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

June 1, 2015

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

RE: Louisiana 15-0004

Dear Ms. Kennedy:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-0004. The purpose of this amendment is to establish supplemental inpatient hospital payments to qualifying children's specialty hospitals in the New Orleans area.

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. 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 15-0004:

FORM-179

1. Form 179, Block 7 – Please provide a detailed analysis of how the zero impact determination was made and provide supporting documentation for Federal Fiscal Year (FFY) 2016 and 2017.

EFFICIENCY, ECONOMY, AND QUALITY OF CARE

2. SPA amendment LA 15-0004 proposes to establish supplemental inpatient hospital payments to qualifying children's specialty hospitals in the New Orleans area. 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 is consistent with the principles of "efficiency, economy, and quality of care."

SIMPLICITY OF ADMINISTRATION

3. 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 this amendment is consistent with simplicity of administration and in the best interest of the recipient in the New Orleans area.

LEGISLATION

4. Please clarify if the State, Parish, or a Hospital Service District has issued any proposals or enacted any legislation to support the new supplemental payments methodology for non-rural non-state hospitals in the New Orleans area. Please submit that documentation for our review.

UPPER PAYMENT LIMIT (UPL)

5. Please note CMS has not received a "clean" SFY 2014 UPL demonstration calculation.

   Additionally, there is an outstanding deferral for Inpatient Hospital supplemental payments in the amount of $10,094,583 Federal Financial Participation (FFP). The deferral was issued because the State submitted a revised SFY 2014 UPL demonstration that "zeroed out" column H and I for Children's Hospital in New Orleans. This is not a reasonable estimate.

   Please note that CMS must have a "clean" SFY 2014 UPL prior to CMS taking action on the SPA 15-0004.

STATE PLAN LANGUAGE – 4.19-A

6. Please clarify if there are one or more hospitals that qualify under this methodology. If only one hospital qualifies, then please correct Attachment 4.19-A, Item 1, page 8c (7) to reflect that only one hospital will qualify under this methodology.

7. Is this facility a non-state or private acute care hospital? Please add clarifying language on the State plan page that specifies the type of hospital and if it is state, non-state or private hospital.

8. 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.

Currently, the State uses the DRG methodology to determine the Medicare equivalent for all the hospitals in the "private bucket" except for the Children's Hospital in New Orleans. It appears some sort of cost method was utilized in the revised UPL demonstration for State Fiscal Year (SFY) 2014. Currently, the State's treatment of Children's Hospital in New Orleans is inconsistent with a reasonable Medicare estimate. Therefore, the methodology for TN#15-0004 must be specific. There should be step by step instructions that a provider could follow. For example,

- How will the State assign a neonatal Medicaid case to the Medicare DRG?
- What fiscal year (FY) are the cost reports?
- Will the State use filed or audited cost reports?
- What columns will be pulled from the cost reports? Where the data was obtained? MMIS or another system
- How the data will be calculated?
- How will the acuity level information be used?
- What inflation factor will the State use? The State must list the web-site on the plan page.
- Will the State adjust the inflation factor every year?
- How will the State adjust for managed care?
- Please note that language should be added that that UPL demonstration is an annual calculation.

9. CMS has concerns with the appearance of contingent funding proposed in the plan language. To comply with regulation at 42 CFR 447.252(b), please review the state plan pages to remove any language pertaining to payments based upon the availability of funding.
   For example, it mentions "the budgeted state fiscal year supplemental payment amount included in the Annual Appropriations Act as allocated to this specific program in the budget spread pursuant to the Department's reimbursement policy". The State should include specific language in the proposed State plan pages.

10. CMS wants the State's assurance regarding financial transactions including 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."

11. Did the State receive any feedback or complaints from the public regarding the current proposal or about the changes to children's specialty hospitals in the New Orleans area arrangements? If so, what were the concerns and how were they addressed and resolved?

12. Please justify why Louisiana needs to pay supplemental payments to children's specialty hospitals in the New Orleans area.

13. Why do these payments need to be made to these specific providers?

14. Why has Louisiana decided to target children's specialty hospitals in the New Orleans area to the exclusion of other providers of the same services?

15. Does the state expect that these payments will positively impact access to care or quality of care?

16. If it is to improve access, please provide data that shows there is an access issue.

17. What outcome does the state hope to achieve by targeting payments to children's specialty hospitals in the New Orleans area?

18. Will the state monitor the impact of the supplemental payments with respect to the expected outcomes?

19. How will the state measure if targeting payments resulted in the desired outcome?

20. How do the supplemental payments compare to the base payments?

21. Has the State done any analysis to increase the base payments to children's specialty hospitals in the New Orleans area?

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.

22. 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.)

23. 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).

24. 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.

25. Please provide a detailed description of the methodology used by the state to estimate the 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.

26. 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?

In accordance with our guidelines to 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.

We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material. A new 90-day clock will not begin until we receive your response to this request.

Please submit your response to the following address:

Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health Operations
Dallas Regional Office
Attention: Bill Brooks
1301 Young Street, Suite 833
Dallas, Texas 75202

If you have any questions, please contact Tamara Sampson, of my staff, at (214) 767-6431 or by e-mail at Tamara.Sampson@cms.hhs.gov

Sincerely,

Bill Brooks
Associate Regional Administrator
Division of Medicaid and Children's Health Operations