Bobby Jindal
GOVERNOR

Kathy H. Kliebert
INTERIM SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

April 25, 2013

Mr. Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

RE: Louisiana Title XIX State Plan
Transmittal No. 12-64

Dear Mr. Brooks:

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 12-64 with a revised proposed effective date of April 15, 2013. We are providing the following additional information as requested in your correspondence dated January 30, 2013 which stopped the clock on this transmittal.

This amendment proposes to revise the reimbursement methodology for outpatient hospital services to establish supplemental Medicaid payments to 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.

A separate set of State Plan Amendments (SPAs) will be submitted relative to each hospital that enters into a Cooperative Endeavor Agreement (CEA); therefore, the language of this SPA has been revised to address the Baton Rouge agreement only and our responses are specific to the Baton Rouge location.

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 SPA language has been revised to only include the CEA for Our Lady of the Lake (OLOL) Regional Medical Center (Baton Rouge). The fiscal impact has been revised. The State requests a pen and ink change to Block 7 of the Form 179. The FFY for 2013 is $1,637,750 and FFY 2014 is $6,257,583. The supporting documents are attached.

2. Please explain why the State proposes an effective date of November 1, 2012 when no agreements have been signed.

Response: We have revised the effective date of this SPA to April 15, 2013 to coincide with the effective date of the CEA.

TRANSFER OF VALUE AGREEMENTS

3. CMS must have copies of all signed standard Cooperative Endeavor Agreements. In addition, please provide copies of all signed Intergovernmental Transfer (IGT), 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.

   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.

   Please note that these agreements are needed before we can approve TN#12-62, TN#12-63, and TN#12-64.

   Response: We are submitting copies of the signed CEA documents with Our Lady of the Lake (OLOL) Regional Medical Center. These documents address CMS' concern that the financial arrangements are in compliance with Federal statute and regulations. DHH worked with OLOL to determine expected utilization based on past performance. Payments are based on a reasonable expectation of utilization of services to be provided by OLOL under the terms and conditions of the CEA. All lease agreements were analyzed by third party professionals to ensure that they met the fair market value of the property/asset to be leased. There are no loan agreements involved.

4. 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?

   1. **Concern Regarding Acceleration of OLOL Assuming Operations**

      The 2010 CEA between Louisiana State University (LSU) and the Franciscan Missionaries of Our Lady/OLOL Hospital called for OLOL to assume inpatient operations for Earl K. Long Medical Center (EKLMC) effective November 2013. During the February 2013 LSU Board of Supervisors hearing, the Board approved accelerating closure of EKLMC by seven months (from November to April 15th). Rep. Regina Barrow, who represents the district where EKLMC was located, and was in attendance at the meeting, requested the Board "*consider slowing this train down.*" She said, "*I have concerns relative to (health care) access and what we expect to have in our community once it's completed.*" [1]

      How Addressed/Resolution: Teams from LSU Health Sciences, EKLMC and OLOL worked together to successfully prepare for the April 15 transition, which included communication with patients, medical records transfer, patient scheduling and follow up for both procedures and on-going care. One of the factors leading to the decision to accelerate the takeover was the loss of EKLMC employees who were accepting jobs with other employers in advance of the scheduled November transition.

      Dr. Frank Opelka, speaking on behalf of LSU, said it was essential to accelerate the turnover citing the number of people leaving hospital employment and a need to stabilize the workforce.[2] He said "*while we are accelerating our timeline for this partnership, the staff and administrators of LSU and Our Lady of the Lake have been discussing this transition for some time, giving serious consideration to how we can provide the highest quality of care and the greatest educational experience. We are in agreement that our plan to move services in April is the best decision for our patients, our residents and the community, and we look forward to this new era of providing health services and medical education in the Baton Rouge area.*"

   2. **Concern Regarding Impact of CEA on Earl K. Long Hospital Employees**

      In a hearing before the Legislative House Health & Welfare Committee on January 24, 2013, lawmakers "were concerned about the effect these moves would have on people currently working in the LSU Hospitals system."[3]

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[1] http://theadvocate.com/home/5077755-125/lsu-board-moves-to-accelerate
[2] http://theadvocate.com/home/5011597-125/key-steps-for-ekl-closure
[3] http://www.fox44.com/news/lsu-unveils-public-private-partnership-plan

