Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

VIA ELECTRONIC MAIL ONLY

November 18, 2015

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

Dear Mr. Brooks:

RE: Louisiana Title XIX State Plan
Transmittal No. 15-0032

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material.

I recommend this material for adoption and inclusion in the body of the State Plan.

Sincerely,

Kathy H. Kliebert
Secretary

Attachments (3)

KHK:WJR:JH

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-0032**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **October 1, 2015**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447, Subpart F

7. FEDERAL BUDGET IMPACT:
a. FFY **2016** **$(12,407.11)**
b. FFY **2017** **$(13,967.58)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Item 1, Page 8c(3)
Attachment 4.19-A, Item 1, Page 8c(3)(a)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same (TN-12-59)
None (New Page)

10. SUBJECT OF AMENDMENT: **The SPA proposes to amend the reimbursement methodology governing inpatient hospital services in order to amend the provisions governing supplemental Medicaid payments to qualifying non-rural, non-state public hospitals.**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Kathy H. Kliebert

14. TITLE:
Secretary

15. DATE SUBMITTED:
November 19, 2015

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

LA TITLE XIX SPA
TRANSMITTAL #: 15-0032
TITLE: Inpatient Hospital Services, NR, NS Hospitals Public Hospitals Supplem
EFFECTIVE DATE: October 1, 2015

FISCAL IMPACT:
Decrease

	year	% inc.		fed. match	*# mos	range of mos.	dollars
1st SFY	2016			0.00%	8	October 1, 2015 - June 30,2016	($14,424,054)
2nd SFY	2017	3.0%		0.00%	12	July 2016- June 2017	($22,285,163)
3rd SFY	2018	3.0%		0.00%	12	July 2017 - June 2018	($22,953,718)

*#mos-Months remaining in fiscal year

Total decrease in cost FFY 2016

SFY 2016 ($14,424,054) for 8 months October 1, 2015 - June 30,2016 ($14,424,054)

SFY 2017 ($22,285,163) for 12 months July 2016- June 2017
($22,285,163) / 12 X 3 July 2016 - September 2016 = ($5,571,291)
($19,995,345)

FFP (FFY 2016) = ($19,995,345) X 62.05% = ($12,407,112)

Total decrease in cost FFY 2017

SFY 2017 ($22,285,163) for 12 months July 2016- June 2017
($22,285,163) / 12 X 9 October 2016 - June 2016 = ($16,713,872)

SFY 2018 ($22,953,718) for 12 months July 2017 - June 2018
($22,953,718) / 12 X 3 July 2017 - September 2017 = ($5,738,430)
($22,452,302)

FFP (FFY 2017)= ($22,452,302) X 62.21% = ($13,967,577)

e. Non-Rural Non-State Government Hospitals

Effective for dates of service on or after May 15, 2011, quarterly supplemental payments will be issued to qualifying non-rural, non-state governmental hospitals for inpatient services rendered during the quarter. Payment amount shall be up to the Medicare inpatient upper payment limits as determined in accordance with 42 CFR §447.272.

1. **Qualifying criteria**: In order to qualify for the supplemental payment, a non-rural, non-state governmental acute care hospital must meet one of the following:

   a. Be designated as a major teaching hospital by the Department in state fiscal year 2011; and have provided at least 17,000 Medicaid acute care and distinct part psychiatric unit paid days for state fiscal year 2010 dates of service; or,

   b. Effective for dates of service on or after October 1, 2012 through June 30, 2013, be:
      i. located in a Medicare Metropolitan Statistical Area (MSA) per 42 CFR 413.231(b)(1), and be located within 15 miles of a state-owned hospital scheduled to closed in SFY 2013; or

   c. Effective for dates of service on or after July 1, 2013, be designated as a non-teaching hospital and:
      i. located in a Medicare Metropolitan Statistical Area (MSA) per 42 CFR 413.231(b)(1), and
      ii. provide inpatient obstetrical and Neonatal Intensive Care Unit services, and
      iii. per the cost report period ending in SFY 2012, have a Medicaid inpatient day utilization percentage in excess of 21 percent and a Medicaid newborn day utilization percentage in excess of 65 percent as documented on the as filed cost report; or

   d. Effective for dates of service on or after January 1, 2014, be located in a city with a population of over 300,000 as of the 2010 U.S. Census; or

   e. Effective for dates of service on or after July 1, 2015, be designated as a major teaching hospital by the Department and have at least 300 licensed acute hospital beds.

2. **Reimbursement methodology**:

a. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Quarterly payments shall be the difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for covered inpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the Department.

b. With respect to qualifying hospitals that are enrolled in Medicaid **after January 1, 2014**, actual Medicaid utilization and claims data for the hospital for the preceding quarter per the Department's paid claims data will be used as the basis for making quarterly supplemental payments during the hospital's start-up period.

