DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification

Mr. Don Gregory, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

NOV 18 2010

Attention: Sandra Victor

RE: Louisiana 10-50

Dear Mr. Gregory:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 10-50. Effective for dates of services on or after August 1, 2010, the inpatient per diem rate paid to private acute care hospitals, including long term hospitals, shall be reduced by 4.6 percent of the per diem rate as of July 31, 2010. In addition, prospective per diem rates paid to children's specialty hospitals and to non-rural, non-state distinct part psychiatric units shall be reduced by 4.6 percent. The amendment also changes the administrative process and criteria for any hospital seeking an adjustment to the operations, movable equipment, fixed capital, or education component of its inpatient rate when costs exceed Medicaid reimbursement.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process the State was asked to provide information regarding access to care issues and the funding of the State share of expenditures under Attachment 4.19-A. Based upon your assurances, Medicaid State plan amendment 10-50 is approved effective August 1, 2010. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Sandra Dasheiff, CPA at (214) 767-6490.

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid, CHIP, and Survey & Certification

Enclosures

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: **10-50**

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: **August 1, 2010**

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 C

7. FEDERAL BUDGET IMPACT: *
a. FFY **2010** (**$3,124,924**) ~~($3,096.93)~~
b. FFY **2011** (**$17,371,073**) ~~($14,747.32)~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

8.	9.
Attachment 4.19-A, Item 1, Page 7c	* ~~**Pending**~~ **(TN 10-08)**
Attachment 4. 19-A, Item 1, Page 9	**Same (TN 09-42)**
Attachment 4. 19-A, Item 1, Pages 9a-9e	**Same (TN 94-32)**
Attachment 4.19-A, Item 1, Pages 101(1)(b), 101(1)(c)	~~**Pending**~~ **(TN 10-08)**
Attachment 4.19-A, Item 14a, Page 2	~~**Pending**~~ **(TN 10-08)**
Attachment 4.19-A, Item 16, Page 2	~~**Pending**~~ **(TN 10-08)**

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to reduce the reimbursement rates paid to inpatient non-rural, non-state hospitals and amend the criteria for qualifying loss.**

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:
[redacted]

13. TYPED NAME:
Bruce D. Greenstein

14. TITLE:
Secretary

15. DATE SUBMITTED:
September 29, 2010

16. RETURN TO:
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: 30 Sept 2010

18. DATE APPROVED: 11-18-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
AUG - 1 2010

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
William Lasowski

22. TITLE:
Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

* Pen and ink changes requested by Allyson Lamy, Program Manager, on 10/25/10.

2. Qualifying NICU Level III regional services with current per diem rates that are less than 85 percent of the NICU Level III regional specialty group rate shall have their per diem rates adjusted to equal 85 percent of the specialty group rate.

3. Qualifying PICU Level I services with current per diem rates that are less than 77 percent of the PICU Level I specialty peer group rate shall have their per diem rates adjusted to equal 77 percent of the specialty peer group rate.

4. Qualifying PICU Level II services with current per diem rates that are less than the PICU Level II specialty peer group rate shall have their per diem rates adjusted to equal 100 percent of the specialty group rate.

Effective for dates of service on or after February 3, 2010, the inpatient per diem rate paid to private acute care hospitals, including long term hospitals, shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

Effective for dates of service on or after August 1, 2010, the inpatient per diem rate paid to private acute care hospitals, including long term hospitals, shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

Payment for Graduate Medical Education (GME) costs must be limited to the direct cost of interns and residents in addition to the teaching physician supervisory costs. Teaching physician supervisory costs shall be limited in accordance with the provisions of the Medicare Provider Reimbursement Manual. The GME component of the rate shall be based on hospital specific graduate medical education Medicaid cost for the latest year on which hospital prospective reimbursements are rebased trended forward in accordance with the prospective reimbursement methodology for hospitals.

Hospitals implementing GME programs approved after the latest year on which hospital prospective reimbursements have been rebased shall have a GME component based on the first full cost reporting period that the approved GME program is in existence trended forward in accordance with the prospective reimbursement methodology for hospitals.

If it is subsequently discovered that a hospital has been reimbursed as a major or minor teaching hospital and did not qualify for that peer group for any reimbursement period, retroactive adjustment shall be made to reflect the correct peer group to which the facility should have been assigned. The resulting overpayment will be recovered through immediate recoupment from any funds due to the hospital from the Department.

