid nursing home days divided by total Medicaid nursing home paid days = relative share) x (supplemental pool \$\$) = supplemental payment.

TN No: 19-0011
Supersedes
TN No: 19-0008

Approval Date: 08/22/2019

Effective Date: 04/01/2019

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g. Interest

Interest will not be paid on underpayments nor collected on overpayments.

Patient
Personal
Accounts
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a. The accurate maintenance of patient accounts is critical for purposes of continuing eligibility.

TN No. 03-002
Supersedes
TN No. _____

Approval Date FEB - 9

Effective Date 02/17/03

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Patient
Personal
Accounts
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To remain eligible for nursing facility care, the individual may have no more than \$2,500 total resources. This amount may be accumulated from more than one source, meaning that the patient account is not always the client's sole resource.

Upon establishing an account for a patient, the nursing home should contact the District Office to determine existing resources to establish the maximum allowable personal account.

Under either level of care, nursing homes must view the patient's total resources to be assured of continuing eligibility for payments.

Approved expenditures may be necessary to maintain patient eligibility. Such expenditures may include, but are not limited to, application of all or part of the funds to the cost of nursing care, purchase of personal items needed or desired by the patient, prepayment of funeral and burial costs. These expenditures must clearly demonstrate patient and/or representative knowledge and approval as detailed above.

- b. All nursing facilities are required to maintain an accounting system for the management of personal funds belonging to patients residing there. There must be no charge for these services and proper documentation must be maintained. The Bureau of Provider Audits and Rate Setting will review personal needs accounts as a part of the field audit.
- c. Patients may handle their own funds provided that they are able to manage their own affairs and that they do not keep unreasonable sums of cash on their persons or in their rooms. If the nursing home is the legal representative responsible for managing a patient's personal funds, such delegation of authority shall be in accordance with present State law and a quarterly accounting of all transactions and current status shall be provided.
- d. A Declaration of Intent must be completed for each Medicaid recipient residing in the institution. This declaration must identify either the nursing facility, the patient, the patient's relatives, or his legal guardian as being accountable for his personal funds.

TN No. 90-70
Supersedes
TN No. 87-10

Approval Date 9/26/90

Effective Date 10/01/90

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Patient
Personal
Accounts
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- e. As the patients now residing in nursing homes retain amounts described in Attachment 2.6-A of the State Plan, it is imperative that the accounting system be supported by adequate records and bookkeeping procedures. This is important for two (2) reasons:
 - (1) the patient can request a quarterly accounting, and
 - (2) the accounts are subject to audit by the Division of Human Services
- f. A sample format which may be used as a ledger is included at the end of this chapter.
- g. A patient may make a withdrawal at any time during normal facility business hours. Under no circumstances are funds to be arbitrarily removed from a patient's account. The patient or his representative must have a complete understanding and final approval of all transactions. Regardless of whether it is an individual or general account, any interest accrued belongs to the patient(s) and not the facility or anyone else.
- h. These funds may not be used to reimburse the home for the differences between the customary charges and the Human Services rate; that is, no personal funds can be used to pay or supplement payment for any item or service already included in or coverable by Division of Human Services reimbursement to any provider.
- i. Certain items such as enema sets, syringes with needles and suction catheters are payable to the pharmaceutical supplier by the Division of Human Services. These are not proper charges against the personal funds of a Medicaid patient.

TN No. 89-11
Supersedes
TN No. 87-10

Approval Date 1/12/89

Effective Date 06/01/89

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Patient
Personal
Accounts
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- J. Recurring charges indirectly included in the facility's per diem rates are also not proper charges against a patient's personal funds. Such charges may include, but are not limited to, the following: shampoo, wheelchair rental, walker rental, geriatric chairs, johnnies, posey vests, personal laundry, non-therapeutic lotions, disposable gloves, absorbent cotton, diapers. The nursing home rate includes the cost of an adequate supply of equipment to carry out patient treatments at the ICF level of care. All those items listed above are considered necessary for ICF care and are included in the per diem rate developed by the Division of Human Services.

TN No. 87-10
Supersedes
TN No. 85-7

Approval Date 6/27/88

Effective Date 11/01/87

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Patient
Personal
Accounts
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- k. Medicaid recipient's personal funds may be used to reimburse the nursing facility for leave days if it is necessary to hold the bed during an absence. Use of these funds in this manner is subject to the following:
- (1) The Division of Human Services can make no payment for a day or period paid for by recipients or their authorized representatives
 - (2) If a recipient's personal funds are used, either the patients or their representatives or both must be aware or and fully understand the proposed expenditure in advance, and grant permission in writing for such use. The nursing facility must document the transaction in the patient's personal account.
- l. Legally, the money in the patient account of a deceased resident of a nursing facility belongs to the estate and should not be given to anyone except the administrator, executor, or voluntary administrator of the estate upon displaying proof of appointment.
- m. The individual nursing home is responsible for the maintenance of these funds with control mechanisms as are required. It is further suggested that a person other than the bookkeeper of the funds reconcile the bank and cash funds at the end of the month.

