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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Regional Operations Group

June 14, 2019

Ms. Jen Steele, State Medicaid Director
Department of Health
628 North 4th St.
Post Office Box 91030
Baton Rouge, LA 70821-9030

Attention: Karen Barnes

RE: State Plan Amendment LA 19-0005

Dear Ms. Steele:

We have completed our review of the proposed amendment submitted under transmittal number (TN) LA 19-0005. This plan amendment has an effective date of March 20, 2019 and was submitted in order to amend the provisions governing school-based medical services covered in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit and school-based behavioral health services in order to: 1) add services categorized as 504 plans, individual health plans or otherwise medically necessary in addition to those covered by an individual education plan, to the services available for school-based Medicaid claiming; 2) amend the reimbursement methodology to expand allowable billing providers for direct/therapy and nursing services; and 3) add applied behavioral analysis, personal care services and transportation to allowable Medicaid billing.

Before we can continue processing this amendment, we need additional or clarifying information.

General Comments/Questions

1. General: Consistent with 1902(a)(10)(A) and 1902(a)(23)of the Act, please assure that comparable services are available to children outside of the school setting based on medical necessity, regardless of a child's school status, and that children have a free choice of any qualified Medicaid provider, not just practitioners furnishing services in the school setting.

2. Attachment 3.1-A, Item 4.b, Page 9h(1):

    a. Behavioral Health Services Provided by Local Education Agencies: In accordance with 1905(r) of the Act, the EPSDT benefit requires that states provide all medically necessary 1905 (a) services coverable under the Medicaid program to EPSDT eligible children. Please remove language on the plan pages that limits services to specific age ranges of children.

b. Service Exclusion: The state indicates that Medicaid does not reimburse for habilitative services; however, the therapies at 42 CFR 440.110 and preventive services at 42 CFR 440.130(c) may include habilitative services. Please clarify in the state plan circumstances in which habilitative services may be covered under Medicaid or remove the reference to habilitative services as a service exclusion.

c. LEA Responsibilities, 4: The state has listed that behavioral health services must be provided within the scope of practice or under the supervision of licensed practitioners consistent with the requirements of 42 CFR 440.60. Please add to the state plan clarification that licensed practitioners also assume professional responsibility for unlicensed/certified practitioners under their supervision and within their scope of practice consistent with 42 CFR 440.60.

d. Other Licensed Professionals 7: To comport with the requirements of the Other Licensed Practitioner (OLP) benefit at 42 CFR 440.60, please clarify if APRNs are licensed by the state. For clarity, please identify the benefit title as "Other Licensed Practitioners," to be consistent with the regulation.

e. Other Licensed Professionals 9. School psychologists: The OLP benefit covers the services of a licensed practitioner; however the state has indicated that the certified "school" psychologists are not licensed. Consequently, the state may wish to consider covering the services they provide under a different benefit category, such as the rehabilitative services benefit at 42 CFR 440.130(d).

3. Attachment 3.1-A, Item 4.b, Page 9h(2) Applied Behavioral Analysis -Based Services Provided by Local Education Agencies: It appears that the state is proposing to cover the services of a licensed behavioral analyst, and those working under the supervision of a licensed behavioral analyst, in the school setting. If our understanding is correct, the language submitted on this page is duplicative of the services covered in the state plan at Attachment 3.1-A Item 4.b, Page 20. The state may amend the currently approved Item 4.b, Page 20 state plan page to add that the services are furnished in the school setting, but this is not required.

4. Attachment 3.1-A, Item 4b, Page 19c. The state's language provided on the Personal Care Services plan pages, as written, may not fully comply with regulations at 42 CFR 440.167. The following recommendations are being requested in order to assist CMS in moving towards approval of LA-19-0005.
   a. Please remove the last sentence that reads: "The goal of these services is to enable the recipient to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost effective."

   b. Please remove the first sentence in this section and replace with the following: "In accordance with 440.167(a)(2), personal care assistants providing school-based PCS shall not be a member of the individual's family."

c. We do not need to see specific medical necessity criteria on the plan page. Please revise the language in this section to read as follows: “School-based PCS shall be covered for all Medicaid recipients in the school system. Personal care services must meet medical necessity criteria as established by the Bureau of Health Services Financing.”

d. Please remove the last sentence in this section that reads: “The plan of care shall be acceptable for submission to BHSF only after it has been signed and dated by the physician.”

