



**Division of Medicaid & Children's Health, Region VI**

February 23, 2012

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

Attention: Darlene York

RE: Louisiana 11-38

Dear Mr. Gregory:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-38. The purpose of this amendment is to provide for a supplemental payment to nursing facilities that enter into an agreement with a state or local governmental entity to provide health care services to low income and needy patients.

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 regulations at 42 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 11-38.

1. Please provide documentation to support the \$375,410,716 amount on the fiscal impact attachment.
2. This amendment is effective November 1, 2011. Therefore, FMAP rates for FFY 2012 and FFY 2013 should be used on the fiscal impact attachment. Please recalculate the fiscal impact using the proper rates. In addition, please submit a revised CMS-179 or authorize pen and ink changes.
3. Please provide copies of all signed standard Low Income and Needy Care Collaboration Agreements and all signed Prospective Conditions of Participation in the LA UPL Supplemental

Reimbursement Program for Private and Non-State Nursing Facilities. In addition, please provide copies of all signed Intergovernmental Transfer (IGT) agreements that will be used to implement this funding source.

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

5. 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/parish or some other source? Please provide the county/city/parish legislation authorizing the IGTs.

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

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

8. Please provide the UPL demonstration applicable to the current rate year for all classes (state government, non-state government, private) of nursing facilities that are affected by this amendment. The UPL demonstrations should include a comprehensive narrative description of the methodology (step by step) used to determine the UPL. The demonstrations 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 and column, claims reports, etc) in the demonstrations. Please submit all source documentation for CMS to review.

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.

9. 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.).

10. 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).

11. 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.

12. 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. In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will continue to defer FFP for State payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

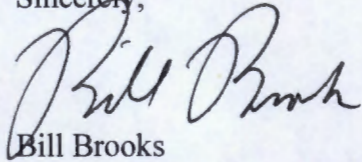
We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material. A new 90-day clock will not begin until we receive your response to this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

Please submit your response to:

National Institutional Reimbursement Team  
Attention: Mark Cooley  
CMS, CMCS  
7500 Security Boulevard, M/S S3-13-15  
Baltimore, MD 21244-1850

If you have any questions please contact Sandra Dasheiff, CPA of my staff. She may be reached at (214) 767-6490 or by email at [sandra.dasheiff@cms.hhs.gov](mailto:sandra.dasheiff@cms.hhs.gov).

Sincerely,

A handwritten signature in black ink, appearing to read "Bill Brooks". The signature is written in a cursive style with a large initial "B".

Bill Brooks  
Associate Regional Administrator