DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
233 North Michigan Ave., Suite 600
Chicago, IL 60601

Financial Management Group

August, 2023

Tara LeBlanc
Medicaid Director State of Louisiana
Department of Health
628 N 4th Street
P.O. Box 91030
Baton Rouge, LA 70821-9030

RE: Official Request for Additional Information (RAI) State Plan Amendment (SPA) LA-23-0020

Dear Director Tara LeBlanc:

The Centers for Medicare & Medicaid Services (CMS) has completed our initial review of the proposed amendment submitted under transmittal number (TN) LA-23-0020. This state plan amendment (SPA) has a proposed effective date of July 1, 2023. The purpose of this SPA is to amend provisions governing medical transportation services, to include emergency medical transportation in the Louisiana Medicaid fee schedule.

Section 1902(a) of the Social Security Act (the Act) requires that states have a state plan for medical assistance that meets certain federal requirements that set out a framework for the state program. Implementing regulations at 42 CFR 430.10 require that the state plan be a comprehensive written statement containing "all information necessary for CMS to determine whether the plan can be approved as a basis for Federal Financial Participation (FFP) in the state program".

To be comprehensive, payment methodologies should be understandable, clear, and unambiguous. In addition, because the plan is the basis for FFP, it is important that the plan language provide an auditable basis for determining whether payment is appropriate.

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 Act and the regulations at 42 CFR 447. Before we can continue processing this amendment, we need additional or clarifying information.

179 Form:

1. Please process pen and ink changes, or grant permission for CMS to process pen and ink changes to include the following reference on the 179 Form, in box 5:

   a. Section 1902(a)(30)(A)
   b. 433.68 (f)(3)(i)(A)
   c. 42 CFR § 433.56
   d. 1903(w)(6)(A)
   e. 1903 (w)(3)(B) and 42 CFR 431.53

2. LA-23-0020 is effective July 1, 2023 – Why doesn't it have a 2023 fiscal impact for one quarter (July 1, 2023, through September 30, 2023)? Can the state please revise budget impact to include the missing quarter 07/01-09/30, 2023 and updated 179 budget impact fields accordingly.

Plan Page Language and Reimbursement Methodology

3. Please describe the specific commercial rates used to set the fee schedule (which commercial payer(s), which provider(s') negotiated fees are being used).
4. Once the commercial fees were accessed, what methodology did the state use in establishing the Medicaid enhanced fee schedule?
5. How many payers' fees did the state review?
6. Will the methodology use a weighted average or a straight average in assessing the fees that would be paid?
7. Please provide documentation showing what the state used in setting these fees (like an Average Commercial Rate (ACR) demonstration but without the full-blown Upper Payment Limit Demonstration (UPL).
8. Is the state paying the full amount of the ACR, or some amount less than the full ACR amount to the providers?
9. Describe the manner/methodology/logic used to determine the amount payable to providers in each regional area of the state (governmental, New Orleans, other). Clarify if any of these percentages will change over time. Note that if the fee schedule is static for all providers and the percentages are variable by region, then the state must be prepared to include the actual percentages that will be paid in the state plan.
10. Please include comprehensive methodology in the state plan so that all providers know what their rate of payment will be.
11. Note that by changing these supplemental payments to a fee schedule, the state must make sure that all providers of the service have a clear, comprehensive method of reimbursement in the Medicaid state plan.
    a. Please reference fee schedule Federal requirement methodology requirement attached in this email or for direct access here is the link: https://www.medicaid.gov/resources-for-states/spa-and-1915-waiver-processing/medicaid-spa-processing-tools-for-states/index.html

12. Please revise 4.19-B pages submitted and replace any uncertain "may" language with "shall" or "will"..
13. Please clarify if the state also pays for the emergency air ambulance services that are not included in the fee schedule containing the new enhanced rates? If no, then the state will need to submit an ACR, if yes, please clarify "all the methodologies" will be utilizing fee schedules.
14. If the state will utilize the fee schedule for all, then please revise plan pages and remove any unnecessary, ambiguous language included on the pages.
15. If the state will utilize the fee schedule for some of the services and the UPL for other, please clarify and submit the ACR-UPL demonstration for CMS review.
16. Please replace the reference to regulation 42 CFR 410.40(b) with 42 CFR 431.53, which applies to both emergency and non-emergency transportation, throughout the plan pages.
17. When payment is made up to the ACR, the state must recalculate this UPL annually, using updated Medicaid and commercial payment data. For payments up to the Medicare equivalent of the ACR, the percentage does not need to be calculated annually, but must be updated at least every three years. Please confirm that the state will provide the annual UPL demonstration pertaining to this SPA payment methodology in accordance to 1902(a)(30)(A).
18. Included below is ACR/UPL related policy and other UPL related materials to assist the state with this SPA submission.
    a. https://www.medicaid.gov/medicaid/financial-management/downloads/upl-instructions-qualified-practitioner-services-06012021.pdf
    b. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/upl-guidance-qualified-practitioner-services-replacement-new.pdf
    c. https://www.macpac.gov/wp-content/uploads/2021/11/Upper-Payment-Limit-Supplemental-Payments.pdf#:~:text=However%2C%20in%20sub-regulatory%20guidance%20CMS%20has%20indicated%20that,reasonable%20estimate%20of%20what%20Medicare%20would%20have%20paid

CMS is requesting this additional/clarifying information under the provisions of section 1915(f) of the 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 August 8, 2023. 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 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 of the SPA through the date of approval.

We ask that you respond to this RAI via the OneMAC portal at http://onemac.cms.gov. and email a copy of your response to Monica Neiman at monica.neiman@cms.hhs.gov.

If you have any questions, please contact Monica Neiman via email at monica.neiman@cms.hhs.gov

Sincerely,

Todd McMillion

Todd McMillion
Director
Division of Reimbursement Review