



# State of Louisiana

Department of Health and Hospitals  
Bureau of Health Services Financing

July 23, 2013

Bill Brooks  
Associate Regional Administrator  
Division of Medicaid and State Operations  
1301 Young Street  
Dallas, TX 75202

**RE: LA SPA 12-62 Disproportionate Share Hospitals Payments – Public-Private Partnerships  
RAI Response**

  
Dear Mr. Brooks:

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 12-62 with a revised effective date of January 2, 2013. The purpose of this SPA is to revise the reimbursement methodology for disproportionate share hospital (DSH) payments to non-state owned hospitals in order to encourage them to take over the operation and management of state-owned and operated hospitals that have terminated or reduced services. We are providing the following additional information as requested in your RAI correspondence dated January 30, 2013 which stopped the clock on this transmittal.

## **FORM-179**

1. Form 179 - Box 7: No financial impact was noted due to the proposed revisions. Please provide a detailed analysis of how this determination was made and provide supporting documentation of the calculation.

**RESPONSE: The SPA language has been revised to include only the free standing psychiatric hospitals that assumed the management and operation of services at the formerly state owned and operated Southeast Louisiana State Hospital, or that are providing services that were previously delivered by the formerly state-owned and operated Southeast Louisiana State Hospital. The fiscal impact has been revised. The State requests a pen and ink change to Block 7 of the Form 179 to reflect the decrease. The federal fiscal impact for FFY 2013 is (\$10,868,156) and for FFY 2014 is (\$14,429,353). The supporting documents are attached (Attachment 1, 1a and 1b).**

2. Please explain why the State proposes an effective date of November 1, 2012 when no agreements have been signed.

**RESPONSE: The State request a pen and ink change to Block 4 of the form 179. The effective date of this SPA is being revised to January 2, 2013 to coincide with the effective date of the CEAs for Meridian Behavioral Health (dba Northlake Behavioral), River Oaks Hospital, and Community Care Hospital.**

### **TRANSFER OF VALUE AGREEMENTS**

3. CMS must have copies of all signed standard Cooperative Endeavor Agreements. In addition, please provide copies of all signed Intergovernmental Transfer (IGT), management agreements, MOUs, management contracts, loan agreements, and any other agreements that would present the possibility of a transfer of value between the two entities.

CMS has concerns that such financial arrangements meet the definition of non-bona fide provider donations as described in federal statute and regulations.

Detailed information needs to be provided to determine whether the dollar value of the contracts between private and public entities had any fair market valuation. There can be no transfer of value or a return or reduction of payments reflected in these agreements.

Additionally, whether the State is a party to the financial arrangement or not, the State is ultimately responsible to ensure that the funding is appropriate. The State would be responsible for refunding any FFP if CMS finds the funding source inappropriate.

Please note that these agreements are needed before we can approve TN#12-62, TN#12- 63, and TN#12-64.

**RESPONSE: The State is submitting copies of the signed CEA documents with Meridian Behavioral Health (dba Northlake Behavioral), River Oaks Hospital, and Community Care Hospital (CEAs Attached). These documents address CMS' concern that the financial arrangements are in compliance with federal statutes and regulations. There are no loan agreements involved.**

4. Did the State receive any feedback or complaints from the public regarding the Cooperative Endeavor Agreement? If so, what were the concerns and how were they addressed and resolved?

**RESPONSE: No feedback or complaints were received by the Department in response to the publication of the associated Emergency Rule.**

### **PUBLIC NOTICE**

5. Please provide information demonstrating that the changes proposed in SPA 12-62, 12-63, and 12-64 comport with public process requirements at section 1902(a)(13)(A) of the Social Security Act (the Act). Please provide copies of the legislation authorizing the proposed changes.

**RESPONSE: Copies of the public notice for this amendment were submitted to CMS. The State is resubmitting these documents. The Public Process Notice (Attachment 2) was published in the statewide newspapers on or before October 31, 2012, and the Emergency Rule was published in the November 20, 2012 edition of the *Louisiana Register*, the State's official journal. The proposed changes did not require legislation.**

### **INTERGOVERNMENTAL TRANSFERS**

6. How many entities does the State anticipate will participate in this arrangement? Please submit a list of all participating hospitals, all transferring entities doing the IGT, and the dollar amount that the transferring entities will IGT. Please describe how the hospitals are related/affiliated to the transferring entity and provide the names of all owners of the participating hospitals.

