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

December 2, 2015

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 15-0028

Dear Ms. Kennedy:

We have reviewed the proposed State plan amendment (SPA) to Attachment 3.1-A and 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 15-0028. The SPA proposes to amend the psychiatric residential treatment facilities (PRTF) for the following items:

1. Allow an Office of Behavioral Health appointed designee to certify providers;
2. Revise the terminology to be consistent with current program operations; and
3. Revise the reimbursement methodology to remove the provisions governing interim payments, and to establish capitation payments to managed care organizations for children's services other than Coordinated System of Care (CSoC). For children/youth enrolled in CSoC, the non-risk payments shall be continued and payments made to a CSoC contractor.

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 Code of Federal Regulations (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 15-0028:

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.

UPPER PAYMENT LIMIT (UPL)

2. Please note CMS has not received the other inpatient and outpatient facility services (PRTF) demonstration for SFY 2015. Regulations at 42 CFR 447.325 for other inpatient and outpatient facility services upper limits of payments, state 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.

   Please submit the SFY 2015 UPL demonstration and include a detailed narrative description of the methodology for calculating the upper payment limit.

STATE PLAN LANGUAGE

3. The State plan methodology must be comprehensive enough to determine the required level of payment and the FFP to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Claims for federal matching funds cannot be based upon estimates or projections. The reimbursement methodology must be based upon actual historical utilization and actual trend factors.

   Please clarify, remove, or add the following items to the plan pages and submit revisions for CMS review.

   a. The Institution for Mental Diseases (IMD) under the age of 21 benefit is under Section 1905(a)(16) of the Social Security Act. Additionally, inpatient psychiatric hospital services for individuals under age 21are defined in subsection (h).

      Therefore, please add the following title, "Institution for Mental Diseases (IMD) for individuals under 21 years of age", for all of the coverage and reimbursement plan pages.

   b. On Attachment 4.19-A, Item 16 page 5, and page 5a, there are a typographical errors. It states the following:

      4.19-A, Item 16 page 5

      Hospital-Based PRTFs: Hospital-based PRTFs shall be reimbursed a per diem rate for covered services. The per diem rate shall also include reimbursement for the following services when included on the active treatment plan:
      a) Dental;
      b) Vision;

      4.19-A, Item 16 page 5a

      4. hospital-based PRTFs specializing in sexually-based treatment programs;
      5. hospital-based PRTFs specializing in substance use treatment programs; and
      6. hospital-based PRTFs specializing in behavioral health treatment programs.

On February 16, 2007, Survey and Certification issued **S&C-07-15**. It clarified Section 4755 of the Omnibus Budget Reconciliation Act (OBRA '90) amended section 1905(h) of the Act to specify that the psych under 21-benefit can be provided in psychiatric hospitals that meet the definition of that term in section 1861(f) of the Act "or in another inpatient setting that the Secretary has specified in regulations."

This amendment affirmed and effectively ratified preexisting CMS policy, as articulated in subpart D of 42 C.F.R. part 441, which interpreted sections 1905(a)(16) and 1905(h) of the Act as not being limited solely to psychiatric hospital settings. OBRA '90 provided authority for CMS to specify inpatient settings in addition to the psychiatric hospital setting for the psych under 21-benefit. In 2001, CMS established PRTFs as a new category of Medicaid facility, and as an additional setting for which the psych under 21-benefit can be provided. (See interim final regulations, 66 FR 28111).

The Social Security Act and federal regulations, expressly identify that services under the psych under 21-benefit can be provided in distinct parts found in psychiatric hospitals; however, a PRTF is not identified as a distinct part of another facility.

A PRTF is a separate, stand-alone entity providing a range of comprehensive services to treat the psychiatric condition of residents on an inpatient basis under the direction of a physician.

The purpose of such comprehensive services is to improve the resident's condition or prevent further regression so that the services will no longer be needed. Current regulation, §483.352, states that a PRTF means "a facility other than a hospital, that provides psychiatric services, as described in subpart D of part 441 of this chapter, to individuals under age 21, in an inpatient setting."

c. On Attachment 4.19-A, Item 16, page 5, it references publicly owned and operated PRTF. Please replace the word 'publicly" with either State and/or Non-State.

d. On Attachment 4.19-A, Item 16, page 5 and 5a, there are partial references to fee schedules. CMS requires specific language if the State intends to use an established fee schedule. 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. Please use the paragraph below to describe the fee schedule.

> *"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)."*

e. On Attachment 4.19-A Item 16, page 5 and 5a, there are references to managed care organizations (MCOs) and the Coordinated System of Care (CSoC) contractor.

Please remove these references and how the managed care organizations or contractors will reimburse the PRTFs.

Additionally, on Attachment 4.19-A, Item 16 page 5, the first 3 paragraphs should be deleted. Attachment 4.19-A section is limited to including a State's methods and standards for setting Fee-For-Service (FFS) rates paid by Medicaid to purchase PRTFs services. The MCO discussion is misplaced and should deleted from this attachment. Please contact Janice Arceneaux, your Dallas Regional Office managed care specialist, for the appropriate location of this language.

According to the ***CMCS Informational Bulletin dated November 2012,*** it allows for **Services Provided under Arrangement** for inpatient psychiatric hospital services for individuals under age 21.

The PRTF may wish to obtain services reflected in the plan of care under the arrangement with the qualified non-facility provider. On page 2, of the Bulletin, it states that "In some cases a psychiatric facility may wish to obtain services reflected in the plan of care under arrangement with qualified non-facility providers. Such services would be components of the inpatient psychiatric facility benefit when included in the child's inpatient psychiatric plan of care and furnished by a qualified provider that has entered into a contract with the inpatient psychiatric facility to furnish the services to its inpatients. To comply with the requirement that services be "provided by" a qualified psychiatric facility, the psychiatric facility must arrange for and oversee the provision of all services, must maintain all medical records of care furnished to the individual, and must ensure that all services are furnished under the direction of a physician.

f. The State has two options regarding payment. **Louisiana must document in the 4.19-A, reimbursement section of the State plan, which payment option the State will utilize.** According to the 2012 Bulletin, either payment option must be claim on the Mental Health Facility Services line of the CMS-64 Medicaid expenditures report. Please advise your State Financial staff of this requirement.

- The first option is that Louisiana can pay the PRTF provider, who has an arrangement with the qualified non-facility provider.

- The second option is to **directly** reimburse individual practitioners or suppliers of arranged services **using payment methodologies that are applicable when the services are otherwise available under the State plan.** However, the reimbursement for services are the **same fees** to such practitioners or suppliers as would otherwise be applicable when the services are furnished to Medicaid beneficiaries **outside** the inpatient psychiatric facility benefit**.**

STATE PLAN LANGUAGE- 3.1-A

4. In accordance with § 440.160, services must be provided under the direction of a physician. Please add language to the plan page accordingly. Additionally, please add language indicating that services are included in an individual's plan of care.

5. Please specify any services that will be provided under arrangement with outside providers.

6. The plan page indicates that services on the inpatient psychiatric active treatment plan that are not related to the provision of inpatient psychiatric care are excluded. Please remove this language as active treatment should be comprehensive and include medical and psychiatric services.

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.

7. 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.)

8. 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).

9. 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.

10. 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.

11. 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