DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

December 13, 2012

Our Reference: SPA LA 12-32

Ms. Ruth Kennedy, State Medicaid Director
Department of Health and Hospitals
628 North 4th St.
P.O. Box 91030
Baton Rouge, LA 70821-9030

Attention: Keydra Singleton

Dear Ms. Kennedy:

We have reviewed your request to amend the Louisiana State Plan submitted under Transmittal No. 12-32, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 26, 2012. This amendment seeks to establish Medicaid payment of uncompensated care costs for services rendered by the Office of Public Health (OPH) to Medicaid eligible recipients for the following services: family planning; sexually transmitted diseases; tuberculosis; Children's Special Health Services (CSHS); laboratory services; newborn screening; Nurse Family Partnership; maternity-prenatal services; and children's health.

We conducted our review of your submittal according to the applicable federal regulations and guidelines. Before we can continue processing this amendment, we need additional or clarifying information. Since the plan is the basis for Federal financial participation, it is important that the plan's language be clear and unambiguous. Therefore, we have the following questions/concerns regarding TN 12-32.

Funding Questions

1. The OPH receives funding from various other federal entities for the services they provide to the public. Does the funding from other federal sources exclude Medicaid eligible beneficiaries? If not, then why is this not a duplicative payment to the OPH?

Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or

for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

2. 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.)

3. 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).

4. 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.

5. 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.

6. 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?

Reimbursement Questions

7. For the categories of services for which the State is requesting reimbursement of the uncompensated care costs for services rendered to Medicaid enrollees, please describe how these services are currently billed and reimbursed by Medicaid?

8. Please provide the methodology for how "costs" will be developed for each service for which the State is requesting reimbursement of the uncompensated costs.

9. How will costs be allocated to insure that only uncompensated care costs applicable to Medicaid enrollees are included in the cost reporting process?

10. Will the State include any indirect costs in determining uncompensated care costs and if so, how will such costs be determined and allocated?

11. How will the State identify true 1905(a) services billed for these individuals? Are these individuals receiving full screenings and meeting the definition of the Medicaid services as listed in the Louisiana State plan?

12. In order to bill for Medicaid services a provider must enroll and meet the qualifications of a State's Medicaid program. If these services are true Medicaid covered services, the OPH can simply enroll as a Medicaid provider and bill accordingly for these services.

Other Related SPAs – Same Page Issues

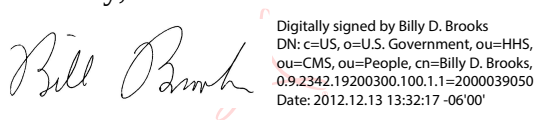
13. This SPA is related to three other SPAs LA SPAs 12-26, 12-31, and 12-40 with an effective date of July 1, 2012. These three rate reduction SPAs are on the same page with the same effective as LA SPA 12-32. The State must either combine these SPAs into one SPA or change the effective dates on these of the SPAs to a later date.

We are requesting this additional/clarifying information under provisions of Section 1915(f) of the Social Security Act. This has the effect of stopping the 90-day time frame for CMS to take action on the material. A new 90-day time frame will not begin until we receive your response to this request.

In accordance with our guidelines to all 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.

If you have any questions regarding this letter, please contact Ford Blunt at 214-767-6381 by phone or by email at ford.blunt@cms.hhs.gov.

Sincerely,



Bill Brooks
Associate Regional Administrator