**RESPONSE: There will be no IGTs with this amendment. As stated in the response to question 1, this SPA is only applicable to the free-standing psychiatric hospitals that are partners to the CEA agreements. The CEA agreements do have some of this ownership information; however, the detailed ownership information for these hospitals (including social security numbers) has been gathered by and is kept on file with the Department's Provider Enrollment Unit.**

7. What is the source of all funds that will be transferred? Are they from tax assessments, special appropriations from the State to the county/city or some other source? Please provide the county/city legislation authorizing the IGTs

**RESPONSE: The state share is paid from the state general fund which is directly appropriated to the Medicaid agency.**

8. What are the sources of IGT funds (for example: tax revenues, loan or other)? Please demonstrate that the State has permissible sources of funding under 1903(w)(6)(A).

**RESPONSE: This amendment does not involve IGTs.**

9. Does the state agree to provide certification from the transferring entities that the Intergovernmental Transfers (IGTs) are voluntary?

**RESPONSE: This amendment does not involve IGTs.**

10. Section 1902(a)(2) of the Social Security Act 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 explain how this proposal complies with this provision.

**RESPONSE: There are no local sources of funding for this amendment.**

#### **UPPER PAYMENT LIMIT (UPL)**

11. Upper Payment Limit (UPL) Demonstration – Regulations at 42 CFR 447.272 require that payments in the aggregate will not exceed a reasonable estimate of what Medicare would pay for similar services. Please provide a UPL demonstration applicable to the payments for the current rate period (i.e. SFY 2013) for all classes (state government, non-state government, private). The UPL demonstrations should include a comprehensive narrative description of the methodology (step by step) used to determine the UPL. The demonstration should also include a spreadsheet with provider specific information that starts with the source data and identifies the numerical result of each step of the UPL calculation. All source data should be clearly referenced (i.e., cost report year, W/S line, columns, and claims reports, etc...) in the demonstration. The State should also keep all source documentation on file for review.

**RESPONSE: The most recent UPL demonstration is attached to the email (Attachment 8).**

12. Please include a detailed narrative description of the methodology for calculating the upper payment limit in the state plan language

**RESPONSE: The State has included the description of the methodology for calculating the upper payment limit in the responses to the funding questions.**

#### **EFFICIENCY, ECONOMY, AND QUALITY OF CARE**

13. SPA amendments LA12-062, 12-063, and 12-64 propose to establish supplemental payments for private-public partnerships. Section 1902(a) (30) (A) of the Social Security Act requires that payment rates must be consistent with

“efficiency, economy and quality of care.” Please justify how the establishment of payments when no contracts have been signed is consistent with the principles of “efficiency, economy, and quality of care.”

**RESPONSE: We have revised the State Plan language so that this SPA will only be applicable to free-standing psychiatric hospitals that are partners to the signed CEA agreements.**

### **SIMPLICITY OF ADMINISTRATION**

14. 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.

**RESPONSE: The State is anticipating that the uncompensated care services for psychiatric services provided through the CEAs will meet or exceed the services previously provided by the formerly state-operated free-standing psychiatric hospital, Southeast Louisiana State Hospitals.**

### **LEGISLATION**

15. Please clarify if the State or a Hospital Service District has issued any proposals or enacted any legislation to support the public-private partnerships. Please submit that documentation for our review.

**RESPONSE: Enabling legislation was not required for this amendment.**

### **STATE PLAN LANGUAGE**

16. The reimbursement methodology outlined on page 4.19-A simply states that supplemental payments will be made on a quarterly basis in accordance with 42 CFR 447.272. This methodology is not comprehensive. To comply with regulations at 42 CFR 447.252(b), please amend the State plan language to include a detailed description of the method that will be used to determine the proposed supplemental payments. The state plan methodology for the supplemental inpatient hospital payments need to be comprehensive based upon services rendered or a quality indicator. Supplemental payments can only occur after a Medicaid service has been rendered.

**RESPONSE: SPA TN 12-62 does not involve supplemental payments.**

17. The reimbursement methodology must be based upon actual historical utilization and actual trend factors. In addition, the methodology must account for 1) the available UPL room and 2) the limitation to charges per regulations at 42 CFR 447.271(a).

**RESPONSE: The State Plan methodology language on Attachment 4.19-A, Item 1, Page 10 k (9) has been revised and complies with applicable federal DSH regulations.**

18. 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. Please add language that describes the actual historical utilization and trend factors utilized in the calculation.

**RESPONSE: The State Plan methodology language has been revised accordingly.**

19. The plan language indicates that payments will be made quarterly. Is the UPL calculation done on a quarterly basis or is it an annual calculation of which a fourth will be distributed on a quarterly basis? Please revise the plan language to indicate when during the quarter that payments will be made.

