John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

March 3, 2016

Bill Brooks
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health Operations
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, TX 75202

Dear Mr. Brooks:

RE: LA SPA TN 15-0031 RAI Response
Disproportionate Share Hospitals – Inpatient Free-Standing Psychiatric Services Rate Reduction

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 15-0031 with a proposed effective date of October 1, 2015. The purpose of this SPA is to amend the provisions governing disproportionate share hospital (DSH) payments to reduce the payments made to non-rural, non-state acute care hospitals for inpatient psychiatric services. We are providing the following in response to your request for additional information (RAI) dated January 28, 2016:

CMS - 179

1. Form 179- Block 7: There is a negative number reflected in Block 7. Will the State reallocate the DSH dollars to other hospitals?

   RESPONSE: The State will not reallocate the DSH dollars to other hospitals.

STATE PLAN LANGUAGE

2. The State should include language to ensure that a hospital does not exceed their hospital specific limit. This language should be included in Attachment 4.19-A, Item 1 page 10k (10) under Item 3. CMS suggests the following language

"Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit."

<u>RESPONSE:</u> The language has been revised as suggested on Attachment 4.19-A Item 1, Page 10 k (10).

3. Please clarify if the proposal in Attachment 4.19-A, Item 1 page 10k (10) applies to private and/or Non-State hospitals. Please add language if it applies to private psychiatric hospitals.

   <u>RESPONSE:</u> Please refer to the language in the *Qualifying Criteria* on the previously approved page, Attachment 4.19-A, Item 1, Page 10k (9). The approved language names the specific hospitals that qualify. These hospitals are private hospitals. Please advise if further changes are necessary.

4. CMS wants the State's assurance regarding financial transactions. The following sentence should be included in the reimbursement methodology:
   "No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity."

   <u>RESPONSE</u>: The language has been revised as suggested on Attachment 4.19-A Item 1, Page 10 k (10).

<u>ADDITIONAL</u>

5. How did the State determine that the Medicaid provider payments are sufficient to enlist enough providers to assure access to care and services in Medicaid at least to the extent that care and services are available to the general population in the geographic area?

   <u>RESPONSE</u>: There are only three hospitals that qualify in this DSH category which are named in the approved State Plan page, Attachment 4.19-A, Item 1, Page 10k(9). The payments are made for uninsured patients, so without the DSH payments the providers would not receive any reimbursement for this population and service.

6. How were providers, advocates and beneficiaries engaged in the discussion around this SPA proposal? What were their concerns and how did the State address these concerns? Was there any direct communication (bulletins, town hall meetings, etc.) between the State and providers regarding the reductions proposed via this amendment?

   <u>RESPONSE</u>: Providers were engaged during the process of the budget reduction scenario to understand and calculate the impact of the five percent

reduction. The providers attested that they were able to absorb the reduction without impacting service provision or reducing staffing, utilization or increasing wait times.

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.

7. 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 38 public, non-state owned hospitals that qualified for (DSH) payments applicable to State Fiscal Year (SFY) 2015 (10 non-rural hospitals and 28 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 2015 was $166,362,894 (FFP $103,174,244). 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 16 of the 2015 Regular Session. Attached are Act 16 of the 2015 Regular Session (Attachment 1) and a listing of the qualifying hospitals in SFY 2015 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.

8. 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 2016 (July 1, 2015- June 30, 2016), the amounts appropriated are $6,260,061,407 for private providers, $248,021,546 for public providers, $540,968,657 for Medicare buy-ins, supplements and clawbacks, and $997,662,436 for uncompensated care costs. As indicated in our response to question 7 above, the non-federal share of the estimated $166,362,894 in SFY 2015 of DSH payments was provided using CPEs for hospital payments. 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 2015, along with estimated payment amounts and amounts retained by each hospital, is supplied in the attachment which responds to question 7 above. These providers are all hospital service districts (HSDs) which have taxing authority, per Louisiana Revised Statute 46:1064 (see Attachment 5). Since HSDs are not state agencies, there is no funding appropriated by the State.

9. 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.

<u>RESPONSE:</u> (See Attachment 4.19-A). Our response to question 7 above also applies to this question.

10. 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.

<u>RESPONSE</u>: (See Attachment 4.19-A). The following steps are used to calculate the Medicare upper payment limit for:

<u>State Hospitals</u>:

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 SFY 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 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"; and**
   d. **the ratio calculated per "c" above is the 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 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"; and**
   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 the SFY to ensure that payments do not exceed the global cap for each bucket.

<u>Individual Hospital Specific Limits – Inpatient and Outpatient</u>
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.

11. 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?

    <u>RESPONSE</u>: 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.

