DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Jacob K. Javits Federal Building
26 Federal Plaza
Room 37-100
New York, New York 10278-0063

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

April 6, 2010

Donna Frescatore
Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
Corning Tower - Empire State Plaza
Room 1441
Albany, New York 12237

Dear Ms. Frescatore:

We have completed our review of New York State Plan Amendment submittal 09-57, "Target Group M – First-time Mothers/Newborn" (Supplement 1 to Attachment 3.1A and Attachment 4.19B) and find it acceptable for incorporation into New York's Medicaid Plan, effective April 1, 2009. Enclosed please find copies of State Plan Amendment 09-57 and Form CMS-179.

If you have any questions or wish to discuss this further, please contact Barbara Waugh of my staff at 212-616-2366.

Sincerely,

[redacted]

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

Enclosures

cc: Dr. Gesten
Mr. Guilz
Ms. Kelly

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: ***09-57***

2. STATE: ***New York***

3. PROGRAM IDENTIFICATION: **TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)**

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
May 1, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.169

7. FEDERAL BUDGET IMPACT:
a. FFY **05/01/09-09/30/09 $1,250,000**
b. FFY **10/01/09-09/30/10 $3,000,000**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 1 to Attachment 3.1-A, Pages 1-M1 thru Page 1-M7, Attachment 4.19-B page 11(g)

**** SEE REMARKS**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Case Management Services Target Group M – First-time Mothers/Newborn

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

[redacted]
13. TYPED NAME: **Donna Frescatore**

14. TITLE: **Deputy Director**
Department of Health

15. DATE SUBMITTED:
June 30, 2009

16. RETURN TO:
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: **APR 0 8 2010**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
APR 0 1 2009

[redacted]
21. TYPED NAME:
Michael Melendez

22. TITLE: **Acting Associate Regional Administrator**
Division of Medicaid and State Operations

23. REMARKS:

Typographical and grammatical errors were corrected throughout the document. Under Definition of Services on Page 1 – M2, the citation in paragraph 2 of 18 NYCRR 505.16(c)(3), was replaced with the actual wording from that regulation and the following paragraph was added to Attachment 4.19-B (10/09):

The agency's rates were set as of May 1, 2009 and are effective for services on or after that date. All rates are published in the various program manuals and are also available upon request from the State agencies involved. Except as otherwise noted in the plan, state developed fee schedules rates are the same for both governmental and private providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

TARGETED CASE MANAGEMENT SERVICES

For First-time Mothers and Newborns

Target Group: M – First-time Mothers and their Newborns

The primary target group consists of low-income, pregnant women who will be first-time mothers and their newborn children up to each child's second birthday. A woman must be enrolled in the targeted case management program during pregnancy, as early as possible, but no later than twenty-eight weeks gestation.

The goals of this program are to improve pregnancy outcomes by providing comprehensive case management services including: 1) assessment of each woman's need for medical, education, social and other services; 2) development of a care plan for each woman with goals and activities to help the woman engage in good preventive health practices; and 3) referral, follow-up and assistance in gaining access to needed services including obtaining prenatal care, improving diets, reducing use of cigarettes, alcohol and illegal substances, improving each child's health and development and reducing quickly recurring and unintended pregnancies.

Areas of State in which services will be provided (Section 1915(g)(1) of the Act):

_____Entire State

__X__ **Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide):**

New York City and Monroe County

Comparability of Services (Sections 1902(a)(10)(B) and 1915(g)(1))

_____Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

__X__Services are not comparable in amount, duration, and scope. (Section 1915(g)(1)). By enrolling in this targeted case management program, first-time mothers and their newborns will be receiving comprehensive case management services that are not comparable to the amount, duration and scope of services provided to all Medicaid eligible pregnant women.

