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New York, N.Y. 10278

MAR 09 2010

Jason A. Helgeson
State Medicaid Director
Deputy Commissioner
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

Dear Commissioner Helgeson:

This letter is being sent as a companion to the Centers for Medicare & Medicaid Services (CMS) approval of New York State Plan Amendment (SPA) 10-38, which was submitted to propose a 1.1% reduction to payments made to providers for the majority of non-institutional services available under the State Plan. During our review of the SPA, CMS performed a program analysis of the corresponding services and a reimbursement analysis related to the services impacted by the provisions of 10-38. This analysis revealed both coverage and reimbursement issues that will require additional information and revisions to the State Plan through a corrective action plan.

Section 1902 of the Social Security Act (the Act) requires that State 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. In addition, section 1902(a)(30)(A) of the 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. 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 to determine whether payment is appropriate.

In order to comply with the above mentioned statutory and regulatory provisions, the State must amend its approved State plan to include information to comprehensively describe the services and the payment rates and methodologies for those services. To this end, CMS welcomes the opportunity to work with you and your staff to discuss options for resolving the concerns outlined below.

Summarized in the two attachments are CMS' concerns with the State plan. Please refer to Attachment #1 for the list of coverage issues that must be revised to address the issues. Please refer to Attachment #2 for a list of the reimbursement issues and specific sections that must be revised to address these issues.

Within 90 days of the date of this letter, the State is required to submit one or more State plan amendments that resolve the issues, or a corrective action plan to resolve the issues, whichever is appropriate. During the 90-day period, CMS is happy to provide any technical assistance that the State may require to comply with the requirements of this letter. State plans that are not in compliance with the requirements outlined above are grounds for initiating a formal compliance process.

If you have any questions or wish to discuss this SPA further, please contact Ricardo Holligan or Shing Jew of this office. Mr. Holligan may be reached at (212) 616-2424, and Mr. Jew's telephone number is (212) 616-2426.

Sincerely

Michael J. Melendez
Acting Associate Regional Administrator
Division of Medicaid and Children's Health

Enclosure: Attachment #1 (Coverage Issues)
Attachment #2 (Reimbursement Issues)

CC: Julberg
PMossman
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Attachment 1- NY SPA 10-38- Companion Issues-Coverage

Home Health Services

The regulations at 42 CFR 440.70 defines home health services as including part-time or intermittent nursing services, home health aide services and medical supplies, equipment and appliances. At the State's option, physical therapy, occupational therapy, speech pathology or audiology services may also be offered. To be comprehensive, the services; the providers and practitioners of the services; the provider and practitioner qualifications; and any limitations on amount, duration or scope of the services must be understandable, clear and unambiguous. To that end, please clarify and, where applicable, include the following information in the State plan.

1. Please add in the State plan coverage pages, after the last paragraph in the introduction, a summary of the agency provider qualifications, standards and certifications, and include the requirement that AIDS home care program providers and certified home health agencies must conduct criminal background checks (State and national) for prospective employees (as indicated on pages 4(a)(i)(A) and 4(a)(i)(2); and on pages 4(a)(viii) and 4(a)(ix) of Attachment 4.19-B). Please clarify that home health agencies meet requirements for participation in Medicare located at 42 Code of Federal Regulations (CFR) Part 484.
2. Please confirm our understanding that home health care services do not include audiology services. If they do, then please revise the first paragraph in the introduction above to include audiology services.
3. Please insert the following in the State plan after the heading, "Intermittent or part-time nursing":

Recipients must be assessed as being appropriate for intermittent or part-time nursing services ordered by a physician pursuant to a written plan of care provided by a home health agency upon admission to an Assisted Living Program (ALP) no later than 45 days from the date of admission, and at least once during each subsequent six month period. The social services district must review the assessment and prior authorize the service.

Registered professional nurses furnish intermittent or part-time nursing services. A registered professional nurse means a person who is licensed and currently registered as a nurse pursuant to Article 139 of the New York State Education law.
4. Please include in the State plan any limitations on amount, duration or scope of intermittent or part-time nursing services. Are these limitations sufficient so that approximately 90% of Medicaid individuals needing these services would be fully served at these limitations?
5. Please include in the State plan any limitations on amount, duration or scope of home health aide services. Are these limitations sufficient so that approximately 90% of Medicaid individuals needing these services would be fully served at these limitations?
6. Please add a definition of "medical supplies, equipment, and appliances" to the State plan coverage pages.