In order for facilities that do not qualify as major or minor teaching facilities to be reimbursed for GME, the GME must be recognized by the Medical Assistance Program for reimbursement and shall be limited to facilities having a documented affiliation agreement with a Louisiana medical school accredited by the Liaison Committee on Medical Education (LCME).

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

12. Qualifying Loss Review Process

Any hospital seeking an adjustment to the operations, movable, fixed capital, or education component of its rate shall submit a written request for administrative review within 30 days after receipt of the letter notifying the hospital of its rate. Rate notification date is considered to be five days from the date of the letter or the postmark date, whichever is later.

The time period for requesting an administrative review may be extended upon written agreement between the Department and the hospital.

The Department will acknowledge receipt of the written request within 30 days after actual receipt. Additional documentation may be requested from the hospital as may be necessary to render a decision. A written decision will be rendered within 90 days after receipt of all additional documentation or information requested.

a. Definitions

"Qualifying loss" in this context refers to that amount by which the hospital's operating costs, movable equipment costs, fixed capital costs, or education costs (excluding disproportionate share payment adjustments) exceeds the Medicaid reimbursement for each component.

"Costs" when used in the context of operating costs, movable equipment costs, fixed capital costs, and education costs, means a hospital's costs incurred in providing covered inpatient services to Medicaid and indigent clients as allowed by the *Medicare Provider Reimbursement Manual*.

"Uninsured Patient" in this context is defined as a patient that is not eligible for Medicare and Medicaid and does not have insurance.

"Uninsured Care Costs" in this context means uninsured care charges multiplied by the cost to charge ratios by revenue code per the last filed cost report, net of payments received from uninsured patients.

b. Permissible Basis

Consideration for qualifying loss review is available only if one of the following conditions exists:

1) rate-setting methodologies or principles of reimbursement are incorrectly applied; or

2) incorrect or incomplete data or erroneous calculations were used in the establishment of the hospital's rate; or

3) the amount allowed for a component in the hospital's prospective rate is 70 percent or less of the component cost it incurs in providing services that conform to the applicable state and federal laws of quality and safety standards.

For administrative review request in cases that relate to an unresolved dispute between the hospital and its Medicare fiscal intermediary as to any cost reported in the hospital's base year cost report, the Department will resolve such disputes for purposes of deciding the request for administrative review.

c. Basis Not Allowable

The following matters are not subject to a qualifying loss review:

1) the use of peer grouped rates;

2) the use of teaching and non-teaching status, specialty hospital status, and bed-size as criteria for hospital peer groups;

3) the use of approved graduate medical education and intern and resident full time equivalents as criteria for major teaching status;

4) the use of fiscal year 1991 medical education costs to establish a hospital-specific medical education component of each teaching hospital-specific medical education component of each teaching hospital's prospective rate;

5) the application of inflationary adjustments contingent on funding appropriated by the legislature;

6) the criteria used to establish the levels of neonatal intensive care;

7 the criteria used to establish the levels of pediatric intensive care;

8) the methodology used to calculate the boarder baby rates for nursery;

9) the criteria used to identify specialty hospital peer groups;

10) the criteria used to establish the level of burn care; and

11) the use of hospital specific costs for transplant per diem limits.

d. Burden of Proof

The hospital shall bear the burden of proof in establishing the facts and circumstances necessary to support a rate adjustment. Any costs that the provider cites as a basis for relief under this provision must be calculable and auditable.

e. Information to be Provided

All requests for qualifying loss review shall specify the following:

1) the nature of the adjustment sought;

2) the amount of the adjustment sought;

3) the reasons or factors that the hospital believes justify an adjustment; and

4) an analysis demonstrating the extent to which the hospital is incurring or expects to incur a qualifying loss in providing covered services to Medicaid and indigent patients. However, such analysis is not required if the request is limited to a claim that:

   a) the rate-setting methodology or criteria for classifying hospitals or hospital claims were incorrectly applied;
   b) incorrect or incomplete data or erroneous calculations were used in establishment of the hospital rates; or
   c) the hospital has incurred additional costs because of a catastrophe.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

f. Factors Considered

In determining whether to award additional reimbursement to a hospital that has made the showing required, the following factors shall be considered:

1) whether unreimbursed costs are generated by factors generally not shared by other hospitals in the hospital's peer group. Such factors may include, but are not limited to, extraordinary circumstances beyond the control of the hospital, and improvements required to comply with licensing or accrediting standards. Where it appears from the evidence presented that the hospital's costs are controllable through good management practices or cost containment measures, or the hospital through advertisement to the general public promoted the use of high costs services that could be provided in a more cost effective manner, the request for rate adjustment may be denied.

