



Bobby Jindal
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Alan Levine
SECRETARY

February 15, 2008

The Honorable Henry A. Waxman
United States House of Representatives
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Chairman Waxman:

In response to your request for information on the impact of the Administration's regulatory action on Louisiana Medicaid, we have analyzed each proposal and outlined an estimate of the expected reduction in federal Medicaid funds over the next five years as well as the effect these proposals will have on applicants and beneficiaries in our state.

If you have any questions regarding the attached information, please feel free to contact Sandra Victor, Medicaid Policy Development and Implementation Section Chief, at (225) 342-0941.

Sincerely,

A handwritten signature in cursive script that reads "Jerry Phillips".

Jerry Phillips
Medicaid Director

JLP/SV/khb

Enclosure

LOUISIANA MEDICAID PROGRAM

CMS 2258-FC - Cost Limits for Public Providers

Intermediate Care Facilities/Developmentally Disabled

Note: Intermediate Core Facilities for the Mentally Retarded (ICF/MR) are referred to as Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) in Louisiana

The cost limitations rule for public providers will affect the payment to public ICFs/DD as our reimbursement methodology is set at 112% of their costs. The new rule establishes a limit of 100%. The fiscal impact has been determined to be approximately \$29,460,982.40 for the first year with increases of approximately 4% each year thereafter.

Effective February 9, 2003, the public rate methodology is as follows:

1. Inflate each facility's routine cost per diems using the skilled market basket index.
2. Inflate each facility's routine cost per diem determined above by .12%.
3. Each public facility's capital and ancillary costs will be paid on a "pass-through" basis.

Using this new rate methodology there would be a reduction in rates as follows:

FY 08 \$29,460,982.40 $\times .70 = \$ 20.6$

FY09 \$30,639,421.70

FY10 \$31,864,998.57

FY11 \$33,139,598.51

FY12 \$34,465,182.45

$159.6 \times .70 = \$ 111.7$

Assume 70%
FMAP

**Refer to Document A for further clarification.*

Nursing Facilities

Based on our understanding of the definition of a "public" provider under the new governmentally-operated regulations (42 CFR §433.50), Louisiana only has two publicly-operated nursing facilities. Both of these facilities are currently reimbursed based on cost and utilize the Medicare cost report and allowable cost rules; therefore, the proposed cost limit on public nursing facility providers will have no fiscal impact for the state.

Public Hospitals

1. Estimated impact for Medicaid inpatient payments above costs to public rural hospitals –
**refer to Document B*

2. The rule eliminates the state's and public hospitals' flexibility in the use of certified expenditures under previous rules. The state and public hospitals could determine if some or all certified expenditures should be used as state match to support the Medicaid Program. The new rule would require the certified expenditures to be paid to the hospital. Document B-1 illustrates the current flexibility. **refer to Document B-1*

Administrative Costs Relative to Public Providers

Currently, Louisiana Medicaid has approximately 3,800 enrolled providers who will be impacted by this rule. Under an existing contract, we review cost reports on more than 300 providers at a cost of approximately \$1 million per year. This rule will significantly increase contract costs to oversee compliance with costs limits for public providers. Additionally, providers will have the added cost of preparing cost reports for the state's review to ensure they have not been paid above cost.

CMS 2279-P - Payment for Graduate Medical Education

For an outline of the estimated impact of elimination of graduate medical education payments in Medicaid rates and DSH payments, **refer to Document C.*

CMS 2213 P - Payment for Hospital Outpatient Services

1. Medicaid outpatient payments above costs to public rural hospitals – **refer to Document D*
2. Rural Health Clinics DSH payments – **refer to Document D-1*

CMS 2275-P - Provider Taxes

ICF-DD

Provider taxes (referred to as fees in Louisiana) are calculated by taking no more than 6% of the total revenue of the ICF/DD program. The current provider fee is \$14.30. Based on the proposed reduction in the calculation of the provider fee to 5.5% and the change in public rate methodology, the provider fee would have to be reduced to less than:

FY 08 \$14.05

FY 09 \$14.44

FY 10 \$14.85

FY 11 \$15.44

FY 12 \$15.88

The above amounts reflect the limits. We would want to consider reducing the provider fee even lower to allow for a cushion. **Refer to Document E.*

Pharmacy

For the pharmacy provider tax, there is no impact in reducing the allowable amount that can be collected from a health care-related tax from 6 to 5.5 percent of the net patient revenues received by the taxpayers since the provider tax on pharmacy services is \$0.10 per prescription.

Nursing Facility

The current Louisiana Nursing Home provider tax is below the 5.5% of revenue threshold for calendar year 2008. Based on the current tax, there would be no fiscal impact to the state.

CMS 2261-P - Coverage for Rehabilitative Services, 72 FR 45201

We do not anticipate an impact to Louisiana's Mental Health Rehabilitation (MHR) services as long as the CMS interpretation of 42 CFR 440.130(d)(1)(vi) *Restorative services* with regard to children includes restoration to an age-appropriate functional level. The age-appropriate level may never before have been reached due to the child's mental illness/severe emotional behavioral disorder. A stricter interpretation of restorative services as "an individual who has had a functional loss and has a specific rehabilitative goal toward regaining that function" would eliminate a large number of children from mental health rehab services.

As of February 6, 2008, 2,599 children are receiving MHR services and we would estimate as many as 90% would no longer qualify for MHR under a strict interpretation of the proposed rehabilitative services rule. We cannot quantify the fiscal impact, since we don't know how many of these children would end up in inpatient psychiatric hospitals (\$538.80 per day), Office of Youth Development (OYD) detention facilities (\$415.48 per day) or Office of Community Services (OCS) congregate care (\$138-\$169 per day). Therefore, the fiscal impact would be significant and negative, since on average, we currently expend only \$12.73 per day or \$381.90 per member per month in the MHR Program.

CMS 2287-P - Payments for Costs of School Administrative and Transportation Services

Medicaid Administrative Claiming Fiscal Impact

Schools offer a very unique opportunity to locate and outreach to current and potential Medicaid recipients to assist them in accessing Medicaid covered services. This program reaches out to Medicaid eligible children and links them to Medicaid covered services. The Medicaid Administrative Claiming (MAC) Program identifies many administrative duties or job functions

being performed to link children to these services. Medicaid reimburses school districts quarterly the Federal share for time spent on administrative medical-related functions.

