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State/Territory Name: NH

State Plan Amendment (SPA) #: 10-011

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

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 10-011

Dear Mr. Toumpas:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 10-011. This amendment modifies reimbursement methodologies for inpatient hospital service providers. Specifically it redesigns the Disproportionate Share Hospital (DSH) reimbursement methodology to prioritize payments to specific types of hospitals and adds provisions for Medicaid inpatient hospital supplemental payments for calendar year 2010 to mitigate the potential impact on cash flow for hospitals with lower uncompensated care cost due to the proposed changes in DSH payment method.

As we explain in greater detail below, we find that the State's submission is consistent with the requirements of the Social Security Act (the Act), including those set forth in section 1902(a)(13)(A)(iv) and section 1923.

At the outset, CMS notes that it does not interpret the requirements of section 1902(a)(30)(A) of the Act to apply to Medicaid DSH payments under section 1923 because DSH payments are not made for specific care or services offered under a state plan. However, assuming that section 1902(a)(30)(A) applied to DSH payments, CMS would still approve SPA 10-011, because the below analysis leads us to conclude that the proposed rates are consistent with that section. 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]

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[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 & 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)..

Under these standards, even assuming that Section 30(A) applies to DSH payments, New Hampshire's SPA would satisfy Section 30(A). 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 10-011 are consistent with the requirements of section 1923. 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. In particular, the Data and Analysis section of the report under "Utilization of Services," the State details inpatient utilization for ambulatory care sensitive conditions and total inpatient hospital utilization, both of which demonstrated a reasonable level of beneficiary access since early 2007. 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 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.

As part of the SPA documentation, the State provided the above referenced *Monitoring Access to Care in New Hampshire's Medicaid Program: Review of Key Indicators August 2012* which included, in part, data that measure:

- Quarterly enrollment trends by eligibility category
- Provider availability by quarter
- Quarterly and annual utilization trends
- Beneficiary requests for assistance accessing providers
- A detailed description of the state's Medicaid call center which assists beneficiaries facing access to care concerns.

The information was submitted to CMS for review in June and August 2012. The State lacked data from before 2007, but studied beneficiary utilization and provider availability data from 2007 to the first quarter of 2012. For the purposes of this SPA, CMS reviewed the data as it related to calendar year 2010. Through the state's beneficiary call center, described above, New Hampshire demonstrated the ability to obtain access to care for beneficiaries who needed assistance. The State also demonstrated that beneficiary utilization and provider enrollment remain within historical norms, indicating that there is no issue with access. Furthermore, New Hampshire has committed to review this data quarterly and address any access issues that arise. In consideration of the information, CMS has determined that the proposed SPA changes comply with section 1923 at the time of this approval.

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 November 14, 2010 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 10-011, including the redesign of the DSH payments to ensure that funds are distributed in a manner reasonably related to qualifying hospitals' uncompensated care costs and the proposed new Medicaid supplemental payments to inpatient hospitals Additionally, the State estimated an aggregate budget neutral financial impact of the SPA, calculated to consider both the changes to DSH and the offsetting addition both the inpatient supplemental payments of this SPA and the outpatient supplemental payment associated with New Hampshire SPA 10-014. Through this SPA, New Hampshire also memorialized the historical base payment rates for inpatient hospitals as of the effective date of the SPA, as listed below. In memorializing this language, CMS considers the content of the public notice sufficient to address all components of the hospital rate including the base medical payments, the supplemental payments, and DSH. 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 the New Hampshire Medicaid state plan amendment (SPA) 10-011 is approved effective November 19, 2010.

