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: 10-014

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 4.19B, page 1
Attachment 4.19B, page 1-Attachment
Attachment 4.19B, page1-1

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19B, page 1, TN 08-017 pending
Attachment 4.19B, none
Attachment 4.19B, none (overflow from page 1, 08-017 pending)

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

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:
/s/

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: 12/28/2010

18. DATE APPROVED: 12/13/2012

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 11/19/2010

20. SIGN: /s/

21. TYPED NAME: Richard R. McGreal

22. TITLE: Associate Regional Administrator
Division of Medicaid & Childrens Health Operations, Boston, MA

23. REMARKS:

PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

1. Outpatient Hospital Services –An interim payment shall be made based on a percent of charges. Final payment is made in accordance with a percent of costs. An audit of each hospital's actual costs eligible for reimbursement shall be performed by the fiscal intermediary in accordance with federal Medicare requirements. The Department shall determine the percent of actual costs to be reimbursed, and then payments made to the hospital shall be cost settled using the percent determined by the Department and the actual cost data audited by the fiscal intermediary. Laboratory services provided as part of an outpatient hospital visit are reimbursed through an add-on fee and are paid in addition to the percentage of cost payment for the outpatient visit.

   The interim rate established for each hospital is set as a Ratio of Cost to Charges (RCC) derived from the last settlement processed. Each hospital shall, after the close of its own unique fiscal period, submit the Medicare Cost Report (CMS Form 2552) as required by Medicare, which is subsequently audited by the Medicare Fiscal Intermediary according to the Medicare auditing schedule and principles of reimbursement. Allowable costs are allocated to the outpatient services rendered to NH Medicaid recipients on Worksheet E-3, Part III. The current reimbursable amount of the costs is at 54.04% for acute care non-critical access hospitals and 91.27% for critical access hospitals and rehabilitation hospitals. The actual interim payments made during the cost period are compared to the reimbursable costs determined by audit and the difference is the settlement payable to the hospital or to the Department. The results of this review are reported by the fiscal intermediary to the Department and to each hospital. Settlements due to the hospitals are paid in accordance with the timely claims payment requirements of 42 CFR 447.45.

   For outpatient 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 the final rate paid as a percentage of costs, as described above in this section. 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 upper payment limit (UPL) for non-public, non-federal hospitals in accordance with principles of Medicare reimbursement, as required under relevant provisions of 42 CFR Part 447. The State then projects the aggregate Medicaid payments to be made for 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 known as the "UPL Gap," and an amount comparable to the estimated UPL Gap is distributed among all qualifying hospitals in an amount as set forth in the payment schedule on the following page numbered "page 1-attachment." The state determines the outpatient hospital-specific adjustment amount with consideration of the following factors: (a) the proportion of outpatient Medicaid services provided by the hospital relative to all hospitals' outpatient Medicaid services, (b) the relative degree to which each hospital's estimated Medicaid payments for CY 2010 contributed to the magnitude of the estimated UPL Gap; and (c) for critical access and rehabilitation hospitals, the extent to which other state compensation is available or unavailable for uncompensated care costs, or the degree to which the hospital's financial stability and ability to provide continuing access to care in a rural region warrants a relatively greater portion of the UPL Gap payments. The State ensures that the total combined Medicaid payments made under this section for outpatient 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

# PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

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

| Hospital Name | Outpatient Payment | | Hospital Name | Outpatient Payment |
|---|---|---|---|---|
| Androscoggin Valley Hospital | $440,367.59 | | The Memorial Hospital | $464,613.58 |
| Alice Peck Day Memorial Hospital | $39,124.47 | | Mary Hitchcock Memorial Hospital | $3,689,128.03 |
| The Cheshire Medical Center | $1,872,940.41 | | Monadnock Community Hospital | $289,635.17 |
| Catholic Medical Center | $3,115,245.21 | | Northeast Rehabilitation Hospital | $0.00 |
| Concord Hospital | $4,131,366.28 | | New London Hospital | $205,476.69 |
| Cottage Hospital | $86,147.46 | | Parkland Medical Center | $819,859.31 |
| Elliot Hospital | $5,088,236.21 | | Portsmouth Regional Hospital | $319,889.70 |
| Exeter Hospital | $1,330,897.79 | | Speare Memorial Hospital | $250,782.22 |
| Frisbie Memorial Hospital | $2,312,799.99 | | Southern New Hampshire Medical Ctr | $1,427,512.93 |
| Franklin Regional Hospital | $183,985.99 | | St. Joseph Hospital | $932,785.00 |
| HealthSouth Rehabilitation Hospital | $0.00 | | Upper Connecticut Valley Hospital | $0.00 |
| Huggins Hospital | $165,184.49 | | Valley Regional Hospital | $436,662.86 |
| Littleton Regional Hospital | $0.00 | | Wentworth-Douglass Hospital | $2,571,221.31 |
| Lakes Region General Hospital | $1,478,476.97 | | Weeks Medical Center | $159,954.16 |
| Total | | | | **$31,812,293.82** |

*Hospitals with $0.00 payment had no "room" under their hospital-specific upper payment limit

## PAYMENT RATES FOR ALL TYPES OF CARE OTHER THAN INPATIENT HOSPITAL, SKILLED NURSING, OR INTERMEDIATE NURSING CARE SERVICES

2. A) Freestanding Laboratory Services: Payment is made in accordance with a fee schedule established by the Department pursuant to NH RSA 161:4, VI. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the lesser of (a) the applicable fee schedule amount, or (b) the provider's usual and customary charge. Payment is made based upon laboratory CPT codes and the fee schedule. The laboratory fee schedule can be accessed at www.nhmedicaid.com/downloads/procedurecodes.html and is applicable to all public and private providers of freestanding laboratory services.

   B) Freestanding X-Ray Services: Payment is made in in accordance with a fee schedule established by the Department pursuant to NH RSA 161:4, VI. In accordance with NH RSA 126-A:3, III, no provider shall bill or charge the department more than the lesser of (a) the applicable fee schedule amount, or (b) the provider's usual and customary charge. Payment is made based upon radiological CPT codes and modifiers, and the fee schedule. The x-ray fee schedule can be accessed at www.nhmedicaid.com/downloads/procedurecodes.html and is applicable to all public and private providers of freestanding x-ray services.

3. Early and Periodic Screening, Diagnosis and Treatment: Payment is made in accordance with the methodology and time frames established for the particular service being rendered as described elsewhere in this attachment. For example, a laboratory service provided to an EPSDT recipient would be reimbursed as per the above. All fee schedules are accessible at www.nhmedicaid.com/downloads/procedurecodes.html and are applicable to all public and private providers.