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State/Territory Name: NH

State Plan Amendment (SPA) #: 09-007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services (CMCS)

December 13, 2012

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

RE: New Hampshire SPA 09-007

Dear Mr. Toumpas:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 09-007. This amendment modifies the reimbursement methodology for inpatient hospital services. Specifically it modifies the reimbursement methodology to reduce catastrophic outlier payments outside the DRG system by adjusting the percentage of expenditures used to calculate the amount of the reserve fund and constricting the qualifying criteria and timing for claims submissions direct medical education (DME) payments, critical access hospital maternity related service payments, and governmental psychiatric hospital payments.

While we review proposed SPAs to ensure their consistency with the relevant provisions of the Social Security Act (the Act) and the implementing federal regulations at 42 CFR 447 Subpart C, we conducted our review of your submittal with particular attention to the statutory requirements at section 1902(a)(30)(A) of the Act ("Section 30(A)"). Section 30(A) of the Medicaid statute requires that State plans contain "methods and procedures . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A). As we explain in greater detail below, we find that the State's submission is consistent with the requirements of the Act, including those set forth in section 1902(a)(30)(A).

States must submit information sufficient to allow CMS to determine whether a proposed amendment to a State plan is consistent with the requirements of section 1902 of the Act. However, consistent with the statutory text, CMS does not require a State to submit any particular type of data, such as provider cost studies, to demonstrate compliance. Rather, as explained in more detail in amicus briefs that the Solicitor General's Office has submitted to the Supreme Court of the United States and to other courts, CMS for many years has believed that the appropriate focus of Section 30(A) is on beneficiary access to quality care and services.[1]

[1] *See, e.g.*, Br. of the United States as Amicus Curiae, *Douglas v. Independent Living Ctr.*, No. 09-958, at 9-10 (2010); Br. of United States as Amicus Curiae, *Belshe v. Orthopaedic Hosp.*, 1997 WL 33561790, at *6-*12 (1997); Br. of Appellant at 16-30, *Managed Pharmacy Care et al. v. Sebelius et al.*, No. 12-55331, ECF No. 26 (Mar. 27, 2012); CMS, Decision Approving Arizona State Plan Amendment 11-015 (Mar. 9, 2012); Proposed Rule, Dep't of Health &

This interpretation—which declines to adopt a bright line rule requiring the submission of provider cost studies—is consistent with the text of Section 30(A) for several reasons. First, Section 30(A) does not mention the submission of any particular type of data or provider costs; the focus of the Section is instead on the availability of services generally. Second, the Medicaid statute defines the "medical assistance" provided under the Act to mean "payment of *part* or all of the cost" of the covered service. *See* 42 U.S.C. § 1396d(a) (emphasis added). Third, when Congress has intended to require states to base Medicaid payment rates on the costs incurred in providing a particular service, it has said so expressly in the text of the Act. For example, the now-repealed Boren Amendment to the Medicaid Act required states to make payments based on rates that "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A). By contrast, Section 30(A) does not set forth any requirement that a State consider costs in making payments. Finally, CMS observes that several federal courts of appeals have interpreted Section 30(A) to give states flexibility in demonstrating compliance with the provision's access requirement and have held that provider costs need not always be considered when evaluating a proposed SPA. *See Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 853 (3d Cir. 1999); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996); *Minn. Homecare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (per curiam). These decisions suggest that CMS's interpretation of Section 30(A) is a reasonable one. In this respect, CMS's interpretation differs from that first adopted by the Ninth Circuit in *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997), which established a bright line rule requiring a state to rely on "responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting."[2] As described above, CMS has consistently taken the position in adjudicating state plan amendments that reduce payment rates that Section 30(A) does not require the types of studies and considerations articulated by the Ninth Circuit in *Orthopaedic.*

CMS has reviewed the proposed SPA and, applying our longstanding interpretation of Section 30(A), determined that the proposed rate cut is consistent with the requirements of that provision, the Medicaid Act, and implementing regulations. In reaching this conclusion, CMS relied on the analysis performed by the State, available at http://www.dhhs.nh.gov/ombp/publications.htm. Specifically, CMS believes that the analysis contained in *Monitoring Access to Care in New Hampshire's Medicaid Program: Review of Key Indicators August 2012* demonstrates that the payment rate changes in SPA 09-007 are consistent with the requirements of Section 30(A). In that analysis, New Hampshire examined beneficiary enrollment, utilization of services, provider availability, and the availability of programs to assist beneficiaries in obtaining access to care. The published report analyzed beneficiaries' access to services over a three year period and established utilization and access thresholds using standard deviation to establish a standard for historical beneficiary access to medical services in the State. For the purposes of this SPA, CMS reviewed the data as it related to calendar year 2009. The published report also included a description of New Hampshire's historical practice of operating a call center. Data in the report, dating back to 2007, indicated that the State was able to assist beneficiaries that were unable to access needed medical services and helped locate providers that were willing to provided

