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

MAR 08 2013

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

RE: New Hampshire SPA 11-005

Dear Mr. Toumpas:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 11-005. Specifically, this State plan amendment (SPA) suspends all direct medical education payments for two years following the effective date of this SPA. This SPA adds language to the state plan that outlines how the state will monitor access to Medicaid services in accordance with section 1902(a)(30)(A) of the Social Security Act (the Act). This amendment, which modifies the reimbursement methodology for inpatient hospital services, is approved by CMS for reasons stated below.

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 11-005 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. 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.

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.

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. CMS also notes that, with the inclusion of the monitoring plan description in the State plan for this SPA, there is an ongoing expectation that the State will review and intervene as soon as possible when the State's efforts indicate that there is an access issue. To the same extent, if CMS receives information from stakeholders, beneficiaries, or other data sources that suggests that access may be an issue, we will follow up with the state to determine if the state needs to take corrective action to ensure that access meets the statutory requirements.

The State provided metrics to demonstrate beneficiary access to care in accordance with section 1902(a)(30)(A) of the Act. These metrics 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 2011. 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 1902(a)(30)(A) at the time of this approval.

Our review of SPA 11-005 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 25, 2011 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 11-005 including the continued suspension of direct medical education for inpatient hospitals for two years after the effective date of the SPA. 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 11-005 is approved effective July 1, 2011.

We are enclosing the CMS-179 and the following amended plan pages.

- Attachment 4.19A, Page 2
- Attachment 4.19A, Page 4
- Attachment 4.19A, Supplement 1, Page 1

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

Sincerely,
/ s /

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: 11-005

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, 2011

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:
42 CFR 447, Subpart C; 447.250; 447:252; 1902(a)(13), 1902(a)(30)

7. FEDERAL BUDGET IMPACT:
($703,820) – FFY 2011
($2,815,280) – FFY 2012

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 1, page 1
Supplement 1, page 2
Attachment 4.19A, page 2
Attachment 4.19A, page 3
Attachment 4.19A, page 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
New page
New page
Attachment 4.19A, page 2, TN 10-004 pending
Attachment 4.19A, page 3, TN 10-006 pending
Attachment 4.19A, page 4, TN 10-011 pending

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Reimbursement – continued suspension of direct medical education, indirect medical education, and catastrophic payments.

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: 9/29/2011

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: MAR 08 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: [redacted]

22. TITLE: DEP. DIRECTOR, CMCS

23. REMARKS:
Pen & Ink Changes to boxes 7&9 per request from State

FORM HCFA-179 (07-92)

(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. 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, 2011 and ending June 30, 2013.

(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. However, day outlier payments shall be suspended beginning with March 1, 2010 discharge dates, except that this suspension shall not apply to claims for infants who have not attained the age of one year, and to claims for children who have not attained the age of six years.

(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 (IME) 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, except that IME payments shall be suspended for the state fiscal year 2012-2013 biennium.

(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. However, catastrophic payments will be suspended for the state fiscal year 2012-2013 biennium. Payment of eligible claims shall be determined by computing the total dollar amount of all hospitals' requests, determining each requesting hospital's total dollars requested as a percent of all requests, and applying that percent to the amount of money in the catastrophic fund in order to calculate payment to that hospital. 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:

(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, 2011 and ending June 30, 2013.

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.

ACCESS SUPPLEMENT

INVESTIGATION OF ACCESS ISSUES AND RESPONSIVE ACTIONS

The State of New Hampshire monitors access to care and produces an access report on a quarterly basis under its monitoring plan. New Hampshire Medicaid will continue to review and revise the monitoring plan itself to ensure the continued relevance of the selected indicators and to expand it over time to include other Medicaid benefits, including behavioral health, long-term care services, and managed care. The access monitoring plan is based upon a two-tier detection system. The first detection method is based on the systematic, ongoing monitoring that is used to address access issues that develop gradually over time. The second method is the real-time and individualized detection of discrete access issues that are generally handled by the Medicaid Client Services Unit.

Surveillance through systematic, ongoing monitoring is one method of detecting an access issue. The following situation in systematic reporting will trigger the deployment of an Access Response Team:

- A data point above the upper control limit or below the lower control limit, depending on the measure; or
- The current period data for a given measure deviates to a degree that the confidence interval does not overlap with the prior period's confidence interval.

Should a systemic access issue be detected through New Hampshire's quarterly access monitoring report, New Hampshire Medicaid would activate an Access Response Team to research the specific cause(s) of the problem and make recommendations for responsive action. The members of the Access Response Team would be drawn from several of the following functional areas: client services, financial management and reimbursement, benefits management, provider network management, and data analytics. The Team would be responsible for determining the cause of the access issue, proposing responsive actions, including assessing the need to make modifications to the access monitoring systems. The Medical Care Advisory Committee (MCAC) will serve as a resource to engage stakeholders in this process of resolving any identified access issue. The Team would then submit a proposed response for the review and approval by the State Medicaid Director and the Department's Medicaid Executive Team. The timing and nature of any responsive action taken will necessarily depend upon the particular nature, complexity and magnitude of the access problem identified and the beneficiary population affected, but responsive action plans will set a target date for resolution of the identified access issue; and, in all cases, the target date will be set sometime within one year of the date that the responsive action plan was approved by the Medicaid Executive Team. Possible responsive actions may include, but are not limited to:

- Resolving provider administrative burdens, such as claims submission and payment issues;
- Assisting beneficiaries in obtaining necessary primary or specialty care services through provider referral, transportation assistance, or enrollment in Medicaid Managed Care;
- Assessing and realigning covered benefits so that additional resources can be directed toward a resource-challenged area;
- Incentivizing the expansion of health care providers in underserved areas in the State; or
- Restructuring rates and targeting them to address the particular underserved areas.

ACCESS SUPPLEMENT

INVESTIGATION OF ACCESS ISSUES AND RESPONSIVE ACTIONS

(continued)

Surveillance by the Medicaid Client Services Unit is a second method of detecting any discrete events which create an access to care issue. This Unit manages a call center, providing ombudsman services to clients who need assistance, maintaining an up-to-date network reference guide, and offering referrals to providers upon request by any recipient or recipient representative, and providing transportation assistance and transportation reimbursement. The Unit is dedicated to resolving Medicaid recipient concerns on a real time, case-by-case basis. The client call tracking logs maintained on each of these individual responses to recipient concerns are a rich source of information about multiple discrete access issues; examination of these logs can assist in identifying indications of a trend across discrete access issues, which may require prompt intervention. New Hampshire has long had in place a toll free 800 number that beneficiaries can call for assistance. The phone number appears on the Medicaid member card, in the member welcome packet, and in all beneficiary communications and outreach materials. Should a discrete access issue be detected, NH would investigate facts directly from those providers implicated, analyze client impact, confirm alternative provider availability, and augment resources to the Client Services Unit to include additional staff and extended hours of operations if needed. Specific messaging to Medicaid beneficiaries potentially impacted would be issued as deemed necessary via media outlets, community network partners, and social media. A written synopsis of access issues identified in each quarter, if any, and New Hampshire Medicaid program's responses to them, is included in the following quarter's access monitoring report. Quarterly access monitoring reports are available under "Medicaid Access Monitoring" at www.dhhs.nh.gov/ombp/publications.htm.