Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

April 22, 2014

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

RE: LA SPA 13-16A RAI Response
Behavioral Health-Supplemental Payments (Outpatient)

Dear Mr. Brooks:

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 13-16A with a proposed effective date of January 20, 2013. The purpose of this amendment is to establish supplemental Medicaid payments for state-owned and operated behavioral health providers. We are providing the following additional information as requested in your RAI correspondence dated June 20, 2013

CMS-179

1. On June 14, 2013, the State submitted a letter to withdraw 13-16B which was the inpatient portion of the original 13-16. Form 179 - Box 7 needs to be revised to reflect the impact of the methodology listed on the 4.19-B page. Additionally, please provide a detailed analysis of how the State determined the revised numbers reflected on Form 179-Box 7 for SPA 13-016A.

   Response: The State did not have a fiscal impact determination for the inpatient portion of the associated rule. We were provided only with the numbers for outpatient services in Jefferson Parish Human Service District.

Reimbursement Questions

2. On Attachment 4.19-B, Item 13d, page 8 the State lists local government juvenile justice programs will be able to receive these supplemental payments. Please clarify to which

programs the State is referring to as a local government juvenile justice program and if the State is currently paying these programs.

Response: Juvenile Justice Systems are parish managed programs associated with juvenile justices in each parish that provide behavioral health services. They are not currently receiving Medicaid payments but are in the process of seeking reimbursement through Louisiana Behavioral Health Partnership.

Average Commercial Rate Demonstration

3. The State requests to pay these supplemental payments by bringing payments up to the community rate level. Please submit a demonstration of the average commercial rate which lists the top five commercial payers that the State will use to determine the Medicare to commercial conversion factor percentage.

   Response: The average commercial rate no longer applies. The State has revised the payment methodology using the Medicare equivalent rate. (Please see Attachment 4.19-B, Item 13d, page 8)

4. CMS requires that the Medicare to commercial conversion factor percentage used to establish the supplemental payment be listed in the State plan. Please provide revised State plan language that includes this percentage. Also provide the calculations to support the percentage.

   Response: The State does not include the actual percentage in the State Plan because it changes as rates change. Please refer to language found in Attachment 4.19-B, Item 13d, page 8 (Section C) of the State Plan which gives the methodology for the calculation.

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 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 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) (ii) the operational nature of the entity (state, county, city, other);
   (iii) (iii) the total amounts transferred or certified by each entity;
   (iv) (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
   (v) (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

   Response: The State share will be funded by the State appropriations comprised of State general funds and voluntary IGTs from non-state governmental entities. DHH does not yet know which of these non-state governmental entities will be participating nor the amounts. DHH will ensure that any IGT in this program is compliant with CMS regulations regarding IGT and general taxing authority.

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: It is estimated that for SFY 12, the total UPL payments to qualifying entities is $2,156,377 total funds.

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: Please see the attached UPL demonstration for Jefferson Parish Human Service District.

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: Through the UPL payment process and demonstration we know that no governmental provider would be paid above their cost. In the event an overpayment is identified, DHH would recoup such funds.

Please substitute the attached revised State Plan pages for the pages originally submitted for this State Plan amendment.

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 Adams at Darlene.Adams@la.gov or by phone (225)342-3881.

Sincerely,

J. Ruth Kennedy
Medicaid Director

JRK:DA:SSJ
Attachments (4)

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: **13-16**

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
January 20, 2013

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 **2013** **$ 951.85**
b. FFY **2014** **$1,323.67**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Item 4b, Page 3d
Attachment 4.19-B, Item 13d, Page 8
~~**Attachment 4.19-A, Item 16, Page 4b**~~ **(remove)**
Attachment 3.1-G, Page 44

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Pending (TN 12-37)
None (New Page)
~~**Pending (TN 12-63)**~~ **remove**
Same (TN 11-13)

10. SUBJECT OF AMENDMENT: **The SPA proposes to establish supplemental Medicaid payments for state-owned and operated behavioral health providers.**

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:
Bruce D. Greenstein

14. TITLE:
Secretary

15. DATE SUBMITTED:
March 27, 2013

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)

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

SUPPLEMENTAL PAYMENTS:

A. Qualifying Criteria:

Effective for dates of service on or after January 20, 2013, providers of behavioral health services may qualify for supplemental payments for services rendered to Medicaid recipients. To qualify for the supplemental payment, the behavioral health provider must be:

1) licensed as necessary by the state of Louisiana;
2) enrolled as a Medicaid provider; and,
3) a government-owned and operated entity or a quasi-governmental entity.

B. Providers of the following services shall be eligible to receive supplemental payments:

1) providers furnishing services thru a Statewide Management Organization (SMO);
2) children's mental health services;
3) behavioral health services;
4) home and community-based waiver services;
5) psychiatric residential treatment facility services;
6) therapeutic group home services;
7) substance abuse services; and
8) local government juvenile justice programs.

C. Payment Methodology: The supplemental payment shall be calculated in a manner that will bring payments for these services up to the Medicare equivalent rate.

