DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

September 4, 2013

Ms. Ruth Kennedy, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

RE: Louisiana 13-027

Dear Ms. Kennedy:

We have reviewed the proposed State plan amendment (SPA) to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-027. This amendment proposes to establish a distinct payment methodology that is independent of the payment methodology established for physician in the professional services program. These physicians render services in a psychiatric residential treatment facility (PRTF).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act)and the regulations at 42 CFR 447 Subpart C. Before we can continue processing this amendment, we need additional or clarifying information.

The regulation at 42 CFR 447.252(b) requires that the State plan include a comprehensive description of the methods and standards used to set payment rates. Section 6002 of the State Medicaid Manual explains further that the State plan must be comprehensive enough to determine the required level of Federal Financial Participation (FFP) and to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Further, since the plan is the basis for FFP, it is important that the plan's language be clear and unambiguous. Therefore, we have the following questions/concerns regarding TN 13-027:

FORM-179

1. Form 179 - Box 7: No financial impact was noted due to the proposed revisions. Please provide a detailed analysis of how this determination was made and provide supporting documentation of the calculation.

2. Form 179 – Block 6: It should be amended to include subpart F, which concerns other inpatient and outpatient facility services upper limits of payment. Please revise the 179, and send us a copy.

3. Form 179- Block 9: This is not a new page. This page replaces TN#11-12. Please revise the 179, and send us a copy.

PUBLIC NOTICE

4. The State must prove that the public was notified before April 20, 2013. In reviewing this public notice, it was not sent until April 20, 2013; therefore, the earliest that the State can have an effective date is April 21, 2013.

   Please provide information demonstrating that the changes proposed in SPA 13-27 comport with public process requirements at section 1902(a)(13)(A) of the Act. Please provide copies of the legislation authorizing the proposed changes.

UPPER PAYMENT LIMIT (UPL)

5. Regulations at 42 CFR 447.325 for other inpatient and outpatient facility services upper limits of payments, state the agency may pay the customary charges of the provider but must not pay more than the prevailing charges in the locality for comparable services under comparable circumstances.

   The UPL demonstrations should include a comprehensive narrative description of the methodology (step by step) used to determine the UPL. The demonstration should also include a spreadsheet with provider specific information that starts with the source data and identifies the numerical result of each step of the UPL calculation. All source data should be clearly referenced (i.e., cost report year, W/S line, columns, and claims reports, etc…) in the demonstration. The State should also keep all source documentation on file for review.

6. Please include a detailed narrative description of the methodology for calculating the upper payment limit in the funding questions.

STATE PLAN LANGUAGE

7. It appears the State intends to establish a fee schedule for physician services that are performed in PRTF. The language requires states to include in the plan the last date on which the schedule was updated. The language identifies the published location of the fee schedule. Most States adjust rates annually or quarterly. Below is a couple suggested paragraphs that state could use to describe the fee schedule.

   Example #1 - Suggested language for Attachment 4.19-A Item16, page 5

   "Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of (ex. case management for persons with chronic mental illness). The agency's fee schedule rate was set as of (insert date here) and is effective for services provided on or after that date. All rates are published (ex. on the agency's website)."

Example #2 - Suggested language for Attachment 4.19-A Item16, page 5
The agency's rates were set as of April #, 2013 and are effective for services performed on or after that date. All rates are published on the agency's website (Louisiana.gov). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of Physician services. Reimbursement rate maximums for Medicaid covered procedures are based on the April #, 2013 Louisiana Medicare Physician Fee Schedule.

8. Please clarify if Attachment 4.19-A, Item 16, page 5, Number I apply to private, State or Non-state PRTFs.

9. Please clarify the terminology under Attachment 4.19-A, Item 16, page 5, Number II. What does publicly owned and operated mean?

10. Under Attachment 4.19-A, Item 16, page 5, Number II, it states publically owned and operated PRTFs. CMS knows that there are two private non-profits, Methodist Children's Home of Southwest Louisiana and Louisiana Methodist Children's Home. Is Number II still relevant? Were there governmental PRTFs prior to 2012?

FUNDING QUESTION

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.

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.

11. 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.)

12. 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).

13. 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.

14. 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.

15. 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?

In accordance with our guidelines to State Medicaid Directors dated January 2, 2001, if we have not received the State's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment.

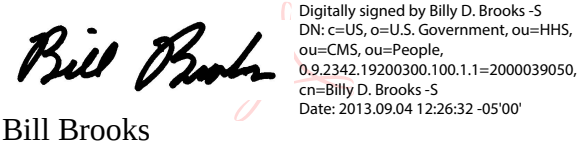
We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material. A new 90-day clock will not begin until we receive your response to this request.

Please submit your response to the following address:

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

If you have any questions, please contact Tamara Sampson, of my staff, at (214) 767-6431 or by e-mail at Tamara.Sampson@cms.hhs.gov

Sincerely,



Bill Brooks
Associate Regional Administrator
Division of Medicaid and Children's Health Operations