Please consider this a formal request to begin the 90-day clock. We trust that this additional information will be sufficient to result in the approval of the pending plan amendment. We look forward to negotiating with CMS to ensure approval.

As always, we appreciate the assistance of Tamara Sampson in resolving these issues. If further information is required, you may contact Darlene A. Budgewater at Darlene.Budgewater@la.gov or by phone at (225) 342-3881.

Sincerely,

Jen Steele
Interim Medicaid Director

JS:DAB:JH

Attachments (6)

c: Ford Blunt
Darlene Budgewater
Tamara Sampson

Effective for dates of service on or after October 1, 2015, the per diem rate in effect as of September 30, 2015, shall be reduced by five percent. The new per diem rate shall be $552.05 per day.

Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit.

No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

BY EXPENDITURE CATEGORY:

Personal Services	$	67,885,026
Operating Expenses	$	6,720,455
Professional Services	$	113,926,037
Other Charges	$	77,088,725
Acquisitions/Major Repairs	$	0
TOTAL BY EXPENDITURE CATEGORY	$	265,620,243

EXPENDITURES:

For the Louisiana Behavioral Health Partnership	$	20,560,738
TOTAL EXPENDITURES	$	20,560,738

MEANS OF FINANCE:

State General Fund (Direct)	$	10,009,572
State General Fund by:		
Interagency Transfers	$	270,797
Federal Funds	$	10,280,369
TOTAL MEANS OF FINANCING	$	20,560,738

The commissioner of administration is hereby authorized and directed to adjust the means of financing for this agency by reducing the appropriation out of Federal Funds by $30,800,000.

09-306 MEDICAL VENDOR PAYMENTS

EXPENDITURES:

Payments to Private Providers - Authorized Positions (0)

Nondiscretionary Expenditures	$	3,818,055,097
Discretionary Expenditures	$	2,627,481,563

Program Description: *Provides payments to private providers of health care services to Louisiana residents who are eligible for Title XIX (Medicaid), while ensuring that reimbursements to providers of medical services to Medicaid recipients are appropriate.*

Payments to Public Providers - Authorized Positions (0)

Nondiscretionary Expenditures	$	72,480,818
Discretionary Expenditures	$	126,508,213

Program Description: *Provides payments to public providers of health care services to Louisiana residents who are eligible for Title XIX (Medicaid), while ensuring that reimbursements to providers of medical services to Medicaid recipients are appropriate.*

Medicare Buy-Ins & Supplements - Authorized Positions (0)

Nondiscretionary Expenditures	$	427,609,800
Discretionary Expenditures	$	113,358,857

Program Description: *Provides medical insurance for eligible Medicaid and CHIP enrollees through the payment of premiums to other entities. This avoids potential additional Medicaid costs for those eligible individuals who cannot afford to pay their own "out-of-pocket" Medicare costs.*

Uncompensated Care Costs - Authorized Positions (0)

Nondiscretionary Expenditures	$	0
Discretionary Expenditures	$	722,972,853

Program Description: *Payments to inpatient and outpatient medical care providers serving a disproportionately large number of uninsured and low-income individuals. Hospitals are reimbursed for their uncompensated care costs associated with the free care which they provide.*

TOTAL EXPENDITURES	$7,908,467,201

1	MEANS OF FINANCE (NONDISCRETIONARY):	
2	State General Fund (Direct)	$ 1,054,011,720
3	State General Fund by:	
4	Statutory Dedications:	
5	Health Excellence Fund	$ 23,663,629
6	Louisiana Medical Assistance Trust Fund	$ 164,865,163
7	Medicaid Trust Fund for the Elderly	$ 1,133,333
8	Overcollections Fund	$ 79,856,978
9	Federal Funds	$ 2,994,614,892
10	TOTAL MEANS OF FINANCING (NONDISCRETIONARY)	$4,318,145,715
11	MEANS OF FINANCE (DISCRETIONARY):	
12	State General Fund (Direct)	$ 1,181,089,311
13	State General Fund by:	
14	Interagency Transfers from Prior and	
15	Current Year Collections	$ 157,439,087
16	Fees & Self-generated Revenues from	
17	Prior and Current Year Collections	$ 118,958,518
18	Statutory Dedications:	
19	2013 Amnesty Collections Fund	$ 52,000,000
20	Community and Family Support System Fund	$ 182
21	Louisiana Fund	$ 4,942,942
22	Health Excellence Fund	$ 6,821,295
23	Health Trust Fund	$ 566,667
24	Federal Funds	$ 2,068,503,484
25	TOTAL MEANS OF FINANCING (DISCRETIONARY)	$ 3,590,321,486
26	BY EXPENDITURE CATEGORY:	
27	Personal Services	$ 0
28	Operating Expenses	$ 0
29	Professional Services	$ 0
30	Other Charges	$ 7,908,467,201
31	Acquisitions/Major Repairs	$ 0
32	TOTAL BY EXPENDITURE CATEGORY	$ 7,908,467,201
33	EXPENDITURES:	
34	Payments to Private Providers Program	$ 91,635,477
35	TOTAL EXPENDITURES	$ 91,635,477
36	MEANS OF FINANCE:	
37	State General Fund (Direct)	$ 34,665,701
38	Federal Funds	$ 56,969,776
39	TOTAL MEANS OF FINANCING	$ 91,635,477
40	EXPENDITURES:	
41	Payments to Private Providers Program for the	
42	hospital outlier program	$ 9,798,000
43	TOTAL EXPENDITURES	$ 9,798,000
44	MEANS OF FINANCE:	
45	State General Fund by:	
46	Interagency Transfers	$ 3,706,583
47	Federal Funds	$ 6,091,417
48	TOTAL MEANS OF FINANCING	$ 9,798,000