We are enclosing the HCFA-179 and the following amended plan pages:

- Attachment 4.19A, Page 4
- Attachment 4.19A, Page 4.1
- Attachment 4.19A, Page 4-Attachment
- Attachment 4.19A, Page 5
- Attachment 4.19A, Page 5a

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: 10-011

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
November 19, 2010

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:
0 – FFY 2011
0 – FFY 2012

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19A, page 4
Attachment 4.19A, page 4-Attachment
Attachment 4.19A, pages 5, 5a, 5b, 5c - reserved
Attachment 4.19A, pages 5d, 5e

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

Attachment 4.19A, page 4, TN 10-004 pending
Attachment 4.19A, none
Attachment 4.19A, pages 5, 5a, 5b, 5c, TN 03-004
Attacahment 4.19A, pages 5d, 5e, TN 03-004

10. SUBJECT OF AMENDMENT:
Disproportionate Share Hospital (DSH) Payment Adjustments - IP

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED 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 OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Nicholas A. Toumpas

14. TITLE: Commissioner

15. DATE SUBMITTED: 12/28/2010

16. RETURN TO:

Dawn Landry
Division of Family Assistance/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: NOV 19 2010

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Cindy Mann

22. TITLE: Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

d. Other relevant calculations:

(1) The Department separates inpatient hospital providers into peer groups according to the intensity of care provided in each. The peer groups are set up for general acute care, critical access hospitals (CAH), distinct part units for psychiatric care, rehabilitative care and maternity care in the northern county. The Department sets a base rate (Price per Point) for each peer group. The Price per Point values for hospital peer groups are accessible at:
http://www.nhmedicaid.com/Downloads/Bulletins.html

(2) The current Price per Point rates are as follows:

Acute Care	= $2,832.85
CAH	= $3,147.61
Psych DPU	= $3,114.01
Psych DRF	= $3,564.21
Rehab	= $14,514.98
Maternity	= $3,147.61

(3) DRG reimbursement is calculated by multiplying the Price per Point for the appropriate peer group times the relative weight assigned to the DRG.

(4) The DRG amount determined above is multiplied by the reimbursement percentage assigned to the provider. The reimbursement percent is 100% except for maternity which is a 300% multiplier effective 7/1/09 as specified in item 3.a.(5) above.

(5) 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 that DRG.

4. Direct medical education costs shall be allowed as a pass through payment in accordance with Department 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 unless payment is suspended in accordance with 3. b. (2). 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.

Calendar Year 2010 Annual Inpatient Hospital Schedule of annual calendar year adjustment payments*

Hospital Name	Inpatient Payment	Hospital Name	Inpatient Payment
Androscoggin Valley Hospital	$608,591.46	The Memorial Hospital	$501,226.43
Alice Peck Day Memorial Hospital	$181,987.44	Mary Hitchcock Memorial Hospital	$12,026,598.39
The Cheshire Medical Center	$2,836,910.95	Monadnock Community Hospital	$789,999.43
Catholic Medical Center	$3,049,745.14	Northeast Rehabilitation Hospital	$0.00
Concord Hospital	$5,705,556.57	New London Hospital	$333,099.75
Cottage Hospital	$199,601.06	Parkland Medical Center	$978,524.28
Elliot Hospital	$8,905,150.08	Portsmouth Regional Hospital	$1,217,878.40
Exeter Hospital	$1,693,345.80	Speare Memorial Hospital	$810,300.16
Frisbie Memorial Hospital	$2,011,055.30	Southern New Hampshire Medical Ctr	$4,768,324.75
Franklin Regional Hospital	$307,264.01	St. Joseph Hospital	$1,551,870.65
HealthSouth Rehabilitation Hospital	$360,776.75	Upper Connecticut Valley Hospital	$1,427,030.00
Huggins Hospital	$567,490.07	Valley Regional Hospital	$1,040,085.45
Littleton Regional Hospital	$504,058.35	Wentworth-Douglass Hospital	$2,552,283.61
Lakes Region General Hospital	$2,620,603.62	Weeks Medical Center	$172,180.08
Total			**$57,721,538.98**

*Any hospital with a $0.00 payment did not have "room" for an adjustment relative to a hospital specific upper payment limit.

