

Table of Contents

State/Territory Name: New Hampshire

State Plan Amendment (SPA) #: NH-21-0037

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 & HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850



Financial Management Group

April 12, 2022

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

RE: New Hampshire 21-0037

Dear Commissioner Shabinette:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 21-0037. Effective July 1, 2021, this amendment provides for Proportionate Share Incentive (ProShare) Adjustment I and II eligible county changes.

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 Subpart C. This is to inform you that Medicaid State plan amendment TN 21-0037 is approved effective July 1, 2021. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Mark Wong at (415) 744-3561 or mark.wong@cms.hhs.gov.

Sincerely,



Rory Howe
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER 21-0037	2. STATE NH
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2021	

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 1923 and 42 CFR Part 447	7. FEDERAL BUDGET IMPACT FFY 2021: \$1,460,204 339,316 FFY 2022: \$1,017,948
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT Attachment 4.19D, page 31(c) Attachment 4.19D, page 31(d) Attachment 4.19-D, pages 31(c.1), 31(c.2), 31(d.1), 31(d.2), 31(d.3), 31(d.4)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) Attachment 4.19D, page 31(c) TN 21-0031(1135 Disaster Relief) Attachment 4.19-D, pages 31(c.1), 31(c.2), 31(d.1), 31(d.2), 31(d.3), 31(d.4), 31(d.5), 31(d.6), 31(d.7)

10. SUBJECT OF AMENDMENT


Proportionate Share Incentive Adjustments (ProShare) I and II County Change

11. GOVERNOR'S REVIEW (Check One)

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

12. SIGNATURE OF STATE AGENCY OFFICIAL 	16. RETURN TO Janine Corbett Division of Medicaid Services/Brown Building Department of Health and Human Services 129 Pleasant Street Concord, NH 03301
13. TYPED NAME Ann H. Landry	
14. TITLE Associate Commissioner	
15. DATE SUBMITTED 9-29-21	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED September 29, 2021	18. DATE APPROVED April 12, 2022
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL July 1, 2021	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME Rory Howe	22. TITLE Director, Financial Management Group

23. REMARKS

Pen-and-ink changes made to Boxes 7, 8, and 9 by CMS with state concurrence.

Attachment 4.19D		ITEM B	PAGE 31(c.1)
MEDICAL ASSISTANCE	SUBJECT NURSING FACILITY REIMBURSEMENT		DATE SR

Policy
(Continued)
9999.8

f. Proportionate Share Incentive Adjustment 1

Only nursing facilities owned or operated by Hillsborough 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. ProShare1 payments are the difference between the Calculated Medicare Equivalent and the total Medicaid payments made to the county nursing facilities.
3. The following steps are used to calculate ProShare1 distributions:
 - a) The Medicare equivalent RUG based rate is calculated using the Total Rate from the Federal Register by RUG score. This Medicare Total Rate for each RUG score is multiplied by the corresponding count of Medicaid residents with the same RUG score.
 - b) The sum total of the Medicare Total rates per Medicaid census count is then divided by the total Medicaid population count from the census to arrive at an average Medicare per diem rate.
 - c) The average Medicare per diem rate is calculated biannually and the average of these two rates, trended using the Market Basket inflation factor for Skilled Nursing Facility PPS, is used as the Average Medicare Per Diem Rate.
 - d) The State takes the sum of the total actual Medicaid paid claims available at the time of the calculation and estimated claims for the remainder of the period then multiplies this by the Average Medicare Per Diem Rate to arrive at a Calculated Medicare Equivalent.
 - e) The total of the Medicaid Payments made to the County Nursing Facility are calculated for the State Fiscal Year.

TN No: 21-0037
Supersedes
TN No: 19-0016

Approval Date: April 12, 2022

Effective Date: 07/01/2021

Attachment 4.19D		ITEM B	PAGE 31(c.2)
MEDICAL ASSISTANCE	SUBJECT NURSING FACILITY REIMBURSEMENT		DATE SR

Policy
(Continued)
9999.8

f. Proportionate Share Incentive Adjustment 1 (continued)

- f) The total of the Medicaid Payments are the sum of:
 - a. The estimated Medicaid NF Per Diem Expenditures for the State Fiscal Year calculated as indicated in Section 9999.8, page 29(f), item 8(b). Estimated expenditures are the sum of the total allowed amounts from actual Medicaid paid claims available at the time of the calculation and estimated claims for the remainder of the period.
 - b. Any class line 504 payments as indicated in Section 9999.8, page 29(f), item 8(c).
 - c. The total of the Supplemental Medicaid Nursing Home payments as indicated in Section 9999.8, page 31(d.8), item f(1).
- g) The difference of the Calculated Medicare equivalent and the total Medicaid payments becomes the total ProShare1 expenditure to the County Nursing Facility.
- h) The State then makes the payment to the county nursing facility in the last quarter of the state fiscal year on or before June 30.

TN No: 21-0037
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TN No: 19-0016

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Attachment 4.19D		ITEM B	PAGE 31(d.1)
MEDICAL ASSISTANCE	SUBJECT NURSING FACILITY REIMBURSEMENT		DATE SR

Policy
(Continued)
9999.8

g. Proportionate Share Incentive Adjustment 2

Effective July 1, 2021, all non-State operated governmental (county) nursing facilities other than those facilities owned or operated by Hillsborough 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 interim 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 for each qualifying nursing facility by tallying allowable costs as reflected on the latest filed Medicaid cost report available for all qualifying nursing facilities applied to the Medicaid fee-for-service population and Medicaid payments received by the nursing facility for Medicaid fee-for-service enrollees. The Proportionate Share Incentive Adjustment 2 shall be no more than the difference between Medicaid Costs and Medicaid Payments. The interim payments are then subject to a reconciliation to final audited net Medicaid fee-for-service costs for the service period.
4. All qualifying nursing facilities shall certify expenditures for Proportionate Share Incentive Adjustment 2 based on the following process.

