Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

July 08, 2015

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

Dear Bill:

RE: LA SPA TN 15-0008 RAI Response
Outpatient Hospital Services - Supplemental Payments for Baton Rouge Area Hospitals (Woman's Hospital)

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 15-0008 with a proposed effective date of February 12, 2015. The purpose of this SPA is to amend the provisions governing the reimbursement methodology for outpatient hospital services rendered by non-rural, non-state hospitals in order to adopt a supplemental payment methodology for services provided by hospitals located in the Baton Rouge area. We are providing the following additional information as requested in your RAI correspondence dated June 10, 2015:

CMS-179

1. Block 7 – This is a SPA that proposes a supplemental payment yet there is no federal budget impact in the associated Block 7 of the CMS-179. Please provide a detailed analysis of how the FFP determination was made and provide supporting documentation of the calculation for Federal Fiscal Year (FFY) 2016 and 2017.

   Response: This State Plan amendment (SPA) has no fiscal impact for SFYs 2016 and 2017 because the State is already at the global Upper Payment Limit (UPL) cap. For each state fiscal year (SFY) under this proposed plan amendment, the State will pay no more than $10,000,000, not to exceed the global UPL cap. This SPA will reduce the UPL amount paid under other UPL SPAs, in effect re-ordering the UPL priorities.

EFFICIENCY, ECONOMY, AND QUALITY OF CARE

2. 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."

Response: Louisiana's health care delivery system continues to transition in the aftermaths of Hurricanes Katrina and Gustav. As providers closed and many residents relocated, both the State and the provider community have pursued a common objective of more efficiently and economically delivering quality healthcare services to citizens. In the Baton Rouge area, where Woman's Hospital is located, low income and uninsured patients in need of obstetrical, gynecological, and neonatal services, that were historically provided in the closed state owned and operated Earl K. Long facility, continue to migrate to Woman's Hospital. This is more efficient from both a financial and delivery of care perspective because the costs of rebuilding or making improvements to the aging state facility were prohibitive. The proposed payments were developed to facilitate the ongoing transition of changes in patterns of utilization and to ensure that access to care remains available as a result of the closure of this state hospital.

The proposed supplemental payments are consistent with 1902(a)(30)(A) as they are within the private hospital annual aggregate UPL cap. These payments are supplements to the existing base payment rates and have been designed to recognize the increases in Medicaid utilization as a result of the current economic conditions, the closure of the Earl K. Long hospital, and the need to ensure continued access to quality care as required by 1902(a)(30)(A).

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 these amendments are consistent with simplicity of administration and in the best interest of the recipients.

Response: As explained in response 2 above, with the closure of the state hospital in Baton Rouge, Medicaid services provided at Woman's Hospital have met or exceeded the services previously provided to Louisiana Medicaid recipients by a state facility that is now closed.

LEGISLATION

4. Please clarify if the State or a Hospital Service District has issued any proposals or enacted any legislation to support these supplemental payments. Please submit that documentation for our review.

Response: There are no proposals or enacted legislation relative to this SPA.

REIMBURSEMENT PAGE

5. The State plan must be more comprehensive in nature for these supplemental payments. 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. What method will the State use to determine these supplemental payments?

   Response: The proposed outpatient supplemental payments will be quarterly lump sum adjustment payments to the qualifying hospital and will not exceed $2,500,000 per quarter.

6. This SPA indicates hospitals located in the Baton Rouge area. Please indicate which hospitals will be receiving these supplemental payments and how much these hospitals will receive by indicating their portion of the maximum allowable cap.

   Response: Only one hospital, Woman's Hospital, will qualify for this proposed outpatient supplemental payment and will receive 100 percent of the proposed payment for this plan amendment.

7. CMS has concerns with the appearance of contingent funding proposed in the plan language. To comply with CMS regulations, 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.

   Response: The Department understands your concern; therefore, we will modify this language to conform with language in other approved State Plan pages.

8. 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."

   Response: This language has been added to the reimbursement methodology.

9. Did the State receive any feedback or complaints from the public regarding the current proposal or about the changes to the outpatient hospital services rendered by hospitals located in the Baton Rouge area? If so, what were the concerns and how were they addressed and resolved?

   Response: No complaints or feedback were received.

10. Please use the applicable lettering, numbering instead of bullet points for the plan page.

Response: The plan page has been amended to reflect this change. Please see Attachment 4.19-B, Item 2.a., Page 11.

