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 will receive and retain 100 percent of the payments. No portion of the payments is 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:
Please see Attachment 4.19-B. Funding of the state's share for this proposed SPA will be state general funds.

Outpatient supplemental payments projected to be paid for state fiscal year (SFY) 2025 service dates that will be matched by intergovernmental transfers (IGTs) from public entities are $4,500,000 to provider #1733725, West Carroll Medical Center. The matching funds from IGTs of $1,198,575 are from the West Carroll Parish Police Jury. Also, an increase in outpatient hospital payments to University Medical Center beginning in SFY 25 will be partially funded with $1,492,478 from IGTs from the LSU Health Sciences Center.

The State confirms and assures that the payment methods are comprehensive and only recognize Medicaid allowable service costs in accordance with 42 CFR 433.51(b).

The State confirms and assures that IGT regulations in the State Medicaid Director Letter (SMDL 14-004) are being followed.

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:
Please see Attachment 4.19-B. The responses to questions 1 and 2 also apply to this question.

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:

State Hospitals

1. **Accumulate outpatient costs, charges, payments, and reimbursement data for each state hospital's outpatient Medicaid services excluding, clinical laboratory services, per the latest filed cost reporting period.**

2. **Subtract the amount paid by Medicaid from the Medicaid costs for each hospital. Trend the difference forward to the midpoint of the current state fiscal year using the CMS Market Basket Index for Perspective Payment System (PPS) hospitals.**

3. **The difference for each hospital, including inflation, is the supplemental payment that can be reimbursed to each state hospital, subject to the limitations on Medicaid outpatient hospital payments in 42 CFR 447.271 and 447.272.**

Non-state Hospitals (Public and Private)

1. **Accumulate Medicaid claims data for outpatient services from the previous SFY.**
2. **Separate charges and payments from paid claims between services reimbursed on a percentage of cost basis from the services reimbursed at a fee-for-service (FFS) rate.**
3. **Calculate cost-to-charge ratio for Medicaid outpatient services from latest filed Medicare/Medicaid cost report (Form CMS 2552).**
4. **For services reimbursed on a FFS rate (other than outpatient clinical laboratory services):**
   a. **Apply cost-to-charge ratio to Medicaid outpatient charges (except for outpatient clinical laboratory services) to determine Medicaid outpatient costs.**
   b. **Subtract claims payments from costs.**
5. **For Medicaid outpatient services reimbursed at a percentage of cost:**
   a. **Apply cost-to-charge ratio to Medicaid outpatient claims charges to determine Medicaid outpatient costs.**
   b. **Multiply Medicaid costs by the applicable percentage to determine the Medicaid payment, which would be calculated upon cost settlement.**
   c. **Subtract calculated payment from costs.**
6. **For each hospital, add the differences of the Medicaid costs less Medicaid payments for the cost-based services and the FFS rate services.**
7. **The sum of the differences for each hospital in the group is the UPL for that group of hospitals.**

LA SPA TN 24-0016 proposes to revise outpatient hospital payments for qualifying other rural hospitals. The state has verified that there is currently room in the outpatient UPL to cover additional payments proposed in this SPA. The impact of these increased payments was included in the most recent SFY 2024 Outpatient UPL Demonstration. Estimated remaining amount under the UPL will be $10,199,281 for private hospitals and $1,024,287 for non-state governmental hospitals if these additional payments are made.

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:

In accordance with our approved State Plan, both Medicaid and DSH payments to state governmental hospitals are limited to costs. In accordance with our approved State Plan, non-state governmental small rural hospitals are reimbursed 110 percent of their Medicaid outpatient costs, with the exception of outpatient clinical laboratory services. 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.