Definition of Services (42 CFR 440.169):

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. This targeted case management program for first-time mothers and their newborns offers a comprehensive set of case management services through home visits by trained registered nurses. Case management services provided include the following:

1. Comprehensive assessment and periodic reassessment of the first-time pregnant woman and her newborn to determine the need for medical, educational, social or other services. These assessment activities include:
   a) taking the woman's history and assessing her risk for poor birth outcomes;
   b) identifying the needs of the first-time mother and her newborn and completing related documentation; gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment.

2. Development (and periodic revision) of a specific care plan. A care plan will be developed based on the comprehensive assessment conducted of the first-time mother. A written care plan must be completed by the case manager within 30 days of the date of the woman's referral to the targeted case management program and must include, but not be limited to, the following activities:

   i. Identification of the nature, amount, frequency and duration and cost of the case management services required by a particular recipient;
   ii. Selection of the long-term and short-term goals to be achieved through the case management process;

iii. Specification of the long-term and short–term goals to be achieved through the case management process;

iv. Collaboration with health care and other formal and informal service providers, including discharge planners and other case managers as appropriate, through case conferences to encourage exchange of clinical information and to assure:
   a. the integration of clinical care plans throughout the case management process;
   b. the continuity of service;
   c. the avoidance of duplication of services (including case management services) and
   d. the establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational and financial needs of the recipient.

The care plan will state:

a) goals and actions to address the medical, social, educational, and other services needed by the woman and child;
b) activities to ensure the active participation of the first-time mother (or the woman's authorized health care decision maker) and others to develop the goals;
c) a course of action identified to respond to the assessed needs of the first-time mother and child; and
d) an agreed upon schedule for re-evaluating goals and course of action.

The plan will be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six (6) months subsequent to the initial plan. Each time the care plan is reviewed, the goals established in the initial plan will either be maintained or revised, and new goals and time frames established.

3. Referral and related activities (such as scheduling appointments for the mother and child) to help the first-time mother and newborn obtain needed services including:

a) activities that help link the mother and child with medical, social, educational providers or other program and services in the community that are capable of providing needed services to address identified needs, and achieve goals as specified in the care plan.

4. Monitoring and follow-up activities

Monitoring and follow-up activities may be with the first-time mother, other family members or providers. Home visits and other contacts that are necessary to ensure that the care plan is implemented and adequately addresses the mother and newborn's needs will be conducted as frequently as necessary, or at least bi-weekly to determine whether the following conditions are met:

- services are being furnished in accordance with the care plan;

- services in the care plan are adequate and

- if there are changes in the needs or status of the woman and/or her child, then, necessary adjustments in the care plan and service arrangements with providers are made.

__X__ Case management includes contacts with non-eligible individuals (such as the newborn's father) who are directly related to identifying the needs and care, for the purposes of helping the first-time mother and her child access services; identifying needs and supports to assist the mother and child in obtaining services; providing case managers with useful feedback and altering case managers to changes in the mother or child's needs (42 CFR 440.169(e)).

Qualifications of Providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

1. Provider Agencies

Providers of targeted case management to first-time mothers and their children in the target groups may be public or private agencies and organizations, whether operated on a profit-making or not-for profit basis.

Case management services may be provided by agencies, facilities, persons and other groups possessing the capability to provide services that are approved by the Commissioner of New York State Department of Health (DOH), the single state Medicaid agency, based upon an approved proposal submitted to the New York State DOH. Providers may include:

a) facilities licensed or certified under New York State law or regulation as Licensed Home Care Services Agencies (LHCSA) or Certified Home Health Agencies (CHHA);

b) a county health department, including the health department of the City of New York.

2. Case Managers

Case managers must have the education, experience, training and/or knowledge in the areas necessary to conduct case management services including: assess the needs and capabilities of the pregnant or parenting woman and her child; develop a care plan based on the assessment; assist the first-time mother/child in obtaining access to medical, social, education and other services; make referrals to medical, social, educational and other providers; and monitor activities to ensure that the care plan is effectively implemented and addresses the assessed needs. Case managers under this program are required to be registered nurses with BSN degrees; and be licensed as professional nurses with the New York State Department of Education. Certification by a nationally-recognized organization, with an evidence-based program in nurse home visits and case management for high risk, first-time mothers and their newborn is preferred.