Please clarify the additional questions related to the new supplemental payments:

11. Please justify why Louisiana needs to pay supplemental payments for outpatient hospital services rendered by hospitals located in the Baton Rouge area? Why do these payments need to be made for these specific services?

Response: The only hospital that will qualify for these proposed supplemental payments is Woman's Hospital. In the Baton Rouge area, Woman's provides the majority of the capacity for specialty hospital services to women and neonates. Woman's Hospital is the only area hospital that offers the entire continuum of care of these specialty services to the low income and Medicaid population. Not only does Woman's Hospital provide basic gynecological, obstetrical and neonatal services to these Medicaid patients, but the following examples demonstrate their focus and commitment to improving both the quality of care and outcomes which will result in decreased future healthcare expenditures by the Medicaid program for recipients treated through these initiatives:

- **Increasing the use of specialized treatment of gynecological cancers through less invasive procedures using robotics for treatment and staging;**

- **Initiated an education and treatment program for HIV/AIDS-infected pregnant women in an effort to reduce mother-to-child transmission rates;**

- **Piloted the use of exclusive human donor breast milk for at least the first 14 days of feeding in infants less than 1000 grams birth weight (approximately 42-60 infants annually);**

- **Obstetrical services began a "performance improvement initiative" to reduce post-partum hemorrhage, and key process measures have been implemented over time to impact change;**

- **Operates an outpatient neurological development clinic to monitor less than 32 week old premature infants until they are at least two to three years old;**

Medicaid outpatient cost reimbursement is currently 66.46 percent of cost and Woman's Medicaid outpatient costs and volumes continue to increase while reimbursement levels remain flat. Without these supplemental Medicaid payments, Woman's would be forced to reevaluate current services that benefit all citizens in the region, including Medicaid patients. Medicaid reimbursements that continue to remain at levels well below the cost of providing services to Medicaid patients may ultimately force Woman's to discontinue services that are the least cost effective. Without the stability in

current Medicaid reimbursement that these Medicaid supplemental payments will provide, it is unlikely that Woman's could absorb new Medicaid patients or ensure that such specialized services would remain available.

12. Does the state expect that these payments will positively impact access to care or quality of care? If so, how?

Response: As detailed in the response to question 11 above, the State expects these payments to maintain access to care and quality of care to Medicaid recipients that require obstetrical, gynecological, and neonatal outpatient hospital services in the Baton Rouge region.

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

Response: Please refer to the response to question 12 above.

14. What specific outcome(s) does the state hope to achieve by making these supplemental payments to the targeted providers?

Response: As detailed in the responses to questions 11 and 12 above, the State Plan amendment for these proposed payments is to maintain access to care and quality of care to Medicaid recipients that require obstetrical, gynecological, and neonatal outpatient services in the Baton Rouge region. Without the stability in current Medicaid reimbursement that these Medicaid supplemental payments will provide, it is unlikely that Woman's could absorb new Medicaid patients or ensure that existing specialized services would remain available.

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

Response: Yes, the State will confirm with Woman's Hospital, that initiatives such as the examples included in the response to question 11 not only remain in place, but are enhanced. The State will also review the statistics that the hospital maintains regarding the effectiveness.

16. How will the State measure if targeting payments resulted in the desired outcome?

Response: The State will also review the statistics that the hospital maintains regarding the effectiveness of these initiatives.

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

Response: Base outpatient rate payments for Woman's Hospital for SFY 2014 dates of service were $2,865,862. The proposed supplemental payments will not exceed $10,000,000 for SFY 2016.

18. Has the State done any analysis to increase the base payments for these outpatient hospital services rendered by hospitals located in the Baton Rouge area?

    Response: No. As explained in the response to question 11 above, Woman's Hospital is the only provider that has the immediate available capacity to accommodate the volume of these obstetrical, gynecological, and neonatal services in the Baton Rouge area.

STANDARD 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.

19. 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.)

    Response: Providers will receive and retain 100 percent of the payments. No portion of the payments is returned to the State.

20. 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).

Response: The state share is paid from the state general fund which is directly appropriated to the Medicaid agency.

21. 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.

Response: This amendment proposes to make outpatient supplemental payments to a private hospital, Woman's Hospital. Estimated payments by provider type for SFY 2015 are included in the UPL demonstration.

22. 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.

