

PAYMENT FOR INPATIENT HOSPITAL SERVICES

The New Hampshire Department of Health and Human Services (the Department) shall make payment for inpatient hospital services, with the exception of governmental psychiatric hospital services, as follows:

1. A diagnosis related group (DRG) method of payment shall be used for all inpatient hospital services, except that in-state hospital pass through payments for capital costs shall not be paid.
2. The DRG relative weights shall be based on the Centers for Medicare and Medicaid Services (CMS) weights and grouper software published annually or periodically for Medicare in accordance with the requirements of 42 CFR 412.60, except that CMS weights shall not be used in the computations in 3 a (3) & (4) below.
3. Reimbursement shall be based on rates and amounts established by the Department in accordance with the following methodology:
 - a. Normal hospital operating costs shall be recognized and paid on a per discharge basis, and these payments shall be considered payment in full for such operating costs. Except where specifically noted otherwise, such payments shall apply to all hospitals—in-state, border, and out-of-state.
 - (1) Inpatient acute care services shall be paid a pre-determined price (in relation to a DRG with a relative weight equal to one; see 3.c. for calculation) associated with the DRG assigned by the Department, to each Medicaid hospital discharge, and this rate shall be uniformly applied, except as specified in (2), (3), (4), and (5) below.
 - (2) For in-state hospitals only, inpatient psychiatric care services shall be paid a pre-determined price associated with the applicable psychiatric DRG as assigned to each Medicaid discharge, but the price shall differ by the DPU or DRF peer group in which the facility is placed based upon severity of care.

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- (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, 2019 and ending June 30, 2021.
 - (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.

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- (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 2020-2021 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 2020-2021 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.

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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.nhmmis.nh.gov> (go to "documents and forms" under the "documentation" tab)

(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	=	\$7,200.00
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, 2019 and ending June 30, 2021.
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.

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10. (Reserved)

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11) Payment for high acuity, out-of-state pediatric specialty hospital inpatient services: When inpatient hospital services are provided to a New Hampshire Medicaid recipient in connection with a transfer or high acuity admission; *i.e.*, at a level of 5.0 or greater on the 3M All-Payer Refined Grouper version 26, to an out-of-state, non-Prospective Payment System (PPS) pediatric specialty hospital that (i) has entered into a Medicaid Provider Enrollment Agreement Addendum with the New Hampshire Department of Health and Human Services to provide tertiary and quaternary hospital care not otherwise sufficiently available within the State of New Hampshire, and (ii) had 200 or more hospital admissions of New Hampshire Medicaid recipients during hospital fiscal year 2011, such transfer or high acuity inpatient hospital services and the services associated with the transfer or high acuity inpatient episode of care, shall be reimbursed at a rate that approximates the cost of the service(s) rendered as follows:

- a. Rates shall be calculated by multiplying billed charges on qualifying claims, as set forth in the hospital or its physician organization's charge master (the standard charges established by any given hospital and/or associated physician organization for any particular service and presented to all payors), by a cost to charge ratio (CCR) of 61.9% which is determined from the Massachusetts Medicaid Cost Report.
- b. The costs associated with services eligible for high acuity payments are determined by the Department through utilization of charge data submitted by the provider as related to the provider's transfer and high acuity admissions.
- c. Providers will first be paid in accordance with the methodologies used to reimburse New Hampshire in-state acute care hospitals (as previously detailed in this Attachment 4.19-A). On a quarterly basis, the Department and the provider(s) shall identify and reconcile those services that are eligible to be reimbursed at a rate as determined by applying the cost to charge ratio of 61.9%. Providers shall have at least one full quarterly reconciliation period (90 days) following the date the initial claim was paid by the MMIS system to submit the necessary documentation to support the request for the high acuity payment. The Department will review the claim and pay providers the variance between actual MMIS payments and payments calculated by applying the CCR to actual charges as described above.
- d. "Transfer admission" means an admission of a New Hampshire Medicaid recipient transferred by ambulance or other emergency transportation from another in-state or out-of-state hospital.

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PAYMENT FOR INPATIENT GOVERNMENTAL PSYCHIATRIC HOSPITAL SERVICES

The New Hampshire Department of Health and Human Services (the Department) shall make payment for governmental psychiatric hospital services as follows:

Governmental psychiatric hospitals shall be paid daily board and care rates for inpatient acute psychiatric services. The daily rate shall be calculated by taking the general fund expenditures from the previous state fiscal year; less general fund capitalized expenditures; plus capital related costs of depreciation expense for buildings, movable equipment, and fixed assets and bond interest expense; plus statewide and department cost allocation expenses, and then allocating to departments based on the Medicare cost allocation step-down methodology. In addition to the above methodology, an inflation factor (if applicable) from the most recent data published by the CMS Market Basket Data Index will be applied to arrive at the daily rate.

