



DEPARTMENT OF HEALTH & HUMAN SERVICES



Re: DMCH: BPW

Region II  
Federal Building  
26 Federal Plaza  
New York, NY 10278

September 7, 2011

Jason A. Helgeson  
State Medicaid Director  
Deputy Commissioner  
Office of Health Insurance Programs  
New York State Department of Health  
Empire State Plaza  
Corning Tower, Room 1466  
Albany, New York 12237

Re: **NY SPA #11-15**

Dear Commissioner Helgeson:

This letter is being sent in conjunction with the Centers for Medicare & Medicaid Services (CMS) approval of New York State Plan Amendment (SPA) #11-15, which amendment provides funds to certified home health agencies, AIDS home care providers and hospice service providers for the purpose of improving recruitment, training and retention.

In reviewing SPA #11-15, CMS staff performed a program analysis of the corresponding services and a reimbursement analysis related to the services impacted by the provisions of SPA #11-15. These analyses revealed issues, set out below, which the State needs to address through a State plan amendment in order to meet the requirements of Section 1902 of the Social Security Act.

In response to the State's request, CMS has agreed that the State may respond to these issues in the context of responding to the SPA 10-38 companion letter issues. To this end, CMS welcomes the opportunity to work with you and your staff and to provide any technical assistance to resolve the issues below.

**Home Health-related Corresponding Coverage Issues for NY SPA #11-15:**

1. Please describe an "AIDS home care program" and a "long term home health care program" and indicate whether either of these programs are part of a hospital, nursing facility or Intermediate Care Facility.
2. Please confirm that the "telehealth services" is simply a different service delivery mode for part-time/intermittent nursing services and not a cluster of services separate and apart from part-time/intermittent nursing services under the home health services benefit. If this articulation is correct, please reflect this understanding in the description of "telehealth

services”. Also, if there are limitations on the amount, duration or scope of part-time/intermittent nursing services, please explain whether “telehealth services” count in the calculation of any limitation on amount or duration. For example, if the visits by a nurse are limited to 12 in a year, would a single “telehealth services” encounter be considered a “visit”?

3. We are enclosing a copy of the CMS (formerly HCFA) September 4, 1998 guidance regarding the circumstances under which a State may use a list to determine coverage of medical equipment to be sure that the State is aware of it. In keeping with that guidance, please explain whether the State has a process by which beneficiaries may request medical equipment, supplies and appliances not on the State’s approved list and, if so, whether the process includes notice of the right to a fair hearing if the request is denied.
4. If the State allows assistants or aides, such as Physical Therapy Assistants, to furnish therapies, please add each type of provider to the State plan along with a brief description of how each is required to work “under the direction of” the qualified therapist.
5. Does the State require that each Physical Therapist be a graduate of a program of physical therapy approved by the Commission on Accreditation in Physical Therapy Education (CAPTE)? If not, please explain whether the State permits a graduate of an unaccredited institution to be licensed and, if so, the process by which the State determines whether the applicant’s education is comparable to one received at a CAPTE-accredited institution.

**Hospice-related Corresponding Coverage Questions for SPA NY#11-15:**

6. Please include a description of the covered hospice services in the State plan. (The State has included some, but not all, of the hospice services in the State plan.) Please delete the word “approximately” from the first sentence in the first paragraph on page 3(c) of Attachment 3.1-A, Supplement under the hospice benefit category.
7. Please replace the word “conventional” with “curative” in the second paragraph on page 3(c) of Attachment 3.1-A, Supplement.
8. Please clarify if the State allows Medicaid State plan personal care services to be furnished in addition to the hospice home health aide services as we are not clear about the State’s intention.
9. Please specify the election periods in the plan. Medicaid hospice coverage must be available for an unlimited duration and may be subdivided into two or more periods. At the State’s option, the State can mirror the Medicare election periods which are divided into an initial 90-day period; a subsequent 90-day period; and an unlimited number of subsequent 60-day periods.
10. The Affordable Care Act made changes to the hospice benefit which were effective on March 23, 2010. Section 2302 of the Affordable Care Act (ACA) amends sections 1905(o)(1) and 2110(a)(23) of the Social Security Act (the Act) to allow State Medicaid and CHIP programs to cover hospice care for children concurrent with curative treatment

