



Refer to DMCH: SJ

Region II  
Federal Building  
26 Federal Plaza  
New York, N.Y. 10278

**AUG 25 2011**

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

Dear Commissioner Helgeson:

This is to notify you that New York State Plan Amendment (SPA) #11-50 has been approved for adoption into the State Medicaid Plan with an effective date of April 1, 2011. The SPA proposes to control certified home health agency (CHHA) utilization by implementing provider specific aggregate annual spending caps, for the period April 1, 2011 through March 31, 2012.

This SPA approval consists of 3 Pages. As New York has requested, we are approving the following Attachment 4.19B Pages which were submitted by the State via electronic transmission on June 24, 2011 to CMS: Attachment 4.19-B-Page 4(3), 4(4) and 4(5). These Pages replace the Attachment 4.19-B-Pages 4(3), 4(4), and 4(5), which were provided with the State's original June 10, 2011 SPA submission. In addition, we are approving the State's request of July 14, 2011 to withdraw Attachment 4.19-B-Page 4(a), which was provided with the original submission but is now no longer required. Finally, we are processing the SPA using the HCFA-179 which was provided by the State to CMS on July 14, 2011.

CMS is approving this SPA; however, due to concerns regarding potential problems with access to care, CMS will continue to inquire about and follow-up on the State's planned efforts to monitor access to care to determine whether there has been negative impact on the program due to this and other rate and program changes. We thank the State in advance for working with CMS on this issue.

This amendment satisfies all of the statutory requirements at sections 1902(a)(13) and (a)(30) of the Social Security Act, and the implementing regulations at 42 CFR 447.250 and 447.272. Enclosed are copies of SPA #11-50 and the HCFA-179 form, as approved.

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

Enclosure: SPA #11-50  
HCFA-179 Form

CC: Julberg  
PMossman  
KKnuth  
RWeaver  
LTavener  
MSchervish  
SFuentes  
MSamuel  
SJew



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**AUG 25 2011**

Jason A. Helgeson  
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 in conjunction with the Centers for Medicare & Medicaid Services' (CMS) approval of New York State Plan Amendment (SPA) #11-50, which amendment enables the State to control certified home health agency (CHHA) utilization by implementing provider specific aggregate annual spending caps, for the period April 1, 2011 through March 31, 2012.

In reviewing SPA 11-50, CMS staff performed a program analysis of the corresponding services and a reimbursement analysis related to the services impacted by the provisions of the SPA. These analyses revealed coverage issues which the State needs to address through State plan amendments in order to meet the requirements of Section 1902 of the Social Security Act. To this end, CMS welcomes the opportunity to work with you and with your staff in resolving the concerns outlined below.

In discussions New York, the State has advised that it wishes to address the corresponding home health related questions in NY 11-50 when the State addresses the home health questions from the companion letter issued in NY 10-38. We are including the questions from the companion letter below as a convenience to the State when it submits its response to the companion letter and to the additional questions in 11-50.

Questions from the Companion Letter issued in NY 10-38

The regulations at 42 CFR 440.70 define 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 and 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 include in the State plan any limitations on amount, duration or scope of PT, OT and Speech Pathology services.
10. 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.
11. 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 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”.
12. 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.
13. 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.

Corresponding coverage questions in NY 11-50


1. Please describe an “AIDS home care program” and a “long term home health care program”. Are any of these programs part of a hospital, nursing facility or ICF?
2. Please explain why the registered professional nurse must be licensed and currently registered as a registered professional nurse pursuant to the New York Education Law.
3. Please confirm our understanding that the telehealth services are not separate services from part-time/intermittent nursing services, but only a different service delivery mode for part-time/intermittent nursing services under the home health services benefit. If this is correct, please reflect this understanding in the description of the telehealth

services. If there are limitations on the amount, duration or scope of part-time/intermittent nursing services, will the telehealth services “count” against any limitation on amount or duration? For example, would it be considered a “visit” if the “visits” by a nurse were limited to 12 in a year?