2) financial ratio data indicative of the hospital's performance quality in particular areas of hospital operation. The hospital may be required to provide additional data.

3) whether every reasonable action to contain costs on a hospital-wide basis has been taken. The hospital may be required to provide audited cost data or other quantitative data (including but not limited to) occupancy statistics, average hourly wages paid, nursing salaries per adjusted patient day, average length of stay, cost per ancillary procedure, average cost per meal served, average cost per pound of laundry, average cost per pharmacy prescription, housekeeping costs per square foot, medical records costs per admission, full-time equivalent employees per occupied bed, age of receivables, bad debt percentage, inventory turnover rate, and information about actions that the hospital has taken to contain costs.

4) An onsite operational review/audit of the hospital by the Department may be required.

g. Determination to Award Relief

Additional reimbursement shall be awarded to a hospital that demonstrates to the Department by clear and convincing evidence that:

1) the hospital demonstrated a qualifying loss; and

2) the hospital's current prospective rate jeopardized the hospital's long-term financial viability; and

3) the Medicaid population served by the hospital has no reasonable access to other inpatient hospitals for the services that the hospital provides and that the hospital contends are under-reimbursed; or

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

4) Alternatively, demonstrates that its uninsured care hospital costs exceeds 5 percent of its total hospital costs, and a minimum of $9,000,000 in uninsured care hospital cost in the preceding 12 month time period and the hospital's uninsured care costs has increased at least 35 percent during a consecutive six month time period during the hospital's latest cost reporting period.

   1. The increase in uninsured care costs must be a direct result of a permanent or long term (no less than six months) documented change in services that occurred at a state owned and operated hospital located less than eight miles from the impacted hospital.

   2. Hospitals with multiple locations of service shall measure uninsured costs separately and qualify each location as an individual hospital and rate adjustments shall not exceed 5 percent of the applicable per diem rate.

h. Relief Awarded

Notification of decision regarding qualifying loss review shall be provided in writing. Should the decision be to award relief, relief consists of making appropriate adjustments so as to correctly apply the rate-setting methodology, or to correct calculations, data errors, or omissions, or increase one or more of the hospital's rates by an amount that can reasonably be expected to ensure continuing access to sufficient inpatient hospital services of adequate quality for Medicaid patients served by the hospital. A hospital's corrected rate component shall not exceed the lesser of its recalculated cost for that component or 105% of the provider's peer group rate for that component.

If subsequent discovery reveals that the provider was not eligible for qualifying loss relief, any relief awarded under this qualifying loss process shall be recouped.

i. Effect of Decision

Decisions to recognize omitted, additional, or increased costs incurred by any hospital; to adjust the hospital rates; or to otherwise award additional reimbursement to any hospital shall not result in any change in the peer group calculations for any rate component.

Rate adjustments granted under this provision shall be effective from the first day of the rate period to which the hospital's request for qualifying loss review relates. Hospitals must document their continuing eligibility at the beginning of each subsequent state fiscal year.

However, no retroactive adjustment will be made to the rate or rates that were paid during any state fiscal year prior to the year for which qualifying loss review was requested.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

j. Administrative Appeal

The hospital may appeal an adverse qualifying loss decision to the Office of the Secretary, Bureau of Appeals for the Department of Health and Hospitals, P.O. Box 4183, Baton Rouge, LA 70821-4183. The appeal must be lodged in writing with the Bureau of Appeals within thirty days of receipt of the written decision, and state the basis for the appeal. Rate notification date is considered to be five days from the date of the letter or the postmark date, whichever is later. The administrative appeal shall be conducted in accordance with the Louisiana Administrative Procedures Act (L.R.S. 49:951 et seq). The Bureau of Appeals shall submit a recommended decision to the Secretary of the Department, who will issue the final decision.

k. Judicial Review

Judicial review of the Secretary's decision shall be in accordance with the Louisiana Administrative Procedures Act) L.R.S. 49:951 et seq) and shall be filed in the Nineteenth Judicial District Court.

b. Services shall be reimbursed at the lesser of cost or the target rate per discharge ceiling. The base period target rate per discharge ceiling amount shall be calculated using the allowable inpatient cost per discharge per the cost reporting period ended in SFY 2009. The target rate shall be inflated using the update factors published by CMS beginning with cost reporting periods starting on or after January 1, 2010.

