House Resolution 209

By the Honorable Representative Christopher Turner

Office for Citizens with Developmental Disabilities

Office of Aging and Adult Services

Medicaid

Prepared by Louisiana Department of Health

Julie Foster Hagan, OCDD Assistant Secretary

Melinda Richard, OAAS Assistant Secretary

Kimberly Sullivan, Interim Medicaid Director

Response to HR 209

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LOUISIANA DEPARTMENT OF HEALTH

Contents

Introduction and Requirements

House Resolution 209 of the 2023 Regular Legislative Session by Representative Christopher Turner urges the Louisiana Department of Health (LDH) to form a group to study the uncompensated work of support coordination agencies (SCAs) in the state.

SCAs are organizations that provide care planning and case management coordination to coordinate services for home- and community-based service participants. These individuals are Medicaid eligible and receive services through the Office for Citizens with Developmental Disabilities (OCDD) and the Office of Aging and Adult Services (OAAS). Once a waiver participant begins receiving waiver services, the SCAs receive a per member per month payment for services they provide. There is work that they must engage in prior to the participant receiving waiver services, known as pre-certification work, and SCAs are currently not reimbursed for this work.

Requirements of the Resolution:

The group was asked to consider the following in its study:

(1) The reimbursement of SCAs for their work beginning at the point of linkage,
(2) The reassignment of all pre-certification work to local governing authorities or OAAS regional offices, and
(3) The possibility of not linking participants to an SCA until they are deemed Medicaid eligible.

The resolution required the working group to include the following individuals:

(1) A representative from OCDD,
(2) A representative from OAAS,
(3) A representative from the Louisiana Medicaid Program,
(4) A representative from a local governing entity (LGE) who has experience working with SCAs,
(5) The executive director of the Community Provider Association (CPA) or designee, and
(6) A designated worker representative who is currently employed by an SCA.

Background

LDH formed a working group consisting of members from OCDD, OAAS, Medicaid, two LGEs, the CPA, and a Support Coordination agency. Workgroup members included:

- OCDD Assistant Secretary Julie Foster Hagan and OCDD team members:
    - Janae Burr
    - Sylvia Melancon
    - Erin Downing
    - Tanya Murphy
- OAAS Assistant Secretary Melinda Richard, OAAS Assistant Secretary and OAAS team members:
    - Emily Andrus
    - Cheryl Dickerson
    - Layne Janet
    - Joni Bercegeay

- Medicaid Deputy Director for Policy, Waiver and Public Affairs Tangela Womack, and Medicaid team members:
    - Brian Bennett
    - Becky Palmer
    - Tracy Barker
- Nicole Sullivan-Green, Jefferson Parish Human Services Authority, Developmental Disabilities Division Director
- Rona Burkett, Florida Parishes Human Services Authority, Waiver Manager
- Caroline Meehan, Director, Community Provider Association
- Shannon Ledet, Vice President of Programs, Louisiana Easterseals (Support Coordination agency)
- Leslie Fontenot, Executive Director, Medical Resources & Guidance, Inc. (Support Coordination Agency)

LDH held an internal meeting on August 4, 2023 and held workgroup meetings with the entire group on August 21, 2023 and September 25, 2023. The group reviewed current state and federal regulations related to SCA linkage and certification and reimbursement related to linkage and certification. They also discussed current practices in other states.

The group looked at the following considerations for this report:

- Reimbursement of SCAs for their work beginning at the point of linkage from an LGE/regional office,
- Reassignment of all pre-certification work to local governing authorities or OAAS regional offices, and
- The possibility of not linking participants to an SCA until they are eligible for Medicaid.

This report provides detailed information on the areas requested for inclusion and recommendations related to the HR 209.

Section 1 Case Management

1.1 CMS Definition of Case Management

Case management services are defined under section 1915(g)(2) of the Social Security Act (the Act) as "services which will assist individuals, eligible under the plan, in gaining access to needed medical, social, educational, and other services." Case management services are often used to foster the transitioning of a person from institutional care to a more integrated setting or to help maintain a person in the community.