5. Attachment 3.1-A, Item 4b, Pages 19d and 19e, Covered Services. We do not need to see the specific Covered Services in the state plan; however, the state may include them in their state provider manual. Any changes to the covered services listed on the plan page would require a state plan amendment. In an effort to lessen state plan amendment submissions by the state, we are suggesting the state remove the language on pages 19d and 19e and use more general (ADL and IADL) language such as: “Covered services include a range of human assistance provided to persons with disabilities and chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability.”

Reimbursement Comments/Questions

1. Cost Report: Please provide instructions for the Cost Report.

2. CMS 179: Please confirm the correct effective date in #4. CMS 179 proposed effective date is March 20, 2019, however SPA pages indicate effective dates of service July 1, 2019. Please indicate how this impacts the federal budget in #7.

3. Reimbursement Methodology: Please describe the allocation methodology in the state plan.

4. Attachment 4.19-B, Item 4.b., Page 1e, Reimbursement Methodology: The state’s interim rate methodology appears to be a “flat fee” in the third paragraph. If the state’s flat fees are less than a cost based interim rate, the state could be making a large prior period adjustment at the end of the year when the provider’s costs are reconciled. We would recommend, but is it is not required, that the state consider using a cost-based interim rate methodology to minimize any prior period adjustments to the claims on the CMS 64.

5. Please update the following language everywhere it is specified in the state plan: *Effective for dates of service on ~~or~~ and after July 1, 2019, reimbursement for services provided by school based service providers (Provider Type 70) shall be 85 percent of the Medicare published rate. The Medicare published rate shall be the rate in effect on July 1, 2019.*

6. Attachment 4.19-B, Item 4.b., Page 1f, Indirect Cost: Please remove OMB Circular A-87 and replace language with so that it refers to 2 CFR 200.

7. Attachment 4.19-B, Item 4.b., Page 1g, Cost Settlement Process: Please remove OMB Circular A-87 and replace language with so that it refers to 2 CFR 200.

8. Attachment 4.19-B, Item 4.b., Page 1f, Indirect Cost: Please update the following language in the third paragraph. *All costs included in the amount of cost to be certified and used subsequently to determine the reconciliation and final settlement amounts as well as interim rates are identified on the ~~CMS approved~~ transportation cost report and are allowed in ~~OMB Circular A-87~~ 2 CFR 200.*

9. Cost Settlement Process: Please specify in the state plan the timeframes in which the state determines the reconciled amount and the final cost settlement.

10. Transportation: Please make sure that transportation is allocated on the basis of one-way trips on a day when an IEP or other care plan (but not Free Care) service is received.

11. States are not permitted to recover funds from future payment. Future claims must be distinct from prior period adjustments. If not it distorts future years reconciliation and the FMAP fluctuates. Please confirm that you understand this and remove the following language everywhere it is specified in the state plan.
    If the interim payments exceed the actual, certified costs of an LEA's Medicaid services, the Department shall recoup the overpayment in one of the following methods:
    i. *offset all future claim payments from the affected LEA until the amount of the overpayment is recovered;*
    ii. *recoup an agreed upon percentage from future claims payments to the LEA to ensure recovery of the overpayment within one year; or*
    iii. *recoup an agreed upon dollar amount from future claims payments to the LEA to ensure recovery of the overpayment within one year.*

12. Please note that based on the state's responses to coverage questions, more questions could be forthcoming related to reimbursement on the 4.19-B pages.

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, which would have expired on June 28, 2019. A new 90-day clock 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, and subsequently reiterated in the August 16, 2018 Center for Medicaid and CHIP Services Informational Bulletin, if a response to a formal request for additional information from CMS is not received from the state within 90 days of issuance, CMS will initiate disapproval of the SPA or waiver action. In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will defer federal financial participation (FFP) for state payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

We ask that you respond to this RAI via the Dallas Regional Office SPA/Waiver e-mail address at CMS SPA_Waivers_Dallas_R06. The original signed response should also be sent to the Dallas Regional Office.

If you have any questions, please contact Tobias Griffin at 214-767-4425.

Sincerely,

Bill Brooks
Director
Centers for Medicaid & CHIP Services
Regional Operations Group