

**Department of Health and Human Services**  
**DEPARTMENTAL APPEALS BOARD**  
**Appellate Division**

New Hampshire Department of Health and Human Services  
Request for Reconsideration of Decision No. 2399  
Ruling No. 2012-2  
October 14, 2011

**RULING ON REQUEST FOR RECONSIDERATION**

The New Hampshire Department of Health and Human Services (New Hampshire) requests reconsideration of the Board's July 13, 2011 decision in *New Hampshire Department of Health and Human Services*, DAB No. 2399 (2011). The Board's decision upheld a determination by the Centers for Medicare & Medicaid Services (CMS) disallowing \$35,325,468 in federal Medicaid funding claimed for disproportionate share hospital (DSH) payments to 24 private hospitals for fiscal year (FY) 2004.

Under the applicable regulations, the Board may reconsider its own decision "where a party promptly alleges a clear error of fact or law." 45 C.F.R. § 16.13. In cases involving Medicaid disallowances, a party has 60 days from the date of the Board's decision to request reconsideration. Social Security Act (Act) § 1116(e)(2)(B). New Hampshire argues that the Board upheld the disallowance on the basis of Medicare cost principles pursuant to a 1994 letter from CMS to State Medicaid Directors (1994 SMDL) and that doing so was a clear error of law. New Hampshire also argues that the Board committed a clear error of fact in finding that CMS had not previously accepted New Hampshire's methodology under a 2004 "global agreement" between the parties. CMS filed a brief opposing the reconsideration request. CMS argues that New Hampshire has not "requested the Board to reconsider the primary basis for its decision – i.e., that the State's methodology for calculating the . . . payments at issue was unreasonable." CMS Opposition Br. at 1. CMS further contends that New Hampshire's allegations of errors have no merit.

For the reasons explained below, we deny the request for reconsideration. The Board did not sustain the disallowance based on a limitation imposed by the 1994 SMDL, as New Hampshire contends. The Board held that the methodology New Hampshire used to determine the DSH payments was not reasonable under section 1923(g)(1)(A) of the Act and New Hampshire's Medicaid State Plan. Specifically, the Board found that New Hampshire's methodology resulted in

allocating, to Medicaid and uninsured patients, costs that (1) could not reasonably be considered costs of “furnishing hospital services” to those patients, as required by the statutory language about how to determine uncompensated care costs (UCC); and (2) were not allowable under the Medicare cost principles adopted in the State Plan. The Board further concluded that New Hampshire’s methodology to determine UCC was inconsistent with basic principles of cost allocation. New Hampshire does not allege any clear error in these conclusions, which are sufficient reasons for upholding the disallowance independent of the SMDL.

We also conclude that New Hampshire has not shown that the Board made a factual error. New Hampshire essentially reargues points it raised previously and proffers two additional declarations which are not newly-discovered evidence of the type warranting reconsideration. Even if we were to take these additional sworn statements into account, however, we would conclude that they do not show clear error in the Board’s finding regarding the alleged global agreement. The statements, which are after-the-fact recollections of negotiations between New Hampshire and federal officials from 2003-2004, are inconsistent with the contemporaneous documentation, which the Board reasonably determined was more inherently reliable than post-hoc statements.

**The decision contains no clear error of law regarding the 1994 SMDL or reference to Medicare cost principles.**

New Hampshire characterizes the Board decision as upholding the disallowance on the basis of Medicare cost principles pursuant to an instruction in the 1994 SMDL that “Medicare cost principles be applied to limit . . . Medicaid DSH payments.” Request for Reconsideration (RR) at 14. The provision in the SMDL cited by New Hampshire stated that—

in defining “costs of services” under [the hospital-specific DSH limit statute], [CMS] would permit the State to use the definition of allowable costs in its State plan, or any other definition, as long as the costs determined under such a definition do not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement.