1 Provided, however, that the Division of Administration, Office of Community Development
2 shall submit an Action Plan Amendment and a request for the reallocation of such monies
3 to the United States Department of Housing and Urban Development for approval.

4	EXPENDITURES:		
5	Uncompensated Care Costs Program		
6	for the Greater New Orleans Community		
7	Health Connection (GNOCHC)		$ 21,169,623
8		TOTAL EXPENDITURES	$ 21,169,623
9	MEANS OF FINANCE:		
10	State General Fund by:		
11	Interagency Transfers		$ 8,000,000
12	Federal Funds		$ 13,169,623
13	TOTAL MEANS OF FINANCING		$ 21,169,623

14 Provided, however, that the Division of Administration, Office of Community Development
15 shall submit an Action Plan Amendment and a request for the reallocation of such monies
16 to the United States Department of Housing and Urban Development for approval.

17 The commissioner of administration is hereby authorized and directed to adjust the means
18 of financing for the Payments to Private Providers Program in this agency by reducing the
19 appropriation out of the State General Fund (Direct) by $26,955,673 and by reducing the
20 appropriation out of Federal Funds by $44,299,080.

21	EXPENDITURES:		
22	Uncompensated Care Costs Program		$ 171,230,503
23		TOTAL EXPENDITURES	$ 171,230,503
24	MEANS OF FINANCE:		
25	State General Fund (Direct)		$ 47,697,169
26	State General Fund by:		
27	Statutory Dedications:		
28	Overcollections Fund		$ 17,010,838
29	Federal Funds		$ 106,522,496
30	TOTAL MEANS OF FINANCING		$ 171,230,503
31	EXPENDITURES:		
32	Payments to Private Providers Program for		
33	payments to partner hospitals		$ 21,035,950
34	Uncompensated Care Costs Program for		
35	payments to partner hospitals		$ 25,749,755
36		TOTAL EXPENDITURES	$ 46,785,705
37	MEANS OF FINANCE:		
38	State General Fund by:		
39	Statutory Dedications:		
40	Overcollections Fund		$ 17,688,732
41	Federal Funds		$ 29,096,973
42	TOTAL MEANS OF FINANCING		$ 46,785,705

1 Payable out of Federal Funds to the Payments to 2 Private Providers Program for an increase in the 3 upper payment limit (UPL) for rural hospitals	$	26,961,993
4 EXPENDITURES:		
5 Payments to the Private Providers Program for 6 mental health services in the event House 7 Bill No. 307 of the 2015 Regular Session is 8 enacted into law	$	202,000
9 TOTAL EXPENDITURES	$	202,000
10 MEANS OF FINANCE:		
11 State General Fund by:		
12 Interagency Transfers	$	76,417
13 Federal Funds	$	125,583
14 TOTAL MEANS OF FINANCING	$	202,000

15 Provided, however, that the Division of Administration, Office of Community Development
16 shall submit an Action Plan Amendment and a request for the reallocation of such monies
17 to the United States Department of Housing and Urban Development for approval.

18 Provided, however, that of the funds appropriated from State General Fund (Direct) to the
19 Payments to Private Providers Program in this agency $100,000 shall be allocated for the
20 Inpatient Major Teaching Hospital Program for hemophilia costs for major teaching
21 hospitals. Further, of the funds appropriated from Federal Funds to the Payments to Private
22 Providers Program in this agency $164,340 shall be allocated for the Inpatient Major
23 Teaching Hospital Program for hemophilia costs for major teaching hospitals.