The final costs of the inpatient daily rate will be calculated by dividing total stepped-down costs by not less than 90% of the total bed days available in each unit for the next state fiscal year.

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Attachment 4.19-A
Page 4b

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19(A)

X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A)

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) nursing facility services, 4.19(b) physician services) of the plan:

In accordance with 42 CFR 447.26(c), the Department assures that:

- (a) No reduction in payment for a provider preventable condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider;
- (b) Reductions in provider payment may be limited to the extent that the following apply: (i) the identified PPC would otherwise result in an increase in payment, and (ii) the State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the PPC; and
- (c) Non-payment for PPC's does not prevent access to services for Medicaid beneficiaries

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CMS Form: CMS-10364

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Health Care-Acquired Conditions and Other PPC (cont.)

Payment Method:

In order to determine the payment amount for inpatient hospital services under Attachment 4.19-A of this State Plan, the Department of Health and Human Services (the Department) will utilize the diagnoses and present on admission (POA) indicator submitted by providers on claims. The Department utilizes the MS-DRG grouper in its methodology to pay for inpatient hospital services. As such, the MS-DRG grouper will not consider hospital acquired diagnoses in the determination of the DRG payment amount.

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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.

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ACCESS SUPPLEMENT**~~REVISIONS TO ACCESS ISSUES AND RESPONSE 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/cmhp/publications.htm.

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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 those 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.

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Disproportionate Share – Payment Adjustment

The second type of payment adjustment is available to in-state, non-public general hospitals and certain specialty 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. In the case of a hospital located in a rural area (as defined in 42 U.S.C. 1395ww), 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.

The DSH payment adjustment methodology for this second type of DSH payment adjustment is detailed in 1, 2, and 3 below. Non-public hospitals participating in Medicaid will receive a DSH payment adjustment in an amount as specified in paragraphs 1, 2, or 3 below, subject to any applicable limits in paragraph 4 below; and, provided that they meet the qualifying criteria stated in items (a) and (b) above.

1. **"Deemed DSH" Hospitals:** Any hospital or specialty hospital in NH that meets the criteria under 42 U.S.C. 1396r-4(b) for "hospitals deemed disproportionate share" will receive a payment adjustment in an amount as follows:

(A) if the deemed DSH is a specialty hospital for rehabilitation or psychiatry, or a hospital that does not participate in the NH Medicaid Care Management program, or a hospital that qualifies for a Supplemental Access Payment under page 5c or 5d of Attachment 4.19-A, the DSH payment amount will be \$250,000, or a lesser amount if an amount less than \$250,000 is required to comply with the hospital-specific DSH limit under 42 U.S.C. 1396r-4(g);

(B) if the deemed DSH hospital is not a specialty hospital for rehabilitation or psychiatry, or a recipient of a Supplemental Access Payment under page 5c or 5d of Attachment 4.19-A, but is a critical access hospital that participates in the NH Medicaid Care Management program, the DSH payment amount shall be in accordance with paragraph #2 below; and

(C) if the deemed DSH hospital is not a specialty hospital for rehabilitation or psychiatry, but is a hospital without critical access designation that participates in the NH Medicaid Care Management program, the DSH payment amount shall be in accordance with paragraph #3 below.

Disproportionate Share – Payment Adjustment
(continued)

2. **Critical Access Hospitals:** Each Critical Access Hospital (CAH) that is not a specialty hospital for rehabilitation or psychiatry, or a recipient of a Supplemental Access Payment under page 5c or 5d of Attachment 4.19-A, and that participates in the provider network of the NH Medicaid Care Management program shall receive a DSH payment equal to 75% of the hospital's uncompensated care costs, except as further adjusted where applicable under the provisions of paragraph 4 below. "Uncompensated care costs" are calculated in accordance with the federal requirements of 42 U.S.C. 1396r-4(g) and any federal regulations promulgated by the federal oversight agency, the Centers for Medicare and Medicaid Services (CMS), further defining or interpreting such federal statutory requirements; and shall take into account any Supplemental Access or enhanced Medicaid rate payments received under Attachment 4.19-A. This payment amount is reconciled in a subsequent year to account for variances identified between projected uncompensated care costs and actual uncompensated care costs as determined by the independent certified audit performed pursuant to 42 CFR, Part 455, Subpart D.

3. **Other DSH Qualifying, Non-Public Hospitals:** Each DSH qualifying hospital that is not a critical access hospital or a specialty hospital for rehabilitation or psychiatry, but which does participate in the provider network of the NH Medicaid Care Management program shall receive a DSH payment adjustment in an amount proportional to, but not greater than, each such hospital's total allowable uncompensated care costs. For each hospital that meets the eligibility criteria under this paragraph 3, the funding and payment amounts shall be as follows, except as further adjusted pursuant to paragraph 4 below:

(A) Funding for State Fiscal and State Plan Year 2015 shall be \$34,355,739; each qualifying hospital under paragraph 3 shall receive a pro rata share of this funding in proportion to its total allowable uncompensated care costs.

