Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

July 6, 2015

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

Dear Bill:

RE: LA SPA TN 15-0004 RAI Response
Inpatient Hospital Services-Children's Specialty Hospitals-Supplemental Payments for New Orleans Area Hospitals

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 15-0004 with a proposed effective date of February 12, 2015. The purpose of this SPA is to adopt a supplemental payment methodology for inpatient hospital services rendered by children's specialty hospitals in the New Orleans area. We are providing the following additional information as requested in your RAI correspondence dated June 1, 2015.

FORM-179

1. Form 179, Block 7 – Please provide a detailed analysis of how the zero impact determination was made and provide supporting documentation for Federal Fiscal Year (FFY) 2016 and 2017.

   Response: This State Plan Amendment (SPA) has no fiscal impact for Federal Fiscal Year (FFY) 2015 because the State is already at the global Upper Payment Limit (UPL) cap. For FFY 2016, the State will pay no more than the global UPL cap and the hospital specific inpatient charge limits. This SPA will reduce the UPL amount paid under other UPL SPAs in effect re-ordering the UPL priorities. The proposed fiscal impact for FFY 2016 and FFY 2017 is 25 percent of the amount based on estimated FY 2015

payments of $78,089,484 which is $19,522,371. The 25 percent reduction factor is due to the expanded managed care implementation July 1, 2015.

EFFICIENCY, ECONOMY, AND QUALITY OF CARE

2. SPA amendment LA 15-0004 proposes to establish supplemental inpatient hospital payments to qualifying children's specialty hospitals in the New Orleans area. 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."

   Response: Children's specialty hospitals, with a full array of pediatric subspecialists, offer numerous advantages that facilitate the delivery of quality care in an efficient and economical manner. The availability of the full gamut of subspecialists has implications for the care of episodic illness or injury in an otherwise healthy child, as well as the ongoing care of chronically ill, medically complex children. The routine availability of subspecialty trained, pediatric-specific services allows the efficient diagnosis and treatment onsite, without the need for multiple visits to multiple providers, incurring increased cost to the Medicaid program. Children's specialty hospitals are able to provide disease specific, team based care where multidisciplinary teams evaluate and treat the patient during the same visit. Diseases as varied as craniofacial abnormalities/cleft palate and autism spectrum disorder are evaluated and treated by this methodology, which in addition to being convenient for the patient, has been shown to increase efficacy and coordination of care. Table 1 (see page 3) lists a selection of comprehensive programs that only Children's Hospital of New Orleans currently offers in the region. As the sole freestanding children's hospital in the area, Children's Hospital of New Orleans is also the primary resource for chronically ill, medically complex children. By virtue of the hospital's mission and the specific assets available for these children being located under one roof, Children's Hospital of New Orleans has become the *de facto* safety net hospital for many chronically ill, medically complex children in the region. Throughout the nation, an increase in both raw numbers and hospitalization rates of children with complex, chronic conditions has been documented[1,2]. Children's specialty hospitals are ideally suited to coordinate and manage the care of these patients because of the availability of specialty resources, and the ability to establish programs to manage chronic complex conditions with the goal of decreasing hospitalization[3]. The Children's Hospital Ventilator Assisted Care Program is a notable example of this concept where technology (home ventilator) dependent children are served by a multidisciplinary team that arranges coordination of the myriad of details of medical care and family support that are required to manage these children at home with a primary goal of reducing hospitalization. This

program is unique within the state of Louisiana. Without this hospital-based program, many of these children would be relegated to a long-term care facility, or require frequent acute care hospitalizations far from home because few community hospitals are able to care for a child on a ventilator. This is but one example of the advantages extended by having a critical mass of pediatric specialty providers oriented solely toward the care of children.

Program	**Multispecialty**
Child Advocacy/Child Abuse Treatment (Audrey Hepburn CARE Center)	Yes
Autism Center	Yes
Craniofacial/Cleft Palate Team	Yes
Speech Augmentative Communication Service	Yes
Epilepsy/Functional Neurosurgery Program	Yes
Stem Cell Transplant (FACT Accredited for Children)	Yes
Genetic Disorder Evaluation and Treatment	No
Child Renal Failure (Dialysis) and Renal Transplant	Yes
Neural Tube Defect (Spina Bifida) Clinic	Yes
Congenital Heart Surgery	Yes

TABLE 1

References:

[1]*Pediatrics* 2010; 126:638-646
[2]*Pediatrics* 2010; 126:647-655
[3]*Health Affairs 33, NO. 12 (2014):*2199-2206

The proposed supplemental payments are consistent with 1902(a)(30)(A) as they are well within Children's Hospital's inpatient charge limits and were developed to ensure that in-state access to care remains available for pediatric specialty services. These payments are supplements to the existing base payment rates and have been designed to recognize the increases in Medicaid utilization as a result of the current economic conditions and the need to ensure continued access to quality care as required by 1902(a)(30)(A).