How Addressed/Resolution: In response to the concern about EKLMC employees, Dr. Opelka stated *"Our partners are very keen on trying to keep all these employees within the partnership because they actually provide a big and important aspect of the clinical care that we deliver."*[4]. LSU worked with the 834 full-time and part-time employees of EKLMC to make them aware of job opportunities with OLOL. OLOL welcomed and encouraged all EKLMC clinic and hospital employees to apply for the many open positions that comprise the continuation of health care services, and anticipated hiring a majority of the EKLMC employees. LSU also worked with the Louisiana Workforce Commission to assist affected EKLMC employees. Information was made available and regularly updated at the website www.transitionLSUHealthBR.com[6].

3. **Concern Feedback Regarding Impact of CEA on Patient Care**

Rep. Regina Barrow expressed concerns during the House Health & Welfare hearing on January 25, 2013 that uninsured women were not getting the care they needed through an agreement under which Woman's Hospital assumed obstetrics and gynecological care that OLOL does not perform.[7] An agreement with Woman's Hospital to take over women's services previously provided by EKLMC was subsequently formalized.[8]

In the Joint Committee on the Budget hearing in April 2013, Rep. Barrow sought a delay in the EKLMC closure, stating "*I am very worried that many people in my area won't have access to care.*"

How Addressed/Resolution: Teams from LSU Health, EKLMC and OLOL worked together to prepare for the April 15 transition, which included communication with patients, medical records transfer, patient scheduling and follow up for both procedures and on-going care.

OLOL focused on the outpatient clinics in order to preserve important heath access, as the majority of patients served through LSU Health and ELKMC received services through the outpatient clinics. Scott Wester, OLOL chief executive officer, stated *"Our goal is to improve clinic access, which should result in fewer ER visits and hospitalizations for patients. This collaboration aligns with our 90-year mission of ensuring that everyone who needs health care has access."*

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[4] Ibid
[5] https://www.lsuhospitals.org/news/2013/EKL-02042013.html
[6] https://www.lsuhospitals.org/news/2013/EKL-02042013.html
[7] http://theadvocate.com/home/5001211-125/earl-k-long-hospital-to
[88] http://theadvocate.com/home/5671669-125/final-vote-to-close-lsu

LSU Health clinics remain open at their former location, which includes the LSU North Baton Rouge Clinic on Airline Highway, Mid City Clinic on South Foster Drive, South Baton Rouge Clinic at the Leo Butler Community Center and the LSU Surgical Facility on Perkins Road. Clinics previously located on the current EKLMC campus have either been transitioned to these existing clinic locations and/or to the resident clinics at OLOL within O'Donovan Medical Plaza.

4. **Concern Regarding Impact of CEA on Prisoner Care**

Rep. Regina Barrow also expressed concerns during the House Health & Welfare Hearing on January 25, 2013 regarding the impact of the CEA on prisoner care. Dr. Opelka said LSU has a lot of "*challenges with prisoner care and it's across all facilities.*" While the OLOL agreement does not include prisoner care that has been provided at EKLMC, *"we are expanding prisoner care capability at Lallie Kemp so we can provide more,"* Opelka said, referring to the LSU hospital in Independence. "*We are talking to corrections about delivering more care at the (prison) site rather than transporting prisoners. We are asking all our partners to do something.*"

How Addressed/Resolution: The State will rely on Baton Rouge-area hospitals to provide emergency care for prisoners with the closure of EKLMC, according to plans provided by State corrections officials. Otherwise inmates in need of non-emergency inpatient medical care will be transported to LSU's Lallie Kemp Regional Medical Center in Independence, La. where a six-bed prison ward has been established, or the Interim Hospital in New Orleans, which sees some inmates today for cases the EKLMC facility could not handle.