If CMS eliminates the MAC Program, the Louisiana school districts will not be reimbursed for the 50% Federal share of their costs. This will seriously impact the school districts' ability to provide these services. Failure to perform the administrative tasks in this program (which encourage early screening) could allow more costly conditions to occur in the future, which would require a much higher dollar amount to be spent by the Medicaid Program. Furthermore, elimination of this program would impact the participating school districts' budgets by eliminating the following projected Federal funds generated by the MAC Program.

The fiscal totals projected for the next 5 years for the MAC Program are:

2008-2009	\$5,000,000 (Federal funds)
2009-2010	\$5,000,000 (Federal funds)
2010-2011	\$5,000,000 (Federal funds)
2011-2012	\$5,000,000 (Federal funds)
2012-2013	\$5,000,000 (Federal funds)

**Refer to Document F* for total funds that would be lost by each school district based on the Fiscal Year 2005/2006 actual claim payments made to the districts.

CMS 2237-IFC - Targeted Case Management

It is anticipated that targeted case management will be affected by the proposed rule. We anticipate that administrative costs will be incurred for updating our claims processing system and our contractor's prior authorization system. In addition, expenses will be incurred for conducting provider training. It is estimated that fiscal impact for system changes will be a one-time cost of approximately \$10,000 (state match). However, we are currently unable to calculate the total fiscal impact.

Another possible issue is the funding for case management services for our early intervention program, EarlySteps, would be affected if CMS' interpretation of the rule is that these services are covered by funding under Part C of IDEA. If this happens, we estimate a loss of approximately \$1,782,000 in federal funds. **Refer to Document G.*



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February 15, 2008

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Schneider
Medicaid
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DOCUMENT A

<u>FACILITY</u>	FY 08 Rate	FY 08 Rate Inflation Only No 112%	Current revenue with 112%	Current Revenue w/o 112%	Current Revenue Difference
Columbia Community Residential & Employment Services	\$287.38	\$257.07	\$1,573,405.50	\$1,407,438.31	\$165,967.19
Columbia Community Residential & Employment Services - Brownville Road Comm Home	\$311.02	\$278.12	\$681,133.80	\$609,083.24	\$72,050.56
Columbia Community Residential & Employment Services - Columbia Heights Group Home	\$307.32	\$274.74	\$511,380.48	\$457,159.54	\$54,220.94
Columbia Community Residential & Employment Services - Copenhagen Comm. Home	\$336.51	\$300.84	\$707,344.02	\$632,369.35	\$74,974.67
Columbia Community Residential & Employment Services-Grayson Comm. Home	\$382.10	\$341.54	\$645,366.90	\$576,866.92	\$68,499.98
Columbia Community Residential & Employment Services-Pine Burr Comm.Home	\$357.36	\$319.45	\$782,618.40	\$699,585.65	\$83,032.75
North Lake Supports & Services Center (formerly Hammond Dev. Ctr.)	\$485.98	\$435.29	\$50,325,658.90	\$45,076,338.44	\$5,249,320.46
North Lake Supports & Services Ctr.-Lynn Lane-eff. 11/22/05	\$485.98	\$435.29	\$1,064,296.20	\$953,282.61	\$111,013.59
North Lake Supports & Services Ctr.-Rene Drive-eff. 11/29/05	\$485.98	\$435.29	\$1,064,296.20	\$953,282.61	\$111,013.59
North Lake Supports & Services Ctr.-Robinwood Dr.-eff. 4/26/07	\$485.98	\$435.29	\$1,064,296.20	\$953,282.61	\$111,013.59
North Lake Supports & Services Ctr.-Trippi Road eff.11/8/06	\$485.98	\$435.29	\$1,064,296.20	\$953,282.61	\$111,013.59
Leesville Residential & Employment Services	\$430.45	\$385.15	\$2,224,135.15	\$1,990,046.82	\$234,088.33
Leesville Residential & Employment Services - Amanda Rock Comm Home	\$461.07	\$412.89	\$738,173.07	\$661,031.75	\$77,141.32
Leesville Residential & Employment Services - Boycher Comm Home	\$399.48	\$357.58	\$852,490.32	\$763,074.75	\$89,415.57
Leesville Residential & Employment Services - John C. Heard Comm Home	\$416.77	\$373.04	\$816,869.20	\$731,163.37	\$85,705.83
Leesville Residential & Employment Services - Ray Charles Smith Comm Home	\$440.08	\$393.85	\$900,843.76	\$806,220.62	\$94,623.14
Leesville Residential & Employment Services - Whispering Pines Comm Home	\$411.85	\$368.79	\$709,617.55	\$635,426.35	\$74,191.20
Greater New Orleans Supports & Services Center (formerly Metropolitan)	\$433.98	\$388.56	\$35,961,318.72	\$32,197,278.05	\$3,764,040.67
Per Madeline new home not yet licensed					
Per Madeline new home not yet licensed					
Northwest Supports and Services Ctr.	\$372.39	\$333.79	\$21,585,213.96	\$19,347,920.32	\$2,237,293.64
Northwest Supports & Services- Center Melanie Eff. 1/24/07	\$372.39	\$333.79	\$815,534.10	\$731,004.51	\$84,529.59
Bayou Region Supports & Services Ctr.-(formerly Peltier-Lawless)	\$419.71	\$376.07	\$5,577,945.90	\$4,997,941.04	\$580,004.86

