Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

March 25, 2014

Bill Brooks
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health Operations
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, TX 75202

RE: LA SPA 13-48 RAI Response
Inpatient Hospital NR, NS Supplemental Payment Pool Reduction (High Medicaid)

Dear Mr. Brooks:

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 13-48 with a proposed effective date of November 20, 2013. The SPA proposes to reduce annual supplemental Medicaid payments to $1,000,000 for qualifying non-rural, non-state acute care hospitals that qualify as high Medicaid hospitals. We are providing the following additional information as requested in your RAI correspondence dated March 4, 2014.

UPPER PAYMENT LIMIT (UPL)

1. Please provide an updated UPL demonstration. CMS needs a better idea of the true impact for TN#13-48 and how much room will be available for inpatient hospital supplemental payments.

   Response: The updated UPL demonstration is attached.

STATE PLAN LANGUAGE

2. 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. 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 447.271(a).

   Response: The language has been revised to meet CMS criteria.

3. 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 state's intent with this state plan amendment is to go from quarterly payment distribution (annual calculation of which a fourth is distributed quarterly) to an annual payment distribution.

4. Please provide CMS with the name and location of hospitals affected by this proposed change.

   Response: The qualifying hospitals in this group are:

1700240	Teche Regional Med. Ctr. (+DPP 1705861)
1730106	Rapides Regional Medical Center
1730254	American Legion (+DPP 1705501)
1734489	Children's Hospital (+DPP 1700851)
1734560	Woman's Hospital - Baton Rouge
1763799	Tulane University Hosp. & Clinic (+DPP 1705594)
1764981	Regional Medical Center of Acadiana
1766062	Savoy Medical Center (+DPP 1705772)
1767671	Womens' & Children's - Lake Charles

5. Please clarify if Attachment 4.19-A, Item 1, page 8b, applies to private, State or Non-state inpatient hospital services.

   Response: The language on this page states that a "non-rural, non-state hospital is a hospital which is owned and operated by either a private entity, a hospital service district or a parish and does not meet the definition of a rural hospital as set forth in Louisiana R.S. 40:1300.143."

6. Please note the title of the section should be revised to include private hospitals.

   Response: The language has been revised (see Attachment 4.19-A, Item 1, Page 8b).

ADDITIONAL

7. 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: The rates for these providers have not changed. Only the supplemental payment pool amount has been reduced due to budget constraints. These hospitals also qualify for DSH UCC payments.

8. How were providers, advocates and beneficiaries engaged in the discussion around this SPA proposal? 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: The reduction in the supplemental pool payment was part of the budget negotiations and included stakeholders and legislators. Additionally, the Louisiana Administrative Procedure Act requirements for public notice were followed with publication of the Public Process Notice and Emergency Rule.

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.)

   Response: (Attachment 4.19-A). There were 37 public non-state owned hospitals that qualified for DSH payments applicable to SFY 2013 (10 Non-Rural Hospitals and 27 Rural Hospitals), and each of these hospitals certified its allowable uncompensated care costs as expenditures eligible for Federal Financial Participation (FFP). The reportable DSH amount in SFY 2013 was $141,339,750 (FFP $86,433,243). 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 14 of the 2013 Regular Session. Attached are Act 14 of the 2013 Regular Session (Attachment 1) and a listing of the qualifying hospitals in SFY 2013 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 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).

   Response: (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 2014 (July 1, 2013- June 30, 2014), the amounts appropriated are $4,175,873,037 for private providers, $270,304,274 for public providers, $2,393,128,806 for Medicare Buy-Ins, Supplements and Clawbacks, and $865,024,767 for uncompensated care costs. As indicated in our response to question 1 above, the non-Federal share of the estimated $141,339,750 in SFY 2013 of DSH payments was provided using CPEs for 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 2013, 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 R.S. 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: (Attachment 4.19-A). Our response to question 1 above also applies to this question.

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.