of the child's terminal illness. This new provision does not change the eligibility criteria for receiving hospice services; however, prior to section 2302 of the Affordable Care Act, curative treatment for the terminal illness ceased upon election of the hospice benefit. This new provision allows the hospice benefit to be elected without forgoing any other service to which the child is entitled under Medicaid or CHIP for treatment of the terminal condition, paving the way for children and families to receive hospice services such as pain and symptom management, and family counseling, provided by the specially-trained staff that hospice requires, without having to forgo curative treatment. CMS is not requiring changes to the State plan at this time as we are planning to issue guidance to the States first. We have attached a copy of the State Medicaid Letter which was issued on September 9, 2010 and an excerpt from the State Medicaid Manual for the State's information and review.

If you have any questions or wish to discuss this SPA further, please contact Shing Jew or Barbara Waugh of this office. Mr. Jew may be reached at (212) 616-2426 and Ms. Waugh at (212) 616-2366.

Sincerely,

*John* Guhl  
Acting Associate Regional Administrator  
Division of Medicaid and Children's Health

Enclosures

cc: J. Ulberg  
G. Critelli  
R. Holligan  
S. Jew  
K. Knuth  
D. Mathurin  
P. Mossman  
M. Schervish  
B. Waugh



DEPARTMENT OF HEALTH & HUMAN SERVICES  
Health Care Financing Administration

Center for Medicaid and State Operations  
7500 Security Boulevard  
Baltimore, MD 21244-1850

September 4, 1998

Dear State Medicaid Director:

We have received a number of inquiries regarding coverage of medical equipment (ME) under the Medicaid program in light of the ruling of the United States Court of Appeals for the Second Circuit in DeSario v. Thomas. In that case, the court examined the circumstances under which a State may use a list to determine coverage of ME and offered its interpretation of HCFA's policies. We have concluded that it would be helpful to provide States with interpretive guidance clarifying our policies concerning ME coverage under the Medicaid program and the use of lists in making such coverage determinations. This guidance is applicable only to ME coverage policy.

As you know, the mandatory home health services benefit under the Medicaid program includes coverage of medical supplies, equipment, and appliances suitable for use in the home (42 C.F.R. § 440.70(b)(3)). A State may establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of such coverage (42 U.S.C. § 1396(a)(17)) based on such criteria as medical necessity or utilization control (42 C.F.R. § 440.230(d)). In doing so, a State must ensure that the amount, duration, and scope of coverage are reasonably sufficient to achieve the purpose of the service (42 C.F.R. § 440.230(b)). Furthermore, a State may not impose arbitrary limitations on mandatory services, such as home health services, based solely on diagnosis, type of illness, or condition (42 C.F.R. § 440.230(c)).

A State may develop a list of pre-approved items of ME as an administrative convenience because such a list eliminates the need to administer an extensive application process for each ME request submitted. An ME policy that provides no reasonable and meaningful procedure for requesting items that do not appear on a State's pre-approved list, is inconsistent with the federal law discussed above. In evaluating a request for an item of ME, a State may not use a "Medicaid population as a whole" test, which requires a beneficiary to demonstrate that, absent coverage of the item requested, the needs of "most" Medicaid recipients will not be met. This test, in the ME context, establishes a standard that virtually no individual item of ME can meet. Requiring a beneficiary to meet this test as a criterion for determining whether an item is covered, therefore, fails to provide a meaningful opportunity for seeking modifications of or exceptions to a State's pre-approved list. Finally, the process for seeking modifications or exceptions must be made available to all beneficiaries and may not be limited to sub-classes of the population (e.g., beneficiaries under the age of 21).

