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

September 4, 2013

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 13-025

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) 13-025. This amendment proposes to revise the reimbursement methodology for disproportionate share hospital (DSH) payments for non-state owned hospitals in order to encourage them to take over the operation and management of state-owned and operated hospitals that have terminated or reduced services. The effect of this amendment is that four hospitals located in New Orleans, Lafayette, Houma, and Lake Charles qualifies for DSH payments.

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 13-025:

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.

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.

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?

INTERGOVERNMENTAL TRANSFERS

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.

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

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).

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

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.

EFFICIENCY, ECONOMY, AND QUALITY OF CARE

9. SPA amendment LA13-025 proposes 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 is consistent with the principles of "efficiency, economy, and quality of care."

SIMPLICITY OF ADMINISTRATION

10. 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

11. 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

12. 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.

13. The proposed DSH payment methodologies on pages 10 and 11 are 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.

14. The following are additional items that need to be made to the proposed reimbursement methodology.

    a. The reimbursement methodology and these types of funding arrangements are still under review.

    b. Please remove CEA from Attachment 4.19-A, Item 1, page 10k(10) and (11).

    c. Please specify the private hospital that will be receiving the DSH payments in the State plan not the non-state owned facility.

    d. The State should substitute the word 'private' instead of using the word 'non-state'. If the State feels that non-state facilities would qualify in the future, then the following are a couple of examples.

        private and non-state owned and operated…..

        OR

        non-state ***(includes private)*** owned and operated…..

    e. Please include a paragraph on not exceeding the hospital specific DSH limit. The State can cut/paste paragraph from LA 12-62. This language should be included under item c.

        Paragraph from 12-62 states the following…

        Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a …..

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?

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?

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?

18. 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)?

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?

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

FUNDING QUESTION

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?

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,

Digitally signed by Billy D. Brooks -S
DN: c=US, o=U.S. Government, ou=HHS, ou=CMS, ou=People, 0.9.2342.19200300.100.1.1=2000039050, cn=Billy D. Brooks -S
Date: 2013.09.04 12:24:40 -05'00'

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