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 this amendment is consistent with simplicity of administration and in the best interest of the children's specialty hospitals in the New Orleans area.

Response: As explained in the response 2 above, Medicaid services provided at Children's Hospital have met or exceeded the services provided through transfers or referrals to other hospitals, both in and out-of state.

LEGISLATION

4. Please clarify if the State, Parish, or a Hospital Service District has issued any proposals or enacted any legislation to support the new supplemental payments methodology for non-rural non-state hospitals in the New Orleans area. Please submit that documentation for our review.

   Response: There are no proposals or enacted legislation relative to this SPA.

UPPER PAYMENT LIMIT (UPL)

5. Please note CMS has not received a "clean" SFY 2014 UPL demonstration calculation.

   Additionally, there is an outstanding deferral for Inpatient Hospital supplemental payments in the amount of $10,094,583 Federal Financial Participation (FFP). The deferral was issued because the State submitted a revised the SFY 2014 UPL demonstration that "zeroed out" column H and I for Children's Hospital in New Orleans. This is not a reasonable estimate.

   Please note that CMS must have a "clean" SFY 2014 UPL prior to CMS taking action on the SPA 15-0004.

   Response: The State has previously submitted the latest SFY 2014 UPL to CMS and is waiting for a response.

STATE PLAN LANGUAGE – 4.19-A

6. Please clarify if there are one or more hospitals that qualify under this methodology. If only one hospital qualifies, then please correct Attachment 4.19-A, Item 1, page 8c (7) to reflect that only one hospital will qualify under this methodology.

   Response: The language has been revised to reflect that this SPA will qualify one hospital, Children's Hospital.

7. Is this facility a non-state or private acute care hospital? Please add clarifying language on the State plan page that specifies the type of hospital and if it is state, non-state or private hospital.

   Response: This facility is a private acute care hospital. The language has been revised to reflect the clarification.

8. Please note that this methodology is not comprehensive. To comply with regulations at 42 CFR 447.252(b), 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.

   Currently, the State uses the DRG methodology to determine the Medicare equivalent for all the hospitals in the "private bucket" except for the Children's Hospital in New Orleans. It appears some sort of cost method was utilized in the revised UPL demonstration for State Fiscal Year (SFY) 2014. Currently, the State's treatment of Children's Hospital in New Orleans is inconsistent with a reasonable Medicare estimate. Therefore, the methodology for TN#15-0004 must be specific. There should be step by step instructions that a provider could follow. For example,

   - How will the State assign a neonatal Medicaid case to the Medicare DRG?
   - What fiscal year (FY) are the cost reports?
   - Will the State use filed or audited cost reports?
   - What columns will be pulled from the cost reports? Where the data was obtained? MMIS or another system
   - How the data will be calculated?
   - How will the acuity level information be used?
   - What inflation factor will the State use? The State must list the web-site on the plan page.
   - Will the State adjust the inflation factor every year?
   - How will the State adjust for managed care?
   - Please note that language should be added that that UPL demonstration is an annual calculation.

   Response: Medicare Diagnosis Related Groups (DRGs) (as used to calculate the aggregate Medicare equivalent UPL for non-critical access acute hospitals other than Children's) are not accurate to price claims for children's specialty hospitals. Medicare currently reimburses children's specialty hospitals using a cost based methodology. Therefore, the Medicare UPL that is included in the Louisiana "private bucket" attributable to Children's Hospital in New Orleans Medicaid claims is calculated using a cost methodology. This cost is calculated by multiplying claim charges for the UPL claims period by a calculated cost-to-charge ratio (CCR), based on the most recently available submitted cost report published by Centers for Medicare and Medicaid Services (CMS) in the Hospital Cost Report Information System (HCRIS) database.

