DEPARTMENT OF HEALTH & HUMAN SERVICES **Centers for Medicare & Medicaid Services**

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

Susan Dreyfus, Secretary
Department of Social and Health Services
Post Office Box 45010
Olympia, Washington 98504-5010

Dear Ms. Dreyfus:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services' (CMS) approval of Washington State Plan Amendment (SPA) Transmittal Number 09-022. During CMS' review of SPA 09-022, CMS performed an analysis of the reimbursement for Targeted Case Management (TCM) for recipients under age 21. This provision was initially submitted on the same page as the reimbursement provision for Infant Case Management. Based on that review, it was determined that TCM for recipients under age 21, which is currently on page 28b of Attachment 4.19-B, is not consistent with statutory and regulatory requirements described below.

Section 1902(a)(30)(A) of the Social Security Act requires that States have methods and procedures in place to assure that payments to providers are consistent with efficiency, economy and quality of care. As the current reimbursement methodology for TCM services rendered by non-governmental providers and furnished to recipients under age 21 utilizes a monthly rate, it appears that it would provide for a fixed payment regardless of the number of services furnished, the specific costs of those services, or otherwise available rates. It is not economic to pay for days of service when the beneficiary is not actually receiving covered services. Nor is it efficient or consistent with quality of care to pay the same amount per patient day if the variability in service would result in insufficient payment for some patients (who would then be underserved) and excessive payment for other patients. Furthermore, monthly rates are more akin to per-member-per-month (PMPM) rates as opposed to fee-for-services and, therefore, should be subject to the contracting requirements at 42 CFR 438.6. In order to comply with the above mentioned statute, the State should change the reimbursable unit of service to either a weekly rate, daily rate, or some other smaller increment. Alternately, the State can demonstrate that the monthly rate meets the requirements of 42 CFR Part 438**.**

The 42 CFR 430.10 requires that the State plan be a comprehensive written statement that describes the nature and scope of the State's Medicaid program and that contains all information necessary for CMS to determine whether the plan can be approved to serve as the basis for Federal Financial Participation (FFP) in the State program. While the current plan provisions indicate that services rendered by state-employed personnel and furnished to recipients under age 21 are reimbursed at cost, they do not describe those costs. Please submit a SPA that complies with federal statute, regulation and policies by comprehensively describing the reimbursement policies for TCM services rendered by state-employed

personnel and furnished to recipients under age 21. In addition, the State will need to publish public notice of any change in methods and standards, in accordance with 42 CFR 447.205, prior to the effective date of the SPA.

To assist you in ensuring compliance with current regulations and policy related to TCM, we are describing in an enclosure to this letter some options that Washington may have related to the above mentioned issues. The enclosure is intended to help the State consider its options and understand the information necessary to support the current State plan reimbursement methodology for TCM services rendered by state-employed personnel and furnished to recipients under age 21.

The State has 90 days from the date of this letter, to address the issues described above. Within that period the State may submit SPAs to address the inconsistencies or submit a corrective action plan (CAP) describing in detail how the State will resolve the issues identified above in a timely manner. Failure to respond will result in the initiation of a formal compliance process. During the 90 days, CMS will provide any required technical assistance. If you have any questions concerning this SPA, please contact me, or have your staff contact Mary Jones at (360) 486-0243 or via email at Mary.Jones2@cms.hhs.gov.

Sincerely,

/s/

Carol J.C. Peverly
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

Options for Funding and Reimbursement of TCM Services

Funding:

In general under Medicaid, the State has three funding options for the non-federal share of Medicaid expenditures: 1) Appropriation provided directly to the single State Medicaid agency; 2) an inter-governmental transfer (IGT); or 3) Certified Public Expenditure (CPE) funding mechanism. Below is a description of the items that should be submitted to the CMS Regional Office for each funding mechanism.

If TCM services will be funded by a direct appropriation to the Medicaid single State agency, please so indicate in any submission.

If an IGT funding mechanism will be used, the State should submit: a) complete description of the IGT transfer process, including State legislative authority for the transfer and completion of the standard CMS funding questions; b) an explanation of the source of the funds and timing of transfers relative to payment made to providers; c) verification that providers receive and retain the total computable amount, including the federal and non-federal share of the payment; and d) a copy of the interagency agreement between the State Medicaid agency and the Children's Administration.

If a CPE funding mechanism will be used, the State should submit: a) the proposed cost report format and the related cost report instructions that will be used to support the identification of Medicaid expenditures; b) the proposed time-study and instructions used to allocate staff time/expense between Medicaid and other activities; c) a copy of the certification statement format that will be used to certify public expenditures; and, d) summary description of the overall funding mechanism.

Note that when CPEs are used as the source of the state share, the State plan must provide for payment of reconciled cost, not rates.

Reimbursement Methodologies

Fee-for-Service Rates:

States may develop rates that reimburse for a unit of service. Those rates may be cost-based/related, meaning that they are developed through an analysis of the reimbursable costs associated with the provision of the Medicaid service. Factors other than cost may also be considered in those rates. States may also develop rates by looking at rates paid for the same service by other States or rates paid within the State for the same or a similar service. Finally, States may develop rates based on what the State must pay to encourage providers to offer the services, i.e., market based rates. The State plan should describe how fee for service rates were developed.

Reconciled Cost:
CMS has approved methodologies that annually reconcile interim payment rates to actual Medicaid cost for states that use CPE, IGT, or Medicaid State appropriated funding. The State plan must include detailed language outlining how cost is identified. Attachment 4.19-B Plan language should include: a list of the services reimbursed at cost, reference to a CMS approved time study protocol and cost report format, a description of how the interim payments are derived, how the interim and final payments are reconciled, and timeframes for submission and settlement of the cost reports. Direct costs include the actual salaries and actual benefits (estimates cannot be used) of Medicaid qualified providers and costs related to contracted employees. Indirect costs are identified by the Cognizant agency indirect cost rate or may be identified directly. A State can choose not to pay providers up to cost but must recover any overpayment. Any aggregate overpayment must be reflected as an adjustment to a State's reported Medicaid expenditures (CMS 64). To maintain efficiency and economy, reconciliation and settlement must be completed within two years of the end of the rate year. This timeframe meets the requirements of 45 CFR 95.7.