7. Please include in the State plan any limitations on amount, duration or scope of medical supplies, equipment, and appliances. Are these limitations sufficient so that approximately 90% of Medicaid individuals needing these services would be fully served at these limitations?
8. Please include the following language in the State plan, “PT, OT and Speech pathology and audiology services, and providers of these services, meet the requirements at 42 CFR 440.110.”
9. Please clarify, in the plan, that Medicaid providers of PT and Speech pathology meet federal provider qualifications at 42 CFR 440 110. Please clarify.
10. Please include in the State plan any limitations on amount, duration or scope of PT, OT and Speech Pathology services.
11. On page 4(a)(i)(3) of Attachment 4.19-B, the State lists “Personal Emergency Response Services” (PERS). Does the State intend PERS to be included as part of “medical supplies, equipment, and appliances”? If so, please define PERS and list it under “medical supplies, equipment, and appliances” on the coverage page.
12. On page 4(a)(i)(A) of Attachment 4.19-B, the State plan indicates that there is “specialty training of direct service personnel in dementia care; pediatric care; and/or the care of other conditions or populations with complex needs.” It also indicates a reason for the higher rates is “providing enhanced access to care for high need populations.”
 - a. In the coverage pages, please add a description of the “specialty training” and explain who will furnish it and who will receive it. It seems appropriate to add this description after the agency provider qualifications section.
 - b. In the coverage pages, please add an explanation for “enhanced access to care for high need populations” including a description of “high need populations”.
13. On page 4(c)(1) of Attachment 4.19-B, the State lists “Assisted Living Programs”. CMS reimburses for State plan services furnished in non-institutional settings, not the settings themselves. If the State intends to provide Personal Care Services, Home Health Care Services, Personal Emergency Response Services and/or Adult Day Health Care in Assisted Living settings, then these settings should be added as settings for each of the relevant services in the coverage pages. Depending on the State’s answer, additional revisions to the coverage and reimbursement pages may be necessary.
14. On page 5(a)(vii) of Attachment 4.19-B, the first paragraph references a “demonstration project”. Please explain this reference. Depending on the State’s answer, this paragraph may need revision.

Private Duty Nursing Services

The regulations at 42 CFR 440.80 defines private duty nursing services as nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. The services are

to be provided by a nurse, under the direction of the recipient's physician and to a recipient at either his/her home, a hospital or a skilled nursing facility. To be comprehensive, the services; the providers and practitioners of the services; the provider and practitioner qualifications; and any limitations on amount, duration or scope of the services must be understandable, clear and unambiguous. To that end, please clarify and, where applicable, include the following information in the State plan.

15. On page 2(a)(iii) of Attachment 3.1-A Supplement, the State indicates that nurses must be "registered by the New York Education Department" in order to provide private duty nursing services. Why are registered nurses who furnish Medicaid private duty nursing services governed by the New York Education Department? Please clarify that provider qualifications are the same for participants receiving these services in all settings, in schools and in the community.
16. Please include in the State plan any limitations on amount, duration or scope of private duty nursing services.
17. On page 5 of Attachment 4.19-B, please replace the reference to "home care" services with "private duty nursing" services.
18. On page 5 of the reimbursement pages, the State plan indicates that there is "specialty training of direct service personnel in dementia care; pediatric care; and/or the care of other conditions or populations with complex needs." It also indicates that a reason for higher rates is "providing enhanced access to care for high need populations."
 - a. In the coverage pages, please add a description of the "specialty training" and explain who will furnish it and who will receive it. It may be appropriate to add this description to the provider qualifications section of private duty nursing.
 - b. In the coverage pages, please add an explanation for "enhanced access to care for high need populations" including a description of "high need populations".
19. On pages 4(a)(i)(3) and 5(a) of Attachment 4.19-B, the State lists "Services Provided to Medically Fragile Children", under both Home Health Services and Private Duty Nursing Services, respectively.
 - a. Please specify the services provided to this population. Based on the State's answer, the coverage for Home Health or Private Duty Nursing Services and the reimbursement pages will need revision.
 - b. If only "continuous nursing services" are provided to this population, then coverage and reimbursement must be placed under "private duty nursing" and all references to home care services and a reimbursement methodology for them under home care services must be deleted in the reimbursement pages.
 - c. Pages 4(a)(i) (3) and 5(a) contain a description for "medically fragile child". This description should be included in the coverage pages under the appropriate service, once that is determined.
 - d. The second paragraph on page 4(a)(i)(3) indicates, "A certified home health agency that receives such rates for continuous nursing services for medically fragile children shall use enhanced rates to increase payments to registered nurses and licensed practical nurses who provide these services." The second paragraph on page 5(a) indicates that "Providers that receive such rates... must use these enhanced rates

to increase payments to registered nurses or licensed practical nurses.” Please explain the reference to “providers” and whether it is intended to mean certified home health agencies. If necessary, the reimbursement and/or coverage pages may need revising.

20. At the bottom of page 5(a) of Attachment 4.19-B, the State lists “Nursing Services (Limited).” The State indicates further that “certain nursing services” may be provided by a “certified operator of an adult home or enriched housing program.” The State further explains that “a limited license to the certified operator of an adult home or enriched housing program” allows the operator to “directly provide certain personal care and nursing services to residents of the adult home or enriched housing program...” Finally, the State lists the types of nursing services to be performed in these settings on page 5(a)(i) of Attachment 4.19-B.
 - a. Please confirm our understanding that the “operator” of the residences is not furnishing the nursing services.
 - b. Please explain whether the limited nursing services are considered “intermittent or part-time” or “continuous”. If the former, the nursing services shall be reimbursed as “home health care services” and if the latter, the nursing services shall be reimbursed as “private duty nursing”. Accordingly, the State will need to revise the coverage pages (either “home health” or “private duty nursing”) to add a description of the “limited” service, the locations in which they are furnished, an explanation of the locations and the qualifications of these entities.
 - c. Please delete the reference to “personal care services” here. If personal care services are furnished in an “adult home or enriched housing program”, please revise the “Personal Care Services” benefit coverage pages to add these locations and also the reimbursement methodology as necessary.