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

<u>State Hospitals</u>

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 sum of the difference for each hospital, including inflation, is the supplemental payment that can be reimbursed to state hospitals subject to the limitations on Medicaid inpatient hospital payments in 42 CFR 447.271 and 447.272.**

Non-state Hospitals (Public and Private)

1. **Calculate estimated Medicare payment per discharge for each hospital by totaling a.-c. below:**

   a. **Medicare operating payments are calculated by taking the Medicaid claims data and running each claim through the Medicare MS-DRG grouper to assign the appropriate DRG and weight from the current Medicare Inpatient PPS system. Total Medicare operating payments are then calculated for each hospital by multiplying the Medicaid case mix index under the Medicare weight set by the Medicare current FFY operating rate, using information from the Federal Register current FFY final rule, the Medicare inpatient Public Use File to determine the CBSA of each hospital, and the Medicare Inpatient Pricer to verify the operating rate for each facility. Since this payment includes the current FFY operating rate, no inflation is applied to this payment.**

   b. **Medicare non-operating acuity-adjusted payments include Medicare payments for IME and Capital and are taken from the Medicare cost report. The per discharge payment is calculated by dividing by the Medicare discharges from the same cost report. The Medicare per discharge payment represents reimbursement at the Medicare patient acuity-level, so the calculated per discharge amount is adjusted by multiplying by the ratio of the CMI of Medicaid claims under the Medicare PPS to the CMI of Medicare claims under the Medicare PPS, which is taken from the Public Use File. This acuity-adjusted per discharge amount represents the estimate of what Medicare would for these services at each hospital if specifically for the Medicaid patient population. The acuity-adjusted payment per discharge is then inflated from the cost report period to current year.**

   c. **Non-Acuity based Medicare payments include Medicare reimbursement from the cost report for outliers, DSH, Direct Graduate Medical Education, pass through costs, and reimbursable bad debt. Each payment total is taken from the Medicare cost report and then divided by the Medicare discharges to create an estimated per discharge payment, which is then inflated from the Medicare cost report period to current year.**

2. **For Critical Access Hospitals, there is insufficient claims data to assign a reliable DRG under the Medicare PPS and the Medicare PPS system is an inappropriate model for estimating Medicare payments, so an alternative methodology is used. For each of these facilities, total Medicare cost and Medicare days are taken from the cost report and a cost per day is calculated. The acuity level of this cost is then tied to the hospital's Medicaid population by multiplying by the claim days per discharge from the MMIS system to create**

an estimated cost per discharge for the Medicaid population. This cost per discharge is then inflated from the cost report period to current year.

3. **Medicaid allowed payments are estimated from the reported hospital payments and TPL payments on the claims from the latest fiscal year or calendar year, scaled to represent the allowed amount for current year. Allowed payments from the claims data are adjusted by the total effect of each rate adjustment which impacted Medicaid hospital payments from the beginning service dates of the historical claims through current state fiscal year to estimate the amount the claims are paid under the Louisiana Medicaid system in the current year. To calculate total Medicaid payments per discharge for comparison to the Medicare allowed rate, Medicaid outlier payments, GME Payments, and supplemental payments for LINCCA, high Medicaid facilities and Major Teaching facilities were added to Medicaid claim payments. The total payments received from Medicaid are divided by claims discharges in the data set to yield the adjusted Medicaid payments per discharge in current year.**

4. **To determine the separate aggregate UPL caps for the inpatient non-state public and private hospital groups, each hospital's adjusted Medicaid payments per discharge is subtracted from their Medicare adjusted payments per discharge. The difference per discharge rate by hospital is multiplied by the hospital's number of claims discharges to determine the individual hospital payments difference between Medicare and Medicaid. The sum of the difference for each hospital for all hospitals in the group is the upper payment limit for that group of hospitals.**

The current UPL demonstration is attached.

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 the page originally submitted with this SPA. 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. We look forward to negotiating with CMS to ensure approval. If further information is required, you may contact Darlene Adams at Darlene.Adams@la.gov or by phone (225)342-3881.

We appreciate the assistance of Tamara Sampson in resolving these issues.

Sincerely,

J. Ruth Kennedy
Medicaid Director

RK/DA/sj

Attachments (7)