In light of this interpretation of the applicable statute and regulations, a State will be in compliance with federal Medicaid requirements only if, with respect to an individual applicant's request for an item of ME, the following conditions are met:

- The process is timely and employs reasonable and specific criteria by which an individual item of ME will be judged for coverage under the State's home health services benefit. These criteria must be sufficiently specific to permit a determination of whether an item of ME that does not appear on a State's pre-approved list has been arbitrarily excluded from coverage based solely on a diagnosis, type of illness, or condition.
- The State's process and criteria, as well as the State's list of pre-approved items, are made available to beneficiaries and the public.
- Beneficiaries are informed of their right, under 42 C.F.R. Part 431 Subpart E, to a fair hearing to determine whether an adverse decision is contrary to the law cited above.

We encourage you to be cognizant of the approval decisions you make regarding items of ME that do not appear on a pre-approved list, to ensure that the item of ME is covered for all beneficiaries who are similarly situated. In addition, your list of pre-approved items of ME should be viewed as an evolving document that should be updated periodically to reflect available technology.

HCFA's Regional Offices will be monitoring compliance with the statute and regulations that are the subject of this guidance. Any questions concerning this letter or the ME benefit may be referred to Mary Jean Duckett of my staff at (410) 786-3294.

Sincerely,

/s/

Sally K. Richardson

Director

cc:

All HCFA Regional Administrators  
All HCFA Associate Regional Administrators for Medicaid and State Operations  
Lee Partridge American Health Services Association  
Joy Wilson National Conference of State Legislatures  
bcc: HCFA Press Office CMSO Senior Staff



**Center for Medicaid, CHIP and Survey & Certification**

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SMD # 10-018  
ACA # 8

September 9, 2010

**Re: Hospice Care for Children in Medicaid and CHIP**

Dear State Health Official:  
Dear State Medicaid Director:

This letter is one of a series intended to provide guidance on the implementation of the Affordable Care Act (Pub. L. No. 111-148 as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152)), together known as the Affordable Care Act.

Specifically, this letter provides guidance to States on the implementation of section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children." Section 2302 of the law amends sections 1905(o)(1) and 2110(a)(23) of the Social Security Act to remove the prohibition of receiving curative treatment upon the election of the hospice benefit by or on behalf of a Medicaid or Children's Health Insurance Program (CHIP) eligible child.

Hospice services are covered under the Medicaid and CHIP programs as an optional benefit. However, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provision requires Medicaid and CHIP programs operating as Medicaid expansions to provide all medically necessary services, including hospice services, to individuals under age 21. In order to qualify for the hospice service in either Medicaid or CHIP, a physician must certify that the eligible person is within the last 6 months of life.

The Affordable Care Act does not change the criteria for receiving hospice services; however, prior to enactment of the new law, curative treatment of the terminal illness ceased upon election of the hospice benefit. This new provision requires States to make hospice services available to children eligible for Medicaid and children eligible for Medicaid-expansion CHIP programs without forgoing any other service to which the child is entitled under Medicaid for treatment of the terminal condition. These services and supports may include pain and symptom management and family counseling provided by specially-trained hospice staff. States with stand-alone CHIP programs continue to have the option to provide hospice services, but if they cover hospice services they must comply with the new requirements under the Affordable Care Act.

We believe implementation of this new provision is vitally important for children and their families seeking a blended package of curative and palliative services. This provision will increase utilization of hospice services since parents and children will no longer be required to forego curative treatment.

This provision was effective upon enactment of the Affordable Care Act on March 23, 2010. Therefore, under Medicaid, including CHIP programs operating as Medicaid expansions, we expect States will continue the provision of medically necessary curative services, even after election of the hospice benefit by or on behalf of children receiving services. States operating stand-alone CHIP programs that offer the optional hospice benefit must now provide it concurrently with medically necessary curative services.