Therapies

The regulations at 42 CFR 440.110 define physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. The regulation also describes the qualifications for the practitioners who furnish these services. To be comprehensive, the services; the providers and practitioners of the services; the provider and practitioner qualifications; and any limitations on amount, duration or scope of the services must be understandable, clear and unambiguous. To that end, please clarify and, where applicable, include the following information in the State plan.

21. Please include the following language on page 6 of Attachment 3.1-A Supplement in items 11a, 11b and 11c: “The State assures that [insert the name of the therapy and the practitioners] meet the requirements of 42 CFR 440.110.” For example, “Physical therapy, and the practitioners furnishing physical therapy, meet the requirements of 42 CFR 440.110.”
22. For each therapy, please indicate the practitioners who furnish the therapy. For example, “Physical therapists and physical therapy assistants are authorized to furnish physical therapy. Physical therapy assistants must work under the direction of the physical therapist.”
23. Please include in the State plan any limitations on amount, duration or scope of PT, OT and Speech, Hearing and Language Therapy.

Rehabilitative Services

The regulations at 42 CFR 440.130(d) defines rehabilitative services as any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level. To be comprehensive, the services; the providers and practitioners of the services; the provider and practitioner qualifications; and any limitations on amount, duration or scope of the services must be understandable, clear and unambiguous. To that end, please clarify and, where applicable, include the following information in the State plan.

24. On page 3 of Attachment 3.1-A Supplement, and Page 2c of Attachment 3.1-B Supplement, under 13d. Rehabilitative Services:

(Please note that the Rehabilitative Services are duplicated again on Supplement pages 2c & 2d of 3.1-A, and pages 2c & 2d of 3.1-B. The State should remove the duplicate rehabilitative services on page 3 of 3.1-A, and page 2c of 3.1-B and revise pages 2c & 2d accordingly.)

- a. Please provide in the State plan a description of the component services furnished under Directly Observed Therapy (DOT).
- b. Please include in the State plan the agency providers and practitioners of the component services as well as the agency provider and practitioner qualifications. The practitioner qualifications should include the level of education/degree required, and any additional information related to licensing, credentialing or registration. The practitioner qualifications should also reference any required supervision for each practitioner who is supervised. The State has the option to reference their State codes in addition to this information.
- c. Please describe the specific rehabilitative services under “off-site” services, indicate the types of providers and practitioners who can furnish the services and include their qualifications.
- d. Please remove the reference to the 14 early intervention services listed on page 3 since the services are already described in detail beginning on pages 2(xii)(A) through page 2(Xii)(P).

25. Please delete page 3.1 of Attachment 3.1-A Supplement and Attachment 3.1-B Supplement as these services are already described in detail beginning on pages 2(xii)(A) through page 2(Xii)(P).

26. On pages 3a and 3b of Attachment 3.1-A Supplement and Attachment 3.1-B Supplement:

- a. Under each residential setting (Community Residences, Family-based treatment and Teaching family homes) please include in the State plan a list of the component services furnished in each setting along with a service description for each component service.
- b. Please include in the State plan the provider qualifications for each residential setting.
- c. Please include in the State plan each practitioner type for each component service and their qualifications. The qualifications should include the level of education/degree required, and any additional information related to licensing, credentialing or registration. The practitioner qualifications should also reference any required supervision for each practitioner who is supervised. The State has the option to reference their State codes in addition to this information.

- d. Please add an assurance in the State plan that all rehabilitative services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual.
- e. Please add an assurance in the State plan that room and board is not covered in these residential settings.
- f. Please assure us that all willing and qualified providers will be permitted to participate in accordance with 42CFR 431.51.
- g. Please add an assurance in the State plan that these community residential facilities are not IMDs based on regulatory requirements and the State Medicaid Manual criteria.
- h. Please clarify if any of these residential settings are considered an inpatient psychiatric facility for individuals under age 21 pursuant to 42 CFR 440.160.

27. On page 3b-1 of Attachment 3.1-A Supplement and Attachment 3.1-B Supplement related to Assertive Community Treatment (ACT):

- a. Please describe in the State plan the component services that comprise ACT (such as crisis assessment, medication administration and monitoring, etc.) along with their service descriptions.
- b. Please indicate if the ACT program is available 24 hours/seven days a week.
- c. Please include in the State plan the agency providers and the qualifications for furnishing ACT.
- d. Please include in the State plan the practitioners that are the members of the ACT team and the practitioner qualifications. The qualifications should include the level of education/degree required, and any additional information related to licensing, credentialing or registration. The practitioner qualifications should also reference any required supervision for each practitioner who is supervised. The State has the option to reference their State codes in addition to this information.

