

**LA SPA TN 18-0009**

**Disproportionate Share Hospital Payments – Major Medical Centers – Specialized Burn Units**

**Effective date: June 30, 2018**

**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) 2017 (9 non-rural hospitals and 27 rural hospitals), and each of these hospitals certified its allowable uncompensated care costs as expenditures eligible for federal financial participation (FFP). The reportable DSH amount in SFY 2017 was \$139,205,544 (FFP \$86,697,151). 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 3 of the 2017 2<sup>nd</sup> Extraordinary Session. Attached are Act 3 of the 2017 2<sup>nd</sup> Extraordinary Session (Attachment 1) and a listing of the qualifying hospitals in SFY 2017 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 2018 (July 1, 2017- June 30, 2018), the amounts appropriated are \$10,293,784 for private providers, \$220,123,243 for public providers, \$522,424,563 for Medicare buy-ins, supplements and clawbacks, and \$914,235,006 for uncompensated care costs. As indicated in our response to question 1 above, the non-federal share of the estimated \$139,205,544 in SFY 2017 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, initially using 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 that provided CPEs in SFY 2017, 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:**

**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 Attachment 4.19-A. The following steps are used to calculate the Medicare upper payment limit 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) to develop a ratio of the prior year claims that remain “fee for service.”
- d. The ratio calculated per c above is applied to the inpatient hospital specific differential (number 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.

**Non-State Hospitals (Public and Private):**

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 Group (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 SFY 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 UPL 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 applied to the inpatient hospital specific differential (number 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 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.