The CCR is a calculated CCR for inpatient services, which is obtained by including charges and cost from three separate inpatient cost center ranges: Routine (Worksheet C, Line 30-40, Columns 6 and 3), Ancillary (Worksheet C, Lines 50-92, Column 6 and the product of columns 6 and 10), and Organ Acquisition (Worksheet D-4, Part III, Line 61, Column 3 and Worksheet C, Part I, Column 3). These separate charges and cost are summed together to create overall hospital inpatient charges and cost. The ratio is the overall hospital inpatient CCR. The resulting CCR is applied to charges for the Medicaid claims so that the result represents the cost of the Medicaid claims at the hospital. Since this claims data is directly from the Medicaid fee-for-service (FFS) claims volume, no further adjustments for acuity, DRG assignment, or managed care programs need to be made. Inflation was not applied to these costs.

9. CMS has concerns with the appearance of contingent funding proposed in the plan language. To comply with regulation at 42 CFR 447.252(b), 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.

   Response: DHH understands your concerns; therefore, we will modify this language to conform with language in other approved State Plans.

10. 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."

    Response: This language has been added to the reimbursement methodology.

11. Did the State receive any feedback or complaints from the public regarding the current proposal or about the changes to children's specialty hospitals in the New Orleans area arrangements? If so, what were the concerns and how were they addressed and resolved?

    Response: The public process notice was published in the eight major daily statewide newspapers on or before February 11, 2015. The State solicited

written comments with a deadline for receipt of March 15, 2015. The State received no written comments.

12. Please justify why Louisiana needs to pay supplemental payments to children's specialty hospitals in the New Orleans area.

    Response: The establishment of supplemental payments is necessary because current base Medicaid rates do not cover the cost of providing these services. At present, greater than 70 percent of the patient population at Children's Hospital of New Orleans is covered by Louisiana Medicaid. The growing population of chronically ill, medically complex patients who are best served by the unique capabilities of a freestanding children's hospital increases the size of the gap between base Medicaid payments and the cost of care required to meet the distinct needs of this growing population.

13. Why do these payments need to be made to these specific providers?

    Response: Please refer to the responses to questions 2 and 12 above.

14. Why has Louisiana decided to target children's specialty hospitals in the New Orleans area to the exclusion of other providers of the same services?

    Response: Please refer to the responses to questions 2 and 12 above.

15. Does the state expect that these payments will positively impact access to care or quality of care?

    Response: As detailed in the response to question 12 above, the State expects these payments to maintain access to care and quality of care to Medicaid recipients that require children's specialty inpatient services in Louisiana.

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

    Response: Please refer to the response to question 15 above.

17. What outcome does the state hope to achieve by targeting payments to children's specialty hospitals in the New Orleans area?

    Response: By targeting payments to decrease the gap between cost of care and Louisiana Medicaid base rates, the State will support access to high quality, pediatric specialty medical care for children with Medicaid. Targeted payments will support specialty care that is difficult or impossible for Medicaid recipients to obtain elsewhere in the State at this time. Examples include congenital heart surgery, complex scoliosis surgery,

management of ventilator dependent children, evaluation for autism spectrum disorders, and treatment for metabolic syndrome/obesity.

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

    Response: Yes.

19. How will the state measure if targeting payments resulted in the desired outcome?

    Response: The State will monitor access to services by Medicaid recipients by having the hospital report patient payer mix for patients other than Neonatal Intensive Care Unit (NICU), which should reflect a percentage of Medicaid recipients at or above the proportion of Medicaid recipients in the general population of the region and state. Evidence of continued innovation in the management of children with chronic, complex conditions will be reported yearly. In order to ensure quality of services and enable comparison to national peer data, participation in national quality registries for Neonatal Intensive Care (Vermont-Oxford), Pediatric Critical Care (Virtual PICU System (VPS) or equivalent), and Congenital Heart Disease (Society of Thoracic Surgeons (STS), Extracorporeal Life Support Organization (ELSO), IMproving Pediatric and Adult Congenital Treatments (IMPACT) and Congenital Cardiac Anesthesia Society (CCAS)) with periodic data sharing will be required.

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

    Response: Medicaid inpatient base rate payments for Children's Hospital FYE December 31, 2013 cost reporting period were $34,444,555. As detailed in the response to #1 above, the proposed supplemental payments are $19,522,371 for SFY 2016.

21. Has the State done any analysis to increase the base payments to children's specialty hospitals in the New Orleans area?

    Response: No. As explained in the response to question 12 above, Children's Hospital is the only provider that offers immediate single location access to accommodate the volume and range of these specialized pediatric and neonatal services in the New Orleans area.

FUNDING QUESTIONS

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.

