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.
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:

   Providers retain 100 percent of the payments, including the state and federal share. No portion of the payments is required to be returned to the State.

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:

The State's share is paid from the state general fund. CPEs and IGTs are not applicable.

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:
Not applicable to this State Plan amendment.

4. 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:

A private intermediate care facility for persons with intellectual disabilities' (ICF/IID) rates are based on the Inventory for Client and Agency Planning (ICAP) rate methodology. Under this methodology costs are divided into four rate categories:

1) Direct Care;
2) Indirect Care (care related);
3) Administrative and Operating; and
4) Capital.

The costs from the providers' cost reports are adjusted for inflation and then arrayed from high to low in each category and a median daily rate is selected. Each rate category is then multiplied by a different factor. These factors are:

1) Direct Care 105 percent;
2) Indirect Care (care related) 105 percent;
3) Administrative and Operating 103 percent; and
4) Capital 103 percent. The rate component for the direct care is further divided and arrayed into categories and groupings based on facility size and ICAP level and adjusted by the ICAP scores.

Based on this methodology the ICAP model should always produce a rate that is below the upper payment limit calculation that is at 112 percent of routine costs since the finding of the State's auditor is that all of the costs reported by the private providers fall into routine cost.

5. 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:
Governmental providers are not paid in excess of costs. The current reimbursement methodology approved by the Centers for Medicare and Medicaid Services (CMS) for state-owned and operated ICF/IID providers allows payments up to 112 percent of costs. Payments determined by audit to exceed allowable payments would be identified as overpayments. If any overpayments are identified, the federal financial participation (FFP) would be returned.