28. On pages 3b-2 and 3b-3 of Attachment 3.1-A Supplement Page and Attachment 3.1-B Supplement related to Personalized Recovery Oriented Services (PROS):

- a. Please describe in the State plan the component services provided under each of the following: community rehabilitation and support, intensive rehabilitation and ongoing rehabilitation and support.
- b. Please include in the State plan the agency providers and their qualifications to furnish the services that comprise PROS.
- c. Please include in the State plan the practitioners that furnish each service component and their qualifications to furnish the services that comprise PROS. The qualifications should include the level of education/degree required, and any additional information related to licensing, credentialing or registration. The practitioner qualifications should also reference any required supervision for each practitioner who is supervised. The State has the option to reference their State codes in addition to this information.
- d. Please explain what is meant by the last sentence in the first paragraph “A limited license will be made available for free-standing Intensive Rehabilitation and Ongoing Rehabilitation and Support Programs that are operated by a provider that does not have the capability to offer Community Rehabilitation and Support.”
- e. Per the PROS description, “Programs may at their option provide clinical treatment services designated to stabilize, ameliorate and control the disabling symptoms.” What does the State mean by “clinical treatment services”? Why are these services

reimbursed at a higher rate than programs that do not provide clinical treatment services? Please explain.

CMS staff could not find State plan coverage pages for the following services listed on the 4.19-B pages. Please clarify whether these services are provided as rehabilitative or clinic services and provide corresponding coverage pages for them.

- e) Methadone Maintenance Treatment Program (MMTP) services.
- r) Chemical Dependence Medically Supervised Treatment and Chemical Dependence Medically Supervised Withdrawal Services provided in facilities certified solely under Article 32 of the State Mental Hygiene Law.
- s) Office of Mental Health Outpatient Programs licensed under 14 NYCRR Parts 579 and 5851 including Clinic, Day and Continuing Treatment Programs.
- t) Office of Mental Health Intensive Psychiatric Rehabilitation Treatment programs specifically Child and Family Clinic Plus programs.
- qq) Intensive Day Treatment Program certified by the Office of Mental Health.
- rr) Office of Mental Health Clinic, Day and Continuing Treatment program services in facilities certified under Article 31 of the State Mental Hygiene Law.
- ss) Rehabilitative services, specifically services provided to persons in freestanding chemical dependence residential facilities and services provided by the Office for Persons With Developmental Disability (OPWDD) freestanding outpatient providers.

CASE MANAGEMENT

CMS, generally, recommends that the State of New York revise pages for Target Groups A, B, C, D, D1, D2, E, F, G, H and resubmit pages that describe case management services under (19) in the State Plan in accordance with section 42 CFR 441.18. Please refer to the guidance that was previously provided to the State which outlines all of the requirements for targeted case management that New York may use to be compliant with TCM regulations. CMS notes that New York did follow this outline for Target Group M, which was just recently approved on April 6, 2010.

(Note: Most, if not all, of the items for each individual Target Group have already been asked in the Requests for Additional Information (RAI's) related to SPAs NY 08-47 through NY 08-58; certain questions are being repeated in this letter informational purposes and to draw the State's attention that questions may still be outstanding).

Target Group A

29. Per 42 CFR 441.18(a)(7), please insert language into the plan that documents how providers will maintain records for individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii), the name of the provider agency and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan.

Target Group B

30. On page 1-B4, bullet 2 states that a case manager may help determine eligibility, however, on page 1-B6, item 2 indicates that Medicaid eligibility determinations and redeterminations will not be conducted by case managers. Please revise the language on Page 1-B4 to clarify that eligibility determinations are not within the scope of case management services defined at 42 CFR 440.169.
31. Please remove the discussion of the method of reimbursement from page the coverage 3.1-A section of the State plan and insert this discussion in the 4.19-B reimbursement section of the State plan.
32. Per 42 CFR 441.18, please insert language insert language that documents how providers will maintain records for individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii), the name of the provider agency and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan.

Target Group C

33. Item B on Page 1-C3 indicates that services to this target group may be provided statewide. Please indicate in the plan, the geographic areas served, per section 1915(g) of the Act.
34. Under provider qualifications, please explain the different roles and qualifications of the primary case manager, the case management technician, and the community follow-up workers. Please include minimum provider qualifications and indicate the responsibilities of each classification in providing services directly to an individual. (42 CFR 441.18(v) and 42 CFR 441.18(b)).
35. The States needs to insert language that documents how providers will maintain records for individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii), the name of the provider agency and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan. (42 CFR 441.18(a)(7)).

Target Groups D, D1 and D2 and H

36. It appears that the three D target groups for D, D1 and D2 and H all serve the mentally ill population and the target populations and definition of services are very similar. CMS questions why 3 separate target groups are necessary for the same population and how flexible/blended case management differs from intensive case management, flexible case

management, or blended case management, since the service descriptions in all three groups are very similar and the target groups are the same. If the State does in fact feel that the three groups are relevant, how does the State avoid duplication of service?

37. The States needs to insert language that documents how providers will maintain records for individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii), the name of the provider agency and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan.
38. The State may want to remove these target groups as currently defined and resubmit a new plan amendment using the attached outline. Target Group M, which was just approved in 2010, does in fact use this format.

Target Group E

39. The States needs to insert language that documents how providers will maintain records for individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii), the name of the provider agency and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan.