Bayou Region Supports & Services Ctr. - Beaujolais	\$362.77	\$325.47	\$623,601.63	\$559,486.71	\$64,114.92
Bayou Region Supports & Services Ctr. - Labadieville	\$419.71	\$376.07	\$919,164.90	\$823,588.48	\$95,576.42
Pinecrest Supports and Services	\$534.43	\$478.83	\$105,011,219.56	\$94,086,382.76	\$10,924,836.80
Pinecrest Supports and Services-Kimball Avenue Comm. Home	\$527.92	\$472.04	\$715,331.60	\$639,614.98	\$75,716.62
Pinecrest Supports & Service /Charles Park effective 10/19/05	\$534.43	\$478.83	\$1,170,401.70	\$1,048,639.02	\$121,762.68
Pinecrest Supports & Services/Edgewood effective 3/8/06	\$527.92	\$478.83	\$1,156,144.80	\$1,048,639.02	\$107,505.78
Pinecrest Supports & Services/Madonna Dr effective 11/15/06	\$527.92	\$478.83	\$1,156,144.80	\$1,048,639.02	\$107,505.78
Northeast Supports and Services	\$483.28	\$432.14	\$11,484,665.92	\$10,269,378.86	\$1,215,287.06
Northeast Supports and Services-Walnut Creek	\$178.03	\$159.13	\$374,753.15	\$334,962.73	\$39,790.42
Northeast Supports and Services-Wesley Chapel-eff. 7/28/05	\$483.28	\$432.14	\$1,058,383.20	\$946,386.96	\$111,996.24
Northeast Supports and Services- Mosely Street	\$190.08	\$169.89	\$416,275.20	\$372,057.01	\$44,218.19
Acadiana Region Supports and Services Ctr.-(formerly Southwest)	\$439.37	\$393.30	\$11,215,797.99	\$10,039,678.54	\$1,176,119.45
Acadiana Region Supports & Services Ctr. - Church Street/Jennings Group Home	\$212.82	\$191.07	\$466,075.80	\$418,453.19	\$47,622.61
Acadiana Region Supports & Services Ctr. - Opelousas Community Home	\$274.01	\$246.05	\$582,545.26	\$523,112.25	\$59,433.01
Acadiana Region Supports & Services Ctr.-Park Avenue-New facility 7/29/05	\$439.37	\$393.30	\$962,220.30	\$861,319.23	\$100,901.07
Acadiana Region Supports & Services Ctr.-Plaquemine 8/10/05	\$439.37	\$393.30	\$962,220.30	\$861,319.23	\$100,901.07
OMH/ELMH/ Warren T Price Sr Comm Home	\$504.89	\$451.00	\$734,110.06	\$655,749.73	\$78,360.33
OMH/ELMH/ T N Armistead Community Home	\$399.58	\$356.95	\$1,166,773.60	\$1,042,302.17	\$124,471.43
OMH/ELMH/ Lelia Jackson Community Home	\$588.49	\$525.64	\$797,403.95	\$712,240.58	\$85,163.37
LA Special Education Center	\$416.00	\$373.75	\$11,362,208.00	\$10,208,194.52	\$1,154,013.48
LA Special Education Center Transitional Family Life 12/23/05	\$416.00	\$373.75	\$911,040.00	\$818,509.35	\$92,530.65
Revised January 30, 2008			\$282,912,716.25	\$253,451,733.85	\$29,460,982.40

	FY 08	FY 09	FY 10	FY 11	FY 12
Lost Revenue	\$29,460,982.40	\$30,639,421.70	\$31,864,998.57	\$33,139,598.51	\$34,465,182.45

The projection was based on a 4% inflation factor.

**DOCUMENT B-1 - Estimated Impact on Medicaid Payments
of Proceeds from CPE's Using Data available In SFY 07**

Per SFY 06 cost report:

		Uncompensated Care Costs Certified as Public Expenditure	Medicaid Shortfall	Total Amount Eligible for CPE	FFP Amount 69.69%	Less -Total Received by Hospital	Net - Available as State Match	Total \$ Medicaid Payments using CPE's as Match
73518	East Jefferson	\$25,497,909	\$4,578,324	\$30,076,233	\$20,960,127	\$9,336,682	\$11,623,445	\$38,348,548
72033	Iberia Parish Hospital	\$4,637,470	\$2,682,610	\$7,320,080	\$5,101,364	\$471,862	\$4,629,502	\$15,273,843
72010	Lane Memorial Hospital	\$4,644,215	\$1,542,447	\$6,186,662	\$4,311,485	\$456,606	\$3,854,879	\$12,718,175
72026	North Oaks Medical Center	\$15,057,613	\$10,099,331	\$25,156,944	\$17,531,874	\$1,243,282	\$16,288,592	\$53,739,994
70287	North Oaks Rehab. Ctr.	\$412,185	\$231,649	\$643,834	\$448,688	\$0	\$448,688	\$1,480,330
72015	Opelousas General Hospital	\$9,766,720	\$2,568,858	\$12,335,578	\$8,596,664	\$80,370	\$8,516,294	\$28,097,309
72031	Slidell Memorial Hospital	\$9,343,896	\$2,268,142	\$11,612,038	\$8,092,429	\$4,715,503	\$3,376,926	\$11,141,294
72025	St. Tammany Parish Hosp.	\$11,170,274	\$5,831,944	\$17,002,218	\$11,848,846	\$5,682,419	\$6,166,427	\$20,344,529
72027	Terrebonne General Hosp.	\$8,301,672	\$5,871,546	\$14,173,218	\$9,877,316	\$490,733	\$9,386,583	\$30,968,600
73684	Thibodaux General	\$1,575,853	\$1,154,007	\$2,729,860	\$1,902,439	\$200,858	\$1,701,581	\$5,613,928
73048	West Calcasieu-Cameron	\$5,666,507	\$2,420,331	\$8,086,838	\$5,635,717	\$2,830,880	\$2,804,837	\$9,253,835
73278	West-Jefferson Med. Ctr.	\$23,141,325	\$6,820,934	\$29,962,259	\$20,880,698	\$12,360,568	\$8,520,130	\$28,109,965
	Totals	\$119,215,639	\$46,070,123	\$165,285,762	\$115,187,648	\$37,869,763	\$77,317,885	\$255,090,348

Inflate Using IPPS Hospital Marketbasket Index

SFY 08 - 3.6% \$ 264,273,601

SFY 09 - 3.1%	\$ 272,466,082
SFY 10 - 2.5%	\$ 279,277,734
SFY 11 - 2.8%	\$ 287,097,511
SFY 12 - 2.9%	\$ 295,423,339
SFY 13 - 3.1%	\$ 304,581,462
Estimated 5 yr Impact SFY's 2009 - 2013	\$ 1,438,846,129

DOCUMENT B - Estimated Medicaid Inpatient Payments to Public Rural Hospitals Above Cost