NH Ex. 5, Att. at 3. New Hampshire contends that the Board relied on the provision’s ceiling on allowable “costs of services” to “invoke[] Medicare principles repeatedly” in support of its determination that New Hampshire’s “DSH calculations did not produce an appropriate measure of UCC.” RR at 8. According to New Hampshire, “[r]ecent court rulings, which became available after the close of briefing in this appeal,” support its argument that the SMDL’s limitation on Medicaid DSH payments by Medicare cost principles was a legislative rule, not an interpretive rule, and thus “was required to be promulgated . . . through notice-and-comment procedures.” *Id.* at 7-14. Consequently, New Hampshire contends, the Board “erred in applying Medicare cost principles to

conclude that the State’s Medicaid DSH payments were too high.” RR at 14. New Hampshire argues that under the Administrative Procedure Act (APA) and applicable precedent, the Board at a minimum should have vacated the disallowance and required CMS to reconsider the State’s Medicaid DSH payments “under prior Medicaid DSH law, without reference to the invalid application of Medicare cost principles as a cap on those payments.” RR at 14-15.

New Hampshire’s contentions mischaracterize the Board’s decision. The Board held that the DSH payments claimed by New Hampshire were excessive because the methodology on which New Hampshire relied to determine UCC was “not reasonable *under section 1923(g)(1)(A) of the Act and the State Plan.*” DAB No. 2399, at 5 (emphasis added). In reaching this conclusion, the Board found that New Hampshire’s methodology distributed to UCC costs that were unallowable under the language of the statute, which itself limits UCC to the “*costs incurred. . . of furnishing hospital services*” by the hospital to individuals who are eligible for Medicaid or who have no health insurance or other source of third party coverage, net of non-DSH Medicaid payments and payments by uninsured patients. *Id.* at 8; Act § 1923(g)(1)(A) (emphasis added). The Board explained that the legislative history of section 1923(g)(1)(A) clarified that the term “costs incurred . . . of furnishing hospital services” means the costs incurred by hospitals in furnishing “*inpatient and outpatient services* to Medicaid and uninsured patients.” DAB No. 2399, at 8-9, citing H.R. Conf. Rep. No. 103-213, at 835 (1993), *reprinted in* 1993 U.S.C.C.A.N. 1088, 1524 (emphasis added).

Applying the language of the statute, clarified in the legislative history, the Board determined that the cost-allocation methodology on which New Hampshire relied was unreasonable because, among other things, it distributed to UCC costs of advertising, gift shop, entertainment, and meals provided to visitors, which cannot reasonably be categorized as allowable inpatient or outpatient hospital services costs. DAB No. 2399, at 8-12. New Hampshire’s Request for Reconsideration does not allege that the Board erred in concluding that New Hampshire’s methodology allocated to UCC costs that were neither hospital inpatient nor hospital outpatient services costs, nor does New Hampshire identify any provision in the Act or legislative history to show that Congress intended to pay for those costs.

Furthermore, the Board’s decision to sustain the disallowance amount calculated by the Office of Inspector General (OIG), which adjusted the pool of allowable costs distributed to UCC (the numerator of the cost distribution ratio) using data collected from each hospital’s Medicare cost report, was not based on the 1994 SMDL. Rather, the Board upheld the calculation adjustment because New Hampshire’s own State Plan provided for Medicaid payments for inpatient and outpatient hospital services to be based on Medicare methodologies and principles. *Id.* at 11. In addition, New Hampshire failed to point to any other provision in its State Plan that allowed for inpatient or outpatient hospital services costs to include

the costs that the OIG identified as unallowable, and New Hampshire did not show that it had otherwise determined that a different definition of hospital services costs should be used to calculate DSH payments. *Id.* at 11, citing CMS Ex. 28, at 6; CMS Ex. 29; CMS Ex. 30, at 1. Indeed, the Board found, New Hampshire had abdicated to the New Hampshire Hospital Association the responsibility for calculating the hospital-specific DSH payment adjustments.

Accordingly, the Board found that “by including unallowable costs in the numerator of the cost-distribution ratio,” the methodology “impermissibly inflated the ratio and effectively allocated to UCC costs that exceeded the uncompensated ‘costs incurred . . . of furnishing hospital services’ to Medicaid and uninsured patients *under section 1923(g)(1)(A) and the State Plan.*” DAB No. 2399, at 12 (emphasis added). New Hampshire’s Request for Reconsideration does not deny that the State Plan called for the use of Medicare principles to calculate Medicaid payment amounts for inpatient and outpatient hospital services. Nor does the Request for Reconsideration allege that New Hampshire elsewhere specified an alternative definition of “costs of furnishing . . . hospital services,” for the purpose of calculating DSH payments.