Target Group F

40. The plan indicates that an assessment under the Neighborhood Based Alliance (NBA) will determine chronic or significant dysfunction from a listing of 12 categories. Who is responsible for conducting this assessment? And, how will the State avoid duplicate services for individuals who meet the criteria for items, iv (foster care placement); (v) physical and/or mental abuse or neglect; (x) criminal justice system involvement, or xii (family violence or sexual abuse). It appears that these activities may be covered as an integral component of another Federal or State program. Case management does not include, and FFP is not available in expenditures for, services defined in sections 441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements (42 CFR 441.18(c)).

41. Page 1-F3 – The third paragraph indicates that case management services will be provided to individuals who are not Medicaid eligible by public and private grant funds and also discusses a sliding fee scale. The State needs to elaborate on what this means. Medicaid-reimbursable case management services are not provided to individuals who are not eligible for Medicaid.
42. The States needs to insert language that documents how providers will maintain records for individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii), the name of the provider agency and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan. (42 CFR 441.18(a)(7)).

Target Group G

43. The State needs to update this target group to update the language concerning Medicaid's responsibility regarding developing Individualized Service Plans (IFSP). Under Part C of the Individuals with Disabilities Education Act, the IFSP may identify a need for case management as well as other services and activities, some of which may be covered under Medicaid and others that, while a necessary component of the Part C program are not covered under Medicaid. One distinction between the IFSP is that the IFSP process for an infant or toddler with a disability under the age of three requires a service coordinator from the outset, some of whose activities may be Medicaid-funded case management or targeted case management services. Case management activities in this context could include taking the infant or toddler's history, identifying service needs, and gathering information from other sources to form a comprehensive assessment. Case management would not include administrative functions that are purely IDEA functions such as scheduling IFSP team meetings, and providing the requisite prior written notice.
44. The States needs to insert language that documents how providers will maintain records for individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii), the name of the p provider agency and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and(viii) a timeline for reevaluation of the plan. (42 CFR 441.18(a)(7)).

Personal Care Services

Attachment 3.1A & 3.1B– 3(d), 3(d)(A), 3(d)(I)

45. Please clarify how the nutritional and environmental support functions meet the definition for personal care services in 42 CFR 440.167, as supplemented by, State Medicaid Manual, section 4480.

46. The SPA references two levels of personal care services in the 4.19B pages, but does not include a coverage description for these levels. It is difficult to determine whether the State is operating its personal care program as required by 1905(a). Please provide descriptions of each level of service including which services listed on the coverage pages constitute Levels I and II. The lack of coverage detail regarding these levels also makes it difficult to determine if this service is provided consistently with comparability requirements. 42 CFR 440.240 indicates that services must be equal in amount, duration and scope.
47. Please clarify the difference between a shared aide and an individual aide. Do they have the same responsibilities? Please include minimum provider qualifications in the plan.

Attachment 2

New York SPA 10-38 – Companion Review-Reimbursement

General Issues

The current approved State plan for New York does not identify the payment rate for many services, nor does it identify a methodology for determining the payment rate. The State indicates in many instances that it uses a fee schedule, but does not include the fee schedule itself, nor does it identify how providers and auditors can locate the applicable fee schedule and the period for which the fee schedule is in effect. In order to comply with the above mentioned statutes and regulation, the State must amend its approved State plan to include information to comprehensively describe its payment rates for these services.

1. Reimbursement of monthly rates. Monthly rates provide for a fixed payment regardless of the number of services furnished or the specific cost of those services. It is not economic to pay for days of service when a beneficiary is not actually receiving covered services. In addition, it is not efficient or consistent with quality of care to pay a monthly patient rate because the variability in service level would result in insufficient payment for some patients (who might then be underserved) and excessive payment for other patients. It is CMS's position that these rates are more appropriate as per member per month capitated payments which are governed by contract rules at 42 CFR 438. On a fee-for-service basis, CMS recognizes units of service up to weekly rates.
2. Unclear reimbursement methodologies. The State should provide a more complete description of how it reimburses for these services. If the State has developed a fee schedule that pays a unit of a week or less, please include the comprehensive fee schedule language described in Attachment A. In addition, please note that for those services that fall under the clinic benefit in accordance with 42 CFR 440.90, the methodology cannot include services provided outside of the clinic e.g. transportation, personal care, home care, etc.
3. Managed care arrangements in the State Plan. In addition to the guidance provided above, there are services/methodologies that appear as managed care in the state plan. These services/methodologies should be removed from the State plan since Attachment 4.19B of the plan is used to describe only the fee for service payment methodologies.
4. Payments for 1905(a) services. In several instances, the state references a payment methodology that does not appear to reimburse for a recognized 1905 (a) service. All payment methodologies must correspond to a 1905(a) service.
5. Payment at Cost. Some sections of attachment 4.19-B indicate that the State will pay providers at cost. However, they do not describe those costs nor do they provide a comprehensive description of the cost identification process.