10. For inpatient services provided in calendar year 2010, an annual Medicaid payment adjustment shall be made to each non-public, non-federal acute care and rehabilitation hospital participating in the state Medicaid program. This payment adjustment is made in addition to all other categories of inpatient services reimbursement otherwise made under the provisions of this section 4.19-A, items 1-9. This annual calendar year adjustment payment will be made in the final calendar quarter of each year for the purpose of ensuring that Medicaid services are compensated as fully as is permitted under the aggregate upper payment limits imposed under relevant provisions of federal regulations under Title XIX of the federal social security act. The State calculates the aggregate inpatient upper payment limit (UPL) for such non-public, non-federal hospitals in accordance with principles of Medicare reimbursement, as required under 42 CFR 447.272, and then projects the aggregate Medicaid payments to be made for such services in calendar year 2010 (before this annual adjustment) by determining actual aggregate 2009 Medicaid payments and adjusting for inflation. The amount of the difference between the so-calculated 2010 aggregate UPL and the projected aggregate 2010 actual reimbursements in calendar year 2010 is distributed to each qualifying hospital in an amount as set forth in the schedule on the following page numbered "page 4-attachment." The state determines the hospital-specific adjustment amount in this schedule based upon two factors: (a) the proportion of inpatient Medicaid services provided by the hospital relative to all hospitals' inpatient Medicaid services, and (b) the unique circumstances of any particular hospital relative to ability to maintain core services and financial stability. Each hospital's payment amount is set in proportion to its relative Medicaid charges, adjusted by certain unique circumstances, if any. Through this methodology, the State can ensure that the total combined Medicaid payments made under this section for inpatient services would not be expected to exceed a reasonable estimate of the amount that would be paid for these services under Medicare principles of reimbursement.

    The Omnibus Budget Reconciliation Act of 1993 established rules limiting the total disproportionate share payment that a hospital can receive. Disproportionate share payments are limited to no more than the cost of providing hospital services to patients who are either eligible for medical assistance under a state plan or have no health insurance for the services provided, less payments received under Title XIX (other than DSH payment adjustments).

    The Department will test the calculated disproportionate share payments allocated to each hospital in each year to ensure that payments do not exceed federal limits established under the Omnibus Budget Reconciliation Act of 1993 or Section 1923 of the Social Security Act using protocols established in the DSH Audit procedures developed by CMS. The source data used to compute this limit is the data from the Base Year that was used to set payments in the DSH State Plan Year (SPY).

    In the event the State (DHHS) or its designated auditor(s) or CMS determines that a hospital's calculated disproportionate share payment exceeds the Hospital Specific Limit, the amount of funds above the limit will be redistributed to the other eligible hospitals in its DSH Eligibility Group; or, in the case where there are no other eligible hospitals in its Eligibility Group, to other DSH-eligible hospitals in an amount proportional to the difference between each eligible hospital's Hospital Specific DSH Limit and DSH payments already received by that hospital for the relevant DSH State Plan Year.

    The Department will ensure that the disproportionate share payments will not exceed the limits.

Disproportionate Share – Payment Adjustments

There are two types of payment adjustments for hospitals qualifying as disproportionate share hospitals.

For both types of adjustments, in the event the Department or its designated auditor(s) or CMS determines that a hospital's calculated disproportionate share payment exceeds the Hospital Specific Limit, the amount of funds above the limit will be redistributed to the other eligible hospitals in its DSH Eligibility Group; or, in the case where there are no other eligible hospitals in its Eligibility Group, to other DSH-eligible hospitals in an amount proportional to the difference between each eligible hospital's Hospital Specific DSH Limit and DSH payments already received by that hospital for the relevant DSH State Plan Year.