24 Payable out of Federal Funds 25 to the Payments to Public Providers Program 26 for Targeted Case Management services	$	34,236,497
27 Payable out of Federal Funds 28 for Medical Vendor Payments	$	32,034,854
29 Payable out of Federal Funds 30 to the Payments to Private 31 Providers Program	$	220,698

32 The commissioner of administration is hereby authorized and directed to adjust the means
33 of financing for the Payments to Private Providers Program in this agency by reducing the
34 appropriation out of the State General Fund (Direct) by $10,009,572, by reducing the
35 appropriation out of the State General Fund by Interagency Transfers by $270,797 and by
36 reducing the appropriation out of Federal Funds by $16,894,807.

37 The commissioner of administration is hereby authorized and directed to adjust the means
38 of financing for the Payments to Private Providers Program in this agency by reducing the
39 appropriation out of the State General Fund (Direct) by $25,000,000 and by reducing the
40 appropriation out of Federal Funds by $41,085,118.

41 EXPENDITURES:		
42 Payments to Private Providers Program	$	66,085,118
43 TOTAL EXPENDITURES	$	66,085,118

MEANS OF FINANCE:
State General Fund by:
Statutory Dedications:
Louisiana Medical Assistance Trust Fund $ 25,000,000
Federal Funds $ 41,085,118

TOTAL MEANS OF FINANCING $ 66,085,118

Expenditure Controls:
Provided, however, that the Department of Health and Hospitals may, to control expenditures to the level appropriated herein for the Medical Vendor Payments program, negotiate supplemental rebates for the Medicaid pharmacy program in conjunction with the preferred drug list. In these negotiations, the preferred drug list may be adjusted to limit brand name drug products in each therapeutic category while ensuring appropriate access to medically necessary medication.

Provided, however, that the Department of Health and Hospitals shall continue with the implementation of cost containment strategies to control the cost of the New Opportunities Waiver (NOW) in order that the continued provision of community-based services for citizens with developmental disabilities is not jeopardized.

Provided, however, that the Department of Health and Hospitals shall authorize expenditure of funds for additional Rural Health Clinics and Federally Qualified Health Centers only in those areas which the department determines have a demonstrated need for clinics.

Provided, however, that the Department of Health and Hospitals shall only make Title XIX payments to public private partners in accordance with its initial budget allocation after appropriation by this body.

Public provider participation in financing:
The Department of Health and Hospitals hereinafter the "department", shall only make Title XIX (Medicaid) claim payments to non-state public hospitals, that certify matching funds for their Title XIX claim payments and provide certification of incurred uncompensated care costs (UCC) that qualify for public expenditures which are eligible for federal financial participation under Title XIX of the Social Security Act to the department. The certification for Title XIX claims payment match and the certification of UCC shall be in a form satisfactory to the department and provided to the department no later than October 1, 2015. Non-state public hospitals, that fail to make such certifications by October 1, 2015, may not receive Title XIX claim payments or any UCC payments until the department receives the required certifications. The Department may exclude certain non-state public hospitals from this requirement in order to implement alternative supplemental payment initiatives or alternate funding initiatives, or if a hospital that is solely owned by a city or town has changed its designation from a non-profit private hospital to a non-state public hospital between January 1, 2010 and June 30, 2014.

SUPPLEMENTARY BUDGET RECOMMENDATIONS
(See Preamble Section 18(D))

Provided, however, that the amount above includes a supplementary budget recommendation in the amount of $41,408,637 from State General Fund (Direct), which is matched with $68,117,839 of federal funds for a total means of financing of $109,526,476.

1	EXPENDITURES:	
2	Payments to Private Providers Program	
3	for home and community based waivers	
4	for people with developmental disabilities	$ 9,251,916
5	TOTAL EXPENDITURES	$ 9,251,916
6	MEANS OF FINANCE:	
7	State General Fund by:	
8	Statutory Dedications:	
9	Tobacco Tax Medicaid Match Fund	$ 3,500,000
10	Federal Funds	$ 5,751,916
11	TOTAL MEANS OF FINANCING	$ 9,251,916
12	EXPENDITURES:	
13	Payments to Private Providers Program	
14	for payments to LSU Physicians	$ 3,627,963
15	Payments to Public Providers Program	
16	for payments to LSU Physicians	$ 14,889,037
17	TOTAL EXPENDITURES	$ 18,517,000
18	MEANS OF FINANCE:	
19	State General Fund (Direct)	$ 7,004,981
20	Federal Funds	$ 11,512,019
21	TOTAL MEANS OF FINANCING	$ 18,517,000
22	EXPENDITURES:	
23	Payments to Private Providers Program for	
24	payments to partner hospitals	$ 42,811,116
25	Uncompensated Care Costs Program for	
26	payments to partner hospitals	$ 52,397,576
27	TOTAL EXPENDITURES	$ 95,208,692
28	MEANS OF FINANCE:	
29	State General Fund (Direct)	$ 35,994,388
30	Federal Funds	$ 59,214,304
31	TOTAL MEANS OF FINANCING	$ 95,208,692
32	EXPENDITURES:	
33	Payments to Private Providers Program for	
34	payments to Children's Hospital	$ 20,000,000
35	Uncompensated Care Costs Program for	
36	payments to the partner hospital in New Orleans	$ 5,000,000
37	TOTAL EXPENDITURES	$ 25,000,000
38	MEANS OF FINANCE:	
39	State General Fund (Direct)	$ 9,455,500
40	Federal Funds	$ 15,544,500
41	TOTAL MEANS OF FINANCING	$ 25,000,000
42	Payable out of the State General Fund (Direct)	
43	to the Payments to Private Providers Program	$ 4,500,000

