DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

December 3, 2013

Our Reference: SPA LA 13-31

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: Darlene York
Jodie Hebert

Dear Ms. Kennedy:

We have reviewed your request to amend the Louisiana State Plan submitted under Transmittal No. 13-31, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 16, 2013. This amendment adds a supplemental payment to physicians and other professional services practitioners employed by a physicians group affiliated with certain non-state owned hospitals participating in public-private partnerships.

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 13-31.

CMS-179

1. There is no fiscal impact listed in block 7 of the CMS-179. Is it the State's intention that the supplemental payment offsets some other payments rendered to these physicians and other professional service practitioners? If so, please explain in more detail. If not, please put in the appropriate federal budget impact amount.

2. In block 10, please indicate the applicable hospital or hospitals with whom these physicians and other professional service practitioners are associated. Please provide a break out of the Federal fiscal impact by hospital.

Reimbursement Issues

3. Why did the state select "participation in a public-private partnership" as the criteria that would allow a facility to qualify for the proposed supplemental payments?

4. How does the State define a public-private partnership? What formal agreements must be in place between the private facility and the public facility to indicate the presence of a public private partnership?

5. Both submitted pages Attachment 4.19-B, Item 5, Page 9a and 9b were submitted in redline format. Please send in those pages in final format with no redline.

6. Please submit the State's ACR demonstration to CMS utilizing the top 5 commercial payers. Provide the name of each payer used in the calculation.

7. The language in the SPA submittal for the calculation of the ACR needs to more comprehensive. CMS suggested the use the language from the ACR approved for the Tulane physician group. Please revise the SPA language so that it is more comprehensive in nature.

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.

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 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).

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.

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.

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?

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