1.1.1 Targeted Case Management

Targeted case management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons:

- Who are about to leave the institution,
- To facilitate the process of transition to community services, and
- To enable the person to gain access to needed medical, social, educational, and other services in the community.

Medicaid is currently revising its guidelines to indicate that TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay, if provided for the purpose of community transition. States may specify a shorter time period or other conditions under which TCM may be provided.

Federal Financial Participation (FFP) is not available for any Medicaid service, including TCM services, provided to persons who are receiving services in an institution for mental disease (IMD), except for services provided to elderly individuals and children under the age of 21 who are receiving inpatient psychiatric services.

1.1.2 Home and Community Based Services (HCBS) Case Management

HCBS Case Management may be furnished as a service under the authority of section 1915(c) when this service is included in an approved HCBS waiver. Persons served under the waiver may receive case management services while they are still institutionalized for up to 180 consecutive days prior to discharge.

FFP is available when the person leaves the institution and is enrolled in the waiver. The case management service begun while the person was institutionalized and is not considered complete until the person leaves the institution and is enrolled in the waiver. In these cases, the cumulative total amount paid is claimed as a special single unit of transitional case management.

To claim FFP for case management services under the waiver, the state may consider the unit of service complete on the date the person leaves the facility and is enrolled in the waiver, and claim FFP for this unit of case management services furnished on that date. The cost of case management furnished as an HCBS waiver service must be estimated in factor D of the waiver's cost-neutrality formula.

1.1.3. Administrative Case Management

Administrative Case Management may be furnished as an administrative activity necessary for the proper and efficient administration of the state Medicaid plan. When case management is furnished in this fashion, FFP is available at the administrative rate, but may only be claimed for the establishment and coordination of Medicaid services that are not services funded by other payors for which the individual may qualify. Case management furnished as an administrative expense may be eligible for FFP even if the person is not eventually served in the community (e.g., due to death, the individual's choice not to receive waiver services, loss of Medicaid eligibility, etc.). This is because the service is performed in support of the proper and efficient administration of the state plan.

When a state elects to provide case management as both an administrative and a service expense (either under the targeted case management state plan authority or as a service under a HCBS waiver), the state must have a policy on file with HCFA that clearly delineates the circumstances under which case management is billed as either an administrative or a service expense. This information must be included in the supporting documentation that the state forwards with its state plan or waiver request.

1.2 LDH Case Management Process for OCDD

- OCDD makes a HCBS waiver offer, and Statistical Resources Inc. (SRI) sends that offer to the individual.

- The individual accepts the waiver offer and chooses a support coordination (SC) agency. After choosing, the individual sends the waiver packet back to Statistical Resources, Inc. (SRI, the Medicaid data contractor).
- When SRI receives the packet, they link the individual with the SC agency; this is when a participant is considered "linked" to waiver services. The SC agency must:
    - Contact the individual within three days of receiving the linkage and
    - Must meet with the individual within 10 days of the linkage.
- The SC agency will complete a plan of care (POC) and a 90-L (*Request for Medical Eligibility Determination*, OCDD-PF-22-004) and turn them in to the local governing entity (LGE).
- The LGE reviews the POC and must make a home visit to the individual within 10 days.
- The LGE submits a 142 (Medically Certified for Services form) to Medicaid.
- Once the individual is approved, Medicaid will send notice to the SC, the family, and the LGE.
    - If the individual is a child with no prior diagnosed disability, the medical eligibility determination team (MEDT) process will begin. If confirmed, services can begin.
- Once Medicaid is confirmed and the MEDT process (if applicable) is complete, the LGE will sign off on the POC and send to SRI.
- SRI will issue prior authorization and services can begin; this is when a participant is considered "certified" into waiver services.

