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

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

MAR 08 2013

RE: New Hampshire SPA 11-006

Dear Mr. Toumpas:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 11-006. This state plan amendment (SPA) was submitted to eliminate supplemental payments authorized under SPA 10-011 for calendar year 2010 to non-public, non-federal acute care and rehabilitation inpatient hospitals. This amendment also amends the distribution of disproportionate share hospitals (DSH) to conform to the state's priorities, first, to critical access hospitals, and then to other eligible hospitals in the state. 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 & 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)..

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 11-006 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. 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

[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.

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 11-006 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 October 31, 2011 and on November 24, 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 two notices, the State adequately described the changes proposed under SPA 11-006 including the elimination of the supplemental payment methodology approved under the previous SPA 10-011 which were only authorized for calendar year 2010, and further prioritization of Medicaid DSH payments, first, to critical access hospitals, and then to other hospitals in the state. 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 11-006 is approved effective December 24, 2011.

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

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

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: 11-006

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
December 14, 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:
SSA 1923 and 42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
~~($89,615,996)~~ FFY 2011 $0
~~($87,979,137)~~ FFY 2012 $63,325,421

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, page 4.1
Attachment 4.19A, page 4-Attachment
Attachment 4.19A, page 5a
Attachment 4.19A, page 5b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A, page 4.1 ~~TN 11-005 pending~~
Attachment 4.19A, page 4-Attachment, ~~TN 10-011 pending~~
Attachment 4.19A, page 5a ~~TN 11-006 pending~~
~~none - new page~~ AM 4.19A, page 5b

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

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:
December 23, 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: DEC 14 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: [redacted]

22. TITLE: DEP. DIRECTOR, CMCS

23. REMARKS:
Pen + ink changes to blocks 7, 8 + 9 per request from State

FORM HCFA-179 (07-92)

10. (Reserved)

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:

(a) 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.

(b) 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 December 14, 2011, the DSH payment adjustment methodology shall be as follows. Non-public hospitals participating in Medicaid will receive a DSH payment adjustment if they (i) meet the qualifying criteria stated in (a) and (b) above, and (ii) meet the specifications in 1, 2, or 3 below.

The DSH payment adjustments detailed in 1, 2, and 3 below are contingent upon the availability of the DSH Allotment Funding.

1. Critical Access Hospitals: Each Critical Access Hospital (CAH) shall receive a DSH payment equal to the highest uniform percentage, but no greater than 100%, of the hospital's uncompensated care costs as available funding may allow, 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, Non-Public Hospitals: If sufficient funding is available, the DSH qualifying hospitals that are not public or critical access hospitals shall receive a DSH payment adjustment in an amount equal to the highest uniform percentage feasible in consideration of the total amount of funds made available in each year for reimbursement of uncompensated care costs. Each hospital's total uncompensated care costs are defined consistent with 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 in a year, less the total amount of payments received for uninsured patient services in a year. Any DSH amount payable under this paragraph is reconciled in a subsequent year to account for variances identified between projected uncompensated care costs and actual uncompensated care costs.

Disproportionate Share – Payment Adjustment

(continued)

3. "Deemed DSH" Hospitals: Any hospital that meets the criteria under 42 U.S.C. 1396r-4(b) shall be provided one of the following payment adjustments consistent with federal regulations and available funding as follows: (a) if the "Deemed DSH" hospital is a CAH, it will receive a payment adjustment in accordance with item #1. above; (b) if the "Deemed DSH" is not a CAH, it will receive the greater of (i) the payment adjustment available under item #2 above, or (ii) a payment in an amount which is proportional to the share of uncompensated care costs incurred by each such "Deemed DSH" relative to the amounts of uncompensated care costs incurred by all "Deemed DSH's" in the state in the relevant fiscal year.

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).

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