In addition, LSU is working with corrections officials to improve medical care offered at the four prisons located in the Baton Rouge area—expanding the telemedicine network where patients videoconference with doctors and expanding clinical exam capacity. Renovations are also underway for new health care clinics. Dr. Opelka said LSU physicians will provide prisoner care support through its telemedicine network and "enhanced clinics" on prison sites. LSU is also in discussions with the corrections department about moving some specialists to the prisons instead of moving prisoners to the specialists. The possibility of onsite medical specialty-based clinics is being explored.[9]

5. **Concern Regarding Impact of CEA on General Financing & State Budget**

At the House Health and Welfare Committee hearing on January 25, 2013 Rep. Katrina Jackson noted the volatility of the State's finances, which has prompted regular budget cuts in health care and questioned whether expenditures would be capped.

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[9] http://theadvocate.com/news/5692912-123/prisoner-medical-care-to-transfer

How Addressed/Resolution: The DHH Secretary's response was, *"At this point no. As we write the cooperative endeavor agreements, we give the department flexibility in adjusting payments"* to the private hospitals. Rep. Jackson felt that the cap should be a part of the CEAs so that the State would not be contractually obligated in the future.

6. **Concern Regarding Impact of CEA on State's Liability**

Rep. Thomas Willmott questioned the State legal liabilities in the new arrangement.

How Addressed/Resolution: Dr. Opelka responded, "*Partners have their own liability*," He said LSU is responsible for the clinical care delivery in the facilities.

7. **Concern Regarding Impact of CEA on Other Area Private Hospitals**

Rep. Bodi White stated in an April 2013 Joint Committee on the Budget Hearing that he was concerned that more uninsured patients would to be showing up in the emergency rooms of Baton Rouge General Mid City and Lane Memorial Regional Medical Center in Zachary, the two Baton Rouge are private hospitals closest to the EKLMC facility. He said that the State needs to provide extra dollars to care for the uninsured or the community hospitals might go bankrupt.

How Addressed/Resolution: Since this concern was initially raised in 2009, DHH published a Rule to address reimbursement changes in the event of increases in uncompensated care above a certain threshold. DHH continues to be committed to working with area hospitals to monitor the fiscal impact as a result of the transition of services from the EKLMC facility located in north Baton Rouge to the OLOL campus in south Baton Rouge and make adjustments in reimbursement for uncompensated care if triggers are reached.

The Mental Health Emergency Room Extension (MHERE) on EKLMC's property had to be closed because utility services to the unit were no longer available with the closure of EKLMC, according to Dr. Jan Kasofsky, Executive Director of Capital Area Human Services District in a January 30, 2013 interview with the Baton Rouge **Advocate**. The unit had relieved area private hospitals of having those with mental health problems take up emergency room beds.[10]

How Addressed/Resolution: Capital Area Human Services District (CAHSD) and local hospitals have convened a number of planning meetings to address behavioral health presentations to emergency departments (ED) at the present time. Dr. Kasofsky has met with Dr. Craig Coenson, CEO of Magellan Health Services the Statewide Management Organization (SMO) for the Louisiana Behavioral Health Partnership, and with Office of Behavioral Health (OBH) Assistant Secretary Anthony Speier to review response plans and system indicators for monitoring behavioral health ED presentations and associated

[10] http://theadvocate.com/home/5011597-125/key-steps-for-ekl-closure

disposition of patient needs. At this time, local hospitals have adjusted their response capacity for anticipated presentations, with OLOL adding 10 additional acute psychiatric beds and Baton Rouge General Medical Center making adjustments within its ED. Psychiatric presentations are being closely monitored during the first 30 days of operations at which time utilizations and treatment dispositions will be reviewed to determine if the current system adjustments are adequately addressing patient needs.

Dr. Kasofsky has scheduled a meeting for interested stakeholders on May 1 to identify data elements that best measure the impact of the MHERE closure on the local hospital EDs. This data will be used to design business opportunities for the private/public sector to support CRCs, residential crisis stabilization units, or other approaches in the greater Baton Rouge area.

8. **Concerns Regarding Legislative Committee Approval of Hospital CEAs**

Legislators passed Resolutions during the week of April 14 that would have allowed a legislative committee to approve the CEA for the LSU hospitals.

How Addressed/Resolution: Governor Jindal noted that legislative resolutions do not carry the force of law and gave assurances that the State would fully comply with existing statute that specifically tells us how to proceed for such agreements.[11]

9. **Concerns Regarding Transportation to Hospital as a Result of CEA**

In an interview with the **Baton Rouge Advocate** published April 22, 2013, Rep. Barrow identified as a continuing issue, how EKLMC patients who live largely in north Baton Rouge would get necessary transportation to the south Baton Rouge OLOL campus.