Hospital Name	Inpatient Costs	Payments New Methodology	Payments Less Costs	Payments Above Costs
Abbeville General	\$ 1,853,240	\$ 2,062,492	\$ 209,252	\$ 209,252
Abrom Kaplan Mem. Hosp.	\$ 111,889	\$ 130,434	\$ 18,545	\$ 18,545
Acadia-St. Landry Hospital	\$ 91,493	\$ 83,851	\$ (7,642)	
Allen Parish Hospital	\$ 150,025	\$ 147,903	\$ (2,122)	
Beauregard Memorial	\$ 2,839,148	\$ 3,179,336	\$ 340,189	\$ 340,189
Bunkie General Hospital	\$ 386,770	\$ 427,405	\$ 40,636	\$ 40,636
Citizens Medical Center	\$ 361,113	\$ 377,328	\$ 16,214	\$ 16,214
East Carroll Parish Hosp.	\$ 585,764	\$ 783,770	\$ 198,006	\$ 198,006
Franklin Foundation Hosp.	\$ 1,179,679	\$ 1,064,437	\$ (115,242)	
Franklin Medical Center	\$ 1,222,981	\$ 1,460,398	\$ 237,418	\$ 237,418
Hardtner Medical Center	\$ 129,483	\$ 208,462	\$ 78,979	\$ 78,979
Homer Memorial Hospital	\$ 1,496,251	\$ 2,345,488	\$ 849,238	\$ 849,238
Hood Memorial Hospital	\$ 330,521	\$ 307,452	\$ (23,068)	
Jackson Parish Hospital	\$ 830,933	\$ 1,108,692	\$ 277,759	\$ 277,759
Lady of the Sea	\$ 985,834	\$ 821,037	\$ (164,796)	
LaSalle General Hospital	\$ 959,790	\$ 1,826,080	\$ 866,290	\$ 866,290
Madison Parish Hospital	\$ 1,155,956	\$ 1,253,101	\$ 97,145	\$ 97,145
Morehouse General Hosp.	\$ 2,696,329	\$ 3,208,451	\$ 512,122	\$ 512,122
Natchitoches Parish Hosp.	\$ 4,463,404	\$ 6,477,461	\$ 2,014,056	\$ 2,014,056
North Caddo Mem. Hosp.	\$ 565,635	\$ 602,094	\$ 36,459	\$ 36,459
Pointe Coupee Gen. Hosp.	\$ 870,479	\$ 791,923	\$ (78,556)	
Prevost Memorial Hospital	\$ 71,951	\$ 47,748	\$ (24,203)	
Richardson Medical Ctr.	\$ 720,545	\$ 937,497	\$ 216,952	\$ 216,952
Richland Parish Hospital	\$ 659,338	\$ 972,434	\$ 313,096	\$ 313,096
Riverland Medical Ctr.	\$ 1,897,280	\$ 2,531,823	\$ 634,543	\$ 634,543
Riverside Medical Center	\$ 597,922	\$ 323,757	\$ (274,165)	
St. Charles Parish Hosp.	\$ 1,424,779	\$ 1,242,620	\$ (182,159)	
St. Helena Parish Hosp.	\$ 313,847	\$ 170,030	\$ (143,816)	
St. James Parish Hospital	\$ 276,978	\$ 215,450	\$ (61,529)	
St. Martin Hospital	\$ 99,509	\$ 95,497	\$ (4,013)	
TriWard General Hospital	\$ 258,910	\$ 303,959	\$ 45,049	\$ 45,049
West Feliciana Parish Hsp.	\$ 319,299	\$ 161,878	\$ (157,421)	
Allen Parish DPP	\$ 1,486,136	\$ 5,426,999	\$ 3,940,863	\$ 3,940,863
Abbeville DPP	\$ 775,267	\$ 1,909,931	\$ 1,134,664	\$ 1,134,664
Abrom Kaplan DPP	\$ 451,906	\$ 786,100	\$ 334,194	\$ 334,194
Acadia - St. Landry DPP	\$ 501,833	\$ 1,121,502	\$ 619,669	\$ 619,669
Franklin Med. Ctr. DPP	\$ 60,243	\$ 51,242	\$ (9,001)	
Hardtner Medical Center	\$ 129,483	\$ 208,462	\$ 78,979	\$ 78,979
Homer Memorial DPP	\$ 61,354	\$ 71,040	\$ 9,686	\$ 9,686
Natchitoches Parish DPP	\$ 238,191	\$ 371,505	\$ 133,314	\$ 133,314
Richland Parish Hosp. DPP	\$ 22,302	\$ 26,786	\$ 4,484	\$ 4,484
St. Charles Parish Hosp. DPP	\$ 1,590,222	\$ 2,536,481	\$ 946,260	\$ 946,260
	\$ 35,224,009	\$ 48,180,336	\$ 12,956,327	\$ 14,432,091

Inflate Using IPPS Hospital Marketbasket Index

SFY 08 - 3.6%

\$ 14,951,647

SFY 09 - 3.1%	\$ 15,415,148
SFY 10 - 2.5%	\$ 15,800,527
SFY 11 - 2.8%	\$ 16,242,941
SFY 12 - 2.9%	\$ 16,713,987
SFY 13 - 3.1%	\$ 17,232,120
Estimated 5 yr Impact SFY's 2009 - 2013	\$ 81,404,722

**DOCUMENT C - Estimated Impact of Elimination of Graduate Medical Education Payments
in Medicaid Rates & DSH Payments**

Hospital Name	Medicaid	Disproportionate Share	Total GME Included in Medicaid & DSH
State Hospitals:			
Medical Center of La. - N.O.	\$5,723,250	\$17,211,817	\$22,935,067
LSU - Shreveport	\$5,153,464	\$6,837,348	\$11,990,812
E.A. Conway	\$2,137,983	\$3,556,235	\$5,694,218
Earl K. Long	\$4,077,635	\$8,291,753	\$12,369,388
L.J. Chabert	\$1,044,524	\$2,067,842	\$3,112,366
University Medical Center	\$2,768,654	\$876,679	\$3,645,333
Huey P. Long	\$163,164	\$537,410	\$700,574
Washington - St. Tammany	\$25,839	\$152,804	\$178,643
Lallie Kemp	\$9,171	\$70,657	\$79,828
Subtotals	\$21,103,684	\$39,602,545	\$60,706,229
Non-state Hospitals:*			
Baton Rouge General	\$7,449,994		\$7,449,994
Children's Hospital	\$2,153,418	\$45,433	\$2,198,851
Christus Schumpert	\$217,441		\$217,441
East Jefferson	\$2,612,998		\$2,612,998
Lake Charles Memorial	\$1,057,768		\$1,057,768
Lakeview	\$573,523		\$573,523
Ochsner Foundation	\$14,671,976	\$717,767	\$15,389,743
Ochsner Kenner	\$1,139,084	\$345,440	\$1,484,524
Our Lady of the Lake	\$2,157,948		\$2,157,948
Rapides	\$2,511,340		\$2,511,340
Slidell Memorial	\$379,665		\$379,665
Touro Infirmary	\$13,149,156	\$79,598	\$13,228,754
Tulane	\$19,572,220	\$1,270,134	\$20,842,354
West Jefferson	\$5,527,381		\$5,527,381
Willis-Knighton	\$2,094,194		\$2,094,194
Subtotals	\$75,268,106	\$2,458,372	\$77,726,478
Totals	\$96,371,790	\$42,060,917	\$138,432,707

Inflate Using IPPS Hospital Marketbasket Index

SFY 08 - 3.6% \$ 143,416,284

SFY 09 - 3.1%	\$ 147,862,189
SFY 10 - 2.5%	\$ 151,558,744
SFY 11 - 2.8%	\$ 155,802,389
SFY 12 - 2.9%	\$ 160,320,658
SFY 13 - 3.1%	\$ 165,290,599
Estimated 5 yr Impact SFY's 2009 - 2013	\$ 780,834,579

* Assumes that Medicaid rates for private hospitals will not be rebased if teaching peer groups are eliminated.