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Human Servs., Ctrs. For Medicare & Medicaid Servs., 76 Fed. Reg. 26342, 26344 (May 6, 2011) (explaining that CMS does not require a State to submit any particular type of data to demonstrate compliance)..

[2] CMS's interpretation does not, of course, *prevent* states or CMS from considering provider costs. Indeed, for certain proposed SPAs, provider cost information may be useful to CMS as it evaluates proposed changes to payment methodologies. CMS also reserves the right to insist on cost studies to show compliance with Section 30(A) in certain limited circumstances – particularly when considering a SPA that involves reimbursement rates that are substantially higher than the cost of providing services, thus implicating concerns about efficiency and economy.

necessary services to those beneficiaries. The sophistication of the described process and the data analytics provided by the State lead CMS to determine that Medicaid beneficiaries have access to medical services to at least to the extent that such services are available to the general population in the geographic area. CMS believes that New Hampshire's analysis indicates that, under the proposed payment rates, Medicaid beneficiaries in New Hampshire are able to and will be able to obtain care to the same extent as the general population in the State.

Our review of SPA 09-007 focused on the SPA's substantive consistency with the requirements of the Act. CMS did not consider, nor does it interpret Section 30(A) to require, a review of a State's subjective motivation in proposing reductions in payment rates. CMS will approve any SPA that determines is consistent with the requirements of the Act regardless of a State's subjective motivation in proposing a SPA. Thus, CMS will approve a SPA that it determines to be consistent with the Act, even if the sole reason a State proposed the SPA was due to budgetary considerations. This interpretation is consistent with the text of Section 30(A), which establishes substantive requirements and does not impose any restrictions on a State's subjective motivations.

Section 1902(a)(30)(A) also requires that payment rates for Medicaid services be "consistent with efficiency, economy, and quality of care." In general, CMS has historically reviewed rate increases for efficiency and economy to ensure that proposed rates are not excessive. However, when a proposed rate results in a reduction in payment rates to providers, CMS has relied on data provided by the State to demonstrate access to care over time, historic provider retention and utilization trends and historic state reimbursement practices to make an informed decision regarding whether a rate reduction is consistent with efficiency and economy so that a state can demonstrate its ability to enlist and retain providers over time. Regarding the quality of care component of 30(A), CMS has developed a variety of quality measures and reporting tools to better evaluate the quality of care delivered and eventually outcomes related to that care. CMS strongly supports initiatives to increase measurement aimed at assuring quality of care. However, in the absence of such information, CMS has relied on the State's determination, through the provider enrollment process, that participating providers provide an acceptable level of quality care to Medicaid beneficiaries. Providers must be licensed by the State to provide services, and we generally defer to their determination that the providers that are enrolled in the Medicaid program and have agreed to receive the Medicaid payment in exchange for providing Medicaid services must also meet State-determined quality and professional standards to carry out their obligations under the Medicaid program.

CMS reviewed the State's public notice and determined that the notice meets the regulatory requirements at 42 CFR 447.205(c). Consistent with the requirements described in the CFR, the State issued public notice on June 29, 2009 in newspapers of widest circulation within the state and identified a local agency where the proposed changes were available for public viewing. Within the content of the notice, the state adequately described the changes proposed under SPA 09-007 including the suspension of DME payments, changes to the calculation and distribution of catastrophic payments, and an added multiplier to DRGs paid to Coos County Critical Access Hospitals for labor and delivery. Additionally, the state estimated an aggregate budget financial impact of the SPA. The State also demonstrated compliance with the public process requirement in Section 1902(a)(13) of the Act by providing the public notice required by 42 C.F.R. 447.205 and by including an assurance of public process in the State plan as required by the Act. In

addition to the assurance, the State provided a description of the public process that occurred as a component of the legislative negotiations and public meetings with interested parties. In describing the changes and the budget impact as related to this SPA, New Hampshire has adequately met the regulatory public notice requirements and the statutory public process requirements as CMS interprets those requirements.

