Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this state plan amendment (SPA). For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

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:
   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).

RESPONSE:
The State share is paid from the state general fund which is directly appropriated to the Medicaid agency.

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:
This SPA does not involve supplemental or enhanced payments.

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.

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 state fiscal year (SFY).**

2. **Separate charges and payments from paid claims between services reimbursed on a percentage of cost basis from services reimbursed at a fee for service 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 fee for service 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 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 fee for service rate services.**

7. **The sum of the difference for each hospital in the group is the UPL for that group of hospitals.**

The outpatient hospital UPL demonstration for SFY 2021 will be forwarded later this month when completed.

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 Disproportionate Share Hospital (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). As all small rural hospitals qualify for DSH payments, 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.