Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

June 11, 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 15-0005 RAI Response
Inpatient Hospital Services- -Supplemental Payments for Woman's Hospital

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 15-0005 with a proposed effective date of February 12, 2015. The purpose of this SPA is to amend the provisions governing inpatient hospital services rendered by non-rural, non-state hospitals in order to adopt a supplemental payment methodology for services provided by Woman's Hospital. 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 FFP determination was made and provide supporting documentation of the calculation for Federal Fiscal Year (FFY) 2016 and 2017.

   Response: This SPA has no fiscal impact for State Fiscal Year (SFY) 2015, because the State is already at the global UPL cap. For SFY 2016, the State will pay no more than the global Upper Payment Limit (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 SFY 2016 is $1,490,738, which is 25 percent of the UPL amount based on estimated FY 2015 payments ($5,962,953). The 75 percent reduction factor is due to the expanded managed care implementation July 1, 2015.

EFFICIENCY, ECONOMY, AND QUALITY OF CARE

2. SPA amendment LA 15-0005 proposes to establish supplemental inpatient hospital payments to qualifying non-rural non-state hospitals in the Baton Rouge 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: Louisiana's health care delivery system continues to transition in the aftermaths of Hurricanes Katrina and Gustav. As providers closed and many residents relocated, both the State and the provider community have pursued a common objective of more efficiently and economically delivering quality healthcare services to citizens. In the Baton Rouge area, where Woman's Hospital is located, low income and uninsured patients in need of obstetrical, gynecological, and neonatal services that were historically provided in the closed state owned and operated Earl K. Long facility, continue to migrate to Woman's Hospital. This is more efficient from both a financial and delivery of care perspective because the costs of rebuilding or making improvements to the aging state facility were prohibitive. The proposed payments were developed to facilitate the ongoing transition of changes in patterns of utilization and to ensure that access to care remains available as a result of the closure of this state hospital.

The proposed supplemental payments are consistent with 1902(a)(30)(A), as they are well within Woman's Hospital's inpatient charge limits. 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, the closure of the Earl K. Long hospital, 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 non-rural non-state hospitals in the Baton Rouge area.

Response: As explained in number 2 above, with the closure of the State hospital in Baton Rouge, Medicaid services provided at Woman's Hospital have met or exceeded the services previously provided to Louisiana Medicaid recipients by a State facility that is now closed.

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-state nursing homes. 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 15-0005.

Response: The State has previously submitted the latest SFY 2014 UPL to CMS and is waiting for 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 (5) to reflect that only one hospital will qualify under this methodology. Additionally, please include the name of the hospital on the Attachment 4.19-A, Item 1, page 8c (5).

   Response: The language has been revised to reflect that this SPA will qualify one hospital, Woman's Hospital. Please see Attachment 4.19-A, Item 1, Page 8c(5).

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 this clarification. Please see Attachment 4.19-A, Item 1, Page 8c(5).

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. What method will the State use for non-rural non-state hospitals in the Baton Rouge area?

   Response: The hospital will be in the private "bucket" and uses Diagnosis-Related Group (DRG) methodology.

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: The State understands this concern and has modified the language to conform to language in other approved State Plan Amendments (SPAs). Please see Attachment 4.19-A, Item 1, Page 8c(5)

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. Please see Attachment 4.19-A, Item 1, Page 8c(5).

11. Did the State receive any feedback or complaints from the public regarding the current proposal or about the changes to non-rural non-state hospitals in the Baton Rouge area arrangements? If so, what were the concerns and how were they addressed and resolved?

Response: The State received no complaints or feedback from the public regarding this SPA.

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

12. Please justify why Louisiana needs to pay supplemental payments to non-rural non-state hospitals in the Baton Rouge area.

Response: The only hospital that will qualify for these proposed supplemental payments is Woman's Hospital. In the Baton Rouge area, Woman's provides the majority of the capacity for specialty hospital services to women and neonates. Woman's Hospital is the only area hospital that offers the entire continuum of care of these specialty services to the low income and Medicaid population. Not only does Woman's Hospital provide basic gynecological, obstetrical and neonatal services to these Medicaid patients, but the following examples demonstrate their focus and commitment to improving both the quality of care and outcomes which will result in decreased future healthcare expenditures by the Medicaid program for recipients treated through these initiatives:

- **Increased use of specialized treatment of gynecological cancers through less invasive procedures using robotics for treatment and staging;**
- **Initiated an education and treatment program for HIV/AIDS-infected pregnant women in an effort to reduce mother-to child transmission rates;**
- **Piloted the use of exclusive human donor breast milk for at least the first 14 days of feeding in infants less than 1000 grams birth weight (approximately 42-60 infants annually); and**
- **Obstetrical services began a "performance improvement initiative" to reduce post-partum hemorrhage, and key process measures have been implemented over time to impact change.**

Woman's performed 84 percent of the Medicaid deliveries in the Baton Rouge area in SFY 2014 and has 78 percent of the available Neonatal Intensive Care Unit (NICU) bassinets in the Baton Rouge area. Medicaid inpatient days provided by Woman's increased by 8 percent in their fiscal year ending (FYE) September 30, 2014 from the previous fiscal year. During the same time period, their Medicaid inpatient cost shortfall increased by over $3 million. Without these supplemental Medicaid payments, Woman's would be forced to evaluate current services that benefit all citizens in the region, including Medicaid patients. Medicaid

reimbursements that continue to remain at levels well below the cost of providing services to Medicaid patients may ultimately force Woman's to discontinue services that are the least cost effective. Without the stability in current Medicaid reimbursement that these Medicaid supplemental payments will provide, it is unlikely that Woman's could absorb new Medicaid patients or ensure that such specialized services would remain available.