This letter affirms that New Hampshire Medicaid state plan amendment (SPA) 09-007 is approved effective July 1, 2009. 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,

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 09-007

2. STATE: NH

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
July 1, 2009

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:

7. FEDERAL BUDGET IMPACT: $125,947
~~$1,128,500 (ip hospital w/o psych)~~ – FFY 2009 – ~~psych $150,000~~
~~($963,000 ip hospital w/o psych)~~ – FFY 2010 – ~~psych $600,000~~ ($117,65

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 1-4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Page 1, TN 05-005; Page 2, TN 07-001; Page 3, TN 04-007, Page 4, TN 05-005

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Reimbursement – Budget related changes to catastrophic payments, direct medical education, CAH maternity related services, and same page update to governmental psychiatric hospitals

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: comments, if any, will follow

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Nicholas A. Toumpas

14. TITLE: Commissioner

15. DATE SUBMITTED:

16. RETURN TO:
Dawn Landry
Program Support/Brown Building
Department of Health and Human Services
129 Pleasant Street
Concord, NH 03301

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: DEC 13 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Cindy Mann

22. TITLE: Director, CMCS

23. REMARKS:
Pen & ink changes to block 7 & 9 per state's request

PAYMENT FOR INPATIENT HOSPITAL SERVICES

The State of New Hampshire shall make payment for inpatient hospital services as follows:

1. A Diagnosis Related Group (DRG) method of payment shall be used for all inpatient hospital services, except that in-state hospital pass through payments for capital costs shall not be paid.

2. The DRG relative weights shall be based on the Centers for Medicare and Medicaid Services (CMS) weights published annually or periodically for Medicare in accordance with the requirements of 42 CFR 412.60, except New Hampshire relative weights will be used as specified in 3.a. (2).

3. Reimbursement shall be based on rates and amounts established by the Office of Medicaid Business and Policy (OMBP) in accordance with the following methodology:

   a. Normal hospital operating costs shall be recognized and paid on a per discharge basis, and these payments shall be considered payment in full for such operating costs. Except where specifically noted otherwise, such payments shall apply to all hospitals—in-state, border, and out-of-state.

      (1) Inpatient acute care services shall be paid a pre-determined price (in relation to a DRG with a relative weight equal to one; see 3.c. for calculation) associated with the DRG assigned by the Office of Finance, OMBP, to each Medicaid hospital discharge, and this rate shall be uniformly applied, except as specified in (2), (3), (4), and (5) below.

      (2) For in-state hospitals only, inpatient psychiatric care services shall be paid a pre-determined price associated with the psychiatric DRG (DRG 880 through 887) assigned to each Medicaid discharge, but the price shall differ by the peer group in which the facility is placed, as follows:

         a) Designated Receiving Facilities (DRF's) in Medicare certified Distinct Part units (DPU's) shall be paid a per DRG average peer group rate.

         b) Medicare certified DPU's without DRG's shall be paid a per DRG average peer group rate.

         c) Psychiatric services provided in a medical/surgical setting (scatter beds) shall be paid a per DRG average rate based on the average cost per psychiatric DRG across such facilities.

d) Governmental psychiatric hospitals shall be paid daily board and care rates for inpatient acute psychiatric services. The daily rate shall be calculated by taking the general fund expenditures from the previous state fiscal year; less general fund capitalized expenditures; plus capital related costs of depreciation expense for buildings, movable equipment, and fixed assets and bond interest expense; plus statewide and department cost allocation expenses, and then allocating to departments based on the Medicare cost allocation step-down methodology. In addition to the above methodology, an inflation factor from the most recent data published by the CMS Market Basket Data Index will be applied to arrive at the daily rate.

The final costs of the inpatient daily rate will be calculated by dividing total stepped-down costs by not less than 90% of the total bed days available in each unit for the next state fiscal year.

(3) For in-state hospitals only, inpatient (physical) rehabilitative Medicaid discharges in Medicare certified DPU's or rehabilitation hospitals shall be paid only a flat rate (with no additional outlier payments) for the rehabilitation DRG's 945 and 946. The rate represents an average cost across such facilities.

(4) Neonatal care for Medicaid discharges assigned certain DRG's (DRG 789 through 794) shall be paid only a per diem rate (with no additional outlier payments) associated with the specific DRG. The rate shall be paid at 65% of the full per diem amount.