Thus, the 1994 SMDL instruction that UCC may “not exceed the amounts that would be allowable under the Medicare principles of cost reimbursement” was not the legal basis of the Board’s decision. While the decision did address the SMDL provision, it did so primarily in response to New Hampshire’s contentions on appeal, as now, that the provision should have been implemented through notice and comment rulemaking and that upholding the disallowance based on the SMDL limitation would violate due process, which requires “clear notice to the State of the standards to which it is expected to conform its behavior.” *Id.* at 9, citing NH Br. at 18. In addition, the OIG and CMS cited the SMDL, as well as section 1923(g)(1)(A) and the State Plan, in support of the disallowance. The Board’s decision explained that the Board previously had held that the SMDL represented an official CMS interpretation of the relevant language of the statute, about which the states had timely notice, and that a federal court had concurred in the Board’s earlier determination. *Id.* at 10, citing *Virginia Dept. of Medical Assistance Services*, DAB No. 2084 (2007), *aff’d*, *Commonwealth of Virginia v. Johnson*, 609 F.Supp.2d 1 (D.D.C. 2009).

New Hampshire’s Request for Reconsideration essentially reargues the same points it made on appeal, with additional references to recent court rulings that, New Hampshire contends, support a conclusion that the SMDL created a legislative rule subject to notice and comment rulemaking under the APA. According to New Hampshire, these rulings “emphasize that ‘the real difference between interpretive and legislative rules is how tightly the rule is linguistically tied to the statute it purports to interpret’” and “make clear that ‘the agency’s characterization of its own rule,’ while relevant, is ‘not dispositive.’” RR at 10-12, citing *Alabama v. Ctrs. For Medicare & Medicaid Servs.*, No. 08-cv-881, 2011

U.S. Dist. LEXIS 16580 (M.D. Ala. Feb. 18, 2011) ; *Nat'l Res. Def. Council v. EPA*, 643 F.3d 311 (D.C. Cir. 2011). New Hampshire also cites a 1997 decision to support its argument that the SMDL limitation on UCC is a legislative or substantive rule subject to the APA notice and comment rulemaking requirement because it “adds to a legal norm based on the agency’s own authority.” RR at 9, citing *Syncor Int'l Corp. v. Shalala*, 127 F.3d 90, 95 (D.C. Cir. 1997).

The recent federal court decisions cited by New Hampshire did not introduce new legal standards but, as reflected in the decisions themselves, restated long-standing principles for determining whether a rule is interpretive or legislative. *Alabama*, 2011 WL 671676 at \* 7 (citing, *inter alia*, *Warshauer v. Solis*, 577 F.3d 1330, 1337 (11<sup>th</sup> Cir. 2009); *General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565 (D.C. Cir. 1984)(en banc); *Fertilizer Inst. V. EPA*, 935 F.2d 1303, 1308 (D.C. Cir. 1991)); *Nat'l Res. Def. Council*, 643 F.3d at 321 (citing, *inter alia*, *Am. Mining Cong. v. Mine Safety & Health Admin.*, 995 F.2d 1106, 1112 (D.C. Cir.1993)). Applying those principles here, we conclude that the Board did not clearly err in determining that the 1994 SMDL limitation, which was directly tied to the language of section 1923(g) of the Act, was an interpretive rule exempt from notice and comment rulemaking. In any event, even if we were to accept New Hampshire’s argument that the SMDL limitation on allowable costs was a legislative rule, that conclusion would not provide a basis for us to reconsider our decision. As discussed above, that decision was based on our determination that New Hampshire’s UCC methodology was unreasonable under New Hampshire’s own State Plan and the language of the Act itself, not the SMDL limitation.

We also find no merit in New Hampshire’s contentions that most of the Board’s “other objections to New Hampshire’s methodology . . . are tied to Medicare principles to some degree and cannot form independent grounds for the decision.” RR at 16-17, n.10. As noted above, the Board found that in addition to including unallowable costs, New Hampshire’s cost-allocation methodology used a distribution base (charges reduced by discounts and retroactive adjustments, or “net patient service revenue”) that did not bear a reasonable relationship to the costs distributed, and that applying that ratio to yet different bases skewed the allocation of costs to Medicaid and uninsured patients. According to New Hampshire, these findings are “inextricably intertwined with the faulty requirement that Medicaid DSH payments be capped by Medicare cost principles.” *Id.* New Hampshire argues that the “only authority cited as expressly requiring the use of gross charges rather than net patient revenues in the denominator of the ratio is the Medicare Provider Reimbursement Manual” (PRM). *Id.* New Hampshire also contends that the Board relied on inapplicable regulatory principles for determining costs applicable to research and development grants to hospitals (45 C.F.R. Part 74, App. E) to find that New Hampshire’s methodology was inconsistent with basic cost allocation principles. *Id.* at 16, n.10. New Hampshire maintains that its methodology was reasonable based on the flexibility states were afforded in developing UCC and New Hampshire’s

“perception that it costs more to provide a service to a patient who is uninsured or on Medicaid than it does to provide the same service to another patient.” *Id.* at 18.

