Informal Request for Additional Information (IRAI)

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 14-025. This amendment proposes to amend the provisions for governing disproportionate share hospital (DSH) payments in order to establish payment for Louisiana Low Income Academic Hospitals.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the regulations at 42 CFR 447 Subpart C and E. Before we can continue processing this amendment, we need additional or clarifying information.

The regulation at 42 CFR 447.252(b) requires that the State plan include a comprehensive description of the methods and standards used to set payment rates. Section 6002 of the State Medicaid Manual explains further that the State plan must be comprehensive enough to determine the required level of Federal Financial Participation (FFP) and to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Further, since the plan is the basis for FFP, it is important that the plan's language be clear and unambiguous. Therefore, we have the following questions/concerns regarding TN 14-025:

FORM-179

1. Form 179 - Box 7: A financial impact was noted. The federal dollar amounts were $508 million for FFY 2014 and $460 million for FFY 2015. Please provide a detailed analysis by facility of how this determination was made, and provide supporting documentation of the calculation. Does the State anticipate these estimate amounts will be offset by what the public hospitals would have claimed?

STATE PLAN LANGUAGE

2. Please note that this methodology is not comprehensive. To comply with regulations at 42 CFR 447.252(b), 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.

   The proposed DSH payment methodology on Attachment 4.19-A, Item 1 page 10k(4) is not comprehensively described. Please add language that fully explains how 100 percent of uncompensated costs are to be calculated and how the annual payment amount will be determined. The plan language should fully describe the cost and patient specific data the hospitals are required to submit, what time period the data is to be from, and when the data is to be submitted by the hospitals. The plan language should also fully describe how the Department will review costs and lengths of stay for reasonableness, how the costs and lengths of stay will be determined to be reasonable, and how the results of the reasonableness review will be used to adjust payments.

3. Will the DSH payments be made annually or quarterly? This must be specified in the plan language.

4. The State should include language to ensure that a hospital does not exceed their hospital specific limit.

5. CMS wants the State's assurance regarding financial transactions including intergovernmental transfers (IGT). The following sentence should be included in the reimbursement methodology:

   "No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity."

6. Please clarify the following:
   a. Does the proposal in Attachment 4.19-A, Item 1 page 10d and Item 1 page 10k(4), apply to private, State and/or Non-State hospitals?
   b. Please provide a list that includes the name, the type (private, State, or Non-State), and the address of the Louisiana Low Income Academic Hospitals that will qualify for DSH payments under proposed TN#14-25.
   c. Please clarify if any of the Louisiana Low Income Academic Hospitals currently receive DSH payments.
   d. Will these new DSH payments have any effect on DSH payments currently received by Louisiana Low Income Academic Hospitals?
   e. Does the State have enough room in their annual DSH allotment to make payments to the Louisiana Low Income Academic Hospitals for FFY 2014?
   f. Based upon current regulation, the overall annual DSH allotment will decrease in 2015. Does the State have a plan on how it will handle a decrease in its allotment?
   g. Are the DSH payments proposed under the SPA limited to the hospitals that were to receive either supplemental and/or DSH payments under LA SPAs 13-23, 13-25, and 13-28.
      i. If yes, why are DSH payments not being made available to other hospitals that have an uninsured patient utilization of "greater than 10 percent" or "greater than 20 percent" as described in the proposed Low-Income Academic Hospital criteria?
      ii. If no, what is the relationship between these additional hospitals that will now qualify to receive DSH payments and Louisiana State University?
   h. Please describe any SPA submissions, planned, or under consideration by the State, that are associated with the privatization of Louisiana State University (LSU)?

7. Attachment 4.19-A, Item 1 page 10d item k, states the following:

   "Effective for dates of service on or after January 21, 2010, be a hospital participating in the Low Income and Needy Care Collaboration; <u>or</u>"

   Please explain how the State's inclusion of payments in Attachment 4.19A targeted to providers participating in Low Income and Needy Care Collaborations comports with the May 9, 2014 State Medicaid Director's Letter #14-004, Accountability #2 Financing and Donations.

FUNDING QUESTIONS

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your State plan, including payments made outside of those being amended with this SPA. Please be aware that some of the questions have been modified. If you have already provided this information in response to other requests for additional information, you may refer us to that response. Please indicate the SPA and date of the response.

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 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 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 government 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 FFP 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. 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?