Case managers in this targeted case management program will meet or exceed the standards set by the single State Medicaid Agency. The case manager must have two years experience in a substantial number of case management activities. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis.

The two years of experience may be substituted by:

a) one year of case management experience and a degree in a health or human services field;

b) one year case management experience and an additional year of experience in other activities with the target population; or

c) a bachelor's or master's degree which includes a practical encompassing a substantial number of activities with the target population.

As a single state Medicaid agency, criteria for case managers is stated in Administrative Directive 89 ADM-29 for case management provider entities and case management staff under section D entitled Provider Qualifications and Participation Standards.

Freedom of Choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case managements services within the specified geographic area identified in this plan.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception (Section 1915(g)(1) and 42 CFR 441.18(b)):

___ Target group consists of eligible individuals with development disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

-Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;

-Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

-Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management services under the plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

Case management providers are paid on a unit-of-service basis that does not exceed 15 minutes. A detailed description of the reimbursement methodology identifying the data used to develop the rate is included in Attachment 4.19B.

Case Records (42 CFR.18(a)(7)):

Providers maintain case records that document for all recipients receiving targeted case management services as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of 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) The timeline for obtaining needed services; and (viii) A timeline for reevaluation of the plan.

Limitations

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in Section 441.169 when the case management activities are an integral and inseparable component of another Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial participation (FFP) is not available in expenditures for, services defined in Section 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)). First-time mothers who are in foster care or under the jurisdiction of the juvenile justice system or the criminal justice system will not be eligible for targeted case management services under this program.

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social educational or other program except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Act. (Sections 1902(a)(25) and 1905(c)).

Case Management Target Group M Method of Reimbursement:

Rate Methodology for Targeted Case Management Services for First-time Mothers/Newborns

Visit-based rates have been calculated for Targeted Case Management services for the First-Time Mothers/Newborn Program. The rates will allow for costs of nurses, supervisors, fringe benefits and overhead related to providing targeted case management services only. Rates are based on a two and one-half year program cycle. The maximum length of a visit is sixty-six minutes and is billed in fifteen-minute increments with a maximum of two-hundred and sixty increments.

Allowable nursing and nursing supervisor salaries are determined based on a time study and an analysis of registered nurses' salaries in the counties in the state that will be providing targeted case management services. The allowable number of supervisors for reimbursement purposes is based on a time study and is to not exceed one supervisor per seven nurses. The allowable number of nurses for reimbursement purposes is based on a time study and is to not exceed one nurse per 24 clients. Fringe benefits are capped at thirty percent (30%) of salaries of agency nurses and supervisors, and agency overhead is capped at twenty-five (25%) of agency nurse and supervisor salaries and fringe benefits.

The total percentage of fringe costs is calculated by dividing the fringe benefit amount by the total amount of agency nurse and supervisor salaries and is capped at 30% of the salaries of agency nurses and supervisors. The total percentage of agency overhead costs is calculated by adding the totals of all other agency administrative and overhead costs (agency costs exclusive of nurse salaries, supervisor salaries and fringe benefits), and then dividing this amount by the total of agency nurses and supervisors salaries and allowable fringe benefit expenditures and is capped at 25% of the allowable salaries and fringe benefits of agency nurses and supervisors.

Hourly rates are calculated by dividing total allowable agency expenditures by the total number of nurse-hours in one year. This amount is divided by four (4) to determine the 15-minute incremental unit-of-service in which the visit will be billed.

The agency's rates were set as of May 1, 2009 and are effective for services on or after that date. All rates are published in the various program manuals and are also available upon request from the State agencies involved. Except as otherwise noted in the plan, state developed fee schedules rates are the same for both governmental and private providers.