To explain why the cost-to-net-charges distribution ratio that was applied to calculate the New Hampshire DSH payments was not reasonable under section 1923(g)(1)(A), the Board’s decision included a background discussion of basic cost-allocation principles. DAB No. 2399, at 6-7. The Board explained that a ratio may be used to distribute a pool of costs among various cost objectives (such as services to various groups of patients) where the pool of costs bears a rational relationship to a quantifiable distribution base. The Board further explained that use of such a ratio is appropriate if the numerator of the ratio (total costs to be allocated) bears roughly the same relationship to the denominator of the ratio (distribution base) as the unknown subset of the costs related to any specific cost objective bears to the part of the distribution base that is identifiable to that cost objective. In support of this general discussion and to illustrate basic cost allocation principles, the Board cited provisions in the regulations at 45 C.F.R. Part 74, Appendix E (Principles for Determining Costs Applicable to Research and Development Under Grants and Contracts With Hospitals). In addition, the Board referred to the Medicare regulations and the PRM provision to illustrate that use of a cost-to-charge ratio to apportion allowable costs of services among different groups of hospital patients is premised on the existence of a correlation between the allowable costs of furnishing services to patients (the numerator of the ratio) and what the hospital charges for those services (the denominator). The Board also pointed out that a report submitted by New Hampshire concluded that the “literature on hospital costs has shown that costs calculated using the RCC method [applying ‘hospital-level ratios of costs to charges that hospitals report each year to . . . CMS in their official Cost Reports’] are a good approximation for true costs when groups of patients are compared.” *Id.* at 14; NH Ex. 16, at 1, 4.

Applying the basic principles underlying the use of cost-allocation ratios to the methodology at issue, the Board concluded that the methodology was unreasonable because the distribution base of the allocation ratio did not bear a reasonable relationship to the costs distributed. In addition, the application of the ratio determined using one set of costs in the distribution base to different bases (for Medicaid patients and for uninsured patients) skewed the allocation of costs to Medicaid and uninsured patients. Thus, while the decision referred to the cost-allocation provisions for hospitals at 45 C.F.R. Part 74, Appendix E, as well as the Medicare regulations and PRM on the use of cost-to-charge ratios, the Board’s findings were not “inextricably intertwined” with the 1994 SMDL’s limitation on allowable costs, as alleged by New Hampshire. Furthermore, New Hampshire’s Request for Reconsideration alleges no error in the Board’s conclusion that reducing hospital charges by discounts and retroactive adjustments for use in the distribution base of a cost-allocation ratio would distort the apportionment of costs. Nor does New Hampshire cite to any principles of cost allocation that differ from the principles on which the Board relied and which are based on logic. In

sum, New Hampshire's Request for Reconsideration does not show clear error in the decision's discussion of the basic principles underlying the use of cost-allocation ratios or in the Board's conclusion that New Hampshire's methodology was inconsistent with those principles.

New Hampshire's Request for Reconsideration also fails to cite to any other authority to show that costs calculated through the use of "net patient service revenue" in the distribution base, applied to different bases to determine costs relating to Medicaid and uninsured patients, reasonably approximated UCC. New Hampshire argues that "its methodology was reasonable in light of [the flexibility available under the statute] and the State's perception that it costs more to provide a service to a patient who is uninsured or on Medicaid than it does to provide the same service to another patient." RR at 18. New Hampshire points to no specific language in the statute affording New Hampshire the flexibility to adopt the methodology it used. As explained in the Board's decision, moreover, New Hampshire provided no evidence to show that the additional costs of treating Medicaid and uninsured patients would not be sufficiently accounted for through a hospital's own charge structure and system of itemizing services. Nor did New Hampshire show how the use of net patient service revenue in the denominator of the allocation ratio would equitably quantify the allegedly higher costs of providing a service to a Medicaid or uninsured patient than to another patient.