How Addressed/Resolution: Medicaid enrollees who do not have access to other sources of transportation are eligible for non-emergency medical transportation, as well as emergency transportation, with no cost sharing requirements. Medicaid transportation policy allows for an attendant to accompany the Medicaid member as well.

10. **Concerns Regarding Patient Confusion as a Result of CEA**

In a story published in the April 22 edition of the **Baton Rouge Advocate**, State Sen. Sharon Broome, in whose north Baton Rouge district the EKLMC is located, commended LSU and OLOL for their outreach efforts, but noted some people are confused still. *"We need to make sure people know where to go for health services,"* Broome said.[12]

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[11] http://theadvocate.com/home/5726123-125/early-prognosis-for-privatization
[12] Ibid

How Addressed/Resolution: OLOL's newly opened Urgent Care Center is a couple of blocks north from the EKLMC site and will handle non-life-threatening conditions. OLOL printed glossy postcards that advertise the new clinic and educated people on the types of maladies that can be treated there, as opposed to the emergency room. The cards are being distributed on city buses and will be inserted into the bags with prescriptions at area pharmacies.[13]

PUBLIC NOTICE

5. Please provide information demonstrating that the changes proposed in SPA 12-62, 12-63, and 12-64 comport with public process requirements at section 1902(a)(13)(A) of the Social Security Act (the Act). Please provide copies of the legislation authorizing the proposed changes.

   Response: Copies of the public notices for this amendment were included with the initial submission to CMS. We have attached them again. The Public Process Notice and Emergency Rule were published in the statewide newspapers on October 31, 2012. The Emergency Rule was published in the November 20, 2012 edition of the *Louisiana State Register*. The proposed changes did not require legislation.

INTERGOVERNMENTAL TRANSFERS

6. 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: There will be no IGTs with this amendment. As revised, this SPA is only applicable to one hospital, Our Lady of the Lake Regional Medical Center. The detailed ownership information for this hospital (including social security numbers) has been gathered by, and is kept on file with, the Department's Medicaid Provider Enrollment Unit. This hospital will manage the day-to-day operations of the facilities involved without any outside input.

7. 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.

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[13] Ibid

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

   Response: Not applicable. This amendment does not involve IGTs.

9. Section 1902(a)(2) of the Social Security 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. There are no local sources of funding for this amendment.

10. 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. This amendment does not involve IGTs.

UPPER PAYMENT LIMIT (UPL)

11. 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.

12. Please include a detailed narrative description of the methodology for calculating the upper payment limit in the state plan language.

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

EFFICIENCY, ECONOMY, AND QUALITY OF CARE

13. SPA amendments LA12-062, 12-063, and 12-64 propose to establish supplemental payments for private-public partnerships. Section 1902(a) (30) (A) of the Social Security Act requires

that payment rates must be consistent with "efficiency, economy and quality of care." Please justify how the establishment of payments when no contracts have been signed is consistent with the principles of "efficiency, economy, and quality of care."

Response: We have revised the State Plan language so that this SPA will only be applicable to the signed CEA for Our Lady of the Lake Regional Medical Center.

SIMPLICITY OF ADMINISTRATION

14. 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: With the closure of the State hospital in Baton Rouge (effective April 15, 2013), it is anticipated that Medicaid services provided through the CEA with Our Lady of the Lake Regional Medical Center will meet or exceed the services previously provided to Louisiana Medicaid recipients by a State facility that is now closed.

LEGISLATION

15. 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: The original CEA and amended CEA were reviewed and approved by the Joint Legislative Committee on the Budget for the Louisiana Legislature.

STATE PLAN LANGUAGE

16. The reimbursement methodology outlined on page 4.19-B simply states that supplemental payments will be made on a quarterly basis in accordance with 42 CFR 447.321. To comply with regulations at 42 CFR 447.321, please amend the State plan language to include a detailed description of the method that will be used to determine the proposed supplemental payments. The state plan methodology for the supplemental outpatient hospital service payments need to be comprehensive based upon services rendered or a quality indicator. Supplemental payments can only occur after a Medicaid service has been rendered. The reimbursement methodology must be based upon actual historical utilization and actual trend factors. In addition, the methodology must account for 1) the available UPL room and 2) the limitation to charges per regulations at 42 CFR 447.321.

