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:

Please see Attachment 4.19-A. There were 36 public, non-state owned hospitals that qualified for disproportionate share hospital (DSH) payments applicable to state fiscal year (SFY) 2019 (9 non-rural hospitals and 27 rural hospitals) that each certified its allowable uncompensated care costs as expenditures eligible for federal financial participation (FFP). The reportable DSH amount in SFY 2019 for these hospitals was $122,844,223 (FFP $79,848,745). DSH payments will be limited to 100 percent of each hospital's specific uncompensated care costs in accordance with Section 1923(g) and the 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 10 of the 2019 Regular Session. Attached are Act 10 of the 2019 Regular Session (Attachment 1) and a listing of the qualifying hospitals in SFY 2019 and the estimated payments/amounts received by the hospitals (Attachment 2). 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:

Please see 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 SFY 2020 (July 1, 2019- June 30, 2020), the amounts appropriated are $11,310,019,701 for private providers, $231,715,318 for public providers, $546,556,636 for Medicare buy-ins, supplements and clawbacks, and $1,141,631,653 for uncompensated care costs. As indicated in our response to question 1 above, the non-federal share of the estimated $122,844,223 in SFY 2019 of DSH payments was provided using CPEs for hospital payments as set forth in question 1 above. 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 3 – small rural public, Attachment 4 – non-rural public) based on cost and payment data per the latest filed Medicare/Medicaid cost report. This form includes a certification statement that the hospital signs.**

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 independent auditor engaged by Louisiana verifies and reconciles the uncompensated care costs to the SFY that the DSH payments are applicable to based on the data from the Medicare/Medicaid cost reporting period(s) for dates of service that the DSH payment is applicable. Louisiana Medicaid follows Medicare cost reporting and audit standards. The DSH reporting and verification is completed in accordance with the CMS final rule effective on 1/19/09 (73 Fed. Reg. 77904 pursuant to statute 42 U.S.C. 1923(j))**

The listing of hospitals that provided CPEs in SFY 2019, along with estimated payment amounts and amounts retained by each hospital, is supplied in Attachment 2 which responds to question 1 above. These providers are all hospital service districts (HSDs) and have taxing authority, per Louisiana Revised Statute 46:1064 (see Attachment 5). As HSDs 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:
Please see Attachment 4.19-A. The response to question 1 also applies to this question.

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:
Please see attached current inpatient hospital UPL demonstration (Attachment 6) which is updated to include the estimated impact of TN 19-0021. The detailed description of the methodology used by Louisiana to estimate our UPL for each class of hospital are included in attached Inpatient UPL Guidance which was submitted to CMS with the annual UPL demonstration (Attachment 7).

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:
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.