Specific Page and Service Issues

Page A

- Item 2(a) Physician Services (Attachment 4.19-B, Page 1)
“Fee schedules are developed by ...”. See Attachment A.
- Item 2(b) Statewide Patient Centered Medical Home and the Adirondack Medial Home
Multipayor Program (Attachment 4.19-B, Pages 1(a)-1(A)(ii); 1(c)(i)(A)-1(c)(i)(H))
Pages 1(c)(i)(A)-1(c)(i)(D) not found in State Plan; are they part of a pending SPA not
yet approved? If so, what is that SPA? If not, where can it be found in the State Plan?
- Item 2(d) Dental Services (Attachment 4.19-B, Page 1(a))
“... the fee schedule developed by ...”. See Attachment A.
- Item 2(d) Podiatrists (Attachment 4.19-B, Page 1(a))
“Fee schedule developed by ...”. See Attachment A
- Item 2(d) Optometrists (Attachment 4.19-B, Page 1(a))
“Fee schedule developed by ...”. See Attachment A.
- Item 2(d) Chiropractic Services (Attachment 4.19-B, Page 1(a))
“Fee schedule developed by ...”. See Attachment A
- Item 2(d) Nurse Midwives (Attachment 4.19-B, Page 1(a))
“Fee schedule developed by ...”. See Attachment A
- Item 2(d) Nurse practitioners (Attachment 4.19-B, Page 1(a))
“Fee schedule developed by ...”. See Attachment A.
- Item 2(d) Clinical Psychologists (Attachment 4.19-B, Page 1(a))
“Fee schedule developed by ...”. See Attachment A.
- Item 2(f) Outpatient Reimbursement for Acute Care Children’s Hospitals (Attachment 4.19-B,
Page 1(b)(ii))
Page 1(b)(ii) not found in State Plan; is it part of a pending SPA not yet approved? If
so, what is that SPA? If not, where can it be found in the State Plan?
- Item 2(g) Ordered Ambulatory Services (Attachment 4.19-B, Pages 1(c)-1(c)(i))
“Fee schedule developed by ...”. See Attachment A.
- Item 2(j) Services for medically supervised chemical dependence treatment and medically
supervised withdrawal services provided in Freestanding clinics licensed by Article 28
of the State Public Health law, excluding Federally Qualified Health Centers
(Attachment 4.19-B, Page 1(d)(i))
“For dates of service beginning on July 1, 2002, ... facilities ... shall be reimbursed at
their existing rate ..., Including Federally Qualified Health Centers.” How does this
comport or comply with the requirement that FQHCs are to be paid at PPS rates or an
alternative rate that pays at least as much as PPS?

Page A(1)

Item 2(k)

Ambulatory Patient Group (APG) reimbursement for hospital outpatient and ambulatory surgery services (Attachment 4.19-B, Pages 1(f)-1(p), and 2(h)-2(t))

Page 1(j)(III)(a) indicates that APG payments shall also reflect an investment of \$178 million on an annualized basis. Since the State is proposing an across the board reduction in payments, what happens to this annualized investment?

Page 1(k) indicates that "All Medicaid ... during the 2007 calendar year will be added to a statutorily enacted funding amount to form the numerator." The total amount of the investment is not indicated; it is not in the enacting legislation. Where can this be found in the State Plan? Also, it should be amended to include the amount.

Page 2(i)(II)(a) indicates that APG payments shall also reflect an investment of \$13.54 million for dates of service from September 1, 2009 through March 31, 2010, and \$12.5 million for each annual period thereafter. Since the State is proposing an across the board reduction in payments, how will it sustain these investments?

Item 2(l)

Ordered Ambulatory Services performed by a freestanding clinic on an ambulatory basis (Attachment 4.19-B, Page 2)

"Fee schedule developed by ...". See Attachment A.

Item 2(n)

Medically supervised chemical dependence treatment; and medically supervised withdrawal services provided in Hospital Based Outpatient Departments and Freestanding Clinics certified under Article 28 of the State Public Health Law (Attachment 4.19-B, Pages 2(b)-2(b)(ii))

Page 2(b)(ii) not found in State Plan; is it part of a pending SPA not yet approved? If so, what is that SPA? If not, where can it be found in the State Plan?

Item 2(o)

Workforce Recruitment and Retention payment for freestanding clinics (Attachment 4.19-B, Pages 2(c)(vii)-2(c)(viii))

Page 2(c)(vii) indicates that for the period April 1, 2010 through March 31, 2011, thirteen million dollars will be available. Since the State is proposing an across the board reduction in payments, how will it sustain this investment?

Item 2(p)

Products of Ambulatory Care reimbursement for Hospital Based Clinics and Freestanding Clinics (Attachment 4.19-B, Pages 2(d)-2(e))

The State needs to describe the rate methodology for Products of Ambulatory Care (PAC) rate structure for prenatal care and postpartum visits. Please confirm that this methodology is no longer applicable. Please remove from the state plan.

Item 2(q)

Office of Mental Retardation and Developmental Disabilities (OMRDD) Clinic Day Treatment Programs (Attachment 4.19-B, Page 3)

"statewide cost related flat fees". Is this the same as a fee schedule? If not, what is it?"

If yes, see Attachment A. We understand that this service is covered under the clinic benefit. Services provided outside of the clinic are not reimbursable under this benefit category. We note that the methodology includes add-ons for items such as transportation. The rate methodology for clinic services cannot include services which do not fall under this benefit. The reimbursement methodology should be modified.