DOCUMENT D - Estimated Medicaid Outpatient Payments to Public Rural Hos

Hospital Name	Outpatient Costs	Payments Under New Methodology	Payments Above Costs
Abbeville General	\$1,096,475	\$1,206,123	\$109,648
Abrom Kaplan Mem. Hosp.	\$370,469	\$407,516	\$37,047
Acadia-St. Landry Hospital	\$350,141	\$385,155	\$35,014
Allen Parish Hospital	\$543,774	\$598,151	\$54,377
Beauregard Memorial	\$1,248,574	\$1,373,431	\$124,857
Bunkie General Hospital	\$862,646	\$948,911	\$86,265
Citizens Medical Center	\$541,609	\$595,770	\$54,161
East Carroll Parish Hosp.	\$700,636	\$770,700	\$70,064
Franklin Foundation Hosp.	\$1,054,145	\$1,159,560	\$105,415
Franklin Medical Center	\$827,961	\$910,757	\$82,796
Hardtner Medical Center	\$213,520	\$234,872	\$21,352
Homer Memorial Hospital	\$728,305	\$801,136	\$72,831
Hood Memorial Hospital	\$621,929	\$684,122	\$62,193
Jackson Parish Hospital	\$538,678	\$592,546	\$53,868
Lady of the Sea	\$963,558	\$1,059,914	\$96,356
LaSalle General Hospital	\$663,791	\$730,170	\$66,379
Madison Parish Hospital	\$599,519	\$659,471	\$59,952
Morehouse General Hosp.	\$1,702,306	\$1,872,537	\$170,231
Natchitoches Parish Hosp.	\$1,820,428	\$2,002,471	\$182,043
North Caddo Mem. Hosp.	\$400,756	\$440,832	\$40,076
Pointe Coupee Gen. Hosp.	\$981,640	\$1,079,804	\$98,164
Prevost Memorial Hospital	\$593,209	\$652,530	\$59,321
Richardson Medical Ctr.	\$745,095	\$819,605	\$74,510
Richland Parish Hospital	\$436,847	\$480,532	\$43,685
Riverland Medical Ctr.	\$980,597	\$1,078,657	\$98,060
Riverside Medical Center	\$1,327,432	\$1,460,175	\$132,743
St. Anne Genera;	\$727,669	\$800,436	\$72,767
St. Charles Parish Hosp.	\$1,714,362	\$1,885,798	\$171,436
St. Helena Parish Hosp.	\$549,172	\$604,089	\$54,917
St. James Parish Hospital	\$669,162	\$736,078	\$66,916
St. Martin Hospital	\$586,280	\$644,908	\$58,628
TriWard General Hospital	\$95,370	\$104,907	\$9,537
West Feliciana Parish Hsp.	\$695,050	\$764,555	\$69,505
Totals	\$25,951,105	\$28,546,216	\$2,595,111

Inflate Using IPPS Hospital Marketbasket Index

SFY 08 - 3.6% \$ 2,688,534

SFY 09 - 3.1%	\$ 2,771,879
SFY 10 - 2.5%	\$ 2,841,176
SFY 11 - 2.8%	\$ 2,920,729
SFY 12 - 2.9%	\$ 3,005,430
SFY 13 - 3.1%	\$ 3,098,598
Estimated 5 yr Impact SFY's 2009 - 2013	\$ 14,637,813

DOCUMENT E - Calculation OF ICFMR FY 2008 PROVIDER FEE

PROVIDER FEE CALCULATION

<u>DAYS</u>			<u>% Days</u>
Estimated Medicaid Days		1,333,552	0.734045387
Public Days (DHH Facilities)		483,164	0.265954613
TOTAL		1,816,716	

<u>REVENUE</u>		<u>(w/o PF)</u> <u>Estimated</u>	<u>MAX</u> <u>PROVIDER</u> <u>FEE</u>	
<u>Private Facilities</u>				
<u>Medicaid</u>	<u>Days</u>	<u>FY2007 Per Diem</u>		
ICAP Days	1,333,552	\$148.00	0.055	\$ 197,465,970
Downsizing of group homes				\$ 1,204,500
Anualization of New Beds				\$ 5,055,431
Increase due to rebasing				\$ 12,135,323
Increase for Dir Care Service Workers Pay Increase				\$ 13,132,208
Sub Total				\$ 228,993,432
Patient Liability Payments to Private Proiders at			0.07	\$ 17,236,065
Total Private ICF Budget				\$ 246,229,497
<u>Other Revenue Sources</u>				
Other Revenue (Public)	SGF			\$19,342,564
	Self Gen			\$7,638,625
Public MR/DD Facilities from Medicaid Forcast Projections				##### \$213,653,848
Total Public DD Budget				\$790,843,689 \$1,907,623.64
ESTIMATED TOTAL REVENUE before "Gross up"				\$1,037,073,186
ESTIMATED TOTAL REVENUE after "Gross up"				0.945 \$1,097,431,943
MAXIMUM PROVIDER FEE REVENUE				\$60,358,757

MAXIMUM PER DIEM PROVIDER FEE
 CURRENT RATE
 AVAILABLE "FLOAT"
 Times: Total Days
 Potential Match Change
 Plus: FFP
 Total Revenue Generation

\$33.22
\$14.30
\$18.92
1,816,716
\$34,379,718
\$87,447,773
\$121,827,491

State Match Rate
 0.2822
 Fed Match Rate
 0.7178

AVAILABLE "FLOAT"

	1 month	11 months	12 months
Estimated three months days	151,393	1,665,323	1,816,716
Available "Float"	\$18.92	\$18.92	
Net Funds from Provider Fee	\$2,864,977	\$31,514,742	\$34,379,718
FFP generated by increase in provider fee	\$7,287,314	\$80,160,459	\$87,447,773
TOTAL increase in funding	\$10,152,291	\$111,675,200	\$121,827,491

* Provider fees are collected on a three month cycle that is not aligned with the state fiscal year. Therefore the increase in provider fee will only be collected for 11 months in the first fiscal year.

