Medicaid Funding Questions

The following questions are being asked and should be answered in relation to all amended payments made to providers paid pursuant to a methodology described in Attachment 4.19-A of this SPA.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

   LDH RESPONSE:
   Providers will receive and retain 100 percent of the payments. No portion of the payments is returned to the State.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

LDH RESPONSE:
Please see Attachment 4.19-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 state fiscal year (SFY) 2026 (July 1, 2025 through June 30, 2026), the current amounts appropriated are $19,177,561,397 for private providers, $264,356,671 for public providers, $901,704,500 for Medicare buy-ins, supplements and clawbacks, and $303,576,471 for uncompensated care costs.

State general funds will be used to match additional payments proposed by this SPA. IGTs from two public entities are currently planned to match SFY 2026 inpatient payments: 1) $2,882,227 from the LSU Health Sciences Center will used as the state's match for to partially fund payments to provider # 1765651 University Medical Center, 2) $10,725 from the West Carroll Parish Police Jury will be used as the state's match for $33,402 in inpatient supplemental payments to provider #1733725, West Carroll Medical Center.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

LDH RESPONSE:
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.

LDH RESPONSE:
This provisions of this proposed SPA will have no impact on the inpatient UPL. This SPA is required as part of the Cell and Gene Therapy Access Model that Louisiana participates in. Provisions of the model require that gene therapy carve-out drugs for sickle cell disease administered during an inpatient stay be billed on an outpatient hospital claim form and reimbursed outside of the per diem rate for the inpatient stay.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

   LDH RESPONSE:
   There are no public/governmental providers receiving payments that exceed their reasonable costs of services provided.