Provided, however, that of the total appropriated in Schedule 09-306 Medical Vendor Payments for the Payments to Private Providers Program, the commissioner of administration is hereby authorized and directed to adjust the means of financing by reducing the appropriation out of Federal Funds by $4,500,000.

09-307 OFFICE OF THE SECRETARY

EXPENDITURES:		
Management and Finance Program - Authorized Positions (384)		
Nondiscretionary Expenditures	$	20,732,971
Discretionary Expenditures	$	71,991,162
Program Description: *Provides management, supervision and support services for: Legal Services; Media and Communications; Executive Administration; Fiscal Management; Planning and Budget; Governor's Council on Physical Fitness and Sports; Minority Health Access and Planning; Health Standards; Program Integrity and Internal Audit.*		
Auxiliary Account - Authorized Positions (2)		
Nondiscretionary Expenditures	$	0
Discretionary Expenditures	$	384,777
Account Description: *The Health Education Authority of Louisiana consists of administration which operates a parking garage in the Medical Corridor of New Orleans. The primary mission of HEAL is to promote biological science, medical and/or health education activities of various public and private organizations in Louisiana through the issuance of HEAL bonds.*		
TOTAL EXPENDITURES	$	93,108,910
MEANS OF FINANCE (NONDISCRETIONARY):		
State General Fund (Direct)	$	5,209,842
State General Fund by:		
Interagency Transfers	$	15,523,129
TOTAL MEANS OF FINANCING (NONDISCRETIONARY)	$	20,732,971
MEANS OF FINANCE (DISCRETIONARY):		
State General Fund (Direct)	$	37,492,456
State General Fund by:		
Interagency Transfers	$	8,239,294
Fees & Self-generated Revenues	$	2,404,298
Statutory Dedication:		
Telecommunications for the Deaf Fund	$	2,386,793
Medical Assistance Program Fraud Detection Fund	$	4,000,000
Nursing Home Residents' Trust Fund	$	150,000
Federal Funds	$	17,703,098
TOTAL MEANS OF FINANCING (DISCRETIONARY)	$	72,375,939
BY EXPENDITURE CATEGORY:		
Personal Services	$	40,970,886
Operating Expenses	$	1,810,991
Professional Services	$	5,216,248
Other Charges	$	45,110,785
Acquisitions/Major Repairs	$	0
TOTAL BY EXPENDITURE CATEGORY	$	93,108,910

LOUISIANA MEDICAID PROGRAM

Table-1: Medical Vendor Program - Means of Finance - SFY 2015/16

Financing Category	Budget
State General Fund	1,873,667,121
Interagency Transfer	165,168,290
Self Generated Revenue	118,958,518
Statutory Dedications	576,449,759
State Total	2,734,243,688
Federal	5,312,470,358
Total Means of Finance	$8,046,714,046

Table-2: Expenditure Forecast by Budget Program - SFY 2015/16

See "Notes" Page 4

Program	Budget Appropriation (1.1)	Current Forecast (2)	Difference	Percent Difference
	A	B	C=A-B	D = (C/A)*100
Private Providers	6,260,061,407	6,790,007,248	(529,945,840)	(8.5)
Public Providers	248,021,546	248,021,546	0	0.0
Buy-Ins & Supplements	540,968,657	539,595,391	1,373,266	0.3
Uncompensated Care	997,662,436	997,662,436	0	0.0
Total Program	$8,046,714,046	$8,575,286,621	($528,572,574)	(6.6)