1.3 LDH Case Management Process for OAAS

- SRI mails a waiver offer, and the individual selects an SCA. Upon selection and receipt by SRI, SRI establishes SCA linkage and notifies the SCA.
- Applicant applies for Medicaid by completing the Long-Term Care Services application and indicates HCBS Waiver on application.
- SCA completes required level of care (LOC) and plan of care (POC) activities.
    - If LOC is approved, 142 approval is submitted in LaMEDS and application moves forward
    - If LOC is denied, 142 denial is submitted in LaMEDS, application is denied, and applicant receives appeal rights
- If no prior disability determination from SSA on file, the Medicaid Eligibility Determination Team (MEDT) completes disability determination. If prior disability determination is on file, Medicaid sends the approval notice decision notice to the SCA, family, and OAAS Regional Office. Disability determination is required in addition to LOC.
    - If MEDT confirms disability determination, application is approved and Medicaid sends approval notice decision notice to SCA, family, and OAAS Regional Office.
    - If MEDT denies disability determination, application is denied and applicant receives appeal rights
- Once LOC is approved, POC is finalized, and Medicaid approval notice decision notice is received, vendor payment date is entered and sent to SRI.
- SRI issues prior authorizations and services may begin.

Section 2 State-by-State Analysis of Payment for Support Coordination

State by State Table State	Eligibility	Process
Michigan	Presumptive Medicaid eligibility	• Eligibility in Michigan can be presumed by waiver agencies, most of which are Area Agencies on Aging, without an arrangement with the state Medicaid agency. The Michigan Department of Health and Human Services (MDHHS) contracts with 20 waiver agencies to perform administrative and case management functions for their waivers. • Prior to program choice, waiver agencies complete level of care determinations (LOCDs). Only licensed registered nurses (RNs) and social workers are allowed to complete LOC assessments. • Applicants who do not have Medicaid at the time of assessment must submit a Medicaid application to the MDHHS Field Office. The waiver agency has two choices when determining Medicaid eligibility: ○ Do not enroll the applicant in a service until they are approved for Medicaid. ○ The waiver agency may presume the applicant will be approved for Medicaid and continue with enrollment. The applicant will begin receiving services prior to official Medicaid approval. Waiver agencies are capitated and if they elect to use presumptive eligibility, it assumes the financial risk. If the person is found ineligible for Medicaid, the waiver agency pays from their own funds. • Once the applicant is certified in a waiver, they are assigned a supports coordinator that will provide their ongoing support coordination services.
Ohio	Presumptive Medicaid eligibility	• Ohio's statewide Presumptive Eligibility (PE) initiative provides uninsured residents with the opportunity to receive immediate healthcare services through Medicaid if they are presumed to be eligible. • Eligibility criteria for Presumptive Eligibility can be found in the following rule: **Administrative Code Rule 5160:1-2-13 – Medicaid: presumptive eligibility** • State-funded programs assist eligible individuals while their Medicaid applications are processed for eligibility for waiver while their Medicaid applications are processed for eligibility for waiver programs. • Federal reimbursement is claimed when the person is determined eligible for Medicaid. • State revenue is used for people found ineligible.

		• Hospitals, Federally Qualified Health Centers, departments of jobs and family services, local health departments, and WIC clinics are eligible to participate in Ohio's PE initiative. To become a Qualified Entity (QE), providers are required to complete a state provided training and submit an acknowledgement form. • Ohio's State Medicaid Agency (ODM) contracts with case management agencies and/or Area Agencies on Aging to complete eligibility work, LOC assessments, and ongoing case management.
Washington	Presumptive Medicaid eligibility	• Washington implemented two initiatives to aid in expediting eligibility: Presumptive Eligibility (PE) and fast track. • PE is used when a person who is applying for Medicaid appears to be eligible for Medicaid services and can be approved before the financial application and functional assessment is completed. • Fast track is used when a person has already applied for Medicaid. The functional assessment for services must be completed before services begin. • The PE process is used for two of Michigan's federally approved 1115 waiver programs. The state uses preliminary information provided through a PE screening to determine if the applicant meets the financial and functional eligibility criteria. • The fast track process is used for people who are seeking services through a 1915(c) waiver or the Medicaid state plan option. • The Medicaid agency delegates financial eligibility determination for older adults and adults with disabilities to the Aging and Long-Term Support Administration (ALTSA), which also operates section 1915(c) waivers and the Medicaid state plan. • Both financial eligibility staff and waiver staff work in the same agency, which expedites the application process. They work together to share information and ensure the financial applications are completed while the applicant is receiving services. • Under fast track, case managers can expedite the financial eligibility decision. Applicants are not required to make an appointment or come to a state office. The case manager can take applications over the phone, by mail, or during a home visit. • Fast track is available only to people who intend to receive services in their home or in a residential setting. Full applications must be completed within 90 days or the LTSS stop.