TN No. 06-003
Supersedes
TN No. 87-10

Approval Date NOV - 7 2006

Effective Date 11/01/87

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Patient
Personal
Accounts
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- n. Maintenance of Funds For facilities with the exception of state owned and operated facilities, patient deposits should be maintained in the following manner:
- (1) NF's shall maintain residents' personal funds such as, cash account funds and bank accounts.
 - (2) 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.
 - (3) The minimum monthly amount of cash retained per recipient shall be the amount cited at RSA 167:27-a.
 - (4) A receipt shall be obtained for all cash amounts given residents from this fund or any expenditures made on their behalf.
 - (5) Expenditures not related to residents' personal needs, such as the cashing of employee checks, shall be prohibited.
 - (6) 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.
 - (7) Residents' personal funds shall not be co-mingled with funds maintained for the general operations of the nursing facility.
 - (8) Interest accumulated by residents' personal funds accounts shall belong to those residents whose money generates the interest.
 - (9) Allocation of interest income shall be made at least quarterly.
 - (10) 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.

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Supersedes
TN No. 87-10

Approval Date NOV - 7 2006

Effective Date 02/01/06

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Patient
Personal
Accounts
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- (11) Authorization by the resident or his/her authorized representative shall be obtained for all disbursements described in (10) above.
- (12) 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.

TN No. 06-003
Supersedes
TN No. 87-10

Approval Date NOV - 7 2006

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Provision
for Public
Review and
Comment
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The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

TN No. 98-01
Supersedes
TN No. 96-07

Approval Date 6-18-78

Effective Date 1/1/98

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Appeals
Procedure
9999.11

a. Reconsideration of Cost Report Adjustments

- (1) There shall be two levels for appeal of cost report adjustments as described in MAM 9999.3 (s) and (t) as follows:
 - (a) A reconsideration by the department, through the bureau administrator of the bureau of elderly and adult services, or his/her designee, as described in (2) through (6) below; and
 - (b) An administrative appeal as specified in MAM 9999.11(b).
- (2) Providers may use either or both the reconsideration of cost reports adjustment as outlined in 9999.11(a) and the appeal process as outlined in 9999.11 (b).
- (3) 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 MAM 9999.3 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
- (4) 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 chief to consider.
- (5) 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 (6) (a) and (a) below.
- (6) The bureau administrator or his/her designee shall make his/her decision on the reconsideration based on:
 - (a) A review of all information submitted by the NF provider; and
 - (b) A review of the cost report adjustments proposed by the department to determine the accuracy of the adjustments.
- (7) 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 hearing.
- (8) 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 MAM 9999.11(b).

TN No. 08-015
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TN No. 06-003

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Appeals
Procedure
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b. Appeals Procedure

- (1) 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.
- (2) 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.
- (3) Requests for appeals shall state the reason for the appeal.
- (4) Appeals shall be held and heard in accordance with He-C 200.
- (5) In accordance with 42 CFR 447.253(e), a provider shall request appeals:
 - (a) As specified in He-E 806; and
 - (b) Due to the action or inaction of the department relevant to He-E 806.
- (6) An NF provider may request an appeal regarding a rate set by the department.
- (7) A provider shall not request an appeal regarding:
 - (a) The department's internal rate setting methodology; or
 - (b) Federal or state constitutional law.
- (8) The hearings officer shall deny any request for an appeal which is not as described in (5) or (6) above.

TN No. 06-003
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c. Retroactive Adjustment

If the fair hearing decision is in favor of the facility, the Bureau of Provider Adjustments and Rate Setting will make a retroactive adjustment.

d. Findings and Conclusions

Any data, findings, conclusions, of the Fair Hearings Officer and any Department data in regard to any provider appeal will be made available to the provider and will become part of the Division of Human Services records.

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Incorrect
Payments
9999.12

- (a) If an 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.

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Fraudulent
Acts
9999.13

There are State and Federal criminal laws which may apply to a provider who commits certain fraudulent acts involving the Rate Setting Process for Long-Term Care Facilities under the Medical Assistance Program (Medicaid) (See 42 CFR 455.1).

Under Federal law (Section 1909 for the Act codified as 42 USC 1396h) it is a crime to make a false statement or representation of a material fact in any application for any benefit or payment under the Medicaid program. It is a crime to solicit or receive a kickback, bribe or rebate in return for purchasing, leasing, ordering, or recommending purchasing, leasing or ordering of any goods or services for which payment may be made in whole or part by the Medicaid program. This includes rebating of a false statement of a material fact about conditions or operations of any institution or facility to secure Medicaid certification is also a Federal crime.

Violation of these provisions is a felony punishable by a maximum prison sentence of five years and/or of up to \$25,000.

Under New Hampshire law (RSA 167: 17b) it is also a crime to intentionally make a false statement or do any other fraudulent act to obtain benefits for payments under the Medicaid program. It is a crime to pay, offer, solicit, or receive any bribe or rebate in return for purchasing, leasing or recommending the purchase or lease of goods or services which will be paid for in whole or part by the Medicaid program. The New Hampshire statute also forbids the providing of merchandise or services to a Medicaid recipient and billing the Medicaid program for different goods and services or for goods and services not provided.

The maximum sentence for violation of these provisions is 15 years in state prison and/or a \$2,000 fine. The maximum fine is increased to \$50,000 if a corporation commits the crime (see RSA 167:17 - c, RSA 651:2)

Both Federal and New Hampshire law make it a crime to solicit or receive any payment or donation as a precondition to admitting or expediting the admission of a Medicaid patient to a long-term care facility or as a requirement for a patient's continued stay in such a facility.

It should be noted that a provider who commits any of these crimes may be prosecuted in both State and Federal court.

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