SFY 2054 Non-State Public Hospitals
DSH Certifications of Public Expenditures

SFY 2015 Non-Rural Non-State Public Hospitals

Prov. #	Provider Name	Ucompensated Care Costs Certified as Public Expenditure	Less: Addional DSH/Supplemental Payments	Net CPE Total $	FFP Amount @ 62.05% FMAP
1735183	EAST JEFFERSON GENERAL HOSP	$17,015,045	$ -	$17,015,045	$ 10,557,835
1720330	IBERIA GENERAL HOSP & MED CTR	$6,263,135	$ 16,834	$6,246,301	$ 3,875,830
1720101	LANE MEMORIAL HOSPITAL	$5,066,951	$ -	$ 5,066,951	$ 3,144,043
1720267	NORTH OAKS MEDICAL CENTER LLC	$30,708,426	$ 70,083	$ 30,638,343	$ 19,011,092
1702871	NORTHOAKS REHAB HOSPITAL LLC*	$929,827	$ -	$ 929,827	$ 576,958
1720151	OPELOUSAS GENERAL HEALTH SYST	$11,927,690	$ -	$ 11,927,690	$ 7,401,132
1720313	SLIDELL MEMORIAL HOSPITAL	$11,911,962	$ -	$ 11,911,962	$ 7,391,372
1720259	ST TAMMANY PARISH HOSPITAL	$21,036,697	$ -	$ 21,036,697	$ 13,053,270
1736848	THIBODAUX REGIONAL MEDICAL CT	$6,422,712	$ -	$ 6,422,712	$ 3,985,293
1730483	WEST CALCASIEU CAMERON HOSP	$9,836,822	$ -	$ 9,836,822	$ 6,103,748
	Totals Non-Rurals	**$ 121,119,267**	**$ 86,917**	**$ 121,032,350**	**$ 75,100,573**

SFY 2015 - Rural Non-State Public Hospitals

Prov. #	Provider Name	Ucompensated Care Costs Certified as Public Expenditure	Less: Addional DSH/Supplemental Payments	Net CPE Total $	FFP Amount @ 62.05% FMAP
1733741	ABBEVILLE GENERAL HOSPITAL	$ 3,022,456	$ -	$ 3,022,456	$ 1,875,434
1720011	ABROM KAPLAN MEMORIAL HOSPITA	$ 783,674	$ -	$ 783,674	$ 486,270
1720038	BEAUREGARD MEMORIAL HOSPITAL	$ 3,321,288	$ -	$ 3,321,288	$ 2,060,859
1735167	BUNKIE GENERAL HOSPITAL	$ 651,845	$ -	$ 651,845	$ 404,470
1740764	CITIZENS MEDICAL CENTER	$ 907,824	$ -	$ 907,824	$ 563,305
1746550	EAST CARROLL PARISH HOSPITAL	$ 254,036	$ -	$ 254,036	$ 157,629
1720062	FRANKLIN FOUNDATION HOSP	$ 2,167,440	$ -	$ 2,167,440	$ 1,344,897
1734888	FRANKLIN MEDICAL CENTER	$ 1,463,945	$ -	$ 1,463,945	$ 908,378
1730114	HARDTNER MEDICAL CENTER	$ 708,697	$ -	$ 708,697	$ 439,746
1735116	HOOD MEMORIAL HOSPITAL	$ 669,124	$ -	$ 669,124	$ 415,191
1731072	JACKSON PARISH HOSPITAL	$ 1,623,903	$ -	$ 1,623,903	$ 1,007,632
1720089	LADY OF THE SEA GENERAL HOSP	$ 958,797	$ -	$ 958,797	$ 594,934
1734977	LASALLE GENERAL HOSPITAL	$ 1,614,381	$ -	$ 1,614,381	$ 1,001,723
1720119	MADISON PARISH HOSPITAL	$ 3,033,797	$ -	$ 3,033,797	$ 1,882,471
1720135	MOREHOUSE GENERAL HOSP	$ 1,254,595	$ -	$ 1,254,595	$ 778,476
1720143	NATCHITOCHES REGIONAL MEDICAL	$ 1,680,480	$ -	$ 1,680,480	$ 1,042,738
1733199	NORTH CADDO MEMORIAL HOSPITAL	$ 875,038	$ -	$ 875,038	$ 542,961
1730521	POINTE COUPEE GENERAL HOSP	$ 1,552,761	$ -	$ 1,552,761	$ 963,488
1743291	PREVOST MEMORIAL HOSPITAL	$ 689,104	$ -	$ 689,104	$ 427,589
1735370	RICHARDSON MEDICAL CENTER	$ 1,059,901	$ -	$ 1,059,901	$ 657,669
1735299	RICHLAND PARISH HOSPITAL	$ 1,237,192	$ -	$ 1,237,192	$ 767,678
1734047	RIVERLAND MEDICAL CENTER	$ 974,427	$ -	$ 974,427	$ 604,632
1734047	RIVERSIDE MEDICAL CENTER	$ 941,675	$ -	$ 941,675	$ 584,309
2700103	ST. BERNARD PARISH HOSPITAL	$ 4,421,617	$ -	$ 4,421,617	$ 2,743,613
1720186	ST CHARLES PARISH HOSPITAL	$ 5,043,082	$ -	$ 5,043,082	$ 3,129,232
1734055	ST HELENA PARISH HOSPITAL	$ 649,624	$ -	$ 649,624	$ 403,092
1720224	ST JAMES PARISH HOSPITAL	$ 1,929,416	$ -	$ 1,929,416	$ 1,197,203
1734811	WEST FELICIANA PARISH HOSP	$ 1,753,508	$ -	$ 1,753,508	$ 1,088,052
	Totals Rurals	**$ 45,243,627**	**$ -**	**$ 45,243,627**	**$ 28,073,671**
	TOTALS ALL NON-STATE	**$ 166,362,894**	**$ 86,917**	**$ 166,275,977**	**$ 103,174,244**