4. We are attaching a copy of the CMS (then HCFA) September 4, 1998 guidance related to the DeSario v. Thomas decision to be sure the State is aware of it. In keeping with the guidance, does the State have a process in place to allow beneficiaries to request medical equipment, supplies and appliances not on the State’s approved list? If so, does the State’s process include notification of the right to a fair hearing if the request is denied?
5. If the State allows assistants or aides, such as PT Assistants, to furnish therapies, please add them to the State plan along with a brief description of the State’s arrangements for how they work “under the direction of” the qualified therapist.
6. Does the State require that Physical Therapists are graduates of a program of physical therapy approved by the Commission on Accreditation in Physical Therapy Education (CAPTE)?
7. Please explain why the State requires that the PT is “licensed by and currently registered with the New York State Education Department” or “has been issued a valid limited permit by that Department”.
8. Please explain why the State requires that the Speech Pathologist is “licensed as required by Article 159 of the New York Education Law”.


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,

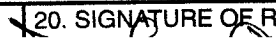


Michael Melendez  
Associate Regional Administrator  
Division of Medicaid and Children’s Health

CC: JUlberg  
PMossman  
KKnuth  
RWeaver  
LTavener  
MSchervish  
SFuentes  
MSamuel  
SJew

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: #11-50	2. STATE New York
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: <b>TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)</b>	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE April 1, 2011	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Section 1902(a) of the Social Security Act, and 42 CFR 447		7. FEDERAL BUDGET IMPACT: a. FFY 04/01/11 - 09/30/11 (\$53.44 million) b. FFY 10/01/11 - 09/30/12 (\$50.00 million)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B: Pages (3), 4(4), 4(5)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):	
10. SUBJECT OF AMENDMENT: Control CHHA Utilization by Implementing Provider Specific Aggregate Annual Spending Caps (FMAP = 56.88% 4/1/11-6/30/11; 50% 7/1/11 forward)			
11. GOVERNOR'S REVIEW (Check One): <input checked="" type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: New York State Department of Health Corning Tower Empire State Plaza Albany, New York 12237	
13. TYPED NAME: Jason Helgerson			
14. TITLE: Medicaid Director & Deputy Commissioner Department of Health			
15. DATE SUBMITTED: July 14, 2011			

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED	18. DATE APPROVED AUG 25 2011
<b>PLAN APPROVED - ONE COPY ATTACHED</b>	
19. EFFECTIVE DATE OF APPROVED MATERIAL APR 01 2011	20. SIGNATURE OF REGIONAL OFFICIAL 
21. TYPED NAME Michael Melendez	22. TITLE Associate Regional Administrator Division of Medicaid and State Operations

23. REMARKS

Approved as submitted



**OFFICIAL**

New York  
4(4)

Attachment 4.19-B  
(04/11)

- (3) Based on the average wages as determined pursuant to this subdivision, as weighted pursuant to this subdivision, an index will be determined for each region, based on a comparison of the weighted average regional wages to the statewide average wages.
- (4) The Department will adjust the regional WIFs proportionately, if necessary, to assure that the application of the WIFs is revenue-neutral on a statewide basis.
- (d) Agency specific case mix indexes (CMIs) will be calculated for each agency and applied to the statewide average CMI. Computation of such CMIs will utilize the episodic payment system group per and will reflect:
- (1) 2009 adjusted agency Medicaid claims as grouped into 60 day episodes of patient care;
  - (2) data for each agency patient as derived from the federal Outcome Assessment Information Set (OASIS) and as reflecting the assignment of such patients to OASIS resource groups;
  - (3) the assignment of a relative weight to each OASIS resource group;
  - (4) the assignment of each agency's CMI index based on the sum of the weights for all of its grouped episodes of care divided by the number of episodes.
- (e) Ceiling limitations determined pursuant to this section will be subject to retroactive adjustment and reconciliation. In determining payment adjustments based on such reconciliation, adjusted agency ceilings will be established. Such adjusted ceilings will be based on a blend of:
- (1) an agency's 2009 average per patient Medicaid claims adjusted by the percentage of increase or decrease in such agency's patient case mix from the 2009 calendar year to the annual period April 1, 2011 through March 31, 2012, weighted at 51 percent, and;
  - (2) the 2009 statewide average per-patient Medicaid claims adjusted by a regional WIF and the agency's patient case mix index for the annual period April 1, 2011 through March 31, 2012, weighted at 49 percent. Such adjusted agency ceiling will be compared to actual Medicaid paid claims for the period April 1, 2011 through March 31, 2012. In those instances when an agency's actual per-patient Medicaid claims are determined to exceed the agency's adjusted ceiling, the amount of such excess will be due from each

