DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

September 16, 2015

Our Reference: SPA LA 15-0018

Ms. Ruth Kennedy, State Medicaid Director
Department of Health and Hospitals
628 North 4th St.
P.O. Box 91030
Baton Rouge, LA 70821-9030

Attention: Darlene Budgewater

Dear Ms. Kennedy:

We have reviewed your request to amend the Louisiana State Plan submitted under Transmittal No. 15-0018, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on June 29, 2015. This amendment seeks to establish reimbursement for targeted case management (TCM) services for Medicaid eligible foster care children with the Department of Children and Family Services (DCFS).

We conducted our review of your submittal according to the applicable federal regulations and guidelines. Before we can continue processing this amendment, we need additional or clarifying information. Since the plan is the basis for Federal financial participation, it is important that the plan's language be clear and unambiguous. Therefore, we have the following questions/concerns regarding TN 15-0018.

CMS – 179

1. On 07/28, CMS sent the State a preprint that is used for targeted case management services. This preprint is normally located in a Supplement to Attachment 3.1-A of the State plan. If the State decides to use this preprint, it will have to amend blocks 8 and 9 of the CMS- 179 to include the correct pages being amended.

2. In block 7 of the CMS-179, the FFP is $24,032,797 for 2016 and $19,883,691 for 2017. Please indicate the total population for the Medicaid foster care children expected to receive these services that justifies the amount of FFP listed. Also indicate why the State feels the FFP will decrease in year 2.

General Questions

3. Care Coordination is an integral part of managed care. If these foster care children fall under managed care, how does the State ensure there is no duplication of services between this reimbursement for TCM and managed care services that already include care coordination?

Coverage Questions

General Comments

CMS has shared the Targeted Case Management (TCM) template with the state. The current coverage plan page language for these TCM programs are missing several key pieces of information that are linked to required elements for TCM, which are specified in the regulation at 42 CFR 441.169 and 441.18. The coverage language must be revised to include all these elements. We strongly encourage the state to use the attached draft TCM outline to ensure that all of the elements of TCM are addressed in the plan page language.

4. In accordance with 42 CFR 441.18(a)(9), "Separate plan amendments for each subgroup within a group must be included if any of the following differs among the subgroups: 1) the case management services to be furnished; 2) The qualifications of case management providers; or 3) the methodology under which case management providers will be paid." In the current state plan pages submitted, the target groups appear to be receiving unique services. Please explain if all target groups in this state plan amendment will receive the same services, have the same provider qualifications, and if the methodology for payment is the same.

Definitions of Target Groups

5. In accordance with federal regulation 42 CFR 441.18(a)(8)(i), the state must "define the group (and any subgroups within the group) eligible to receive case management services." The state has not provided definition for target groups, but rather has included services descriptions for each target groups on the state plan page. Please define each target group that will receive TCM services, specifically describe the populations eligible to receive TCM services.

Practitioner Qualifications

6. In accordance with federal regulations at 42 CFR 441.18(a)(8)(v.), TCM requires the specification of "provider qualifications that are reasonably related to the population being services and the case management services." It is unclear from the state plan page what the provider qualifications are and if there are differences between providers serving the four target groups. As a result, please address the following:
    a. Please describe all individual practitioners providing TCM services, specifically please include any licensure, certification, education, or experience requirements that must be met.
    b. Please describe all case management agencies providing TCM services, specifically please include any licensure, certification, or experience requirements that must be met.

7. Attachment 3.1A, Item 19, Page 2, IV. Standards for Participation:
    a. A., First sentence: T 3. In accordance with federal regulations at 42 CFR 441.18(a)(8)(v.), TCM requires the specification of "provider qualifications that are reasonably related to the population being services and the case management services." The state plan page currently outlines that providers must, "comply with […]provider enrollment requirements." Please further describe what provider enrollment requirements the state is referencing.
    b. A., NOTE: The state plan page currently outlines that providers from the "Office of Aging and Adult Services, as well as DCFS foster care and family support workers are exempt from case management licensing standards." Please describe if these providers furnish services to all target groups outlined within the SPA, and why they receive exemption from case management licensing standards.

Evoking Freedom of Choice Exception

8. Attachment 3.1A, Item 19, Page 2, IV. Standards for Participation, A., First Sentence: In accordance with 42 CFR 441.18(b), federal regulation states that "if the State limits qualified providers of case management services for target groups of individuals with developmental disability of chronic mental illness, in accordance with §431.51(a)(4) of this chapter, the plan must identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed service." The state plan page currently outlines that providers must comply with, "[…] the specific terms of individual contractual agreements." Please describe if this is intended to evoke the Freedom of Choice Exemption, and please note that this exemption is only applicable to developmentally disabled populations.

Other Coverage Questions

9. Attachment 3.1A, Item 19, Page 2. V. Discharge: The state plan page currently outlines that discharge from a case management agency may occur if the individual "chooses to transfer to another case management agency." Please explain if this other case management agency is one beyond those currently furnishing TCM services to the four target groups. In addition, please clarify if individuals receiving TCM will have to repeat all their case management service components when transferring to another agency or if the new agency will continue TCM services seamlessly from the previous agency.

Reimbursement Questions

Attachment 4.19-B Item 19, Page 2

10. Reimbursement Methodology, fourth paragraph: The following coverage language was identified on the payment pages. The state currently has included language stating that, "The licensing regulations for Support Coordination stipulate that the providers must have monthly contact with participants." Please confirm that support coordinators are the same as case managers, and ensure that consistent terminology and titles are used throughout the state plan for providers.

11. The last sentence in the fifth paragraph states "Payment shall be a one monthly fee-for service (FFS) payment". Did the state want to say "one-time" monthly or just monthly fee-for service (FFS) payment? Either way, please clarify this statement.

12. These children fall under managed care. Is managed care just the service delivery model for these foster care children? Please explain how the State intends to pay a FFS rate when these children are now under managed care. If a FFS rate is going to be paid, what are the monthly service delivery requirements that must be met to allow a monthly payment to be made?

13. Please provide the amount of the monthly rate and use the applicable language to list the fee schedule location on the plan page.

14. The State of Louisiana has been providing these services for some time now. What federal funding sources were used to supplement the cost of these services before and what made the State want to use Medicaid TCM funding at this point?

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.)

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).

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.

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.

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?

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

In accordance with our guidelines to all 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.

If you have any questions regarding this letter, please contact Ford Blunt at 214-767-6381 by phone or by email at ford.blunt@cms.hhs.gov.

Sincerely,

Bill Bob Farrell for

Bill Brooks
Associate Regional Administrator