1. The state will align paid Medicaid claims with the Medicare fees for each CPT code for the provider and calculate the Medicare payment amounts for those claims. The Medicare fees will be the most currently available national non-facility fees.
2. For each quarter the state will extract paid Medicaid claims for each qualifying behavioral health service provider for that quarter.
3. The state will then calculate the amount Medicare would have paid for those claims by aligning the claims with the Medicare fee schedule by CPT code. The Medicare fees will be the most currently available national non-facility fees.
4. The amount Medicaid actually paid for those claims is subtracted from the amount determined in C3 to establish the supplemental payment amount for the behavioral health service provider for that quarter.

		Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule. Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in (specify where published including website location). The Agency's fee schedule rate was set as of March 1, 2012 and is effective for services provided on or after that date. All rates are published on the agency's website at www.lamedicaid.com . The fee development methodology will primarily be composed of provider cost modeling, though Louisiana provider compensation studies, cost data and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development. • Staffing Assumptions and Staff Wages • Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation) • Program-Related Expenses (e.g., supplies) • Provider Overhead Expenses • Program Billable Units The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units. Effective for dates of service on or after January 20, 2013, supplemental Medicaid payments for state-owned and operated behavioral health providers shall be made in accordance with the payment methodology as described under **Attachment 4.19-B, Item 13d, page 8.** B. Standards for Payment 1. Providers must meet provider participation requirements including certification and licensure of agencies and clinic, 2. All services must be prior authorized and provided in accordance with the approved Plan of Care. 3. Providers must comply with all state and federal regulations regarding subcontracts.
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

Facility (Public Hospital) Physician Vendor	Jefferson Parish Human Services District
Physician or Group Name	Jefferson Parish Human Services District
Medicaid Billing Provider Number	98669

	Calculation of Average Commercial Rate									Calculation of 1st Supplemental Payment					
Column Reference	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
CPT	Payer 1	Payer 2	Payer 3	Average Commercial Rate per CPT	Medicaid Volume	Medicaid Volume X Avg. Commercial Rate (D * E)	Medicare Rate per CPT (Non-Fac)	Medicare Rate per CPT X Medicaid Volume (G * E)	Avg. Commercial Rate as Percentage of the Medicare Rate (F ÷ H)	Medicaid Volume	Medicare Rate per CPT (Non-Fac)	Medicare Rate per CPT X Medicaid Volume (J * K)	Payment Ceiling = Medicare Rate x Medicaid Volume x ACR (Total L * Total I)	Medicaid Payment	Supplemental Payment
90801/90791	$145.00	$100.38	$100.38	115.25	259	$ [redacted]	$ 100.38	$ 25,998.42	114.81%	259	$ 100.38	$ [redacted]		$ 19,179.34	
99213	$60.00	$47.32	$47.32	51.55	518	$ 26,702.90	$47.32	$ 24,511.76	108.94%	518	$ 47.32	$ 24,511.76		$ 22,170.40	
90805/90833 AG	$70.00	$28.22	$28.22	42.15	71	$ 2,992.65	$28.22	$ 2,003.62	149.36%	71	$ 28.22				
90847 HO	$60.00	$51.88	$51.88	54.59	938	$ 51,205.42	$51.88	$ 48,663.44	105.22%	938	$ 51.88	$ 48,663.44		$ 51,150.74	
90806/90834 AH	$70.00	$50.90	$50.90	57.27	14	$ 801.78	$50.90	$ 712.60	112.51%	14	$ 50.90	$ 712.60		$ 754.50	
90806/90834 HO	$60.00	$46.99	$46.99	51.38	1388	$ 71,246.04	$ 58.82	$ 81,642.16	87.27%	1388	$ 58.82	$ 81,642.16		$ 65,518.50	
Total	[redacted]					$ 182,798.54	[redacted]	$ 183,532.00	99.60%	[redacted]		$ 181,528.38	$ 180,802.27	$ 158,773.48	$ 22,028.79

Notes by Column:

A -C Top 3 (by volume) commercial fee schedule allowed amounts in effect for the period 07/01/2012-06/30/2013.
Contains the payment (allowed amount) by third party payers per CPT up to the allowed amount including co-pays and deductibles.
When a payer pays more than one amount per CPT, determine the average payment weighted by volume.
Exclude data from Medicare, Medicare Crossover, Workers Comp, Champus, and other non-commercial payers and codes not reimbursed by Medicaid.

E Report the Medicaid claims volume for dates of service 07/01/2009-06/30/2010

G Most currently available national non-facility Medicare fee schedule amount.

I To derive the overall ratio of commercial payment to Medicare payment, use the total of column F divided by column H. See the highlighted cell.

Sample Calculation of 1st Supplemental Payment to be made for claims paid 07/01/2010-06/30/2011

J Report the Medicaid claims volume for dates of service 07/01/2010-06/30/2011.

K Most currently available national non-facility Medicare fee schedule amount.

M Payment Ceiling is total of Col L x Total Commercial to Medicare Conversion factor computed in Column I. Note: Ceiling reduced to 80% for non-physician practitioners.

N Medicaid payment in total for dates of service 07/01/10-06/30/2011.

O Column M-Column N

Note 1: The ratio of commercial payment to Medicare payment will be updated at least every 3 years