DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

January 30, 2013

Our Reference: SPA LA 12-64

Ms. Ruth Kennedy, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

Attention: Darlene York
Keydra Singleton

Dear Ms. Kennedy:

We have reviewed your request to amend the Louisiana State Plan submitted under Transmittal No. 12-64, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on November 2, 2012. This amendment is to revise the reimbursement methodology for outpatient hospital services rendered by privately owned and non-state publicly owned hospitals to establish supplemental Medicaid payments to encourage them to take over the operation and management of state-owned and operated hospitals that have terminated or reduced services.

We conducted our review of your submittal according to the applicable federal regulations and guidelines. Before we can continue processing this amendment, we need additional or clarifying information. Since the plan is the basis for Federal financial participation, it is important that the plan's language be clear and unambiguous. Therefore, we have the following questions/concerns regarding TN 12-64.

FORM-179

1. Form 179 - Box 7: No financial impact is noted due to the proposed revisions. Please provide a response and/or a detailed analysis of how this determination was made and provide supporting documentation of the calculation.

2. Please explain why the State proposes an effective date of November 1, 2012 when no agreements have been signed.

AGREEMENTS

3. CMS must have copies of all signed standard Cooperative Endeavor Agreements. In addition, please provide copies of all signed Intergovernmental Transfer (IGT),

management agreements, MOUs, management contracts, loan agreements, and any other agreements that would present the possibility of a transfer of value between the two entities.

CMS has concerns that such financial arrangements can be interpreted as a non-bona fide provider donations as described in federal statute and regulations.

Detailed information needs to be provided to determine whether the dollar value of the contracts between private and public entities had any fair market valuation. There can be no transfer of value or a return or reduction of payments reflected in these agreements.

Additionally, whether the State is a party to the financial arrangement or not, the State is ultimately responsible to ensure that the funding is appropriate. The State would be responsible for refunding any FFP if CMS finds the funding source inappropriate.

Please note that these agreements are needed before we can approve TN#12-62, TN#12-63, and TN#12-64.

4. Did the State receive any feedback or complaints from the public regarding the Cooperative Endeavor Agreement? If so, what were the concerns and how were they addressed and resolved?

PUBLIC NOTICE

5. Please provide information demonstrating that the changes proposed in SPA 12-62, 12-63, and 12-64 comport with public process requirements at section 1902(a)(13)(A) of the Social Security Act (the Act). Please provide copies of the legislation authorizing the proposed changes.

INTERGOVERNMENTAL TRANSFERS

6. How many entities does the State anticipate will participate in this arrangement? Please submit a list of all participating hospitals, all transferring entities doing the IGT, and the dollar amount that the transferring entities will IGT. Please describe how the hospitals are related/affiliated to the transferring entity and provide the names of all owners of the participating hospitals.

7. What is the source of all funds that will be transferred? Are they from tax assessments, special appropriations from the State to the county/city or some other source? Please provide the county/city legislation authorizing the IGTs.

8. Does the state agree to provide certification from the transferring entities that the Intergovernmental Transfers (IGTs) are voluntary?

9. Section 1902(a)(2) of the Act provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please explain how this proposal complies with this provision.

10. What are the sources of IGT funds (for example: tax revenues, loan or other)? Please demonstrate that the State has permissible sources of funding under 1903(w)(6)(A).

UPPER PAYMENT LIMIT (UPL)

11. Upper Payment Limit (UPL) Demonstration – Regulations at 42 CFR 447.321 require that payments in the aggregate will not exceed a reasonable estimate of what Medicare would pay for similar services. Please provide a UPL demonstration applicable to the payments for the current rate period (i.e. SFY 2013). The UPL demonstration should include a comprehensive narrative description of the methodology (step by step) used to determine the UPL. The demonstration should also include a spreadsheet with provider specific information that starts with the source data and identifies the numerical result of each step of the UPL calculation. All source data should be clearly referenced (i.e., cost report year, W/S line, columns, and claims reports, etc…) in the demonstration. The State should also keep all source documentation on file for review.

12. Please include a detailed narrative description of the methodology for calculating the UPL in the state plan language.

EFFICIENCY, ECONOMY, AND QUALITY OF CARE

13. SPA amendments LA 12-062, 12-063, and 12-64 propose to establish supplemental payments for private-public partnerships. Section 1902(a) (30) (A) of the Act requires that payment rates must be consistent with "efficiency, economy and quality of care." Please justify how the establishment of payments when no contracts have been signed is consistent with the principles of "efficiency, economy, and quality of care."

SIMPLICITY OF ADMINISTRATION

14. Section 1902(a) (19) of the Act requires that care and services will be provided with "simplicity of administration and the best interest of the recipients." Please explain why these amendments are consistent with simplicity of administration and in the best interest of the recipients.

LEGISLATION

15. Please clarify if the State or a Hospital Service District has issued any proposals or enacted any legislation to support the public-private partnerships. Please submit that documentation for our review.

STATE PLAN LANGUAGE

16. The reimbursement methodology outlined on page 4.19-B simply states that supplemental payments will be made on a quarterly basis in accordance with 42 CFR 447.321. This methodology is not comprehensive.

To comply with regulations at 42 CFR 447.321, please amend the State plan language to include a detailed description of the method that will be used to determine the proposed supplemental payments. The state plan methodology for the supplemental outpatient hospital service payments need to be comprehensive based upon services rendered or a quality indicator. Supplemental payments can only occur after a Medicaid service has been rendered. The reimbursement methodology must be based upon actual historical utilization and actual trend factors. In addition, the methodology must account for 1) the available UPL room and 2) the limitation to charges per regulations at 42 CFR 447.321.

17. The State plan methodology must be comprehensive enough to determine the required level of payment and the FFP to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Claims for federal matching funds cannot be based upon estimates or projections. Please add language that describes the actual historical utilization and trend factors utilized in the calculation.

18. The plan language indicates that payments will be made quarterly. Is the UPL calculation done on a quarterly basis or is it an annual calculation of which a fourth will be distributed on a quarterly basis? Please revise the plan language to indicate when during the quarter that payments will be made.

ADDITIONAL

19. Are the hospitals required to provide a specific amount of health care service to low income and needy patients? Is this health care limited to hospital only or will health care be provided to the general public? What type of health care covered services will be provided?

20. How did the State determine that the Medicaid provider payments are sufficient to enlist enough providers to assure access to care and services in Medicaid at least to the extent that care and services are available to the general population in the geographic area?

21. How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address these concerns? Was there any direct communication (bulletins, town hall meetings, etc.) between the State and providers regarding the reductions proposed via this amendment?

22. Is the State modifying anything else in the State Plan which will counterbalance impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?

23. Over the last couple of years, Louisiana has both increased and decreased rates for inpatient hospitals. What is the cumulative, net impact of the rate reductions and increases for inpatient hospitals services since SFY 2008?

24. Please provide a list of facilities closings and services that are being cut by LSU.

FUNDING QUESTIONS

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If

supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

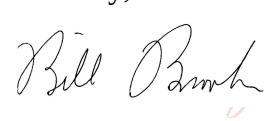
5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

We are requesting this additional/clarifying information under provisions of Section 1915(f) of the Social Security Act. This has the effect of stopping the 90-day time frame for CMS to take action on the material. A new 90-day time frame will not begin until we receive your response to this request.

In accordance with our guidelines to all State Medicaid directors dated January 2, 2001, if we have not received the State's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment.

If you have any questions regarding this letter, please contact Ford Blunt at 214-767-6381 by phone or by email at ford.blunt@cms.hhs.gov.

Sincerely,



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Bill Brooks
Associate Regional Administrator