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 non-rural non-state hospitals in the Baton Rouge 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 and quality of care to Medicaid recipients that require obstetrical, gynecological, and neonatal inpatient services in the Baton Rouge region.

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 non-rural non-state hospitals in the Baton Rouge area?

    Response: As detailed in the responses to questions 12 and 15 above, the SPA for these proposed payments is to maintain access to and quality of care to Medicaid recipients that require obstetrical, gynecological, and neonatal inpatient services in the Baton Rouge region. Without the stability in current Medicaid reimbursement that these Medicaid supplemental payments will provide, it is unlikely that Woman's could absorb new Medicaid patients or ensure that existing specialized services would remain available.

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

    Response: Yes, the State will monitor the impact of the supplemental payments. The State will confirm with Woman's Hospital, that initiatives outlined in the response to question 12 not only remain in place, but are enhanced. The State will also review the statistics that the hospital maintains regarding the effectiveness of the initiatives.

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

Response: The State will also review the statistics that the hospital maintains regarding the effectiveness of the initiatives referenced in question 12, above.

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

Response: Medicaid inpatient base rate payments for Woman's FYE September 30, 2014, cost reporting period were $28,749,116. As detailed in the response to number 2 above, the proposed supplemental payments are $0 for SFY 2015 and $1,490,738 for SFY 2016.

21. Has the State done any analysis to increase the base payments to non-rural non-state hospitals in the Baton Rouge area?

Response: No. As explained in the response to question 12 above, Woman's Hospital is the only provider that has the immediate available capacity to accommodate the volume of these obstetrical, gynecological, and neonatal services in the Baton Rouge 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 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 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.**

<u>Non-State Hospitals (Public and Private)</u>:

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 (CMI) under the Medicare weight set by the Medicare current federal fiscal year (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 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 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 by 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. **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.

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 in the group is the upper payment limit for that group of hospitals.**

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 (3)

c: Ford Blunt
Darlene Budgewater
Tamara Sampson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-0005**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
February 12, 2015

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447, Subpart F

7. FEDERAL BUDGET IMPACT:
a. FFY **2016** 2015 **$0** $231.25
b. FFY **2017** 2016 **$0** $927.39

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Item 1, Page 8c(5)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
None (New Page)

10. SUBJECT OF AMENDMENT: **The SPA proposes to amend the provisions governing inpatient 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.**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
March 19, 2015

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS: The State requests a pen and ink change to Box 7 as noted above.

FORM HCFA-179 (07-92)

LOUISIANA TITLE XIX STATE PLAN
TRANSMITTAL #: **15-0005**
TITLE: **Inpatient Hospitals NR, NS Supplemental Payments for Baton Rouge Area Hospital**
EFFECTIVE DATE: **October 4, 2014**

FISCAL IMPACT
Increase

	year	% inc.	*# mos	range of mos.	dollars
1st SFY	2015	N/A	4.4	February 12, 2015 - June 2015	$0
2nd SFY	2016		12	July 2015- June 2016	$1,490,738
3rd SFY	2017		12	July 2016 - June 2017	$1,490,738

*#mos-Months remaining in fiscal year

Total increase in Cost FFY **2015**

SFY	2015	$0	for	4.4	months	February 12, 2015 - June 2015		
		$0	/	4.4 X	3 months	July 2014 - September 2014	=	$0
SFY	2016	$1,490,738	for	12	months	July 2015- June 2016		
		$1,490,738	/	12 X	3	July 2015 - September 2015	=	$372,685
								$372,685

FFP (FFY 2015)= $372,685 X 62.05% = $231,251

Total increase in Cost FFY **2016**

SFY	2016	$1,490,738	for	12	months	July 2015- June 2016		
		$1,490,738	/	12 X	9	October 2015 - June 2016	=	$1,118,054
SFY	2017	$1,490,738	for	12	months	July 2016 - June 2017		
		$1,490,738	/	12 X	3	July 2016 - September 2016	=	$372,685
								$1,490,739

FFP (FFY 2016)= $1,490,739 X 62.21% = $927,389

Supplemental Payments for Woman'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 Baton Rouge that meets the following qualifying criteria per the as filed cost report ending in state fiscal year 2014:

1. is a privately owned and operated hospital;
2. classified as a major teaching hospital;
3. has at least 3,000 Medicaid deliveries as verified per the Medicaid data warehouse; and
4. has at least 45 percent Medicaid inpatient days utilization rate.

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:

1. the annual Medicaid hospital specific inpatient charges per 42 CFR 447.271;
2. the annual aggregate inpatient hospital upper payment limit for the classification of hospitals per 42 CFR 442.272; and
3. 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.