

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203



Division of Medicaid and Children's Health Operations / Boston Regional Office

March 8, 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 11-007

Dear Commissioner Toumpas:

Enclosed is a copy of approved New Hampshire State Plan Amendment (SPA) No. 11-007. This amendment was submitted to eliminate supplemental payments authorized under SPA 10-014 for calendar year 2010 to non-public, non-federal acute care and rehabilitation outpatient hospitals. 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 outpatient 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

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.” 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 SPAs and, applying our longstanding interpretation of Section 30(A), determined that the proposed payment rates are 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/omb/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 changes in SPA 11-007 are consistent with the requirements of Section 30(A). In that

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)..

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.

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 provide 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 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 these SPAs, 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 SPAs changes comply with section 1902(a)(30)(A) at the time of this approval.

Our review of 11-007 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 October 31, 2011 in newspapers of widest circulation within the state and identified a local agency where the proposed changes were available for public viewing. The public notice adequately described the changes proposed under SPA 11-007 which proposes to remove language previously approved under SPA 10-014 which authorized outpatient hospital payments up the Upper Payment Limit (UPL) for 2010 only. Additionally, the State estimated an aggregate budget neutral financial impact of the SPA due to the limited nature of the previously approved supplemental payments. 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 11-007 is approved effective December 14, 2011 as requested by the State.

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

- Attachment 4.19B, Page 1
- Attachment 4.19B, Page 1 Attachment
- Attachment 4.19B, Supplement 1, Page 1
- Attachment 4.19B, Supplement 1, Page 2

If you have any questions regarding this matter you may contact Joyce Butterworth at 617-565-1220 or by email at Joyce.Butterworth@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure

cc: Kathleen Dunn, State Medicaid Director
Diane Peterson, Medicaid Business and Policy