Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

April 5, 2012

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMSO
7500 Security Boulevard, M/S S3-13-15
Baltimore, MD 21244-1850

RE: TN 11-38

Dear Mr. Cooley:

Please refer to our proposed amendment to the Medicaid state plan submitted under transmittal number (TN) 10-38 with a proposed effective date of November 1, 2011. The purpose of this amendment is to provide for a supplemental payment for inpatient hospital services rendered by non-rural, non-state hospitals designated as a major teaching hospital. We are providing the following additional information as requested in your correspondence dated February 23, 2012, which stopped the clock on this transmittal.

1. Please provide documentation to support the $375,410,716 amount on the fiscal impact attachment.

   Response: See attached.

2. This amendment is effective November 1, 2011. Therefore, FMAP rates for FFY 2012 and FFY 2013 should be used on fiscal impact attachment. Please recalculate fiscal impact using proper rates. In addition, please submit a revised CMS -179 or authorize pen changes.

   Response: Revised fiscal impact worksheet provided on 2/23/12 along with request for pen and ink change to block 7 of the CMS - 179. See attached.

3. Please provide copies of all signed standard Low Income and Needy Care Collaboration Supplemental Reimbursement Program for Private and Non-State Nursing Facilities. In addition, please provide copies of all signed Intergovernmental Transfer (IGT) agreements that will used to implement this funding source.

4. How many entities does the State anticipate will participate in this arrangement? Please submit a list of all participating Nursing facilities, all transferring entities doing the IGT, and the dollar amount that the transferring entities will IGT. Please describe how the nursing facilities are related/ affiliated to the transferring entity and provide names of all owners of the participating nursing facilities.

   Response: There are currently 258 nursing home providers in Louisiana Medicaid.

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/parish or some other source? Please provide the county/city/parish legislation authorizing the IGTs.

   Response: It is currently unknown what entities will participate in this program and where the source funds will be transferred from. DHH will ensure that all IGTs are compliant with CMS regulations applicable.

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

   Response: The Governmental Entity Certification includes a statement (h. on page 3 of the attached document) certifying that participation in the IGT transfers is voluntary. (See attached).

7. Are the nursing facilities required to provide a specific amount of health care service to low and health care 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 UPL Payments. UPL payments are not related to any other health services provided other than already billed Medicaid nursing home services.

8. Please provide the UPL demonstration applicable to the current rate year for all classes (state government, non-state government, private) of nursing facilities that are affected by this amendment. The UPL demonstrations should include a comprehensive narrative description of the methodology (step by step) to determine UPL. The demonstrations should also include a spreadsheet with provider specific information that starts with the source data and result. All source data should be clearly referenced (i.e. cost report year, W/S line and column, claims reports, etc.) in demonstrations. Please submit all source documentation for CMS to review.

   Response: The UPL demonstration for privately owned or operated nursing facilities is attached. The calculation of the Medicare upper payment limit for nursing facilities involves three components. The methodology utilized to calculate the upper payment limit involved:

1. **Estimating what would have been paid for Louisiana Medicaid nursing facility residents using Medicare payment principles.**

2. **Identifying what was actually paid for Louisiana Medicaid nursing facility residents.**

3. **Adjusting for the difference between component one and two for coverage differences between Medicare and Louisiana Medicaid.**

There are many variables within these three major components. Following is a detailed description of how each component was calculated:

Estimating Medicaid rates using Medicare payment principles
The first step in calculating the Medicare upper payment limit is to estimate what Medicaid would pay if they followed Medicare Payment principles. As Medicare has moved to the prospective payment system, this step involves calculating Medicare rates based on Medicaid acuity data. Following is a summary of the steps involved:
Using each resident's minimum data set assessment, the applicable RUG-III grouper code for Medicaid residents was identified. A frequency distribution of Medicaid residents in each of the Medicare RUG classification categories was then generated.
After the Medicaid resident frequency distribution was developed, rural and urban rate differentials and wage index adjustments were used to adjust the Medicare rate tables. The resulting rates were multiplied by the number of Medicaid residents in each RUG category, summed and then averaged.

Determining Actual Medicaid Rates
The actual Medicaid rates were provided from the Department of Health and Hospitals. These rates were updated for each state fiscal year and reflect the rate actually paid by the Department of Health and Hospitals for Medicaid residents in each of the nursing facilities.

Adjusting for Differences between Medicare Principles and Louisiana Medicaid
An adjustment to the calculation of the upper payment limit is necessary to account for the differences in coverage between the Medicare PPS rate and what Louisiana Medicaid covers within the daily rate provided above. To accomplish this, a data file was used by the Department that detailed drug, lab, and x-ray claims that were paid on behalf of nursing facility residents for other than their routine daily care. This data was inflated to the current fiscal year.

Calculation of UPL Difference
The estimated upper payment limit difference is then calculated by subtracting the sum of the routine Medicaid rate from the Medicare rate.

The following questions are being asked and should answered in relation to **all payments**

made to all providers under Attachment 4.19-D of your State plan.

9. Section 1903(a)(l) 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 portion please 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 the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

   Response: Providers receive and retain 100% of the payments, including the state and federal share. No portion is returned to the state.

10. Section 1902(a)(2) provides that the lack of adequate from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under plan. Please describe how the state of each type of Medicaid payment (normal 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 the state to provide state share. Note that, if appropriation is not to the Medicaid agency, the source of the state would necessarily 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 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. transferring level of appropriations).

    Response: The state share will be funded by state appropriations comprised of state general funds and voluntary IGTs from non-state governmental entities. DHH does not yet know which of these non-state governmental entities will be participating or the amounts. DHH will ensure that any insure that any IGT in this program is compliant with CMS regulations regarding IGT and general taxing authority.

11. Section 1902(a)(30) requires payments for services consistent with efficiency,

economy, 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 total amount for each type of supplemental or enhanced payment made to each provider type.

Response: This amendment proposes to make supplemental payments to Nursing Home providers for services provided to Medicaid recipients. It is estimated that for SFY 12 the total UPL payments to qualifying entities is $507,404,544 total funds.

Does any governmental provider receive payments that 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 return the Federal share of the excess to CMS on the quarterly expenditure report?

Response: Non-state government owned or operated nursing facilities are reimbursed using the same prospective payments systems that is used to reimburse privately owned or operating nursing facilities. These providers are not paid in excess of the Upper Payment Limit as demonstrated in the UPL Demonstration for non-state owned government providers and therefore are not cost settled.

State owned or operated nursing facilities are not included in this 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 Keydra Singleton at (225) 342-4294.

We appreciate the assistance of Sandra Dasheiff in resolving these issues.

Sincerely,

Don Gregory
Director

Attachment

c: Sandra Dasheiff, NIRT