		• State funds pay for services in the few instances when the applicant is found ineligible. • State officials believe the risk is limited compared with the savings realized by serving a person in the community. • Under the section 1115 waivers, ALTSA is required to report to CMS how many applicants are ineligible, which has been fewer than 2%.
Alabama	No presumptive Medicaid eligibility	• After a person interested in services makes contact, they are referred to support coordination staff who assist the individual with completing the application and gathering/completing information for eligibility and level of care. • Support coordination prior to waiver approval is considered administrative and billed at the administrative rate.
Mississippi	No Presumptive Medicaid Eligibility	• The Mississippi Department of Medicaid contracts with Mississippi Planning and Development Districts (PDDs), who also act as the Area Agencies on Aging, and are responsible for operational functions of the Elderly and Disabled Waiver. • There is a provider agreement between Medicaid and the PDDs for the provision of case management services. PDDs determine eligibility. • Upon approval of waiver services, participants are assigned to a local case management team that consists of an RN and licensed social worker. They are responsible for assessing health, welfare, and social needs; developing a service plan; and managing and coordinating services on the service plan.
Arkansas	No Presumptive Medicaid Eligibility	• Applicants for participation in waiver services must apply at the Arkansas Division of County Operations (DCO) office in the county of their residence or on any electronic format provided by the Arkansas Division of Human Services (DHS). • The DCO determines Medicaid eligibility based on non-medical and medical criteria. • An RN who works for the Independent Assessment Contractor will then assess each applicant to determine the applicant's functional need. • A DHS Person-Centered Service Plan/Care Coordinator (PCSP/CC) nurse will use the independent assessment to

		develop the participant's service plan and serve as the primary care coordinator. • Targeted Case Management is included on all PCSPs (unless refused by the participant) and the participant chooses the agency that will provide case management services.

Section 3 Possible Solutions

3.1 Reimbursement from Linkage

Consideration	Pros	Cons	Fiscal Impact
LDH could set up a contract (similar to the single point of entry (SPOE)). Once this and the comprehensive plan of care (CPOC) are approved, it would move on to family support coordination (FSC). The SC has a contract to cover the first part and then get paid. This is different for the SPOE and the SC. Prior to implementation, LDH would need to: • Set parameters for invoicing. • Ensure this option is not considered "double dipping" from CMS, meaning whether the current rates paid to the support coordinators once the waiver participant is certified do not include an assumption of pre-certification work. • Outline Freedom of Choice process for pre-certification and ultimately support coordination in the contract, ensuring the participant is able to select a support coordinator different from the pre-certification work	• For contract, if use administrative match this would be in line with normal process – get invoice and pay invoice with administrative match.	• A contract would require an RFP, which would take a minimum of 18 months and require re-procurement at established intervals. • The Medicaid Long-Term Care eligibility determination section would need additional resources if this shift occurs.	• This would be a new contract for services that are not currently paid for in this manner. The fiscal impact would be dependent on the cost of the contract for these services and the number of newly enrolled OCDD and OAAS waiver participants. There would be some reduction in available funding because this would move from a regular Federal Match to an administrative match (i.e. 50% match rate).

Pay SCs directly using the existing claiming process with administrative match. The state would need to clarify whether the current rates paid to support coordinators have consideration of this pre-certification work.	• This option is more seamless for SC agencies	• A process would need to be developed to allow administrative FFP to be applied to claims payments, which is not currently done. Claims are automatically matched at the higher FMAP rate, but this would require a manual process every quarter where these costs are identified and re-allocated with the correct admin FFP rate to ensure the state is claiming the appropriate federal match.	• Fiscal impact is unknown; we would need a projection on added cost to get an accurate fiscal impact.
Add value-based service to "front end" development of a plan of care for reimbursement. Some states have done an 1115 demonstration to achieve this.		• This may not be available for pre-certification work because the payment has to be associated with waiver services that are already approved demonstrations. These show an offset of the high administrative costs associated with meeting the regulatory and reporting requirements for 1115 demonstrations.	• 1115 is very costly to stand up and maintain, so it is typically used for larger programs to have return on investment.