- For purposes of these provisions, the start-up period shall be defined as the first three years of operation.
- During the start-up period, each quarterly supplemental payment shall be made no later than the 60th day of the subsequent quarter to allow the Department sufficient time to compile actual inpatient Medicaid claims data for the new hospitals to calculate the actual quarterly. Inpatient charge differential. These retroactive quarterly payments shall be applicable to service dates in the preceding quarter.

c. Payments in the aggregate will not exceed the UPL for all hospitals included in the non-state government owned group.

LA SPA TN 15-0032

Louisiana Press Association

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Public Notice

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County: Calcasieu
Printed In: American Press
Printed On: 2015/09/28

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Public Notice:

PUBLIC PROCESS
NOTICE

Department of Health and Hospitals
Bureau of Health
Services Financing

Inpatient Hospital
Services
Non-Rural, Non-State Hospitals
Public Hospitals
Supplemental
Payments

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing inpatient hospital services to provide supplemental Medicaid payments to qualifying non-rural, non-state public hospitals (Louisiana Register, Volume 39, Number 6). The department now proposes to amend the reimbursement methodology governing inpatient hospital services in order to amend the provisions governing supplemental Medicaid payments to qualifying non-rural, non-state public hospitals. This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to inpatient hospital services through the maximization of federal dollars.

Effective October 1, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing proposes to promulgate an Emergency Rule to amend the provisions governing the reimbursement methodology for inpatient hospital services rendered by non-rural, non-state public hospitals.

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to all inquiries regarding this public process notice. The deadline for receipt of all written comments is October 31,

2015, by 4:30 p.m. A copy of this public notice is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

Sep 28 1t
00931272

Public Notice ID: 22816482

Print This Notice

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Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

October 8, 2015

Karen Matthews, Health Director
Chitimacha Health Clinic
3231 Chitimacha Trail
Jeanerette, LA 70544

Angela Martin
Chitimacha Tribe of Louisiana
P. O. Box 640
Jeanerette, LA 70544

Anita Molo
Chitimacha Tribe of Louisiana
P. O. Box 640
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Marshall Pierite, Chairman
Misty Hutchby, Health Director
Tunica-Biloxi Tribe of Louisiana
P. O. Box 1589
Marksville, LA 71351-1589

Lovelin Poncho, Chairman
Paula Manuel, Health Director
Coushatta Tribe of Louisiana
P. O. Box 818
Elton, LA 70532

Chief Beverly Cheryl Smith
Holly Vanhoozen, Health Director
The Jena Band of Choctaw Indians
P. O. Box 14
Jena, LA 71342

Dear Louisiana Tribal Contact:

RE: Notification of Louisiana Medicaid State Plan Amendments

In compliance with the provisions of the American Recovery and Reinvestment Act (ARRA) of 2009, the Department of Health and Hospitals, Bureau of Health Services Financing is taking the opportunity to notify you of State Plan amendments (SPAs) that may have an impact on your tribe.

Attached for your review and comments is a summary of the proposed State Plan amendments. Please provide any comments you may have by October 15, 2015 to Mrs. Darlene Budgewater via email to Darlene.Budgewater@la.gov or by postal mail to:

Department of Health and Hospitals
Bureau of Health Services Financing
Medicaid Policy and Compliance
P.O. Box 91030
Baton Rouge, LA 70821-9030

Should you have additional questions about Medicaid policy, Mrs. Budgewater will be glad to assist you. You may reach her by email or telephone at (225) 342-3881. Thanks for your continued support of the tribal consultation process.

Sincerely,

Darlene A. Budgewater

for J. Ruth Kennedy
Medicaid Director

Attachment (1)

JRK/DB/KS

c: Ford J. Blunt, III
Stacey Shuman

State Plan Amendment for submittal to CMS

Request for Tribal Comments
October 8, 2015

15-0030 Adult Mental Health Services- Covered Services and Recipient Qualifications
Effective 12/01/15

The SPA proposes to revise the provisions governing adult behavioral health services in order to:

- Provide Medicaid coverage and reimbursement for license mental health professional services and mental health rehabilitative services to adult members enrolled in Bayou Health and terminate the behavioral health services rendered under the 1915(i) State Plan authority;
- Establish the recipient qualifications criteria; and
- Revise the assessment and plan of care requirements.

15-0031 Disproportionate Share Hospitals (DSH) - Inpatient Psychiatric Services-Reimbursement Rate Reduction (CEA Bed decrease)
Effective October 1, 2015

The SPA proposes to revise the provisions governing DSH payments to reduce the payments made to non-rural, non-state acute care hospitals for inpatient psychiatric services.