   Effective for dates of services on or after September 1, 2009, payment shall be the lesser of the allowable inpatient costs as determined by the cost report or the Medicaid days for the period for each specialty or type of transplant multiplied times the per diem limitation for the period.

   Costs and per discharge/per diem limitation comparisons shall be calculated and applied separately for acute, psychiatric and each specialty service.

c. Children's specialty hospitals shall not be eligible for outlier payments after September 1, 2009.

d. Qualifying and receiving reimbursement as a children's specialty hospital shall not preclude these hospitals from participation in the Medicaid Program under the high Medicaid or graduate medical education supplemental payments provisions. Medicaid supplemental payments related to the high Medicaid and graduate medical education supplemental payment provisions shall be included as an interim Medicaid inpatient payment in the determination of the cost settlement amounts on the filed cost report.

Effective for dates of service on or after February 3, 2010, the rates to children's specialty hospitals shall be reduced by 5 percent. Final payment shall be the lesser of allowable inpatient acute care and psychiatric costs as determined by the cost report or the Medicaid discharges or days as specified for the period, multiplied by 95 percent of the target rate per discharge or per diem limitation as specified for the period.

Effective for dates of service on or after August 1, 2010, the rates paid to children's specialty hospitals shall be reduced by 4.6 percent. Final payment shall be the lesser of allowable inpatient acute care and psychiatric costs as determined by the cost report or the Medicaid discharges or days as specified for the period, multiplied by 90.63 percent of the target rate per discharge or per diem limitation as specified for the period.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

11. Effective for dates of service on or after October 1, 2009, the prospective per diem rate paid to non-rural, non-state distinct part psychiatric units shall be increased by 3 percent of the rate on file.

12. Effective for dates of service on or after February 3, 2010, the prospective per diem rate paid to non-rural, non-state distinct part psychiatric units shall be reduced by 5 percent of the rate on file as of February 2, 2010.

13. Effective for dates of service on or after August 1, 2010, the prospective per diem rate paid to non-rural, non-state distinct part psychiatric units shall be reduced by 4.6 percent of the rate on file as of July 31, 2010.

G. Transplant Services

Routine operating costs and ancillary charges associated with an approved transplant are carved out of the hospital's cost report. Reimbursement is limited to the lesser of cost or the hospital-specific per diem limitation for each type of transplant.

Cost is defined as the hospital-specific ratio of cost to charges from the base period multiplied by the covered charges for the specific transplant type.

Per diem limitation is calculated by deriving the hospital's per diem for the transplant type from the hospital's base period trended forward using the Medicare target rate percentage for PPS-exempt hospitals each year.

The base period is the cost reporting period for the hospital fiscal year ending September 30, 1983 through August 31, 1984 or the first cost report filed subsequently that contains costs for that type of transplant.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

e. Effective for dates of service on or after February 20, 2009, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals shall be reduced by 3.5 percent of the rate on file as of February 19, 2009.

f. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals shall be reduced by 5.8 percent of the rate on file as of August 3, 2009.

g. Effective for dates of service on or after October 1, 2009, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals shall be increased by 3 percent of the rate on file.

h. Effective for dates of service on or after February 3, 2010, the prospective per diem rate paid to non-rural, non-state free standing psychiatric hospitals shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

i. Effective for dates of service on or after August 1, 2010, the prospective per diem rate paid to non-rural, non-state free standing psychiatric hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

2. Provisions for Disproportionate Share Payments

a. Effective for services provided on or after July 1, 1988, hospitals qualifying as disproportionate share providers shall have payment adjustment factors applied in accordance with the guidelines outlined in Attachment 4.19-A, Item 1, Section D.

b. Disproportionate share payments cumulative for all DSH payments under the pools or any other DSH payment methodology shall not exceed the federal disproportionate share state allotment for each federal fiscal year established under Public Law 102-234.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

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g. Effective for dates of service on or after October 1, 2009, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals shall be increased by 3 percent of the rate on file.

h. Effective for dates of service on or after February 3, 2010, the prospective per diem rate paid to non-rural, non-state free standing psychiatric hospitals shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

i. Effective for dates of service on or after August 1, 2010, the prospective per diem rate paid to non-rural, non-state free standing psychiatric hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

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