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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

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. 10-016 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 10-016, 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 personal care services. You requested an effective date of September 1, 2010.

Below you will find our questions and comments regarding this SPA.

General Questions

1. As submitted, the SPA currently is paginated as "Attachment 3.1-A Page 9," "Attachment 3.1-A Page 10a," and then numerous "Attachment 3.1-A Page 10"; this is incorrect and confusing.
    a. We suggest paginating this SPA in numerical order, starting with "Attachment 3.1-A Page 9" and then "Attachment 3.1-A Page 10(a)," "Attachment 3.1-A Page 10(b)", "Attachment 3.1-A Page 10(c)," etc.
    b. Please be sure to correct the pagination on the Transmittal form, #8 to reflect these changes and include the range of pages found in this SPA
2. Please note that the SPA pages have erroneous footers: the TN number, superseding SPA number, effective dates are wrong on many of the submitted pages. Please correct.

Coverage Questions and Comments

1. The plan language indicates Home Health nursing and aide services will count towards the service cap of personal care services. Reducing the amount of one service because of the use of another service does not comply with the comparability requirement found at 42 CFR 440.240.
    a. Please remove the requirement that Home Health nursing and aide services count towards the service cap of personal care services.

2. The plan language says individuals under the age of 21 may be eligible for any level of PCA services. Individuals over the 21 years of may be eligible for only the "at risk" level of the "extended level services". In its response to informal questions on December 2, 2010, the State advised that there are nine levels-level of care for PCA services. However it is still unclear which level(s) is considered "at risk". Furthermore, please explain "extended level services."

3. The plan language indicates that PCS services provided by an agency may be provided "outside the home setting, as authorized in the plan of care for services in a group setting such as a PNMI".
    a. Please clarify if PCA services provided by an agency provider may only be provided in the home or a residential group setting? Can an individual receive these services in another setting outside the home, such as at school?

4. It is CMS' understanding that individuals receiving PCA services under the consumer directed model may receive such services anywhere outside the home setting if authorized by the plan of care. Is this a correct understanding?

5. The plan page referenced a "CAN registry". What does CAN stand for?

6. An Institution for Mental Diseases (IMD) is defined at 42 CFR 435.1010 as a facility of more than 16 beds that is primarily engaged in providing treatment services for individuals diagnosed with mental illness. FFP is not available for services for any individual age 21-64 who is a patient in an IMD.

    a. In its response to informal questions on December 2, 2010, the state advised that Substance Abuse facilities could have more than 16 beds, and currently, some facilities have as much as 41 beds. Section 4390 of the State Medicaid Manual, indicates that alcoholism and other chemical dependency syndromes are considered mental disorders. It appears as though Substance Abuse Facilities may meet the definition of an IMD. Additionally, depending on the services provided, Case Mix facilities may also meet the definition of an IMD. CMS requests further discussion with the state to understand the overall character of the facilities.

7. What does ASA stand for?

8. In its response to informal questions on December 2, 2010, the state submitted revised plan pages describing the various components of supportive services provided to individuals who choose to self-direct personal care services. Please clarify if the State claims FFP for the supportive services under the personal care benefit.

9. If the codes referenced in the plan pages are State codes, please revise the plan language to make this clear. If these are not State codes, please explain what codes these are.

10. It is unclear what Appendix A is. Please explain.

11. Please clarify which of the service limits on this page only apply to consumer directed personal care services.

12. Please add the following language to the limitation section: "For individuals qualifying under EPSDT, the service caps may be exceeded if services are determined medically necessary."

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) 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.)

3. Section 1902(a)(2) 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, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the State to provide State share. Please provide an estimate of

total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share 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 government 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) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation (FFP) 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 request for additional information (RAI) no later than March 22, 2011. 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.

Should you have questions, please contact Kathryn Holt at 617/565-1246 or via email at kathryn.holt@cms.hhs.gov.

Sincerely,

Richard R. McGreal

Richard R. McGreal
Associate Regional Administrator

cc: Tony Marple, Director, Office of MaineCare Services