Schedule of Uncompensated Care Cost (per CMS Audit Rule) for Public Hospitals SFY 2015

Yellow Highlighted Areas Are Input

Hospital Name	HOSPITAL NAME
Medicaid #	7 Digit Billing #
FYE	00/00/0000

CMS Audit Rule --Medicaid Summary Sheet	Inpatient	Inpatient Psychiatric	Outpatient	Inpatient Rehab	Hospital Based Ambulance	Totals
PLEASE DO NOT OVERRIDE FORMULAS (NOTE: UNINSURED PATIENT DATA REQUIRES DIRECT INPUT ON SUMMARY)						
Cost:						
Medicaid Inpatient Costs - Traditional Medicaid & Shared Plans **	$ -	$ -				$ -
Medicaid Inpatient Costs - Prepaid Plans **	$ -	$ -				$ -
Medicaid Outpatient Costs - Trad. Medicaid & Shared Plans *(net of fee for service)* **			$ -			$ -
Medicaid Outpatient Costs -Trad. Medicaid & Shared Plans *(net of fee for service)* **			$ -			$ -
Fee Schedule Costs - Traditional Medicaid & Shared Plans *(see calculation)*			$ -			$ -
Fee Schedule Costs - Prepaid Plans (see calculation)			$ -			$ -
Crossover Costs - *All Plans*		$ -	$ -	$ -		$ -
Ambulance Costs (see calculation)					$ -	$ -
Total Costs (1)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Payments:			``			
Cost Report Outpatient Settlement *(Claims + Cost Report Settlement)-T&S*			$ -			$ -
Cost Report Outpatient Settlement *(Claims + Cost Report Settlement)-Prepaid*			$ -			$ -
Medicaid Inpatient Payments (Per EIDR) ** - T & S Plans	$ -	$ -				$ -
Medicaid Inpatient Payments (Per EIDR) ** - Prepaid Plans	$ -	$ -				$ -
Primary Payers (Per EIDR) - T & S Plans	$ -	$ -	$ -	$ -		$ -
Primary Payers (Per EIDR) - Prepaid Plans	$ -	$ -	$ -	$ -		$ -
Crossover Payments (see calculation--see (G) on templets) -*All Plans*		$ -	#N/A	#DIV/0!		#N/A
Fee Schedule Payments --Lab, ASC, Rehab -*T & S Plans*			$ -			$ -
Fee Schedule Payments --Lab, ASC, Rehab - Prepaid Plan			$ -			$ -
Ambulance Payments (see calculation					$ -	$ -
Total Payments (2)	**$ -**	**$ -**	**#N/A**	**#DIV/0!**	**$ -**	**#N/A**
Medicaid Shortfall/(Long fall) (1) - (2)	**$ -**	**$ -**	**#N/A**	**#DIV/0!**	**$ -**	**#N/A**
(Hospital Internal Records)						
Costs of Treating Uninsured Patients *(Per Provider's Records)*	$ -	$ -	$ -	$ -		$ -
Less : Payments from Patients	$ -	$ -	$ -	$ -		$ -
Net Uninsured Costs (3)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Total Uncompensated Care Costs	**$ -**	**$ -**	**#N/A**	**#DIV/0!**	**$ -**	**#N/A**
(Medicaid Shortfall(Long fall) + Net Uninsured Costs)						

** Filed cost report #'s as submitted to Medicaid Intermediary to be used & updated using more recent EIDR or Provider's logs on attached worksheets.Please submit copies of applicable CR pages, Fee Sch w/PS&R cost calculation and uninsured log summary of charges, days & payments.

