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State/Territory Name: NH

State Plan Amendment (SPA) #: 18-0006

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850



Financial Management Group

Jeffery A. Meyers, Commissioner
Department of Health and Human Services
State of New Hampshire
129 Pleasant Street
Concord, NH 03301

JUN 28 2018

RE: New Hampshire SPA 18-0006


Dear Commissioner Meyers:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 18-0006. January 1, 2018, this amendment proposes a Certified Public Expenditure (CPE) Cost Protocol to fund unreimbursed costs for seven counties with eight county government owned nursing facilities under the state's Proportionate Share Incentive Two (2) supplemental payment program. For the remaining three non-state government owned nursing facilities, the state proposes to fund Proportionate share Incentive One (1) supplemental payments with Intergovernmental Transfer (IGT). Additionally, New Hampshire proposes a reimbursement methodology for supplemental payments under the Medicaid Quality Incentive Program (MQIP) funded by the state Nursing Facility Quality Assessment Tax (NFQA).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447. We are pleased to inform you that Medicaid State plan amendment 18-0006 is approved effective January 1, 2018. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,


Kristin Fan
Director

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
18-0006

2. STATE
NH

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2018

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
SSA 1902(a)(13) and 42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
FFY 2018: ~~10.4M~~ 16,122,512
FFY 2019: ~~FBD~~ 18,122,512

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19D, page 31(c) and 31(d)
Attachment 4.19D, page 31(d.1) - 31(d.8)
~~Attachment 4.19D, page 31(d.2)~~

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Attachment 4.19D, page 31(c) & 31(d), TN 03-0002
New Pages
New Page

10. SUBJECT OF AMENDMENT:

Nursing Facility Reimbursement - Proportionate Share Incentive Adjustment and MQIP

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OF FICEREPORTED NO COMMENT OTHER, AS SPECIFIED: comments, if any, will follow
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE: [Redacted]

16. RETURN TO:

13. TYPED NAME: Jeffrey A Meyers

Dawn Landry
Office of Medicaid Business and Policy/Brown Building
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

14. TITLE: Commissioner

15. DATE SUBMITTED: 3/26/2018

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JUN 28 2018

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2018

20. SIGN: [Redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMC

23. REMARKS:

pen + inks 6/27/2018 by NH per cms request
Box 7 pen + mk update 6/25/2018 by NH per discussion w/cms

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MEDICAL ASSISTANCE	SUBJECT NURSING FACILITY REIMBURSEMENT		DATE SR

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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.

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TN No: 03-0002

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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.

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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.

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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)

- 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)
- 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.
- 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.
- 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.
- 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.
- 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.
- 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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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)

- 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.
- Net All Payor allowable costs is total reimbursable costs less the disallowed portion of the NFQA tax
- The Medicaid census (patient) days are taken from the Medicaid Cost Report Summary, Section J.
- Total All Payor census (patient) days are taken from Medicaid Cost Report Summary, Section I.
- The percentage of Medicaid residents at the facility and is calculated by dividing the Medicaid census by the total All Payor census.
- The allocable Medicaid costs are determined by multiplying the total costs by the Medicaid percentage calculated referenced immediately above.
- A certification statement of total computable CPE is made by an officer of the governmental provider on a State provided form.
- 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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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 April 2018 quarterly payment shall be \$18,386,824. 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 April 2018 quarterly payment is 375,770. 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.