### **Implementation**

#### **Medicaid**

The Centers for Medicare & Medicaid Services (CMS) is revising the Medicaid State plan hospice preprint page of Attachment 3.1-A and 3.1-B to reflect this new feature of the hospice benefit. Once approved, CMS will release the new preprint page for States' use. States will need to submit the revised preprint page to indicate that hospice is provided to children concurrently with curative treatment. States are not required to submit any needed revisions to their State plan coverage language until the preprint page is made available but are expected, in the interim, to be providing these services consistent with the requirements described in this guidance.

#### **CHIP**

As noted above, the Medicaid guidance also applies to CHIP programs operating as a Medicaid expansion. States with separate CHIP programs that currently cover hospice services do not need to submit a State Plan amendment (SPA) to modify this definition, but States are expected to implement these services in compliance with the Affordable Care Act. We are, however, happy to work with States that are interested in submitting SPAs to explicitly modify the definition of hospice services. States with separate CHIP programs that do not currently cover hospice services and would like to extend this benefit to children do need to submit a SPA indicating this intention and confirming that hospice services will be offered concurrently with curative treatment.

We are ready to work with States to provide assistance in implementing this new requirement, and we look forward to our continuing collaboration. If you have any questions, please contact Ms. Barbara Edwards, Director of the Disabled and Elderly Health Programs Group, at 410-786-7089, or at [Barbara.Edwards@cms.hhs.gov](mailto:Barbara.Edwards@cms.hhs.gov). If you have any questions on implementing this provision in the CHIP program, please contact Ms. Victoria Wachino, Director of the Family and Children's Health Programs Group, at 410-786-9535, or at [Victoria.Wachino@cms.hhs.gov](mailto:Victoria.Wachino@cms.hhs.gov).

Sincerely,

/s/

Cindy Mann  
Director

cc:

**CMS Regional Administrators**

**CMS Associate Regional Administrators  
Division of Medicaid and Children's Health**

**Richard Fenton  
Acting Director  
Health Services Division  
American Public Human Services Association**

**Joy Wilson  
Director, Health Committee  
National Conference of State Legislatures**

**Matt Salo  
Director of Health Legislation  
National Governors Association**

**Carol Steckel  
President  
National Association of Medicaid Directors**

**Debra Miller  
Director for Health Policy  
Council of State Governments**

**Christine Evans, M.P.H.  
Director, Government Relations  
Association of State and Territorial Health Officials**

**Alan R. Weil, J.D., M.P.P.  
Executive Director  
National Academy for State Health Policy**

Please describe in the State plan the hospice benefit. As you develop the description, you may wish to refer to the following excerpt from the State Medicaid Manual:

## Hospice Care

4305.4 Requirements for Coverage.--To be covered, a certification that the individual is terminally ill must have been completed as set forth in §4305.1, and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care in accordance with §4305.2, and a plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care.

4305.5 Covered Services.--All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

- o Nursing care provided by or under the supervision of a registered nurse.
  - o Medical social services provided by a social worker who has at least a bachelors degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.
  - o Physicians' services performed by a physician (as defined in 42 CFR 410.20) except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.
  - o Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.
  - o Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.
  - o Medical appliances and supplies, including drugs and biologicals. Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care.
- Home health aide services furnished by qualified aides and homemaker services. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

o Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Nursing care, physicians' services, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted for during periods of peak patient loads and to obtain physician specialty services.

4305.6 Special Coverage Requirements.--Continuous home care is to be provided only during a period of crisis. A period of crisis is a period in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of 8 hours of care must be provided during a 24-hour day which begins and ends at midnight. This care need not be continuous, i.e., 4 hours could be provided in the morning and another 4 hours provided in the evening of that day. Homemaker and aide services may also be provided to supplement the nursing care. Continuous home care is covered when it is provided to maintain an individual at home during a medical crisis. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the hospice patient is a nursing home resident.

Bereavement counseling consists of counseling services provided to the individual's family after the individual's death. Bereavement counseling is a required hospice service but it is not reimbursable.