- Item 2(r) Chemical Dependence Medically Supervised Treatment and Chemical Dependence Medically Supervised Withdrawal Services provided in facilities certified solely under Article 32 of the State Mental Hygiene Law (Attachment 4.19-B, Page 3(i))
There is nothing on Page 3(i) about “Chemical Dependence” programs. Is this the correct Page for these programs, or should the name(s) be changed if the programs listed on the Page are correct?
- Item 2(s) Office of Mental Health Outpatient Programs licensed under 14 NYCRR Parts 479 and 585; including clinic, Day and continuing Treatment Programs (Attachment 4.19-B, Pages 3(i)-3(k))
“Flat fee developed by”, “ ... establish regional fee schedules ...”, “ ... fees will be tiered ...”, “ ... set project specific fees ...” – which of these are fee schedules? For those that are not fee schedules, what are they? For fee schedules, see Attachment A. We understand that this service is covered under the clinic benefit. Services provided outside of the clinic are not reimbursable under this benefit category. We note that the methodology includes add-ons for items such as transportation. The rate methodology for clinic services cannot include services which do not fall under this benefit. The State will need to modify the reimbursement methodology.
- Item 2(t) Office of Mental Health Intensive Psychiatric Rehabilitation Treatment Programs (Attachment 4.19-B, Page 3L)
“develop a flat fee”. Is this the same as a fee schedule? If not, what is it”? It is not clear what specific services are being provided. In addition, monthly rates are not economic and efficient reimbursement methodologies for non-institutional services. These rates are more akin to per member per month capitated payments which are governed by contract rules of 42 CFR 438. CMS permits units up to a weekly rate. Payments of a monthly and half-monthly rate is not appropriate as a fee-for-service payment. The state must revise this methodology to units less than a month and provide a comprehensive methodology.
- Item 2(t) Personalized Recovery Oriented Services (PROS) , Community Rehabilitation and Support (Attachment 4.19-B, page 3L-1)
“a regionally based, tied monthly case payment”. ”. Is this the same as a fee schedule? If not, what is it” If yes, see Attachment A. Monthly rates are not economic and efficient reimbursement methodologies for non-institutional services. These rates are more akin to per member per month capitated payments which are governed by the contract rules of 42 CFR 438. CMS permits units up to a weekly rate. The state must revise this methodology to units less than a month and provide a comprehensive methodology.
- Item 2(t) Intensive Rehabilitation (Attachment 4.19-B, Page 3L-1)
“a regionally based, tied monthly case payment”. ”. Is this the same as a fee schedule? If not, what is it”? If yes, see Attachment A. Monthly rates are not economic and efficient reimbursement methodologies for non-institutional services. These rates are more akin to per member per month capitated payments which are governed by the contract rules of 42 CFR 438. CMS permits units up to a weekly rate. The state must revise this to units less than a month and provide a comprehensive methodology.

- Item 2(t) Clinic and continuing Day Treatment programs excluding Child and Family Plus clinics (Attachment 4.19-B, pages 3(L)-3(M))
The listed programs do not appear on the indicated Pages. Are the programs correctly identified, or are the Pages wrong?
- Item 2(t) Child and Family Clinic Plus Programs (Attachment 4.19-B, Pages 3(L)-3(M))
These programs were part of SPA #06-48, which was subsequently withdrawn by the State. They should be deleted as they are not in the approved State Plan.
- Item 2(t) Assertive Community Treatment (ACT) programs (Attachment 4.19-B, Page 3M)
“Monthly fees as approved by ...” “. Is this the same as a fee schedule? If not, what is it? If yes, see Attachment A. Monthly rates are not economic and efficient reimbursement methodologies for non-institutional services. These rates are more akin to per member per month capitated payments which are governed by the contract rules of 42 CFR 438. CMS permits units up to a weekly rate. The state must revise this methodology to units less than a month and provide a comprehensive methodology.

Page A(2)

- Item 2(u) Laboratory services (Attachment 4.19-B, Page 4)
- Item 2(v) Home health services provided by Certified home health Agencies (CHHA), including services to patients diagnosed with AIDS (Attachment 4.19-B, Pages 4(a)(i)(4)-4(a)(i)(5))
Pages 4(a)(i)(4)-4(a)(i)(5) not found in State Plan; are they part of a pending SPA not yet approved? If so, what is that SPA? If not, where can it be found in the State Plan?
- Item 2(x) Assisted Living Program (Attachment 4.19-B, Page 4(c)(1))
Based on the methodology, it appears this service is Personal Care. Please rename this section to fit within a Federally recognized benefit category. In addition, the reimbursement methodology is not clear.
- Item 2(aa) Prescribed Drugs; E-Prescription Financial Incentive program to retail pharmacies; Pharmacy Medication Therapy; immunization reimbursement for pharmacists; and Non-prescription drugs (Attachment 4.19-B, Page 4(d))
Page 4(d) not found in State Plan; is it part of a pending SPA not yet approved? If so, what is that SPA? If not, where can it be found in the State Plan?
- Item 2(bb) Private Duty Nursing (Attachment 4.19-B, Page 5)
“Fees determined by ...” Is this a fee schedule? If yes, see Attachment A.
- Item 2(bb) (Nursing) Services provided to eligible residents of an adult home or enriched housing program that is issued a limited license by the Department of Health (Attachment 4.19-B, Pages 5(a)-5(a)(i))
“... establishes reimbursement rates ...” Is this the same as a fee schedule? If not, what is it? If yes, see Attachment A.

