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

June 10, 2015

Our Reference: SPA LA 15-0008

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 Budgewater

Dear Ms. Kennedy:

We have reviewed your request to amend the Louisiana State Plan submitted under Transmittal No. 15-0008, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 20, 2015. This amendment proposes to amend the provisions governing outpatient hospital services rendered by non-rural, non-state hospitals in order to adopt a supplemental payment methodology for services provided by hospitals located in the Baton Rouge area.

We conducted our review of your submittal according to statutory requirements at sections 1902(a)(15), 1902(a)(30) of the Social Security Act (the Act) and the regulations at 42 Code of Federal Regulations (CFR) 447 Subpart F. 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 15-0008.

CMS-179

1. Block 7 – This is a SPA that proposes a supplemental payment yet there is no federal budget impact in the associated Block 7 of the CMS-179. Please provide a detailed analysis of how the FFP determination was made and provide supporting documentation of the calculation for Federal Fiscal Year (FFY) 2016 and 2017.

EFFICIENCY, ECONOMY, AND QUALITY OF CARE

2. Section 1902(a) (30) (A) of the Act requires that payment rates must be consistent with "efficiency, economy and quality of care." Please justify how the establishment of payments is consistent with the principles of "efficiency, economy, and quality of care."

SIMPLICITY OF ADMINISTRATION

3. 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.

LEGISLATION

4. Please clarify if the State or a Hospital Service District has issued any proposals or enacted any legislation to support these supplemental payments. Please submit that documentation for our review.

REIMBURSEMENT PAGE

5. The State plan must be more comprehensive in nature for these supplemental payments. 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. What method will the State use to determine these supplemental payments?

6. This SPA indicates hospitals located in the Baton Rouge area. Please indicate which hospitals will be receiving these supplemental payments and how much these hospitals will receive by indicating their portion of the maximum allowable cap.

7. CMS has concerns with the appearance of contingent funding proposed in the plan language. To comply with CMS regulations, please review the state plan pages to remove any language pertaining to payments based upon the availability of funding. For example, it mentions "the budgeted state fiscal year supplemental payment amount included in the Annual Appropriations Act as allocated to this specific program in the budget spread pursuant to the Department's reimbursement policy". The State should include specific language in the proposed State plan pages.

8. CMS wants the State's assurance regarding financial transactions including IGT. The following sentence should be included in the reimbursement methodology:

   "No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity."

9. Did the State receive any feedback or complaints from the public regarding the current proposal or about the changes to the outpatient hospital services rendered by hospitals located in the Baton Rouge area? If so, what were the concerns and how were they addressed and resolved?

10. Please use the applicable lettering, numbering instead of bullet points for the plan page.

Please clarify the additional questions related to the new supplemental payments:

11. Please justify why Louisiana needs to pay supplemental payments for outpatient hospital services rendered by hospitals located in the Baton Rouge area? Why do these payments need to be made for these specific services?

12. Does the state expect that these payments will positively impact access to care or quality of care? If so, how?

13. If it is to improve access, please provide data that shows there is an access issue.

14. What specific outcome(s) does the state hope to achieve by making these supplemental payments to the targeted providers?

15. Will the state monitor the impact of the supplemental payments with respect to the expected outcomes?

16. How will the State measure if targeting payments resulted in the desired outcome?

17. How do the supplemental payments compare to the base payments?

18. Has the State done any analysis to increase the base payments for these outpatient hospital services rendered by hospitals located in the Baton Rouge area?

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.

19. 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.)

20. 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).

21. 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.

22. 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

23. Please provide a detailed description of the methodology used by the State to estimate the 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.

24. 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