Response: The State Plan methodology language has been revised accordingly.

17. 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.

    Response: The State Plan methodology language has been revised accordingly.

18. The plan language indicates that payments will be made quarterly. Is the UPL calculation done on a quarterly basis or is it an annual calculation of which a fourth will be distributed on a quarterly basis? Please revise the plan language to indicate when during the quarter that payments will be made.

    Response: The UPL calculation will be done on an annual basis with payments distributed on a quarterly basis. The State Plan methodology language has been revised accordingly.

ADDITIONAL

19. 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.

20. 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; agreed upon payments to Our Lady of the Lake Regional Medical Center 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 Greater Baton Rouge area.

21. 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 Administrative 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.

22. 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)?

Response: Not applicable, as rates are not being decreased.

23. 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 are attached.

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

Response: Relative to this SPA, Earl K. Long Medical Center in Baton Rouge closed its inpatient facility effective April 15, 2013. Prisoner care services have been taken over by the Department of Corrections to be provided at Lallie Kemp Hospital in Independence, LSU Interim Public Hospital in New Orleans, or outsourced to other appropriate private hospitals as needed. Women's services that will not be provided by OLOL due to the Ethical Religious Directives will be provided by Woman's Hospital in the Baton Rouge area. All services that were previously provided by Earl K. Long Medical Center will remain available through this agreement and through other means of delivery.

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.

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: (See Attachment 4.19-A). There were twelve public non-state owned hospitals qualified for DSH payments applicable to SFY 2012, and each of these hospitals certified its allowable uncompensated care costs as expenditures eligible for Federal Financial Participation. The reportable DSH amount in SFY 2012 was $132,298,052 (FFP $80,697,962). DSH payments will be limited to 100% of each hospital's specific uncompensated care costs in accordance with Section 1923(g) and our approved State Plan. Act 10 of the 2009 Regular Session of the Louisiana Legislature directed these non-state public hospitals to certify their uncompensated care cost expenditures to be used as matching funds which was continued in Act 13 of the 2012 Regular Session. Attached are Act 13 of the 2012 Regular Session (Attachment 1) and a listing of the qualifying hospitals in SFY 2012 and the estimated payments/amounts received by the hospitals (Attachment 2). Medicaid payments are made directly to Medicaid providers. Providers retain all of the Medicaid payments. Providers do not return any portion of any payment.

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 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: (See Attachment 4.19-A). The Legislature does not appropriate funds for specific line item programs, such as inpatient hospitals. Appropriations for the total Medicaid Program are divided into four categories: (1) private provider payments; (2) public providers; (3) Medicare Buy-Ins, Supplements, and Clawbacks; and (4) Uncompensated Care Costs. For state fiscal year 2013 (July 1, 2012- June 30, 2013), the amounts appropriated are $4,085,659,765 for private providers, $512,246,407 for public providers, $1,997,626,194 for Medicare Buy-Ins, Supplements and Clawbacks, and $828,780,813 for uncompensated care costs. As indicated in our response to question 1 above, the non-federal share of the estimated $132,298,052 in SFY 2012 of DSH payments was provided using CPEs for Non-Rural Community Hospital payments as set forth in question 1 above. The following steps are taken by Louisiana to verify that the total expenditures certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b):

1. **Each qualifying public hospital completes a "Calculation of Uncompensated Care Costs" Form (Attachment 3) based on cost and payment data per the latest filed Medicare/Medicaid cost report. This form includes a certification statement that the hospital signs. Please see the attached explanation of Louisiana's process for the determination of DSH CPEs (Attachment 4).**

2. **Upon receipt of the completed form, the State Medicaid agency verifies the figures for accuracy utilizing the as filed cost report and paid claims data.**

3. **The Medicaid contract auditor reconciles the uncompensated care costs to the State fiscal year that the DSH payments are applicable to using initially the as filed cost reports, and ultimately the finalized cost reports for the period. Louisiana Medicaid follows Medicare cost reporting and audit standards.**

The listing of hospitals which provided CPEs in SFY 2012, along with estimated payment amounts and amounts retained by each hospital, is supplied in the attachment which responds to question 1 above. These providers are all Hospital Service Districts which have taxing authority, per Louisiana RS 46:1064 (see Attachment 5). As Hospital Service Districts are not State agencies, there is no funding appropriated by the State.