In sum, the Board's decision did not, as New Hampshire contends, hold "that the State need[ed] to employ the most reliable method conceivable" to calculate UCC. *Id.* Rather, the Board held that New Hampshire failed to show that the methodology it did use was reasonable, based on substantiated assumptions, and rationally apportioned allowable inpatient and outpatient hospital costs to identify the uncompensated costs of furnishing hospital services to Medicaid and uninsured patients under section 1923(g)(1)(A).

**The decision contains no clear error of fact in finding that CMS had not previously approved New Hampshire's DSH payment methodology.**

New Hampshire contends that the Board committed a factual error in finding that CMS had not previously approved the DSH payment methodology under a 2004 "global agreement" relating to New Hampshire's DSH program. New Hampshire previously submitted a declaration by James P. Fredyma, the Controller of the New Hampshire Department of Health and Human Services, to support its contention that CMS was aware of the State's methodology and approved of it, as "confirmed in the course of negotiations between high-level Federal and State officials in the 2003-2004 timeframe." Fredyma Decl. ¶ 14. During this period, Mr. Fredyma stated, "CMS personnel closely reviewed various aspects of New Hampshire's DSH calculations and required certain changes following a sunset date, but did not question the ratio the State used to calculate [UCC]." *Id.* After

“meetings among high-level State and federal officials,” Mr. Fredyma stated, the parties reached a “global agreement” under which, among other things, “the general hospital DSH program would continue ‘as is’ through June 30, 2005, with changes to occur beginning July 1, 2005.” *Id.* ¶ 25. Mr. Fredyma stated, “Particularly in light of the sunset clause that CMS requested and approved in TN 03-004, DHHS understood that, in keeping with the usual significance of such clauses, it could continue to use its existing DSH methodology for FFY 2004, without risk of a retroactive disallowance.” *Id.* ¶ 31. “If CMS in 2004 had had concerns with the payment methodology,” Mr. Fredyma added, New Hampshire “reasonably understood that CMS would have expressed such concerns.” *Id.*

New Hampshire argues in its Request for Reconsideration that the Board’s finding that CMS had not previously approved New Hampshire’s DSH payment methodology was clearly erroneous because “CMS provided no evidence to rebut [the Fredyma] declaration.” RR at 3. New Hampshire proffers two additional declarations, by a former Governor, Craig Benson, and a former Commissioner of the New Hampshire Department of Health and Human Services, John Stephen, to “eliminate any uncertainty about the nature of the 2004 settlement with CMS.” *Id.*; NH Exs. 26-27. New Hampshire also contends that the evidence regarding the State officials’ understanding of the scope of the settlement is “particularly compelling” given the additional, “unrebutted” evidence “showing that CMS, through its on-site representatives, knew or should have known all material details of the State’s methodology for calculating UCC.” RR at 5; *see* NH Br. at 10-12, NH Reply Br. at 9-10.

Reconsideration of a decision is not a routine step, but a means for the parties and the Board to point out and correct any error that makes the decision clearly wrong. Under this standard, reconsideration in general “will not be granted to address an issue that could have been raised before, but was not, or to receive additional evidence that could have been presented to the Board before it issued its decision, but was not.” *Ruling on Request for Partial Reconsideration of DAB No. 2103, Alaska Department of Health and Social Services, Ruling No. 2008-1, at 4 (2007).*\* Here, New Hampshire essentially reargues points that were raised and addressed previously, and has not shown that the additional two declarations could not have been presented to the Board before it issued its decision. While the declarations are dated after the decision, New Hampshire does not explain why it was not aware of or was unable to obtain the statements of these witnesses in a timely fashion. Thus, we conclude that these declarations are not newly-discovered evidence of the type warranting reconsideration.

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\* This standard is similar to the one applied under Federal Rule of Civil Procedure 59(e), which authorizes a motion to alter or amend a judgment. In general, Rule 59(e) motions are granted only to correct manifest errors of law or fact, or to consider newly discovered or previously unavailable evidence. *See* Wright, Miller & Kane, 11 *Federal Practice and Procedure* 2d § 2810.1. The Federal Rules are not controlling here, however.



