DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

November 30, 2015

Ms. Ruth Kennedy, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

RE: Louisiana 15-0023

Dear Ms. Kennedy:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 15-0023. This amendment proposes to suspend the current provisions governing private and non-state nursing facility payments in order to ensure that the rates in effect do not increase for the state fiscal year 2016 rating period.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act (the Act) and the regulations at 42 Code of Federal Regulations (CFR) 447 Subpart C. Before we can continue processing this amendment, we need additional or clarifying information.

The regulation at 42 CFR 447.252(b) requires that the State plan include a comprehensive description of the methods and standards used to set payment rates. Section 6002 of the State Medicaid Manual explains further that the State plan must be comprehensive enough to determine the required level of Federal Financial Participation (FFP) and to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Further, since the plan is the basis for FFP, it is important that the plan's language be clear and unambiguous. Therefore, we have the following questions/concerns regarding TN 15-0023:

FORM-179

1. Form 179 - Box 7: The financial impact indicates a zero impact. Please provide a detailed analysis of how this determination was made and provide supporting documentation of the calculation.

STATE PLAN LANGUAGE

2. Attachment 4.19-D page 5, Item p, states the following: "Index Factor - will be based on the Skilled Nursing Home without Capital Market Basket Index published by Data Resources Incorporated (DRI-WEFA), or **a comparable index if this index ceases to be published.**"

   Also, on Attachment 4.19 page 5, Item W, states the following: "RUG-III Resident Classification System - the resource utilization group used to classify residents. When a resident classifies into more than one RUG-III group, **or its successor's group**, the RUG-III or its successor's group with the greatest CMI will be utilized to calculate the facility average CMI and Medicaid average CMI.

   Please note that this methodology is not comprehensive. Currently, the bold sentences are too broad based 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.

3. 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."

ACCESS AND QUALITY OF CARE

Given the effect of provider rate reductions that have been implemented during this past year, CMS has concerns that access to care or quality of care could be negatively impacted. As such, please provide responses to the following questions regarding the State's compliance with section 1902(a)(30)(A) of the Social Security Act as it specifically relates to all of the proposed rate reductions amendments.

In general, CMS would like the State in its access responses to address three fundamental issues: 1) the manner in which providers were actively engaged in, and had an impact on, the nature of the cuts; 2) the impact on beneficiary utilization of the cuts and; 3) the state's plans to monitor and address the impact of the cuts on beneficiary access to services or the quality of care.

IMPACT ON ACCESS

4. 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?

5. What types of studies or surveys were conducted or used by the State to assure that access would not be negatively impacted? Please summarize the findings, the date the study was conducted, and the age of the data. Examples of data that might be studied include:

    - Proposed rates as compared to commercial rates, Medicare rates, or rates in other states
    - Total number of providers by type and geographic location
    - Total number of participating Medicaid providers by type and geographic area

    Percentage of participating Medicaid providers accepting new patients

    - Total number of Medicaid Beneficiaries by eligibility type
    - Utilization of services by eligibility type over time

6. How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the State address those concerns? Was there any direct communication (bulletins, town hall meetings, etc.) between the State and providers regarding the reductions proposed via this amendment?

7. Did the State receive any feedback or complaints from the public regarding this rate reduction? If so, how were the complaints addressed and resolved?

8. What types of mechanisms does the State have in place for beneficiaries to raise access issues to the Medicaid agency?

9. Is the State modifying anything else in the State plan which will counterbalance the impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?

10. Does the State have a plan to monitor the impact of the new rates and implement a remedy should a problem arise with access? Provide specific details about the measures to be used, how these measures were developed, data sources, and plans for reporting, tracking and monitoring. What are the specific benchmarks for each measure that would indicate an access problem?

11. What action(s) does the State plan to implement after the rate modification(s) take place to counter any decrease to access if such a decrease is found to prevent sufficient access to care?

12. Does the State monitor the number of providers who have closed their practices to additional Medicaid patients (i.e., they no longer accept additional Medicaid patients)? If yes, please provide data on the number of providers by geographic service area and by quarter who have notified the State that they have closed their practices to additional Medicaid patients over the last year or as a result of the pending reductions.

13. Does the State require providers to notify the State when they are no longer accepting additional Medicaid patients to their practice? If yes, please describe the notification process.

How does the State consider the (enrolled providers who no longer accept additional Medicaid patients) in its plan to monitor access?

14. What is the current utilization volume of the services that will be affected by this amendment?

15. If the state has made other rate reduction for the services covered under this SPA in the last 4 years, please provide information on the following over the course of those years:

    - The changes in the number of participating providers by type and geographic area, who provide services covered under this amendment;
    - A history of the utilization of the services covered under this amendment; and,
    - A history of rate changes for services covered under this amendment.

IMPACT ON QUALITY OF CARE

16. How did the State determine that the proposed reduction in Medicaid provider payments will not negatively impact quality of care?

17. What types of studies were conducted or what data/information was used by the State to determine that quality of care will not be negatively impacted?

18. How will the state prospectively monitor the impact of the rate reductions on quality of care?

19. Does the State have a plan to implement a remedy should a problem arise with quality of services?

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-D of your State plan, including payments made outside of those being amended with this SPA.

20. 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.)

21. 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).

22. 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.

23. 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.

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?

In accordance with our guidelines to 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.

We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material. A new 90-day clock will not begin until we receive your response to this request.

Please submit your response to the following address:

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

If you have any questions, please contact Tamara Sampson, of my staff, at (214) 767-6431 or by e-mail at Tamara.Sampson@cms.hhs.gov

Sincerely,

Bill Brooks
Associate Regional Administrator
Division of Medicaid and Children's Health Operations