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: (See Attachment 4.19-A). Our response to question 1 above also applies to this question.

4. 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 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: (See Attachment 4.19-A). The following steps are used to calculate the Medicare upper payment limit for:

State Hospitals:

1. **Accumulate Medicaid costs, charges, payments, and reimbursement data for each State hospital 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 State fiscal year using the CMS Market Basket Index for 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. **Using Medicaid claims data from the previous state fiscal year, estimated Medicare payments are determined by running claims data through the Medicare DRG grouper and then using Medicare hospital rates and DRG weights. Outlier and Medical Education payments are added and an adjustment is made to account for differences in the payment mechanism for mothers and neonates (Medicare makes two separate payments, one for the mother and one for the infant) while Louisiana Medicaid makes one payment covering both the mother and infant. The difference in acuity between the Medicare and Louisiana Medicaid population is accounted for by using actual historical Medicaid claims with Medicare DRG weights to determine the facility's case mix index (CMI) instead of the facility's Medicare CMI from their Medicare patients.**

2. **The estimated Medicaid payments are equal to the actual paid amount on a per diem basis plus any other payments that the facility is entitled (e.g. outlier payments, etc.) based on state guidelines. Medicaid DSH payments will be excluded from consideration as required.**

3. **The difference between the estimated Medicare payments less the Medicaid payments for each hospital is totaled for each group of hospitals (public non-state and private) to determine the aggregate upper payment limit.**

The latest UPL demonstration is attached. See note below.

Capitated Payments Adjustments - Methodology and Assumptions:

NOTE: This methodology assumes that recipient behavior and utilization of services is consistent.

1. **Identified all recipients receiving inpatient service last calendar year and identified their expenditures for that service as well as their current status in Bayou Health (BH).**

2. **Identified percentages of expenditures for those recipients in pre-paid vs. fee for service.**

3. **Sorted these recipients and expenditures by Provider.**

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: In accordance with our approved State Plan, both Medicaid and DSH payments to State governmental hospitals are limited to costs. DSH payments to non-State public governmental hospitals are limited to costs, per our approved State Plan and Section 1923(g). 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 paid to the hospital. Only payments determined by audit to exceed allowable payments as defined in our approved State Plan are identified as overpayments.

Please substitute the attached revised State Plan page for Attachment 4.19-B, Item 2a, Page 10 originally submitted for this State Plan amendment. The state also request a pen and ink change to remove Attachment 4.19-B, Item 2a, Page 9 from the Form 179.

Please consider this a formal request to begin the 90-day clock. It is anticipated that this additional information will be sufficient to result in the approval of the pending plan amendment, or we look forward to negotiating with CMS to ensure approval. If further information is required, please let me know.

Sincerely,

J. Ruth Kennedy
Medicaid Director

Attachments

JRK/DA

c: Ford J. Blunt III, Dallas Regional Office

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **12-64**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 15, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447, Subpart F

7. FEDERAL BUDGET IMPACT:
a. FFY **2013** **$1,637,75**
b. FFY **2014** **$6,257,58**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Item 1, Page 10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
None (New Pages)

10. SUBJECT OF AMENDMENT: **The purpose of this SPA is to revise the reimbursement methodology for outpatient hospital services to establish supplemental Medicaid payments to encourage them to take over the operation and management of state-owned and operated hospitals that have terminated or reduced services.**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Interim Secretary

15. DATE SUBMITTED:
April 25, 2013

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

LOUISIANA TITLE XIX STATE PLAN

TRANSMITTAL #: **12-64**

FISCAL IMPACT:

TITLE: **Outpatient Hospital Services - Public-Private Partnerships-Reimbursement Methodology**