TN    #11-50     
Supersedes TN   NEW  

Approval Date           APR 25 7:00            
Effective Date           APR 01 2011          

**New**

**OFFICIAL**

New York  
4(5)

Attachment 4.19-B  
(04/11)

such agency to the state and will be recouped by the Department in a lump sum amount or through reductions in the Medicaid payments due to the agency. In those instances where an interim payment adjustment was applied to an agency, and such agency's actual per-patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling will be remitted to each such agency by the Department in a lump sum amount or through an increase in the Medicaid payments due to the agency.

- (f) Interim payment adjustments pursuant to this section will be based on Medicaid paid claims for services provided by agencies in the base year 2009. Amounts due from reconciling payment adjustments will be based on Medicaid paid claims for services provided by agencies in the base year 2009 and Medicaid paid claims for services provided by agencies in the reconciliation period April 1, 2011 through March 31, 2012.
- (g) The payment adjustments will not result in an aggregate annual decrease in Medicaid payments to providers in excess of \$200 million. If upon reconciliation it is determined that application of the calculated ceilings would result in an aggregate annual decrease of more than \$200 million, all providers' ceilings would be adjusted proportionately to reduce the decrease to \$200 million. Such reconciliation will not be subject to subsequent adjustment.
- (h) The Commissioner may require agencies to collect and submit any data required to implement the provisions of this subdivision.

TN #11-50

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Supersedes TN NEW

Effective Date APR 01 2011

**New**

**OFFICIAL**

**New York  
4(3)**

**Attachment 4.19-B  
(04/11)**

**Certified home health care agency ceilings.**

(a) Effective for services provided on and after April 1, 2011 through March 31, 2012, Medicaid payments for certified home health care agencies (agencies), except for such services provided to children under eighteen years of age, shall reflect ceiling limitations determined in accordance with this section. Ceilings for each agency shall be based on a blend of:

- (1) the agency's 2009 average per patient Medicaid claims, weighted at 51 percent, and
- (2) the 2009 statewide average per patient Medicaid claims for all agencies, as adjusted by the regional wage index factor and by each agency's patient case mix index, and weighted at 49 percent.

(b) Effective for rate periods on and after April 1, 2011, the Department shall determine, based on 2009 claims data, each agency's projected average per patient Medicaid claim for the period April 1, 2011 through March 31, 2012, as compared to the applicable ceiling, computed pursuant to this section. To the extent that each agency's projected average claim exceeds such ceiling, the Department shall reduce such agency's payments for periods on and after April 1, 2011 by the amount that exceeds such ceiling.

(c) The regional wage index factor (WIF) will be computed in accordance with the following and applied to the portion of the statewide average per-patient Medicaid claim attributable to labor costs:

- (1) Average wages will be determined for agency service occupations for each of the 10 labor market regions as defined by the New York State Department of Labor.
- (2) The average wages in each region will be assigned relative weights in proportion to the Medicaid utilization for each of the agency service categories as reported in the most recently available agency cost report submissions.

TN #11-50

Approval Date AUG 25 2011

Supersedes TN NEW

Effective Date APR 01 2011

**New**