Amounts Desired to Generate	\$12,135,323.00
% Private Days	0.73404539
% Public Days	0.26595461
Private \$\$	\$8,907,877.87
Public \$\$\$	\$3,227,445.13
Total	\$12,135,323.00

DOCUMENT F

Amount that will be lost based on FY 2006 completed totals:

MAC Claim Payments**Paid Fiscal Year 2005/2006****School District** **Final Amount**

Acadia \$41,049

Ascension \$95,639

Avoyelles \$3,718

Caddo \$347,690

Calcasieu \$143,406

Caldwell \$9,210

Catahoula \$4,816

Claiborne \$6,725

DeSoto \$27,397

East Feliciana \$2,108

EBR \$191,669

Evangeline \$9,579

Franklin \$40,028

Grant \$28,800

Iberia \$61,210

Jackson \$9,047

Jefferson \$589,836

Jefferson Davis \$11,177

Lafayette \$178,933

Lafourche \$140,432

Livingston \$64,741

Madison \$3,934

Morehouse \$76,075

Natchitoches \$31,179

Orleans \$606,370

Ouachita \$12,806

Plaquemines \$56,525

Pointe Coupee \$13,322

Rapides \$223,042

Red River \$16,523

Richland \$42,341

Sabine \$4,188

St Bernard \$37,139

St Charles \$12,834

St James \$15,657

St Landry \$63,009

St Martin \$101,418

Tangipahoa \$12,900

Tensas \$18,498

Terrebonne	\$106,122		
Washington	\$9,930		
Webster	\$22,949		
West Baton Rouge	\$33,566		
West Feliciana	\$8,738		
Winn	\$5,079		
Zachary	\$27,939		
TOTAL	\$3,569,293		



Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Frederick P. Cerise, M.D., M.P.H.
SECRETARY

December 7, 2006

DOCUMENT G

Mr. Dennis Smith
Centers for Medicare and Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard, Mail Stop C5-11-24
Baltimore, MD 21244-1850

Dear Mr. Smith:

RE: Targeted Case Management TN 06-15

I would like to take this opportunity to follow up on the conversation that we had at the State Medicaid Directors meeting regarding Louisiana Medicaid State Plan Amendment (SPA) Transmittal Number (TN) 06-15, relating to targeted case management (TCM) in our disability waivers. A copy of the current approved SPA and a copy of TN 06-15 are attached for your easy reference. As you can see the only change that we are proposing is to correct the name of the MR/DD waiver to New Opportunities Waiver (NOW) and add the new Supports Waiver, which was approved effective July 1, 2006.

As I explained to you, during our conversation, that from our discussions with your staff (Linda Tavenor, Mary Cieslicki, Andrew Fredrickson, Bill Brooks, Lisa Davis, Michael Jones, and Ford Blunt) who have all been very professional and helpful, we have concluded that the only way CMS will approve TN 06-15 is for us to change our reimbursement methodology to a 15 minute increment modeled after the approved Ohio SPA. To change our reimbursement methodology to 15 minute billing increments will require changes ranging from amending existing contracts with an increase in the contract prices to canceling existing contracts and allowing all case management agencies to participate.

I have attended many meetings where you have spoke about the abuses in TCM and read many reports regarding TCM problems. The abuses cited by yourself and the articles are not present in our TCM programs. We have changed other SPA where we understood the reasoning for making the changes, but **changing our TCM reimbursement will result in CMS and the state paying more for TCM in Louisiana with a less efficient program and less services. For example, our current TCM program requires 24 hour access, toll free numbers, and an obligation to assist the client whenever required. Whereas under the 15 minute increment method, clients will not be assured of 24 hour access to their case manager.**

Mr. Smith
December 7, 2006
Page 2

We are requesting that you allow TN 06-15 be approved as submitted. I have attached a brief history on how we partnered with then HCFA to move from a TCM program with a 15 minute reimbursement methodology which was fraught with fraud and abuse to the current competitively bid contract methodology that has provided services without the past problems.

We appreciate your consideration of Louisiana's continued use of a monthly fee schedule for TCM. If you have any further concerns please feel free to contact me at 225-342-3891.

Sincerely,


Jerry Phillips
Medicaid Director

JLP:taw

Attachments

HISTORY

Louisiana billed in 15 minute units until October 1, 1995 when the SPA was amended to incorporate monthly rate. Utilizing the 15 minute unit billing encouraged TCM to bill for direct provision of medical, educational or social services, such as taking a recipient to the Doctor and waiting for a period of hours in order to inflate billing. The amount of monitoring that had to be done to curtail this kind of practice resulted in a costly system that centered on measuring billing units rather than individualized outcomes.

A monthly rate was developed using analysis of MMIS claim data for 3 years (1992-1994). Data found that proposed flat rate reimbursement system would reduce costs per participant as compared to a 15 minute unit of service. Proposed savings were over \$10 million each year by using flat monthly rate as opposed to 15 minute units. Continuing the 15 minute units would have created a budget deficit in the medical assistance programs.

TCM were asked to "test" the new rates utilizing a prior and post authorization system for payment. The majority found the system efficient and effective, felt it may reduce fraud, and found the rates acceptable and reasonable. Additionally, the state office did a survey via phone contact with other states at this time. The mean average of the 21 states that paid fee for service in 15 minute units was \$13.63 per unit. Using that mean average from 1995 would mean that today Louisiana could provide a little less than 3 hours (2.84) of case management per month. Increasing the current monthly rate is not an option for our state at this time.

The monthly fee schedule that Louisiana has been using since 1995 allows TCM to provide individualized amounts of services in order to assist recipients to gain access to specific medical, social, education and other services without inflating hours to get maximum payment, or not providing enough hours to meet needs. It also makes it possible to properly monitor and assure that TCM are providing allowable services; that is assessment to the beneficiary to determine service needs, development of a specific plan referral to needed services and monitoring and follow-up of needed services, and not providing any direct medical, educational or social services to which the Medicaid eligible individual has been referred.

Billing discrepancies rarely occur as there is a prior and post authorization system for payment that tracks minimum required contacts by TCM, and because the monthly rate cannot be exceeded. Yearly validation reviews of TCM records by the operating agency's TCM Program Manager and 5% yearly sample monitoring of all participants in MRDD waivers by the Bureau of Health Services Financing's (BHSF) Health Standards Section (HSS) identify any discrepancies that are not caught on the front end by system edits.