15-0032 Inpatient Hospital-Non-Rural, Non-State Hospitals-Public Hospitals Supplemental Payments (East Jefferson)
Effective October 1, 2015

The SPA proposes to revise the reimbursement methodology governing inpatient hospital services in order to amend the provisions governing supplemental Medicaid payments to qualifying non-rural, non-state public hospitals.

Standard Funding Questions
TN 15-0032 Inpatient Hospital Services - Non-Rural, Non-State Hospitals - Public Hospitals Supplemental Payments

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.

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: (See Attachment 4.19-A). There were 39 public, non-state owned hospitals that qualified for disproportionate share hospital (DSH) payments applicable to State Fiscal Year (SFY) 2014 (10 non-rural hospitals and 29 rural hospitals), and each of these hospitals certified its allowable uncompensated care costs as expenditures eligible for FFP. The reportable DSH amount in SFY 2014 was $146,129,893 (FFP $89,058,680). DSH payments will be limited to 100 percent of each hospital's specific uncompensated care costs in accordance with Section 1923(g) and our 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 15 of the 2014 Regular Session. Attached are Act 15 of the 2014 Regular Session (Attachment 1) and a listing of the qualifying hospitals in SFY 2014 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: (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 2015 (July 1, 2014- June 30, 2015), the amounts appropriated are $6,249,233,589 for private providers, $265,444,863 for public providers, $556,369,912 for Medicare buy-ins, supplements and clawbacks, and $1,040,577,785 for uncompensated care costs. As indicated in our response to question 1 above, the non-federal share of the estimated $146,129,893 in SFY 2014 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) based on cost and payment data per the latest filed Medicare/Medicaid cost report. This form includes a certification statement that the hospital signs. Please see the attached explanation of Louisiana's process for the determination of DSH CPEs (Attachment 4).**

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 Medicaid contract auditor reconciles the uncompensated care costs to the SFY that the DSH payments are applicable to, using initially the as filed cost reports, and ultimately the finalized cost reports for the period. Louisiana Medicaid follows Medicare cost reporting and audit standards.**

The listing of hospitals which provided CPEs in SFY 2014, along with estimated payment amounts and amounts retained by each hospital, is supplied in the

attachment which responds to question 1 above. These providers are all hospital service districts (HSDs) which 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: (See Attachment 4.19-A). Our response to question 1 above 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: (See Attachment 4.19-A). The following steps are used to calculate the Medicare UPL for:

   State Hospitals:

   1. **Accumulate Medicaid costs, charges, payments, and reimbursement data for each state hospital 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 Prospective Payment System (PPS) hospitals.**
   3. **The sum of the difference for each hospital, including inflation, is the supplemental payment that can be reimbursed to state hospitals subject to the limitations on Medicaid inpatient hospital payments in 42 CFR 447.271 and 447.272.**
   4. **If a change is projected in the volume of inpatient claims in current UPL demonstration year covered by managed care due to expansion, adjustments are made to each hospital's differential as explained in a –d below:**
      - **a. a report is produced from the Medicaid claims data warehouse which includes the entire universe of non-capitated inpatient claims by hospital for the period covering the dates of service in the UPL demonstration which for state hospitals is the latest cost report period (SFY);**
      - **b. claims for patients that are projected to be covered by managed care in the current year are subtracted from the prior year non-capitated claim total;**

c. The revised non-capitated claim total (determined per b) is divided by the total universe of claims (described in a, above) to develop a ratio of the prior year claims that remain "fee-for-service";

d. The ratio calculated per "c" above is then applied to the inpatient hospital specific differential (#3 above) which reduces the estimated upper payment limits to account for the impact that the managed care expansion has on the non-capitated claims payments.

<u>Non-State Hospitals (Public and Private)</u>:

1. **Calculate estimated Medicare payment per discharge for each hospital by totaling a-c below:**
   a. **Medicare operating payments are calculated by taking the Medicaid claims data and running each claim through the Medicare Severity Diagnostic Related Grouper (MS-DRG) to assign the appropriate DRG and weight from the current Medicare Inpatient PPS. Total Medicare operating payments are then calculated for each hospital by multiplying the Medicaid case mix index under the Medicare weight set by the Medicare current federal fiscal year (FFY) operating rate, using information from the Federal Register current FFY final rule, the Medicare inpatient Public Use File to determine the Core Based Statistical Area (CBSA) of each hospital, and the Medicare Inpatient Pricer to verify the operating rate for each facility. Since this payment includes the current FFY operating rate, no inflation is applied to this payment.**
   b. **Medicare non-operating acuity-adjusted payments include Medicare payments for Indirect Medical Education (IME) and capital and are taken from the Medicare cost report. The per-discharge payment is calculated by dividing by the Medicare discharges from the same cost report. The Medicare per discharge payment represents reimbursement at the Medicare patient acuity-level, so the calculated per discharge amount is adjusted by multiplying by the ratio of the Case Mix Index (CMI) of Medicaid claims under the Medicare PPS to the CMI of Medicare claims under the Medicare PPS, which is taken from the Public Use File. This acuity-adjusted per discharge amount represents the estimate of what Medicare would pay for these services at each hospital if specifically for the Medicaid patient population. The acuity-adjusted payment per discharge is then inflated from the cost report period to current year.**
   c. **Non-Acuity based Medicare payments include Medicare reimbursement from the cost report for outliers, DSH, Direct Graduate Medical Education, pass through costs, and reimbursable bad debt. Each payment total is taken from the Medicare cost report and then divided by the Medicare discharges to create an estimated per discharge payment, which is then inflated from the Medicare cost report period to current year.**

2. **For Critical Access Hospitals, there is insufficient claims data to assign a reliable DRG under the Medicare PPS and the Medicare PPS is an inappropriate model for estimating Medicare payments, so an alternative**

methodology is used. For each of these facilities, total Medicare cost and Medicare days are taken from the cost report and a cost per day is calculated. The acuity level of this cost is then tied to the hospital's Medicaid population by multiplying by the claim days per discharge from the Medicaid Management Information System (MMIS) to create an estimated cost per discharge for the Medicaid population. This cost per discharge is then inflated from the cost report period to current year.

3. **Medicaid allowed payments are estimated from the reported hospital payments and third party liability (TPL) payments on the claims from the latest fiscal year or calendar year, scaled to represent the allowed amount for current year. Allowed payments from the claims data are adjusted by the total effect of each rate adjustment which impacted Medicaid hospital payments from the beginning service dates of the historical claims through current state fiscal year to estimate the amount the claims are paid under the Louisiana Medicaid system in the current year. To calculate total Medicaid payments per discharge for comparison to the Medicare allowed rate, Medicaid outlier payments, Graduate Medical Education (GME) payments, and supplemental payments for Low-Income and Needy Care Collaboration Agreement (LINCCA), high Medicaid facilities and major teaching facilities were added to Medicaid claim payments. The total payments received from Medicaid are divided by claims discharges in the data set to yield the adjusted Medicaid payments per discharge in current year.**

4. **To determine the separate aggregate UPL caps for the inpatient non-state public and private hospital groups, each hospital's adjusted Medicaid payments per discharge is subtracted from their Medicare adjusted payments per discharge. The difference per discharge rate by hospital is multiplied by the hospital's number of claims discharges to determine the individual hospital payments difference between Medicare and Medicaid. The sum of the difference for each hospital for all hospitals in the group is the upper payment limit for that group of hospitals.**

5. **If a change is projected in the volume of inpatient claims in current UPL demonstration year covered by managed care due to expansion, adjustments are made to each hospital's differential as explained in a–d, below:**
    a. **a report is produced from the Medicaid claims data warehouse which includes the entire universe of non-capitated inpatient claims by hospital for the period covering the dates of service in the UPL demonstration**
    b. **claims for patients that are projected to be covered by managed care in the current year are subtracted from the prior year non-capitated claim total.**
    c. **The revised non-capitated claim total (determined per b) is divided by the total universe of claims (described in a) to develop a ratio of the prior year claims that remain "fee for service".**

d. The ratio calculated per c above is the applied to the inpatient hospital specific differential (#4 above) which reduces the estimated upper payment limits to account for the impact that the managed care expansion has on the non-capitated claims payments.

Below are the ongoing procedures that are in place to ensure that supplemental payments do not exceed either the global or hospital–specific UPL caps:

Global UPL Cap:
At the beginning of each SFY, the State utilizes the prior SFY global cap as the basis and makes adjustments that are expected (i.e. Managed Care transition. The UPL global cap is updated in the last quarter of each calendar year to allow for claim lag.

"UPL Aggregate Available Cap Summary Spreadsheet"
Upon establishment of the UPL global cap, the State maintains an "UPL aggregate available cap summary spreadsheet" for each category (bucket) (inpatient and outpatient) to post all payments/adjustments made during to ensure that payments do not exceed the global cap for each bucket.

Individual Hospital-Specific Limits (Inpatient and Outpatient)
The State maintains an individual hospital-specific limit worksheet for each hospital. Upon establishment of the individual caps, payments (i.e. supplemental/DSH) are backed out to show available hospital-specific balances.

All supplemental payments are reconciled to the CMS 64.

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.