**RESPONSE: This amendment does not involve supplemental payments. The DSH payments will be made monthly.**

### **ADDITIONAL**

20. Are the hospitals required to provide a specific amount of health care service to low income and needy patients? Is this health care limited to hospital only or will health care be provided to the general public? What type of health care covered services will be provided?

**RESPONSE: There is no linkage between health related care or service obligations and the public-private partnership. Agreements are not related to any other health services provided other than already billed Medicaid hospital services.**

21. How did the State determine that the Medicaid provider payments are sufficient to enlist enough providers to assure access to care and services in Medicaid at least to the extent that care and services are available to the general population in the geographic area?

**RESPONSE: The State does not anticipate any service reductions nor increases in access to care and services as a result of these CEAs.**

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

**RESPONSE: The State went through the normal public process in promulgating the associated Emergency Rule which solicited public comments and no comments were received. The CEA and its amendment went through public discussions at the legislature in the Joint Legislative Committee on the Budget where public input was received.**

23. Is the State modifying anything else in the State Plan which will counterbalance 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)?

**RESPONSE: The State does not anticipate the need to counterbalance the impact of this State Plan amendment.**

24. Over the last couple of years, Louisiana has both increased and decreased rates for inpatient hospitals. What is the cumulative, net impact of the rate reductions and increases for inpatient hospitals services since SFY 2008?

**RESPONSE: The cumulative rate changes and UPL payments from FY 2009 to FY 2013 is provided in Attachment 9.**

25. Please provide a list of facilities closings and services that are being cut by LSU.

**RESPONSE: The formerly state-operated free-standing psychiatric hospital, Southeast Louisiana State Hospital, is no longer in operations. All services that were previously provided by Southeast Louisiana State Hospital will remain available through these CEA agreements and through other means of delivery.**

### **FUNDING QUESTION**

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your State plan, including payments made outside of those being amended with this SPA. Please be aware that some of the questions have been modified. If you have

already provided this information in response to other requests for additional information, you may refer us to that response. Please indicate the SPA and date of the response.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process.

Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

**RESPONSE: (4.19-A, Attached to the original submittal). There were twelve public non-state owned hospitals qualified for DSH payments applicable to SFY 2012, and each of these hospitals certified its allowable uncompensated care costs as expenditures eligible for Federal Financial Participation. The reportable DSH amount in SFY 2012 was \$132,298,052 (FFP \$80,697,962). 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 13 of the 2012 Regular Session. Attached are Act 13 of the 2012 Regular Session (Attachment 3) and a listing of the qualifying hospitals in SFY 2012 and the estimated payments/amounts received by the hospitals (Attachment 4). Medicaid payments are made directly to Medicaid providers. Providers retain all of the Medicaid payments. Providers do not return any portion of any payment.**

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an

IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

**RESPONSE: (Attachment 4.19-A). The Legislature does not appropriate funds for specific line item programs, such as inpatient hospitals. Appropriations for the total Medicaid Program are divided into four categories: (1) Private Provider Payments, (2) Public Providers, (3) Medicare Buy-Ins, Supplements, and Clawbacks, and (4) Uncompensated Care Costs. For state fiscal year 2013 (July 1, 2012- June 30, 2013), the amounts appropriated are \$4,085,659,765 for private providers, \$512,246,407 for public providers, \$1,997,626,194 for Medicare Buy-Ins, Supplements and Clawbacks, and \$828,780,813 for uncompensated care costs. As indicated in our response to question 1 above, the non-federal share of the estimated \$132,298,052 in SFY 2012 of DSH payments was provided using CPEs for Non-Rural Community Hospital payments as set forth in question 1. 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 5) 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 Payment Amounts for Large Public Non-state Hospitals (Attachment 6).**
- 2. Upon receipt of the completed form, the state Medicaid agency verifies the figures for accuracy utilizing the as filed cost report and paid claims data.**
- 3. The Medicaid contract auditor reconciles the uncompensated care costs to the**

**state fiscal year that the DSH payments are applicable to using initially the as filed cost reports, and ultimately the finalized cost reports for the period. Louisiana Medicaid follows Medicare cost reporting and audit standards.**

**The listing of hospitals which provided CPEs in SFY 2012, along with estimated payment amounts and amounts retained by each hospital, is supplied in the attachment which responds to question 1 above. These providers are all Hospital Service Districts which have taxing authority per Louisiana RS 46:1064 (see Attachment 7). As Hospital Service Districts are not state agencies, there is no funding appropriated by the State.**