Quality initiatives that Louisiana has been able to build and enforce since the implementation of the TCM monthly fee schedule include:

- A data driven Quality Enhancement (QE) Plan from each Case Management agency that supports agency's mission, vision and values. This plan is approved by the waiver operating agency prior to the start date of services.
- Intensive coordination of the plan to enhance flow of supports and services, including a reduction in costs through adjustments in supports and services without compromising planning outcomes, including utilization and coordination of Medicaid State Plan services without duplication of services.
- Development, maintenance and updates of resource directories that allow TCMs to access all available resources and link recipients to needed services and supports, and ensure that natural resources are exhausted prior to using waiver funding.
- Requirement that TCM use the waiver operating agency's person-centered planning framework for individualized service planning; this framework strengthens their ability to ensure recipients get what they need, not more or less than they need.
- Increased requirements for health and safety through ongoing assessment and monitoring, including having more thorough, stronger emergency back-up plans and ongoing monitoring of participants who have to evacuate their home.

These quality initiatives are dependent on the monthly fee schedule, as is the state's fiscal ability to continue to provide TCM.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

VI. Recipient Eligibility Requirements for Targeted Populations

Case management providers must ensure that recipients of Medicaid funded targeted case management services are Medicaid eligible and meet the additional eligibility requirements specific to the targeted population. With respect to Infants and Toddlers With Special Needs, this determination is made through the Multidisciplinary Evaluation (MDE) process and is not the responsibility of the case management/family service coordination agency. The eligibility requirements for each targeted population are listed below:

A. Mentally Retarded/Developmentally Disabled Individuals

Participants in the MR/DD waiver are eligible to receive MR/DD case management services.

B. Infants and Toddlers with Special Needs

1. Eligibility is limited to recipients who meet the following conditions:

(a) a documented established medical condition determined by a licensed medical doctor. In the case of a hearing impairment, licensed audiologist or licensed medical doctor must make the determination;

OR

(b) a developmental delay in one or more of the following areas:

- Cognitive development
- Physical development, including vision and hearing eligibility must be based on a documented diagnosis made by a licensed medical doctor (vision) or a licensed medical doctor or licensed audiologist (hearing)
- Communication development
- Social or emotional development

A	
STATE	Louisiana
DATE RECD	3-29-99
DATE APPLD	6-10-99
DATE EFF	3-1-99
WIC PLAN	99-06

TN# 99-06 Approval Date 6-10-99 Effective Date 3-1-99

Supersedes

TN# 96-23

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION Medical and Remedial
42 CFR Care and Services
447.201 Item 19
447.302

OPTIONAL TARGETED CASE MANAGEMENT SERVICES

REIMBURSEMENT METHODOLOGY

Case Management services for Mentally Retarded/Developmentally Disabled Waiver recipients and EPSDT recipients on the MR/DD Waiver Request for Services Registry are reimbursed at a negotiated provider specific monthly rate in accordance with the terms of the contract. Reimbursement for HIV Infected Persons is a fixed monthly rate for the provision of the core elements of case management.

Reimbursement for case management services for infants and toddlers is a fixed monthly rate based on cost data from the state fiscal year ending June 30, 2002. Public state agencies providing these services are reimbursed at 75% of the recommended rate based on historical utilization and budgetary constraints. Public state agencies shall have on file an approved cost allocation plan.

At least every three years, audited cost report items will be compared to the rate calculated for the cost report year to determine whether the rate remains reasonably related to costs or if the rate should be rebased.

Private providers will be reimbursed at the same rate as the public providers.

Effective for dates of service on or after February 1, 2005, the reimbursement rate for targeted case management services for infants and toddlers shall be 75 percent of the rate (a 25 percent reduction) in effect on January 31, 2005.

Payments made to providers do not duplicate payments for the same or similar services furnished by other providers or under other authority as an administrative function or as an integral part of a covered service.

Reimbursement is not available for case management services that are furnished to recipients without charge by any other agency or entity. With the statutory exceptions of case management services included in Individualized Educational Programs (IEP'S) or Individualized Family Service Plans (IFSP'S) and services furnished through Title V public health agencies, payment for case management services cannot be made when another third party payor is liable, nor may payments be made for services for which no payment liability is incurred by the recipient.

04-19

A	
STATE <u>Louisiana</u>	
DATE REC'D <u>3-24-05</u>	
DATE APP'VD <u>12-19-05</u>	
DATE EFF <u>2-1-05</u>	
HCFA 179 <u>05-02</u>	

TN# 05-02 Approval Date 12-19-05 Effective Date 2-1-05
Supersedes
TN# 04-19



Kathleen Babineaux Blanco
GOVERNOR

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Frederick P. Cerise, M.D., M.P.H.
SECRETARY

May 25, 2006

Mr. Andrew Fredrickson
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

Re: Louisiana Title XIX State Plan
Transmittal No. 06-15

Dear Mr. Fredrickson:

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material.

I recommend this material for adoption and inclusion in the body of the State Plan.

Sincerely,

Frederick P. Cerise, M.D., M.P.H.
Secretary

Attachments

LOUISIANA TITLE XIX STATE PLAN
 TRANSMITTAL #06-15
 Targeted Case Management- Supports Waiver Program
 EFFECTIVE DATE: June 1, 2006

FISCAL IMPACT
 Increase

	year	% inc.	fed. match	*# mos	range of mos.	dollars
1st SFY	2006		70.10%	1	June 1, 2006-June 30, 2006	\$0
2nd SFY	2007	3.0%	69.72%	12	July 2006- June 2007	\$3,083,191
3rd SFY	2008	3.0%	69.72%	12	July 2007 - June 2008	\$3,699,432

*# mos = Months remaining in fiscal year.