Increase

EFFECTIVE DATE: **April 15, 2013**

	year			*# mos	range of mos.	state fiscal year years
1st SFY	2013			0	January 2, 2013 - June 2013	$0
2nd SFY	2014			12	July 2013 - June 2014	$10,000,000
3rd SFY	2015			12	July 2014 - June 2015	$10,300,000

*#mos-Months remaining in fiscal year

Total Increase in Cost FFY **2013**

State Fiscal Year	2013	$0	for	0	months	January 2, 2013 - June 2013		$0
Federal Fiscal Year								
State Fiscal Year	2014	$10,000,000	for	12	months	July 2013 - June 2014		
Federal Fiscal Year		$10,000,000	/	12 X	3	July 2013 - September 2013	=	$2,500,000
								$2,500,000

FFP (FFY 2013) = $2,500,000 X 65.51% = $1,637,750

Total Increase in Cost FFY **2014**

State Fiscal Year	2014	$10,000,000	for	12	months	July 2013 - June 2014		
Federal Fiscal Year		$10,000,000	/	12 X	9	October 2013 - June 2014	=	$7,500,000
State Fiscal Year	2015	$10,300,000	for	12	months	July 2014 - June 2015		
Federal Fiscal Year		$10,300,000	/	12 X	3	July 2014 - September 2014	=	$2,575,000
								$10,075,000

FFP (FFY 2014)= $10,075,000 X 62.11% = $6,257,583

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 Public-Private Partnerships

The department shall provide supplemental Medicaid payments for outpatient hospital services rendered by non-state privately owned hospitals that meet the following conditions.

A. Baton Rouge area CEA

Qualifying Criteria

In order to qualify for the supplemental payment, the non-state hospital must enter into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of outpatient Medicaid and uninsured hospital services by providing services that were previously delivered and terminated by the state owned and operated facility in Baton Rouge, Earl K. Long Medical Center.

Reimbursement Methodology

Effective for dates of service on or after April 15, 2013, a quarterly supplemental payment shall be made to this qualifying hospital for outpatient services based on the annual upper payment limit calculation up the maximum Medicare upper payment limit per state fiscal year. Maximum payments shall not exceed the upper payment limit.

The newspapers of **Louisiana** make public notices from their printed pages available electronically in a single database for the benefit of the public. This enhances the legislative intent of public notice - keeping a free and independent public informed about activities of their government and business activities that may affect them. Importantly, Public Notices now are in one place on the web (www.PublicNoticeAds.com), not scattered among thousands of government web pages.

County: Orleans
Printed In: The Times-Picayune
Printed On: 2012/10/31

PUBLIC PROCESS NOTICE Department of Health and Hospitals Bureau of Health Services Financing Inpatient and Outpatient Hospital Services Public-Private Partnerships Supplemental Payments The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend the provisions governing inpatient and outpatient hospital services to establish supplemental Medicaid payments to non-state owned hospitals in order to encourage them to take over the operation and management of state-owned hospitals that have terminated or reduced services. Participating non-state owned hospitals shall enter into a cooperative endeavor agreement with the department to support this public-private partnership initiative. This action is being taken to promote the health and welfare of Medicaid recipients by maintaining recipient access to much needed hospital services. Effective November 1, 2012, the Department of Health and Hospitals, Bureau of Health Services Financing proposes to promulgate Emergency Rules to adopt provisions to establish supplemental Medicaid payments for inpatient and outpatient hospital services provided by non-state owned hospitals participating in public-private partnerships. Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required. Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to inquiries regarding this public notice. The deadline for receipt of all written comments is December 3, 2012 by 4:30 p.m. A copy of this public notice is available for review by interested parties at parish Medicaid offices. Bruce D. Greenstein Secretary

Public Notice ID: 19519656

36:2044 (September 2010), amended LR 37:3267 (November 2011), LR 38:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein
Secretary

1211#094

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Outpatient Hospital Services—Public-Private Partnerships
Supplemental Payments (LAC 50:V.Chapter 67)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.Chapter 67 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend the provisions governing outpatient hospital services to establish supplemental Medicaid payments to non-state-owned hospitals in order to encourage them to take over the operation and management of state-owned hospitals that have terminated or reduced services. Participating non-state-owned hospitals shall enter into a cooperative endeavor agreement with the department to support this public-private partnership initiative.