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

**RESPONSE: (Attachment 4.19-A). Our response to question number 1 also applies to this question.**

Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

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

#### **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 state fiscal year using the CMS Market Basket Index for PPS hospitals.**
- 3. The sum of the difference for each hospital, including inflation, is the supplemental payment that can be reimbursed to state hospitals subject to the limitations on Medicaid inpatient hospital payments in 42 CFR 447.271 and 447.272.**

**Non-State Hospitals (Public and Private)**

- 1. Calculate estimated Medicare payment per discharge for each hospital by totaling a.-c. below:**
  - a. Medicare operating payments are calculated by taking the Medicaid claims data and running each claim through the Medicare MS-DRG grouper to assign the appropriate DRG and weight from the current Medicare Inpatient PPS system. Total Medicare operating payments are then calculated for each hospital by multiplying the Medicaid case mix index under the Medicare weight set by the Medicare current FFY operating rate, using information from the Federal Register current FFY final rule, the Medicare inpatient Public Use File to determine the CBSA of each hospital, and the Medicare Inpatient Pricer to verify the operating rate for each facility. Since this payment includes the current FFY operating rate, no inflation is applied to this payment.**
  - b. Medicare non-operating acuity-adjusted payments include Medicare payments for IME and Capital and are taken from the Medicare cost report. The per discharge payment is calculated by dividing by the Medicare discharges from the same cost report. The Medicare per discharge payment represents reimbursement at the Medicare patient acuity-level, so the calculated per discharge amount is adjusted by multiplying by the ratio of the CMI of Medicaid claims under the Medicare PPS to the CMI of Medicare claims under the Medicare PPS, which is taken from the Public Use File. This acuity-adjusted per discharge amount represents the estimate of what Medicare would reimburse for services at each hospital, if specifically for Medicaid patients. The acuity-adjusted payment per discharge is then inflated from the cost report period to current year.**
  - c. Non-Acuity based Medicare payments include Medicare reimbursement from the cost report for outliers, DSH, Direct Graduate Medical Education, pass through costs, and reimbursable bad debt. Each payment total is taken from the Medicare cost report and then divided by the Medicare discharges to create an estimated per discharge payment, which is then inflated from the Medicare cost report period to current year.**
- 2. For Critical Access Hospitals, there is insufficient claims data to assign a reliable DRG under the Medicare PPS and the Medicare PPS system is an inappropriate model for estimating Medicare payments, so an alternative methodology is used. For each of these facilities, total Medicare cost and Medicare days are taken from the cost report and a cost per day is calculated.**

**The acuity level of this cost is then tied to the hospital's Medicaid population by multiplying by the claim days per discharge from the MMIS system to create an estimated cost per discharge for the Medicaid population. This cost per discharge is then inflated from the cost report period to current year.**

- 3. Medicaid allowed payments are estimated from the reported hospital payments and TPL payments on the claims from the latest fiscal year or calendar year, scaled to represent the allowed amount for current year. Allowed payments from the claims data are adjusted by the total effect of each rate adjustment which impacted Medicaid hospital payments from the beginning service dates of the historical claims through current state fiscal year to estimate the amount the claims are paid under the Louisiana Medicaid system in the current year. To calculate total Medicaid payments per discharge for comparison to the Medicare allowed rate, Medicaid outlier payments, GME Payments, and supplemental payments for LINCCA, high Medicaid facilities and Major Teaching facilities were added to Medicaid claim payments. The total payments received from Medicaid are divided by claims discharges in the data set to yield the adjusted Medicaid payments per discharge in current year.**
- 4. To determine the separate aggregate UPL caps for the inpatient non-state public and private hospital groups, each hospital's adjusted Medicaid payments per discharge is subtracted from their Medicare adjusted payments per discharge. The difference per discharge rate by hospital is multiplied by the hospital's number of claims discharges to determine the individual hospital payments difference between Medicare and Medicaid. The sum of the difference for each hospital for all hospitals in the group is the upper payment limit for that group of hospitals.**
4. 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**

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It is anticipated that this additional information will be sufficient to result in the approval of the pending plan amendment. Please consider this a formal request to begin the 90-day clock. If further information is required, you may contact Darlene Adams at (225) 342-3881 or by email to [Darlene.Adams@la.gov](mailto:Darlene.Adams@la.gov).

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

Sincerely,

A handwritten signature in blue ink, appearing to read "J. Ruth Kennedy". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

J. Ruth Kennedy  
Medicaid Director

JRK/DA/ye

Attachments (13)