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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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(14)

Division of Medicaid and Children's Health Operations/Boston Regional Office

December 22, 2010

Brenda M. Harvey, Commissioner
Department of Health and Human Services
11 State House Station
Commissioner's Office
Augusta, Maine 04333-0011

Dear Commissioner Harvey:

We have completed our review of proposed State plan amendment (SPA) No. 10-013 and find that we cannot approve it at the present time. We need additional information concerning several issues before we can make a final decision. Please provide the additional information as discussed below.

SPA 10-013, received September 23, 2010, transmitted a proposed amendment to your Department's approved Title XIX State plan to provide more information and details regarding coverage of services for categorically needy recipients. You requested an effective date of September 1, 2010.

Below you will find our questions and comments regarding this SPA. As you know, CMS regional office staff and subject matter experts drafted informal questions and comments which were sent to the State earlier this fall. Please note that many of the below-listed questions and comments are responsive to the State's answers to those informal comments and questions.

General Questions and Comments

1. The SPA's pagination does not correspond with that listed on the Transmittal Form (the 179):
    a. Number 8 on the 179 suggests that the SPA's page numbers are "5a, 5b" but the submitted SPA is paginated as "5b", "5b (i)" and 5b (iii).
    b. Please correct this pagination (i.e. "5a," "5b," "5c," etc) and provide the accurate pages numbers on the 179.
2. The 179 suggests that the new pages supersede "Attachment 3.1-A (TBA)"; this is an error—the pages aren't TBA if they are being replaced. Please revise.

3. The SPA has no identifying information in the footer section. Please revise to reflect the proper SPA page format with the TN#, the superseding TN# (04-011), and the effective date. Additionally, please include a blank section in the middle for the approval date.

Coverage Questions and Comments

1. We have reviewed the State's changes to Supplement 1 to Attachment 3.1A, pages 5 & 6, item 13a Diagnostic Services; the changes regarding one time lead investigations are acceptable. However, please correct the typographical error in the third sentence: please add an "a" to make the word "available" instead of "vailable."
2. We have reviewed the State's changes to Supplement 1 to Attachment 3.1A, pages 5 & 6, item 13c—Preventative Services; please add a website or a reference to where the Bright Future guidelines can be found.
3. We note that the State's answers to our informal question #2 are organized according to the type of PNMI. The CMS, however, reimburses for services furnished in the facility not the facility itself. Accordingly, please set forth in the State plan each rehabilitative service, such as individual therapy, behavior management, medication education, etc. Next, please indicate in the State plan the particular location where that service is furnished. After that, please list each of the practitioners that will furnish each of the services. In a separate section of the State plan, please describe the qualifications that the residential facilities must meet in order to furnish rehabilitative services. Finally, please describe the qualifications that the practitioners must meet in order to furnish rehabilitative services. For the practitioners, please summarize in the State plan the State's requirements for education, training, experience, licensure, registration and certification. Please also indicate any supervisory requirements.

4. Please include in the State plan any limitations on amount, duration and scope of each of the rehabilitative services.

5. Please clarify the difference between the "Case Mixed Medical & Remedial Services" and "Non-Case Mixed Medical & Remedial Services".

6. Please confirm that the provision of food, shelter, nursing and personal care services (PCS) are not covered as rehabilitative services. If the State does furnish PCS or nursing services, please move these services to the appropriate sections of the State plan if the State intends to cover them in the residential facilities. Please delete the references to "personal care", "personal care services" staff, and "nursing" from the State plan rehabilitative services section.

7. Please more fully describe what is meant by "instrumental functioning in daily living" that is included under "Child Care Facility" and "Non-Case Mixed Medical and Remedial Facilities" in the State plan.

8. Please delete the reference to "certified interpreters" as practitioners who furnish rehabilitative services. If the State so desires, it can move "certified interpreters" to be covered under the "Other Licensed Practitioners" section of the State plan.

9. Please explain the role of "clinical consultants" and how they will furnish rehabilitative services.

10. Please note that the references to "other qualified alcohol and drug treatment staff" and "other qualified mental health staff" and "other qualified staff" are ambiguous and should be replaced with the specific practitioners qualified to furnish each of the rehabilitative services.

11. Please delete the reference to "dentists" and move to section 10 of the State plan.

12. Please explain the role of the "psychological examiner" and how they will furnish rehabilitative services.

13. Please explain why "plans of care" must be recommended by a physician.

14. Informal Question #7: The State's answer indicated that PNMIs that serve adults with mental illness and substance abuse disorders, and children with mental illness and severe emotional disorders have more than 16 beds "in some instances".

15. Please provide the number of PNMIs that have more than 16 beds.

16. Of those that have more than 16 beds, are the facilities established and maintained primarily for the care and treatment of individuals with mental diseases?

17. Please define in the State plan what is meant by "temporary high intensive services" on page 5 b(iii) of Supplement 1 to Attachment 3.1-A.

18. Please include in the State plan a description of the services entitled, "treatment foster care" and "crisis stabilization", including any component services. Please also include in the State plan the practitioners that furnish these services and their qualifications.

Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the State plan for such service.

1. Section 1903(a) (1) of the Act provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers

retain all of the Medicaid payments including the Federal and State share (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

2. Section 1902(a) (2) of the Act provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the State share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the State share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), CPEs, provider taxes, or any other mechanism used by the State to provide State share. Note that, if the appropriation is not to the Medicaid agency, the source of the State share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal shares is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the State agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   (i) A complete list of the names of entities transferring or certifying funds;
   (ii) The operational nature of the entity (State, county, city, other);
   (iii) The total amounts transferred or certified by each entity;
   (iv) Clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) Whether the certifying or transferring entity received appropriations (identify level of appropriations).

3. Section 1902(a) (30) of the Act requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) of the Act provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-State government owned or operated, and privately owned or operated).

5. Does any public provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

In accordance with the State Medicaid Director letter dated January 2, 2001, we request that you provide a formal response to this RAI no later than March 22, 2010. If you do not provide us with a formal response by that date, we will conclude that the State has not established that this proposed SPA is consistent with all statutory and regulatory requirements. Thus, we will have no alternative but to initiate disapproval action.

In addition, because this amendment was submitted after January 2, 2001, and is effective on or after January 1, 2001, please be advised that we will continue to defer FFP for State payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date of actual approval.

This RAI is made pursuant to §1915(f) (2) of the Act. This section requires action on a SPA within 90 days unless we request additional information necessary to make a final determination. A second 90-day period will begin when we receive your response to this request.

Please contact Kathryn Holt at 617/565-1246 or via email at kathryn.holt@cms.hhs.gov if you have any questions.

Sincerely,

Richard R McGreal

Richard R. McGreal
Associate Regional Administrator

Enclosure

cc: Tony Marple