This action is being taken to promote the health and welfare of Medicaid recipients by maintaining recipient access to much needed hospital services. It is estimated that implementation of this Emergency Rule will be cost-neutral to the Medicaid Program for state fiscal year 2012-2013 as the supplemental payments to participating non-state-owned hospitals will be funded with the savings realized from the reduced payments (DSH and Medicaid) to state-owned and -operated hospitals.

Effective November 1, 2012, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions to establish supplemental Medicaid payments for outpatient hospital services provided by non-state-owned hospitals participating in public-private partnerships.

Title 50
PULIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 5. Outpatient Hospital Services
Chapter 67. Public-Private Partnerships
§6701. Qualifying Hospitals

A. Non-State Privately Owned Hospitals. Effective for dates of service on or after November 1, 2012, the department shall provide supplemental Medicaid payments for outpatient hospital services rendered by non-state privately owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a non-state privately owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of outpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state-owned and -operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state-owned and -operated facility.

B. Non-State Publicly Owned Hospitals. Effective for dates of service on or after November 1, 2012, the department shall make supplemental Medicaid payments for outpatient hospital services rendered by non-state publicly owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a non-state publicly owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of outpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state-owned and -operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state-owned and -operated facility.

C. Non-State Free-Standing Psychiatric Hospitals. Effective for dates of service on or after November 1, 2012, the department shall make supplemental Medicaid payments for outpatient psychiatric hospital services rendered by non-state privately or publicly owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a non-state privately or publicly owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of outpatient Medicaid and uninsured psychiatric hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state-owned and -operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state-owned and -operated facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:

§6703. Reimbursement Methodology

A. Payments to qualifying hospitals shall be made on a quarterly basis in accordance with 42 CFR 447.272.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Bruce D. Greenstein
Secretary

1211#009

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Outpatient Hospital Services—Small Rural Hospitals
Low Income and Needy Care Collaboration
(LAC 50:V.5311, 5511, 5711, 5911 and 6113)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.5311, 5511, 5711, 5911, and 6113 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

In compliance with Act 327 of the 2007 Regular Session of the Louisiana Legislature, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the reimbursement methodology governing state fiscal year 2009 Medicaid payments to small rural hospitals for outpatient hospital services (*Louisiana Register*, Volume 35, Number 5). The Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for outpatient hospital services to provide for a supplemental Medicaid payment to small rural hospitals that enter into an agreement with a state or local governmental entity for the purpose of providing healthcare services to low income and needy patients (*Louisiana Register*, Volume 37, Number 11). The department promulgated an Emergency Rule which amended the provisions of the October 20, 2011 Emergency Rule in order to clarify the qualifying criteria (*Louisiana Register*, Volume 37, Number 12). This Emergency Rule is being promulgated to continue the provisions of the December 20, 2011 Emergency Rule. This action is being taken to secure new federal funding and to promote the public health and welfare of Medicaid recipients by ensuring sufficient provider participation in the Hospital Services Program.

Effective December 17, 2012, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for outpatient hospital services rendered by small rural hospitals.

Title 50
PULIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 5. Outpatient Hospital Services
Chapter 53. Outpatient Surgery
Subchapter B. Reimbursement Methodology
§5311. Small Rural Hospitals

A. – B.

C. Low Income and Needy Care Collaboration. Effective for dates of service on or after October 20, 2011, quarterly supplemental payments will be issued to qualifying non-state hospitals for outpatient surgery services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement

a. A non-state hospital is defined as a hospital which is owned or operated by a private entity.

b. A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Payments shall be distributed quarterly based on Medicaid paid claims for service dates from the previous state fiscal year. Payments to hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program shall be limited to the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period. Aggregate payments to qualifying hospitals shall not exceed the maximum allowable cap for the state fiscal year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:956 (May 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:

Chapter 55. Clinic Services
Subchapter B. Reimbursement Methodology
§5511. Small Rural Hospitals

A. - B. …

C. Low Income and Needy Care Collaboration. Effective for dates of service on or after October 20, 2011, quarterly supplemental payments will be issued to qualifying non-state hospitals for outpatient hospital clinic services rendered during the quarter. Maximum aggregate payments to all