22. 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: (See Attachment 4.19-A). There were 39 public, non-state owned hospitals that qualified for disproportionate share hospital (DSH) payments applicable to SFY 2014 (10 non-rural hospitals and 29 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 2014 was $146,129,893 (FFP $89,058,680). DSH payments will be limited to 100 percent 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 15 of the 2014 Regular Session. Attached are Act 15 of the 2014 Regular Session (Attachment 1) and a listing of the qualifying hospitals in SFY 2014 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.

23. 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 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: (See 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 SFY 2015 (July 1, 2014- June 30, 2015), the amounts appropriated are $6,249,233,589 for private providers, $265,444,863 for public providers, $556,369,912 for Medicare buy-ins, supplements and clawbacks, and $1,040,577,785 for uncompensated care costs. As indicated in our response to question 1 above, the non-federal share of the estimated $146,129,893 in SFY 2014 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 SFY 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 2014, 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 (HSDs) which have taxing authority, per Louisiana Revised Statute 46:1064 (see Attachment 5). As HSDs are not state agencies, there is no funding appropriated by the State.

24. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for FFP 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: (See Attachment 4.19-A). Our response to question 1 above also applies to this question.

25. 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.

    Response: (See Attachment 4.19-A). The following steps are used to calculate the Medicare UPL for:

    State Hospitals:

    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 SFY using the CMS Market Basket Index for Prospective Payment System (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 Severity Diagnostic Related Grouper (MS-DRG) to assign the appropriate DRG and weight from the current Medicare Inpatient PPS. 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 Core Based Statistical Area (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 Indirect Medical Education (IME) and capital and are taken from the Medicare cost report. The per discharge payment is calculated by dividing 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 Case Mix Index (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 pay 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 (GME), 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 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 the claim days per discharge from the Medicaid Management Information System (MMIS) 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. **The UPL for children's specialty hospitals is calculated using a cost methodology as Medicare does not reimburse these hospitals through DRGs. This cost is calculated by multiplying claim charges for the UPL claims period by a calculated cost-to-charge ratio (CCR), based on the most recently available submitted cost report published by CMS in the HCRIS database. The CCR is a calculated CCR for inpatient services, which is obtained by including charges and cost from three separate inpatient cost center ranges: Routine (Worksheet C, Line 30-40, Columns 6 and 3), Ancillary (Worksheet C, Lines 50-92, Column 6 and the product of columns 6 and 10), and Organ Acquisition (Worksheet D-4, Part III, Line 61, Column 3 and Worksheet C, Part I, Column 3). These separate charges and cost are summed together to create overall hospital inpatient charges and cost. The ratio is the overall hospital inpatient CCR. The resulting CCR is applied to charges for the Medicaid claims so that the result represents the cost of the Medicaid claims at the hospital. Since this claims data is directly from the Medicaid FFS claims volume, no further adjustments for acuity, DRG assignment, or managed care programs need to be made. Inflation was not applied to these costs.**

4. **Medicaid allowed payments are estimated from the reported hospital payments and third party liability (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 Low-Income and Needy Care Collaboration Agreement (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.**

5. **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 in the group is the UPL for that group of hospitals.**

The State has already submitted a current UPL demonstration to CMS.

26. 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 consider this a formal request to begin the 90-day clock. We trust 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.

As always, we appreciate the assistance of Tamara Sampson in resolving these issues. If further information is required, you may contact Darlene A. Budgewater at Darlene.Budgewater@la.gov or by phone (225) 342-3881.

Sincerely,

J. Ruth Kennedy
Medicaid Director

JRK:DAB:MVJ

Attachments (6)

c: Ford Blunt
Darlene Budgewater
Tamara Sampson

Supplemental Payments for Children's Hospital

Qualifying Criteria

Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for inpatient hospital services rendered in New Orleans that meets the following qualifying criteria per the as filed cost report ending in state fiscal year 2014:

- is a privately owned and operated hospital;
- classified by Medicare as a specialty children's hospital;
- has at least 100 full-time equivalent interns and residents;
- has at least 70 percent Medicaid inpatient days utilization rate;
- has at least 25,000 Medicaid inpatient days; and
- has a distinct part psychiatric unit.

Reimbursement Methodology

Supplemental payments for inpatient hospital services will be paid quarterly up to the hospital specific upper payment limit (the difference between Medicaid inpatient charges and Medicaid inpatient payments). The payments to the qualifying hospital(s) shall not exceed:

- the annual Medicaid hospital specific inpatient charges per 42 CFR 447.271;
- the annual aggregate inpatient hospital upper payment limit for the classification of hospitals per 42 CFR 442.272; and
- subject to the Appropriation Act.

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.