Response:

State Hospitals

1. **Accumulate outpatient costs, charges, payments, and reimbursement data for each state hospital's outpatient Medicaid services excluding clinical laboratory services per the latest filed cost reporting period.**

2. **Subtract the amount paid by Medicaid from the Medicaid costs for each hospital. Trend the difference forward to the midpoint of the current SFY using the CMS Market Basket Index for Perspective Payment System (PPS) hospitals.**

3. **The difference for each hospital, including inflation, is the supplemental payment that can be reimbursed to each state hospital subject to the limitations on Medicaid inpatient hospital payments in 42 CFR 447.271 and 447.272.**

Non-state Hospitals (Public and Private)

1. **Accumulate Medicaid claims data for outpatient services from the previous state fiscal year (SFY).**

2. **Separate charges and payments from paid claims between services reimbursed on a percentage of cost basis from services reimbursed at a fee-for-service (FFS) rate.**

3. **Calculate cost-to-charge ratio (CCR) for Medicaid outpatient services from latest filed Medicare/Medicaid cost report (Form CMS 2552).**

4. **For services reimbursed on a FFS rate (other than outpatient clinical laboratory services):**
    a. **Apply CCR to Medicaid outpatient charges (except for outpatient clinical laboratory services) to determine Medicaid outpatient costs.**
    b. **Subtract claims payments from costs.**

5. **For Medicaid outpatient services reimbursed at a percentage of cost:**
    a. **Apply CCR to Medicaid outpatient claims charges to determine Medicaid outpatient costs.**
    b. **Multiply Medicaid costs by the applicable percentage to determine Medicaid payment which would be calculated upon cost settlement.**
    c. **Subtract calculated payment from costs.**

6. **For each hospital, add the differences of the Medicaid costs less Medicaid payments for the cost-based services and the FFS rate services.**

7. **The sum of the difference for each hospital in the group is the UPL for that group of hospitals.**

23. 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.

    Response: Please see the response to question 22 above for the detailed description of the methodology used by the State to estimate the UPL for each class of hospitals. The current UPL demonstration has already been submitted to CMS.

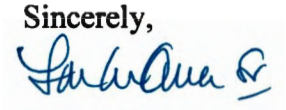
24. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly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

Response: In accordance with our approved State Plan, both Medicaid and disproportionate share hospital (DSH) payments to state governmental hospitals are limited to costs. In accordance with our approved State Plan, non-state governmental small rural hospitals are reimbursed 110 percent of their Medicaid outpatient costs, with the exception of outpatient clinical laboratory services. DSH payments to non-state public governmental hospitals are limited to costs per our approved State Plan and Section 1923(g). As all small rural hospitals qualify for DSH payments, Medicaid payments (including those in excess of Medicaid cost) must be deducted from costs in the determination of each hospital's specific DSH limit. The end result is a reconciliation of the Medicaid overpayments against the hospital's DSH limit which causes a corresponding decrease in the amount of DSH payments made to the hospital. Only payments determined by audit to exceed allowable payments as defined in our approved State Plan are identified as overpayments.

Please consider this a formal request to begin the 90-day clock. We trust that this additional information will be sufficient to result in the approval of the pending plan amendment. We look forward to negotiating with CMS to ensure approval.

As always, we appreciate the assistance of Ford Blunt in resolving these issues. If further information is required, you may contact Darlene A. Budgewater at Darlene.Budgewater@la.gov or by phone (225) 342-3881.

Sincerely,



J. Ruth Kennedy
Medicaid Director

JRK:DAB:MVJ

Attachment (1)

c: Ford Blunt
Darlene Budgewater
Tamara Sampson

PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICES LISTED IN SECTION 1905(A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN AS DESCRIBED AS FOLLOWS:

Supplemental Payments for Woman's Hospital

Qualifying criteria

Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for outpatient hospital services rendered in a hospital in the Baton Rouge area that meets the following qualifying criteria per the as filed cost report ending state fiscal year 2014:

1. classified as a major teaching hospital;
2. has at least 3,000 Medicaid deliveries, as verified per the Medicaid data warehouse; and
3. has at least 45 percent Medicaid inpatient days utilization rate.

Payment Methodology

Supplemental payments for outpatient hospital services will be paid quarterly. The payments to the qualifying hospital shall not exceed:

1. the aggregate outpatient hospital upper payment limits for the classification of hospitals pursuant to 42 CFR 447.321; and
2. subject to the Annual Appropriation Act.

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.