- Item 2(cc) Physical Therapy (Attachment 4.19-B, Page 5(a)(i))
“Fee schedule developed by ...” See Attachment A.
- Item 2(dd) Occupational Therapy (Attachment 4.19-B, Page 5(a)(i))
“Fee schedule developed by ...” See Attachment A.
- Item 2(ee) Eyeglasses and Other Visual Services (Attachment 4.19-B, Page 5(b))
“Fee schedule developed by ...” See Attachment A.
- Item 2(ff) Hearing Aid Supplies and Services (Attachment 4.19-B, Page 5(b))
“Fee schedule developed by ...” See Attachment A.
- Item 2(gg) Prosthetic and Orthotic Appliances (Attachment 4.19-B, Page 5(b))
“... fee schedule developed by ...” See Attachment A.
- Item 2(hh) Comprehensive Psychiatric Emergency programs (Attachment 4.19-B, Page 5(b))
“Flat fee developed by ...” Is this the same as a fee schedule? If not, what is it? If yes, see Attachment A.

Page A(3)

- Item 2(ii) Transportation (Attachment 4.19-B, Page 6)
“ ... fees will be established by ...” Is this the same as a fee schedule? If not, what is it? If yes, see Attachment A.
- Item 2(mm) Out of State Services for fee-based providers (Attachment 4.19-B, Page 6a)
The reimbursement methodology is not clear, “ ... up to the appropriate New York State fee ...”.
- Item 2(nn) HMO’s and prepaid Health Plans (Attachment 4.19-B, Page 6a)
This appears to be related to managed care and not fee-for-service. Therefore, it must be removed from the state plan, as managed care programs are contained in separate CMS approved contracts and follow Federal requirements contained in 42 CFR 438. Guidance regarding existing issues with certain prepaid health plans will be transmitted under separate cover.
- Item 2(rr) Office of Mental Health Clinic, Day and continuing Treatment program services in facilities certified under Article 31 of the State Mental Hygiene Law (Attachment 4.19-B, Page 9)
“Flat fee developed by ...” Is this the same as a fee schedule? If not, what is it? If yes, see Attachment A.
- Item 2(ss) Rehabilitative Services (Attachment 4.19-B, Page 10-1)
The methodology described on this Page appears to reimburse rehabilitative services as if these are clinic services. The rehab benefit does not include payment for facility services as the reimbursement is based on practitioner services. This methodology is not comprehensive as the methodology does not link to an identifiable service. If these services are clinic services that meet the definition at 42 CFR 440.90, the methodology could not include services rendered outside of the clinic.

- Item 2(ss) School supportive Health Services (Attachment 4.19-B, Page 10-1-B to G)
This methodology appears to be out of date, since the reimbursement methodology for services provided in schools was approved in SPA 09-61.
- Item 2(tt) Case Management Services to Target Group B, D, D1, D2 (Attachment 4.19, Page 11)
These target groups reference payment at a monthly rate. Monthly rates are not economic and efficient reimbursement methodology for non-institutional services. These rates are more akin to per member per month capitated payments which are governed by the contracting rules of 42 CFR 438. Payment of a monthly and half-monthly rate is not appropriate as a fee-for-service payment. CMS permits units up to a weekly rate. The state must revise this methodology to units less than a month and provide a comprehensive methodology. This guidance was also communicated in outstanding Requests for Additional Information (RAI's) for these target groups.
- Item 2(tt) Case Management Services to Target Group M (Attachment 4.19-B, Page 11(g))
Page 11(g) not found in State Plan; is it part of a pending SPA not yet approved? If so, what is that SPA? If not, where can it be found in the State Plan?
- Item 2(xx) Health Maintenance Organization Obstetrical and Pediatric Services (Attachment 4.19-B, Page 12-6)
This appears to be related to managed care and not fee-for-service. Therefore, it must be removed from the state plan, as managed care programs are contained in separate CMS approved contracts and follow Federal requirements contained in 42 CFR 438.

ATTACHMENT A

The State needs to address the following for the service reimbursement methodology provided in Attachment 4.19-B:

Rationale: State plan reimbursement methodologies are reviewed with respect to the following:

Does the state plan specify that governmental and non-governmental providers are paid the same, uniform rate unless otherwise noted on the reimbursement pages?

Does the State plan contain the effective date of the fee for service rate paid for State plan services?

If the plan does not include this information, CMS requires that the following language be added:

“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)*.”

Specific exceptions include:

1. When a state lists the actual rates in the plan.
2. When a state sets rates at a percentage of the Medicare fee schedule and follows the Medicare updates published by CMS.
3. When a state sets rates at a percentage of the Medicare fee schedule for a certain year (e.g., 2005) and trends those rates using an inflation factor identified in the plan.
4. When a state includes a complete, comprehensive, and self contained description of how the fee schedule was determined. The description must have enough information to determine the actual rate.