The first type of disproportionate share payment adjustment shall be made for governmental psychiatric hospitals in which 50% or more of service revenue is attributable to any combination of the following:

- public funds, excluding Medicare/Medicaid
- bad debts
- free care

Hospitals of this type shall receive payment equal to the cost of services furnished to Medicaid patients, less the amount paid under the non-DSH payment under this plan, plus the cost of services provided to patients who have no health insurance or source of third party payments, less the amount of payments made by these patients.

Additionally, hospitals of this type which, during December 1994, had a Medicaid utilization rate of at least one standard deviation above the mean Medicaid utilization rate in the state shall receive payment equal to the cost of services furnished to Medicaid patients, less the amount paid under the non-DSH payment under this plan, plus the cost of services provided to patients who have no health insurance or source of third party payments for services provided during the current state fiscal year, less the amount of payments made by these patients. This payment will be made based on the most current cost and revenue data for the year and shall be adjusted based on actual cost and revenue data following conclusion of the fiscal year.

The psychiatric hospital definition meets the exception under 1923(d)(2).

Outlier payments per Section 302(b) of the Medicare Catastrophic Coverage Act are not applicable to this class of provider.

Disproportionate Share – Payment Adjustment

The second type of payment adjustment is to in-state, non-public general hospitals and special rehabilitation hospitals which qualify as follows:

The hospital must have at least 2 obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the state Medicaid plan. The term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. The above obstetric-related criteria do not apply to hospitals in which the inpatients are predominantly individuals under 18 years of age, or to hospitals which do not offer non-emergency obstetric services as of December 21, 1987.

All disproportionate share hospitals must, in addition to the qualifying conditions noted above, have a Medicaid utilization rate equaling or exceeding 1%. The Medicaid utilization rate shall be computed using the formulas specified in Section 1923(b)(2) of the Social Security Act.

Effective November 19, 2010, and on an annual basis thereafter in the time period beginning October 1, 2011, each in-state, non-public general hospital and special rehabilitation hospital that meets the above-referenced qualifying criteria for the second type of payment adjustment shall receive a Disproportionate Share Hospital (DSH) payment adjustment, under one of the following two DSH categories, in an annual amount specified by the described methodology for that category:

1. Critical Access Hospitals and Rehabilitation Hospitals: Each Critical Access Hospital and Rehabilitation Hospital shall receive a DSH payment equal to one hundred percent (100%) of the otherwise uncompensated portion, if any, of the costs of services provided to Medicaid patients and to all patients who have no source of insurance or third party payment for the services provided, where "uncompensated" care costs are calculated in accordance with and not in excess of the federal requirements of 42 U.S.C. 1396r-4(g); *i.e.*, the sum of (a) the costs of inpatient and outpatient hospital services furnished to Medicaid patients, less the total amount of payments made or payable for those services furnished under the non-DSH sections of this plan; and (b) the costs of inpatient and outpatient services furnished to patients with no source of insurance or third party payment for the services furnished, less the total amount of payments received from those individual uninsured patients for those services. This payment amount is reconciled in a subsequent year to account for variances identified between projected uncompensated care costs and actual uncompensated care costs.

2. Other DSH Qualifying, Private, Non-Public General Hospitals: The remaining DSH qualifying hospitals; *i.e.*, general hospitals that are not public, critical access or special rehabilitation hospitals, shall receive a DSH payment adjustment in an amount equal to a uniform percentage (%) of each such hospital's total uncompensated care costs as defined under 42 U.S.C. 1396r-4(g); *i.e.*, the sum of (a) the costs of inpatient and outpatient services furnished to Medicaid patients, less the total amount of payments made or payable for those services furnished under the non-DSH sections of this plan; and (b) the costs of inpatient and outpatient services furnished to patients with no source of insurance or third party payment for the services furnished, less the total amount of payments received from individual uninsured patients for those services. This payment amount is reconciled in a subsequent year to account for variances identified between projected uncompensated care costs and actual uncompensated care costs. Said uniform percentage shall be set at the highest percentage feasible in consideration of the total amount of funds made available in each year for reimbursement of said uncompensated care costs.