Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

September 6, 2013

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

RE: Louisiana Title XIX State Plan
Transmittal No. 13-23

Dear Mr. Brooks:

Please refer to our proposed amendment to the Louisiana Medicaid State Plan submitted under transmittal number (TN) 13-23 with a proposed effective date of June 24, 2013. This amendment proposes to establish supplemental Medicaid payments for non-state-owned hospitals participating in public-private partnership. The effect of this amendment is that two hospitals, New Orleans and Lafayette qualify for supplemental payments. We are providing the following additional information as requested in your correspondence dated September 4, 2013 which stopped the clock on this transmittal.

FORM- 179

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

   Response: The fiscal impact has been revised. The total annual fiscal impact for this SPA is $105,000,702. The State requests a pen and ink change to Block 7 of the Form 179. The revised fiscal worksheet is attached. The FFY for 2013 is $17,196,490 and FFY for 2014 is $65,215,937. The supporting documents are attached.

TRANSFER OF VALUE AGREEMENTS

2. CMS must have copies of all signed standard Cooperative Endeavor Agreements or agreements under active consideration. In addition, please provide copies of all signed Intergovernmental Transfers (IGTs), 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. Please disclose all entities with which the State is in discussions concerning the actions proposed under this SPA and the intended outcome of such discussions.

   CMS has concerns that such financial arrangements meet the definition of 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.

   Response: We are submitting copies of the signed CEA documents with Lafayette General Health System, Inc. and Louisiana Children's Medical Center (New Orleans). These documents address CMS' concern that the financial arrangements are in compliance with federal statute and regulations. There are no loan agreements involved.

3. 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?

   Response: To date the State has not received any negative feedback or complaints regarding the Cooperative Endeavor Agreements in this State Plan Amendment. All indications are that despite some initial startup slowdowns in service the private partners have improved access to, and quality of, care along with enhanced Graduate Medical Education. Below is a sampling of some of the press reports that have been generated by the Cooperative Endeavor Agreements:

   http://www.nola.com/politics/index.ssf/2012/08/response_to_medicaid_cuts_divi.html

   http://www.lsuhospitals.org/News/2012/partnerships-12112012.html

   http://theadvocate.com/news/neworleans/neworleansnews/6338907-123/private-company-takes-over-management

   http://www.businessreport.com/article/20130725/BUSINESSREPORT02/130729879

http://www.nola.com/education/baton-rouge/index.ssf/2012/12/lsu_enters_into_public-private.html

http://theadvocate.com/home/4648610-125/partnerships-announced-for-three-lsu

INTERGOVERNMENTAL TRANSFERS (IGT)

4. 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.

   Response: The two entities are named above (see response # 2). There will be no IGTs with this amendment. The CEA agreements do have some of this ownership information; however, the detailed ownership information for this hospital (including social security numbers) has been gathered by and is kept on file with the Department's Provider Enrollment Unit.

5. 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.

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

6. 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).

   Response: Not applicable as this amendment does not involve IGTs.

7. Does the state agree to provide certification from the transferring entities that the IGTs are voluntary?

   Response: Not applicable as this amendment does not involve IGTs.

8. 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.

   Response: Not applicable as there are no local sources of funding for this amendment.

UPPER PAYMENT LIMIT (UPL)

9. Upper Payment Limit (UPL) Demonstration – Regulations at 42 CFR 447.272 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) for all classes (state government, non-state government, private). The UPL demonstrations 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.

   Response: The most recent UPL demonstration is attached.

10. Please include a detailed narrative description of the methodology for calculating the upper payment limit in the funding questions.

    Response: The language in the amendment has been revised accordingly.

EFFICIENCY, ECONOMY, AND QUALITY OF CARE

11. SPA amendment LA13-023 proposes to establish supplemental payments for private-public partnerships for non-state-owned and operated hospitals. 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: The hospitals affected by this SPA are paid the private per diem base rate based on their individual peer group level. This SPA proposes quarterly supplemental payments which are consistent with federal regulations at 42 CFR 447.271 and 42 CFR 447.272.

SIMPLICITY OF ADMINISTRATION

12. 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: It is anticipated that Medicaid services provided through the CEAs will meet or exceed those services previously provided to Louisiana Medicaid recipients through a State-run facility. In order to ensure a seamless transition, each of the

private partners performed outreach to the employees, patients, and others throughout the community to ensure that those relying on the services provided at the formerly State-run facilities would still receive those same services after the private-partner took over operation and management.

LEGISLATION

13. 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

Response: There was not any RFPs or legislation enacted to support the public-private partnerships. Each CEA was submitted and reviewed by the Joint Legislative Committee on the Budget of the Louisiana Legislature.

STATE PLAN LANGUAGE

14. The reimbursement methodology and these types of funding arrangements are still under review. Additionally, please remove the CEA from Attachment 4.19-A, Item 1, page 8c(5).

Response: The language has been revised to remove references to the CEA.

ADDITIONAL

15. 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?

Response: There is no linkage between Health Related Care or Service obligations and the public-private partnership. Agreements are not related to any other health services provided other than already billed Medicaid hospital services.

16. 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?

Response: We do not anticipate service reductions. The agreed upon payments to the private partners are sufficient to assure that they will provide access to care and services for the Louisiana Medicaid population to the same extent that they provide care and services to the general population within the respective area that the private-partner's current facility services..

17. 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?

Response: There are no rate modifications contained in the current SPA. The State went through the normal public process in promulgating the Rule. The CEA and its amendment went through public discussions at the legislature in the Joint Legislative Committee on the Budget where public input was received.

18. Is the State modifying anything else in the State plan which will counterbalance the 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)?

Response: The state does not anticipate the need to counterbalance the impact of this state plan amendment.

19. 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?