Interim Payments: The Department will develop and pay interim payments to qualifying facilities based on filed cost reports from the most recent period for which such information is available, adjusted by inflation to the current payment period. The interim payments are provisional in nature and subject to reconciliation after the completion of cost reconciliation and settlement.

Cost Reports: Final reimbursement for services provided by each qualifying facility will be based on a finalized certified cost report provided by the facility to the Department. The Department will review and audit the data before finalizing the

Attachment 4.19D		ITEM B	PAGE 31(d.2)
MEDICAL ASSISTANCE	SUBJECT NURSING FACILITY REIMBURSEMENT		DATE SR

Policy
(Continued)
9999.8

certified cost report. The cost reports used in the final reconciliation are for the applicable service period for which the Proportionate Share Incentive Adjustment 2 (ProShare 2) payments are made.

- Cost Methodology: In determining Medicaid allowable costs for providing services at each facility, the Department will tally all Medicaid allowable costs as reflected on the Medicaid cost report for all qualifying nursing facilities.
 - 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.
 - Support Group Cost Centers 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 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 including gift shop, ambulance and staff physician expenses.
 - Administration Cost Centers 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. Reclassifications Schedule A-1 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. Schedule A-2 includes explanations for each adjustment.

Attachment 4.19D		ITEM B	PAGE 31(d.3)
MEDICAL ASSISTANCE	SUBJECT NURSING FACILITY REIMBURSEMENT		DATE SR

Policy
(Continued)
9999.8

- Medicaid Reclassifications – Medicaid auditors reclassify items assigned to incorrect cost centers or shared costs between cost centers in Column 4a. The Explanation of Reclassifications and Adjustments includes an explanation and the authority for each reclassification.
- Medicaid Adjustments – Medicaid auditors make adjustments to remove unallowable costs, (i.e. miscellaneous revenue, depreciation and purchased services) in Column 4b. The Explanation of Reclassifications and Adjustments includes an explanation and the authority for each adjustment.
- Adjusted Total – General ledger costs are adjusted based on reclassifications and adjustments made by both the Provider and the Medicaid auditor and summed.
- Allocation – The Adjusted Total is multiplied by the identified statistics to allocate the adjusted total costs from each cost center to the applicable components of the facility, including ICF, SNF, Hospital, and Non-Reimbursable. 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. Patient Care costs are multiplied by patient days to allocate costs as either reimbursable or non-reimbursable. Administration costs are allocated by accumulated costs. The non-reimbursable costs would be those costs allocated outside of applicable nursing facility costs, for example costs attributed to running a jail.
- Medicaid Reimbursable Costs: The sum of the Allocated reimbursable adjusted total, described in Allocation above, is the total All-Payor cost. The All-Payor allocated reimbursable costs are divided by total patient days, subject to a floor of 85% occupancy for the capital component, from the cost report to arrive at a reimbursable cost per day amount then multiplied by the number of covered and adjudicated Medicaid fee-for-service days for the ProShare 2 period (either estimated for interim payment or actual for final reconciliation) for the total Medicaid Reimbursable Costs.
- Medicaid Payments: Each facility's Medicaid reimbursable costs, as determined above, are offset by its Medicaid payments to arrive at net expenditures for ProShare 2 adjustment payment. Medicaid payments are to include payments received by the facility from all sources for the Medicaid services included in the ProShare 2 calculation. These payments include but are not limited to:
 - Per Diem Payments- Base rate reimbursements for dates of service of the ProShare 2 period are determined from NH MMIS reports. For interim payments, estimate payments may be based on the average monthly payment for the State

TN No: 21-0037
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TN No: 18-0006

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Attachment 4.19D		ITEM B	PAGE 31(d.4)
MEDICAL ASSISTANCE	SUBJECT NURSING FACILITY REIMBURSEMENT		DATE SR

Policy
(Continued)
9999.8

Fiscal Year available. These interim payments are reconciled with the final cost settlement.

- Supplemental Payments- Payments for the Medicaid Quality Incentive Payments (MQIP) are summed for the applicable dates of service of the ProShare 2 period. For interim payments, estimated payments for any unpaid quarters may be allocated based on the facility's percentage of MQIP payments for the prior quarter. These interim payments are reconciled with the final cost settlement.
- Nursing Facility account balance payments (class 504)- Payments are summed for the applicable dates of service of the ProShare 2 period. For interim payments, estimated payments may be based on reimbursement data from MMIS and are reconciled with the final cost settlement.
- Settlement: Within 24 months of the end of a reporting period, the Department will compare its interim ProShare 2 payments made for the period with final certified net Medicaid fee-for-service costs. The determination of final certified net costs should take into account audited Medicaid costs from the final cost report for the service period as well as actual payments for the Medicaid services in the same period, including the actual per diem payments, actual supplemental payments, actual class 504 payments, and actual payments for the Medicaid services from all other sources. If the interim payments exceed the audited net costs, the Department will return the federal share of the overpayments to the federal government pursuant to 42 CFR 433, Subpart F. Following the settlement of costs, if it is determined that the facility was overpaid, the Department would recoup those payments. If the final certified net costs exceed the interim payments, the Department will submit claims to the federal government for the underpayment. If it were determined that the facility was underpaid, the Department would update the ProShare 2 claiming and make the additional payment to the facilities.
- 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.
- Allowable costs from the Medicaid cost reports are defined consistent with applicable Medicare cost principles at 42 CFR 413 and Medicare Provider Reimbursement Manual, Part I and II, and federal cost principles at 2 CFR Subpart E.