Total Increase in Cost FFY		2006					
SFY	2006	\$0 for 1	months	June 1, 2006-June 30, 2006	=		\$0
SFY	2007	\$3,083,191 for 12	months	July 2006- June 2007			
		\$3,083,191 / 12 X 3		July 2006-September 2006	=	\$770,798	
						<u>\$770,798</u>	
	FFP (FFY	2006) =	\$770,798 X 69.79%	=		<u>\$537,940</u>

Total Increase in Cost FFY		2007					
SFY	2007	\$3,083,191 for 12	months	July 2006- June 2007			
		\$3,083,191 / 12 X 9		October 2006 - June 2007	=	\$2,312,393	
SFY	2008	\$3,699,432 for 12	months	July 2007 - June 2008			
		\$3,699,432 / 12 X 3		July 2007 - September 2007	=	\$924,858	
						<u>\$3,237,251</u>	
	FFP (FFY	2007) =	\$3,237,251 X 69.69%	=		<u>\$2,256,040</u>

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED

VI. Recipient Eligibility Requirements for Targeted Populations

Case management providers must ensure that recipients of Medicaid funded targeted case management services are Medicaid eligible and meet the additional eligibility requirements specific to the targeted population. With respect to Infants and Toddlers With Special Needs, this determination is made through the Multidisciplinary Evaluation (MDE) process and is not the responsibility of the case management/family service coordination agency. The eligibility requirements for each targeted population are listed below:

A. Individuals with Developmental Disabilities

Case management services are provided to individuals with developmental disabilities who are participants in the New Opportunities Waiver (NOW) or the Supports Waiver Programs.

B. Infants and Toddlers with Special Needs

1. Eligibility is limited to recipients who meet the following conditions:

- (a) a documented established medical condition determined by a licensed medical doctor. In the case of a hearing impairment, licensed audiologist or licensed medical doctor must make the determination;

OR

- (b) a developmental delay in one or more of the following areas:
- Cognitive development
 - Physical development, including vision and hearing eligibility must be based on a documented diagnosis made by a licensed medical doctor (vision) or a licensed medical doctor or licensed audiologist (hearing)
 - Communication development
 - Social or emotional development

TN# _____ Approval Date _____ Effective Date _____
Supersedes
TN# _____

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202



Division of Medicaid & Children's Health, Region VI

August 21, 2006

Mr. Jerry Phillips, Director
Bureau of Health Services Financing
Department of Health and Hospitals
Post Office Box 91030
Baton Rouge, Louisiana 70821-9030

RECEIVED

AUG 25 2006

Filing Date: 08/25/06 10:01 AM

Attention: Allyson Lamy

RE: Louisiana 06-015

Dear Mr. Phillips:

We have reviewed your State Plan amendment (SPA) transmittal number (TN) 06-15 which amends the targeted case management description for individuals with developmental disabilities to include the participants in the New Opportunities Waiver (NOW) and the Supports Waiver Programs.

We conducted our review of your submittal according to the regulation at 1915(g) of the Social Security Act. 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 06-15.

Financial Questions

1. Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. Section 1902(a)(4) of the Act specifies that the State plan must provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of the plan.

In evaluating a State's TCM rate, CMS asks the state to identify the payment per unit. (Note that CMS does not recognize daily, weekly or monthly rates as being an economical method for reimbursing for non-institutional services.) For example, a state has proposed a fee schedule reimbursement of approximately \$16 for each 15 minute unit of service. Annualized in the following manner--\$16 per fifteen minute unit X 4 units per hour X 2080 working hours in a year, the rate results in approximately \$133,120 of reimbursement. This raises concerns that, on the face of it, this annualized amount appears to exceed the reasonable cost of providing targeted case management.

In developing an economic and efficient rate for TCM services, CMS currently recognizes the following types of cost:

- (1) Salary cost of direct practitioners by type of practitioner (not supervisors or support staff) by FTE adjusted for other sources of funding such as Federal and State grants.
- (2) Some fringe benefits such as employer cost of health insurance, Medicare and Social Security contributions. The State must show the actual cost for each type of benefit proposed for inclusion in the rate.
- (3) Indirect costs -- CMS has accepted an indirect cost component of 10 percent.
- (4) A reallocation of general and administrative costs ("non-productive time") is permissible only if the State has used a CMS-approved, statistically valid time study to identify the percentage of time spent performing these activities. If no time study is available, the State must provide specific documentation (e.g. State statute specifying number of required training hours, paid state holidays, etc) to justify the amount of such "non-productive time" to be reallocated.
- (5) The State must assure that billed time does not exceed available productive time by practitioner to deliver the targeted case management services and must specifically identify billing limits in the SPA.

CMS requires the State to justify its payment based on cost incurred to provide the service. For each of the cost components recognized as eligible for reimbursement, please provide complete data to support the proposed payment.

CMS requests the State to show how its rate comports with these guidelines for evaluating TCM rates. You are requested to provide data as described above for the various components of cost that CMS recognizes for payment through the rate. Your calculation of the rate should include the salary and benefit cost of all practitioners, not a sampling of such cost. Similarly, any other direct cost should be reported for all providers eligible for this payment. Please indicate the source of data and the time period from which it was drawn. CMS is available to work with this State as it assembles this information.

2. If the State plans to pay different rates to different providers, please explain the rationale for doing so. Your narrative should be supported by a calculation of the difference(s) and indicate how public and private providers are affected.
3. What are the sources of funds used for the payment of targeted case management services? Reimbursement for Medicaid services provided by governmental providers is dependent upon the manner in which a state funds the non-Federal share of those services. Specifically:

If certified public expenditures (CPE) are the source of funds, the State Plan must provide for reimbursement to the governmental provider at cost. In addition, the provider must have a cost-accounting system in place to appropriately identify, out of the total pool of

costs incurred in providing services to all of its clients, only those that represent expenditures made on behalf of Medicaid beneficiaries for targeted case management services. The process would involve use of a statistically valid time study to identify the time spent providing medical services, costs would have to be allocated to Medicaid and the state would have to delineate in its plan the specific direct and indirect costs the provider would certify and how they are used to develop the rate. The interim payments made during the year must be annually reconciled to actual Medicaid cost at the level of the provider certifying the expenditures. The certification of expenditures would be based on this year's (or last year's) costs (salaries, fringes, etc., as allocated using last year's time study). Reconciliation at the end of the year would compare Medicaid costs for this year allocated according to this year's time study.

4. Under 42 CFR 447.205, Medicaid agencies must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services before the change becomes effective. Please provide evidence that a public notice has been issued on the State's proposed changes.

Standard funding questions

The following questions are being asked and should be answered in relation to 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 retain all of the Medicaid payments including the Federal and State share (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, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. 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).
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 for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).
 5. Does any public 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?

This additional/clarifying information is being requested under provisions of §1915(f) of the Social Security Act (added by P.L. 97-35). This has the effect of stopping the 90-day time period for CMS to act on the material. A new 90-day time frame will not begin until we receive your response to this request.

If you have any questions, please call Ford Blunt of my staff at 214-767-6381.

Sincerely,



Andrew A. Fredrickson
Associate Regional Administrator
Division of Medicaid & Children's Health