Prepared By | Telephone # | E-mail address

The following certification is to be completed by the hospital's CEO or CFO:

Based on the above cited source reporting fiscal year end cost report, I certify that the hospital has incurred those uncompensated costs. I certify that from a review of currently available information and to the best of my knowled from such review, that the hospital will incur similar uncompensated care costs constituting public expenditures during state fiscal year 2015. Since these uncompensated care costs are public expenditures, they are eligible for Medicaid disproportionate share payments in state fiscal year 2015. I agree to maintain all documentation to support the above calculation. I understand that this information will be audited in accordance with CMS DSH audit & reporting rule to ensure accuracy and compliance with state and federal regulations. I understand that in accordance with federal law and the approved state plan, the limit for State Fiscal Year 2015 disproportionate share payments will be determined based on actual hospital uncompensated costs for dates of service from July 1, 2014 through June 30, 2015.

Signature | Title | Date

E-Mail Address

Determination of DSH Payment Amounts for Large Public Non-state Hospitals

Each large public non-state hospital's DSH interim payment amount is calculated using the latest filed Medicare/Medicaid 2552 cost report. For example: Louisiana would obtain the most current cost data from the qualifying DSH hospital's FYE 12/31/14 cost report. The most recently Medicare finalized cost report would either be the FYE 12/31/12 or 12/31/13 cost report for most hospitals in Louisiana. More accurate interim payments can be calculated utilizing the most current cost report and payment data that is in a verifiable format, such as the filed cost report and corresponding paid claims reports, than utilizing data that is more than five years old and may be obsolete. The resulting interim DSH payments more accurately reflect current services and costs of the qualifying hospitals. Description of the data elements used to calculate DSH payments for large public non-state hospitals are as follows:

I. Total Medicaid Costs are calculated by using the appropriate per diems or cost-to-charge ratios from each hospital's latest filed cost report, then multiplying the ancillary charges and routine days from the most current Medicaid paid claims report as generated by the Medicaid Management Information System (MMIS). Costs for Medicare crossover (dual Medicare/Medicaid eligibles) claims are also included with Medicaid costs.

II. Total Medicaid Payments are compiled from the most current Medicaid paid claims report for the latest filed cost reporting period, including any supplemental Medicaid payments or Section 1011 payment where applicable.

[Item II is subtracted from I. to determine Medicaid shortfall/longfall.]

III. Net Uninsured costs are the costs of treating patients with no third party source of coverage for services provided and reducing the costs by any payments received from patients. These costs and payments are derived from each hospital's financial statements or other auditable accounting records.

[The Medicaid shortfall/longfall (determined by subtracting Item II from Item I) added to Item III is the Uncompensated Care Cost amount allowable for the DSH payment.]

Each large public non-state hospital's DSH interim payment amount will subsequently be verified and reconciled to determine final Uncompensated Care Cost limit based on data from the Medicare/Medicaid 2552 cost report for the cost reporting period(s) for dates of service for which the DSH payment is applicable by the independent auditor engaged by the state in accordance with per CMS final rule effective on 1/19/09 (73 Fed. Reg. 77904 pursuant to statute 42 U.S.C. 1923(j)).

§1064. Districts as political subdivisions; acquisition of land and physical facilities; special maintenance taxes; incurring debt; bonds; audits

A. The hospital service districts as defined in R.S. 46:1072 are hereby declared to be political subdivisions of the state, and for the purpose of purchasing and acquiring lands and purchasing, acquiring, constructing and maintaining hospitals, nursing homes, physicians and dentists offices, laboratories, and other physical facilities necessary to carry out the purposes of this Chapter. Title to such land and physical facilities shall be in the public. Such districts shall be subdivisions of the state of Louisiana within the meaning of the laws of Louisiana relating to the voting and levy of special maintenance taxes incurring debt and issuing bonds therefor, including particularly but without limitation R.S. 39:504.1, 515-518, 551-571, 575-577, 611-617, 701-706, and 911, and shall be authorized to issue hospital revenue bonds pursuant to R.S. 39:559.1 and 1011-1024, and as otherwise permitted by law. Hospital service districts are hereby further authorized to issue bonds pursuant to the foregoing to refund outstanding bonded indebtedness whether issued by such hospital service district or by another political subdivision of the state on behalf of such hospital service district or in respect of any hospital facilities owned or operated by any such hospital service district.

B. Each district shall cause to be conducted annually, by a duly qualified certified public accountant, an audit and examination of its books and accounts, said audit to be filed with the legislative auditor within six months after the close of the period audited. The legislative auditor shall have the authority to prescribe the terms and conditions of any such audit conducted by a certified public accountant and to require the district to present said terms and conditions to him for approval prior to the commencement of said audit. The legislative auditor shall have access to the working papers of the accountant during the examination and subsequent to its termination. The legislative auditor is authorized to conduct an independent audit and examination of the books and accounts of any hospital service district pursuant to R.S. 24:513.

Acts 1950, No. 420, §14. Acts 1983, No. 93, §1; Acts 1987, No. 481, §1.

Attachment 5