Medicaid Funding Questions

The following questions are being asked and should be answered in relation to all amended payments made to providers paid pursuant to a methodology described in Attachments 4.19-A, 4.19-B, and 4.-19-D of this SPA.

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.)

   LDH 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 through 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 governmental 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).

LDH 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.

LDH RESPONSE:
Not applicable to this State Plan amendment

4. For clinic or outpatient hospital services 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.

LDH RESPONSE:
See attached sheet that explains and list current UPL

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?

LDH RESPONSE:
Governmental providers are not paid in excess of costs. If any overpayments are identified, the federal financial participation (FFP) would be returned.

Background

The Upper Payment Limit (UPL) is a federal regulation that limits the amount of Medicaid reimbursement that a state can pay to providers of certain services. The UPL is based on the estimated amount that Medicare would pay for the same services. The UPL is applied separately to different classes of providers, such as state-owned, non-state government-owned and privately-owned facilities. Louisiana's demonstration of the UPL compliance for ICF/DD providers is a cost-based demonstration using the CMS approved Louisiana Cost Report that follows the cost principles of the PRM 15-1 and 2.

All ICF/DD providers in Louisiana are required to file an annual cost report for the year ended June 30. The providers are required to follow the Medicare cost principles and the Louisiana ICF/DD Provider Manual when making adjustments to costs reported on the cost report.

- For private providers, the annual cost report requires providers to report their actual costs in four cost categories, Direct Care, Care Related, Administrative and Operating, and Capital. Ancillary costs are not required to be separately reported and, if incurred, are a component of the Direct Care cost category.
- For public providers, the cost reports require state-owned providers to categorize their actual costs into Basic Support and Programmatic costs. Ancillary costs are separately reported as a component of Programmatic costs.

The UPL is compared to Medicaid payments as follows:

- UPL: Cost per diems from the ICF/DD costs reports are adjusted for inflation and Medicare equivalency factor to compute the UPL for ICF/DD providers.
- Medicaid Payments: The Medicaid payments are obtained from Gainwell MMIS payment reports for the demonstration year (actual payment data through March 31 each year and projected forward to June 30.)
    - Any dedicated funding pool payments are added to the MMIS payment data, if applicable.

*UPL = the inflated cost using cost report data * 1.12 (the Medicare equivalent)*

Current Status

A gap of approximately $45 million existed in the UPL calculation submitted to CMS in June 2022. The gap closed in due to higher rates effective 7/1/22, the $12 add-on rate, and the one-time lump sum payment.

The most recent UPL demonstration is for the period ending 6/30/23. The results were as follows:

UPL Demonstration for State Owned and Private Facilities
For the Projected Rate Year Ending June 30, 2023

Category	Actual Medicaid Days (FY 2021-Private & FY 2022-State Owned)	UPL based on Medicare Equivalent Costs	Projected Medicaid Payments	Total adjusted UPL Gap	Demonstration Met?	Source
Private	1,211,718	$282,487,942	$281,645,125	842,817	Yes	CMS UPL template
State Owned	186,688	$161,936,805	$146,590,459	15,346,346	Yes	CMS UPL template

Medicaid Payments exclude Patient Liability Income.

Note: This demonstration included $27.9 million in one-time dedicated pool funding payments paid in May 2023.

The next UPL demonstration will be performed in June 2024.