(B) For State Fiscal and State Plan Years 2016 and 2017, each such hospital shall be paid 50% of its uncompensated care costs.

(C) For State Fiscal and State Plan Year 2018 and 2019, each such hospital shall be paid a pro rata share of the difference between (i) the maximum amount of DSH payments permitted for all qualifying hospitals for fiscal year 2018 and 2019, as specified in paragraph 4(B), and (ii) the total payments made in fiscal year 2018 and 2019, respectively, to critical access hospitals under paragraph 2; where each hospital's share is proportional to its relative share of total uncompensated care costs incurred by all hospitals qualifying under this paragraph 3.

4. Notwithstanding the provisions of paragraphs 1, 2, or 3 above:

(A) if in Fiscal Year 2016 or 2017, qualifying hospitals' total aggregate uncompensated care costs, as reported to the NH Department of Health and Human Services, is less than \$350 million, the State shall pay such hospitals not less than \$175 million in DSH payments, shared among such hospitals in proportion to the amount of uncompensated care costs incurred by each such hospital relative to the total; provided that New Hampshire hospitals with a critical access designation shall continue to receive reimbursements of no less than 75% of each such hospital's uncompensated care costs; and

(B) total statewide DSH payments to hospitals qualifying under this second type of DSH payment adjustment shall not exceed \$207,184,916 in Fiscal Year 2016, \$217,271,699 in Fiscal Year 2017, \$223,829,358 in Fiscal Year 2018, and \$215,083,692 in Fiscal Year 2019.

Supplemental Access Payment

The NH Department of Health and Human Services will make a Supplemental Access payment annually to those hospitals with critical access designation by the Centers for Medicare and Medicaid Services that also meet the “qualifying criteria” of this section as a Type I or Type II Access Hospital. Such access payments shall be made in addition to any other non-DSH Medicaid rate payments available to such qualifying hospitals under the provisions of Attachment 4.19-A of the NH State Plan. Hospitals receiving a Supplemental Access Payment under this section in any fiscal year shall not be qualified to receive a Disproportionate Share Hospital (DSH) payment in the same fiscal year unless such hospital meets the criteria for a Deemed DSH payment under page 5a, paragraph 1.(a) of this Attachment 4.19-A and said payment would not result in payments in excess of the hospital-specific DSH limit under 42 USC 1396r-4(g).

I. Type I - Essential Critical Access Hospital

A. Qualifying criteria for the Essential Critical Access Hospital, Type I:

- 1) The hospital is designated as a critical access hospital (CAH) in accordance with criteria established by the Centers for Medicare and Medicaid Services;
- 2) The hospital is the smallest CAH located in Coos County, as measured by net inpatient service revenue in fiscal year 2012;
- 3) The hospital has the highest ratio of Medicaid and uninsured charges to total charges in the state for state fiscal year 2012, as determined by the Department; and
- 4) The hospital has the highest ratio of uncompensated care costs to total operating costs in Coos County for state fiscal year 2012, as determined by the Department.

B. The Type I Supplemental Critical Access payment shall be made during the last fiscal quarter of each state fiscal year and shall reimburse 100% of the qualifying hospital’s estimated uncompensated care costs incurred in each state fiscal year, as determined by the state using the best available data at the time of the payment. For State Fiscal Year 2019, the amount of the Type I payment shall be \$4,014,097.

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Supplemental Access Payment
(continued)

II. Type II - Essential Maternity Access Hospital

A. Qualifying criteria for the Essential Maternity Access Hospital, Type II:

- 1) The hospital qualifies for the enhanced payments for maternity-related labor and delivery services payment under paragraph 3.a (5) at page 2 of Attachment 4.19-A in a fiscal year; and
- 2) The hospital has critical access designation by the Centers for Medicare and Medicaid Services.

B. The Type II Supplemental Access Payment shall be made once annually during the last fiscal quarter of each state fiscal year. For State Fiscal Year 2019, the amount of the Type II payment shall be \$6,599,165.

All Type I and Type II Supplemental Access Payments made under this section shall be included in the determination of total Medicaid payments made to the eligible hospital for purposes of determining the hospital's DSH limit, as defined by federal law at 42 USC 1396r-4(g). The State of New Hampshire will ensure that no hospital participating in the Medicaid program shall receive any DSH payment in excess of such federal limit.

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Inpatient Hospital Services
Public Process for Determination of Rates

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

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