Response: The cumulative rate changes and UPL payments from FY 2009 to FY 2013 have previously been submitted to CMS with the following SPAs: 12-63, 13-02, and 13-01.

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

Response: Relative to this SPA, the operation and management of University Medical Center (Lafayette) and Medical Center of Louisiana at New Orleans (Interim LSU Hospital) have been transferred to private operation and management. These facilities are now named University Hospital and Clinics in Lafayette and University Medical Center Management Corporation (d/b/a University Medical Center) in New Orleans.

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.

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.)

Response: Please see the response for LA SPA 12-63 dated April 25, 2013.

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 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) 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,
   (iv) whether the certifying or transferring entity received appropriations (identify level of appropriations).

   Response: Please see response for LA SPA 12-63 dated April 25, 2013.

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.

   Response: Please see response for LA SPA 12-63 dated April 25, 2013.

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.

Response: Please see response for LA SPA 12-63 dated April 25, 2013. The UPL demonstration has been updated to include the impact of TN 13-23 and is attached.

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?

   Response: Please see response for LA SPA 12-63 dated April 25, 2013.

Please substitute the attached revised State Plan pages for the pages originally submitted for this State Plan amendment.

It is anticipated that this additional information will be sufficient to result in the approval of the pending plan amendment. Please consider this a formal request to begin the 90-day clock. If further information is required, you may contact Darlene Adams at (225) 342-3881 or by email to Darlene.Adams@la.gov. We appreciate the assistance of Tamara Sampson in resolving these issues.

Sincerely,

J. Ruth Kennedy
Medicaid Director

Attachments (5)

JRK/DA/jh

c: Ford J. Blunt III, Dallas Regional Office

LOUISIANA TITLE XIX STATE PLAN
TRANSMITTAL #: 13-23
TITLE: Inpatient Hospitals-Public Private Partnership Hospitals (South)-Supplemental
EFFECTIVE DATE: June 24, 2013

FISCAL IMPACT: Increase

	year			*# mos	range of mos.	state fiscal year years
1st SFY	2013			0.2	June 24, 2013-June 30, 2013	$0
2nd SFY	2014			12	July 2013 - June 2014	$105,000,702
3rd SFY	2015			12	July 2014 - June 2015	$105,000,702

*#mos-Months remaining in fiscal year

Total Increase in Cost FFY 2013

State Fiscal Year	2013	$0	for	0.2	months	June 24, 2013-June 30, 2013		$0
Federal Fiscal Year								

State Fiscal Year	2014	$105,000,702	for	12	months	July 2013 - June 2014		
Federal Fiscal Year		$105,000,702	/	12 X	3	July 2013 - September 2013	=	$26,250,176
								$26,250,176

FFP (FFY 2013) = $26,250,176 X 65.51% = $17,196,490

Total Increase in Cost FFY 2014

State Fiscal Year	2014	$105,000,702	for	12	months	July 2013 - June 2014		
Federal Fiscal Year		$105,000,702	/	12 X	9	October 2013 - June 2014	=	$78,750,527

State Fiscal Year	2015	$105,000,702	for	12	months	July 2014 - June 2015		
Federal Fiscal Year		$105,000,702	/	12 X	3	July 2014 - September 2014	=	$26,250,176
								$105,000,703

FFP (FFY 2014)= $105,000,703 X 62.11% = $65,215,937

2. New Orleans Area CEA

Qualifying Criteria

Effective for dates of service on or after June 24, 2013, a quarterly supplemental payment shall be made to Louisiana Children's Medical Center.

Reimbursement Methodology

Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year. Payments shall not exceed the allowable Medicaid charge differential. The Medicaid inpatient charge differential is the Medicaid inpatient charges less the Medicaid inpatient payments (which includes both the base payments and supplemental payments). The payments will be made in four equal quarterly payments based on 100 percent of the estimated charge differential for the state fiscal year. The qualifying hospital will provide quarterly reports to DHH that will demonstrate that, upon implementation, the annual Medicaid inpatient payments do not exceed the annual Medicaid inpatient charges per 42 CFR 447.271. The Department will verify the Medicaid claims data of these interim reports using the state's MMIS system. When the Department receives the annual cost report as filed, the supplemental calculations will be reconciled to the cost report. If there is additional cap room, an adjustment payment will be made to assure that supplemental payments are the actual charge differential. The supplemental payments will also be reconciled to the final cost report. The annual supplemental payments will not exceed the allowable Medicaid inpatient charge differential per 42CFR 447.271. Maximum inpatient payments shall not exceed the upper payment limit per 42CFR 447.272.

3. Lafayette Area CEA

Qualifying Criteria

Effective for dates of service on or after June 24, 2013, a quarterly supplemental payment shall be made to Lafayette General Health System.

Reimbursement Methodology

Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year. Payments shall not exceed the

allowable Medicaid charge differential. The Medicaid inpatient charge differential is the Medicaid inpatient charges less the Medicaid inpatient payments (which includes both the base payments and supplemental payments). The payments will be made in four equal quarterly payments based on 100 percent of the estimated charge differential for the state fiscal year. The qualifying hospital will provide quarterly reports to DHH that will demonstrate that, upon implementation, the annual Medicaid inpatient payments do not exceed the annual Medicaid inpatient charges per 42 CFR 447.271.

The Department will verify the Medicaid claims data of these interim reports using the state's MMIS system. When the Department receives the annual cost report as filed, the supplemental calculations will be reconciled to the cost report. If there is additional cap room, an adjustment payment will be made to assure that supplemental payments are the actual charge differential. The supplemental payments will also be reconciled to the final cost report. The annual supplemental payments will not exceed the allowable Medicaid inpatient charge differential per 42 CFR 447.271. Maximum inpatient payments shall not exceed the upper payment limit per 42CFR 447.272.