Even if we were to take into account the additional sworn statements, however, we would conclude that New Hampshire has not shown a clear error of fact in the Board's decision. The Benson and Stephen Declarations, like the Fredyma Declaration, consist of after-the-fact recollections of the officials' intentions entering into and during the 2003-2004 negotiations, as well as their recollections of the substantive discussions. The sworn statements also reflect the declarants' understanding of the scope of the oral agreement that was reached -- that the agreement would preclude *any* retroactive adjustment to federal DSH funds received by the State prior to making the prospective changes, "regardless of the degree to which the parties had focused on any particular issue during the negotiations." Stephen Decl. at ¶ 11; *see also* Benson Decl. at ¶¶ 11-14.

The declarants' stated understanding of the breadth of the agreement lacks support in the contemporaneous written documentation, which the Board finds more inherently reliable than the declarants' post-hoc statements. The contemporaneous documentation, which CMS submitted to rebut New Hampshire's contentions as to the all-encompassing scope of the agreement, shows that in the course of reviewing several proposed state plan amendments (SPAs) during the 2003-2004 period, CMS representatives did take "the opportunity to raise issues *outside* the scope of those amendments," as New Hampshire alleges. RR at 2; CMS Exs. 21-25. As reflected in the documentation, however, the issues discussed focused on New Hampshire's Medicaid Enhancement Tax (MET) and did not include the hospital-specific DSH payment methodology at issue here. CMS Exs. 21-25. For example, SPA TN 03-004, which included the "sunset provision" referenced repeatedly by New Hampshire, addressed an increase in the hospital-specific limit for the state-owned psychiatric hospital and reflected an agreement between CMS and New Hampshire that effective July 1, 2005, New Hampshire would not apply the DSH payment cap of six percent of gross patient services revenue (the basis of the MET). NH Ex. 13; CMS Ex. 22. Neither the SPA, nor any other contemporaneous document, mentions the methodology New Hampshire used to calculate UCC for the general and rehabilitative hospitals at issue here.

Moreover, none of the contemporaneous documents indicates that CMS had comprehensively analyzed every facet of New Hampshire's DSH program or that the "handshake agreement between Governor Benson and Secretary Thompson" involved a blanket promise precluding CMS from taking a retroactive disallowance relating to an issue not identified during the discussions. CMS Ex. 24 (January 30, 2004 letter from John A. Stephen to Mark Cooley, CMS). To the contrary, in the February 20, 2004 CMS notice to New Hampshire of the approval of SPA TN 03-004, CMS explicitly stated that it "reserves the right to perform a financial management review at any time to ensure that the State funds and makes DSH payments in accordance with sections 1902, 1903 and 1923 of the Act." CMS Ex. 22. In light of this clear written notice to New Hampshire limiting the scope of the agreement reached, and the lack of any contemporaneous written evidence to support the declarants' post-hoc statements about the scope of the

agreement, we conclude that the Board did not commit a clear error of fact in finding that the agreement reached did not preclude this disallowance.

Finally, we reject New Hampshire's contention that the Board clearly erred in finding that CMS had not approved the DSH methodology because on-site CMS representatives knew or should have known every material detail of the methodology based on the documents provided to them. According to New Hampshire, the documents provided "reveal the very details of the State's calculations challenged by CMS and the [OIG]." RR at 5. This assertion is belied by the fact that New Hampshire officials themselves were unable to fully explain and verify the information on the same documents and "did not fully understand all material aspects of the FY 2004 DSH payment calculations at the time the payments were made," as the Board found and New Hampshire does not deny. DAB No. 2399, at 15-16, *citing* CMS Exs. 1; 9, at 4-5. New Hampshire also does not deny that the documentation was misleading because it referred to a "Ratio of Costs to Charges" and failed to indicate that the cost data reported by the hospitals included costs such as the costs of advertising, running a gift shop, and providing meals to visitors. Moreover, while New Hampshire argues that "the whole purpose of having CMS representatives on-site at State Medicaid offices presumably is to monitor for compliance and raise issues so that they can be timely addressed" (RR at 6), New Hampshire has not shown that the unidentified CMS on-site representatives had any responsibility for evaluating New Hampshire's DSH payment methodology. In sum, New Hampshire's reconsideration request fails to show that the Board made a clear error in finding that the evidence failed to show that CMS had approved the DSH payment methodology prior to issuing the disallowance.

### **Conclusion**

For the reasons stated above, we deny the reconsideration request.

/s/

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Leslie A. Sussan

/s/

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Constance B. Tobias

/s/

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Judith A. Ballard  
Presiding Board Member