Consider presumptive eligibility as a long term care (LTC) eligibility option through an 1115 demonstration.		• Many southern states do not use this option because there is a risk of a large number of people receiving services who would not be eligible once the process is completed. • Research for this option would require substantial internal and external resources, which would have a fiscal impact prior to implementation. It would take a minimum of two to three years to implement.	• Substantial research and development of fiscal impact for both utilization of an 1115 demonstration would be required prior to this substantial change in eligibility is considered.

3.2 Reassign pre-certification work to the LGE or the regional office

LGE or regional office responsibilities would shift to assign all pre-certification work to this section until certification into the waiver is complete.

Consideration	Pros	Cons	Fiscal Impact
Build infrastructure in LGE/regional office.	• The LGE / regional office have staff with waiver expertise.	• In addition to upfront costs, the LGEs would have additional costs associated with raise/benefits/etc. • The regional office would have to do workload assessment and determination.	• This option would require substantial increases in TOs and resources as this work cannot be completed with current staff resources.
Outsource the pre-certification work to another company/agency/provider group.	• Would provide assistance to support coordination with workload	• Different entities would assess and plan, which may not truly reflect the waiver beneficiary's goals. • Waiver beneficiaries and	• This would require an RFP and cost would be determined through the contracting process.

		their families may have concerns with adding another group / entity that they have to work with and share information with; families report that what is currently in place can be overwhelming.	

3.3 Delay linking participants until they are deemed Medicaid eligible

Individuals would be referred to Long-Term Care Medicaid (LTC) to determine financial eligibility prior to linking to the support coordinator for plan of care and level of care determination.

Consideration	Pros	Cons	Fiscal Impact
Do not "link" until after financial LTC determination made.	• People typically meet financial eligibility.	• Under the current process, the financial eligibility takes longer than clinical eligibility. • This option would extend the timeframe for people to begin receiving waiver services if waiver/level of care and financial eligibility are not determined concurrently longer.	• None identified
Enact a process for a warm hand off between the SC and the LTC Medicaid eligibility specialists.	• Would assist waiver beneficiaries and families to have mechanism for communication and understanding of process	• Implementation could result in greater delays because it would require Medicaid staff to respond, taking them away from other eligibility work.	• Unknown
For OCDD waiver participants only, consider a mechanism for LaPlus (the OCDD evaluation tool) to link the participant to the correct	• This would simplify the process for support	• This option would require substantial revision to policies	• Unknown

waiver, rather than placing the person in the lowest-tier waiver and going through the bumping process (this would be part of what is determined in the pre-certification piece).	coordination agencies.	and potential waiver amendments.	

3.4 Develop a procedure code to allow support coordinators to bill one time for all initials at a set rate if planning is done timely and submitted for review.

Consideration	Pros	Cons	Fiscal Impact
Develop a procedure code that aligns with assessment and planning. The state needs to clarify that the current rates were not established with the intention that the rate includes the pre-certification work.	• Payment reimbursement solution • Applies to Medicaid eligible individuals prior to or after certification occurred		• Additional funding needed to cover cost of a new rate for initial assessments

Conclusion

The working group collectively identified several considerations to address the concerns brought forth through this house resolution. All of the considerations identified have a potential fiscal and/or programmatic impact for implementation. Many of the considerations will require additional research to determine the true fiscal impact and to fully assess compliance with federal requirements. The workgroup also identified opportunities for efficiencies during the workgroup discussions.

LDH will continue to work with identified partners in this resolution regarding these considerations and other efficiencies identified through this process.

Louisiana Department of Health
628 North Fourth Street, Baton Rouge, Louisiana 70802
(225) 342-9500
www.ldh.la.gov


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