(5) In order to ensure recipient access to maternity-related labor and delivery services, critical access hospitals in Coos County in New Hampshire will be paid as a separate peer group at an enhanced rate for those services by applying a percentage multiplier of 300% to the DRG based payment.

b. Certain costs over and above normal hospital operating costs shall be recognized and paid in addition to the DRG payments made under 3.a. above. These payments shall be made as pass-through payments to individual hospitals or in the form of payments for day outlier cases added to the discharge (DRG) payment. Except where specifically noted otherwise, such payments shall apply to all hospitals—in-state, border, and out-of-state.

(1) For in-state hospitals only, direct medical education costs shall be paid at a rate proportional to the Medicaid share, as calculated using Medicare principles, of actual hospital-specific costs and proportional to each hospital's share of the Medicaid annual budgeted amount. Such payments shall be made semi-annually, except that direct medical education payments shall be suspended for the period beginning July 1, 2009 and ending June 30, 2011.

(2) Day outliers shall be paid (except as specified in 3.a.(3) and (4)) for all DRG's for all facilities on a per diem basis, at 60% of the calculated per diem amount (see 3.d. for calculation), and outlier payments shall be added to the DRG payments. Payment shall be made for medically necessary days in excess of the trim point associated with a given DRG. Medicare trim points shall be used except where New Hampshire specific trim points have been established.

(3) The Medicare deductible amount for patients who are Medicare/Medicaid (dually) eligible shall be recognized and paid.

(4) For only in-state hospitals with approved graduate medical education programs, indirect medical education costs shall be recognized and paid on a per discharge basis using the Medicare methodology at 42 CFR 412.105 to determine the amount of payment. Such payment shall be added to the DRG payment.

(5) There shall be a reserve "catastrophic" fund equal to 3.3 percent of the projected annual Medicaid inpatient hospital expenditures.

This fund shall be used to provide for payments for inpatient hospital services outside the DRG system where (a) the DRG payment plus third party liability is below 25% of hospital charges, (b) the claim is for a DRG weight greater than 4.0, (c) the claim involves an inpatient stay in excess of 30 days, and (d) the hospital requests additional funding.

Reimbursement for each request shall be limited to 65% of charges reduced by prior payments, DRG allowed amounts and third party liabilities. Hospitals shall submit claims by December 15 and June 15 in order to be considered for payment for the six-month period ending, respectively, December 31 and June 30 of each year. The state shall expend half of the catastrophic fund no later than December 31 of each year and the second half no later than June 30 of each year. Payment of eligible claims shall be based on the date of service until catastrophic funds for the six-month period are exhausted. No claims or portions of claims shall be carried over into the subsequent six-month period, nor shall any excess funds be carried over into the subsequent six-month period.

c. The calculation for the price for a DRG with a relative weight equal to one (1.0000), to be used for all DRG's except those specified above for psychiatric, rehabilitation and neonatal services shall be as follows:

(1) Beginning October 1, 1999, and each year thereafter, take the current DRG price per point(s) and inflate each by the same percent as the Medicare market basket estimated increase for prospective payment hospitals minus any Medicare or state Medicaid defined budget neutrality factors and other generally applied Medicare adjustments appropriate to Medicaid.

d. Other relevant calculations: The price per DRG (unless otherwise specified) shall be calculated by multiplying the relative weight for that DRG by the price for a DRG with a relative weight equal to one (1.0000). The per diem price associated with a given DRG shall be calculated by dividing the price for that DRG by the geometric mean length of stay associated with a given DRG(s). The price for a day outlier shall be the per diem amount times a percentage factor, currently 60%. The cost for outlier payments associated with a given DRG(s) shall be calculated by multiplying the day outlier price by the number of outlier days for that DRG.

4. Direct medical education costs shall be allowed as a pass through payment in accordance with OMBP guidelines which shall be based on Medicare guidelines established at 42 CFR 412.2, except that direct medical education pass through payments shall be suspended for the period beginning July 1, 2009 and ending June 30, 2011.

5. Day outliers shall be reimbursed on a per diem DRG payment. Cost outliers shall not be recognized nor reimbursed. (also, see 3.b.(2) and 3.d. for day outliers.)

6. Periodic interim payments as made under the Medicare Program shall not be made by the Medicaid Program.

7. Pricing shall be prospective and payment shall be retrospective.

8. Payment rates shall be based on the relative weights and payment rates in effect at the time of discharge, taking into account the requirement to pay the lesser of the usual and customary charge or the computed rate, in accordance with 42 CFR 447.271 and RSA 126-A:3.

9. Providers of hospital services shall make quarterly refunds of Medicaid payments that are in excess of the Medicaid allowed amounts.