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ME 10-16: Personal Care Services

CMS REVIEW OF MAINE'S REPONSES TO FORMAL RAI

A. General Comments and Questions

1. Please amend the TN number for Supplement 1 to Attachment 4.19-B Page 5
   a. Replace 10-017 with 10-016
2. Please amend the 179 to reflect that Supplement 1 to Attachment 4.19B Page 5 is included in this SPA

B. Coverage Questions and Comments

Page 10(b)

1. Please verify if the levels of care/need (Levels I – III, V – 9) are used to determine the service cap. If yes, please revise the plan page to specify the number of hours an individual may receive for each level.

2. The 1st paragraph specifies that services provided by home health aides and certified nursing aides are delegated and the supervised by a registered nurse. This information is repeated in the 2nd paragraph; however, the certified nursing aide is omitted. For consistency, please reconcile.

Page 10(c)

3. The state revised the 1st paragraph to remove "registered nurse" and replaced this language with "as designated in rule". Please revise the language to make it clear what the new language means.

4. 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.

   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. In the Request for Additional Information (RAI) dated March 11, 2011, CMS advised the State that as described in section 4390 of the State Medicaid Manual, alcoholism and other chemical dependency syndromes are considered mental disorders. In its response to the RAI, the State maintains that Substance Abuse Facilities do not meet the definition of an IMD. Please explain the rationale for believing Substance Abuse Facilities do not meet the definition of an IMD.

5. The state included provider qualifications for the individuals who are allowed to provide PCA services in a PNMI setting. The terms used for these individuals (qualified medical and remedial services facility staff) and the providers qualifications listed are very broad. It is

difficult to understand who the practitioners are and what the specific qualifications, such as type of education or training, are. Please revise the language to identify the type of practitioners that are considered qualified medical and remedial services staff and provide detailed information for education, training and experience these individuals must have as it related to the provision of PCA services. Additionally, please describe "specified functions".

6. The plan page indicates "qualified mental health staff" may provide PCA services. Please explain which PNMIs have qualified mental health staff.

Page 10(d)

7. The plan specifies the settings in which consumer directed personal care may not be provided. Can traditional (non-consumer directed) personal care services be provided in these setting? If the settings are the same, please reconcile and have these limits apply to all in-home PCA settings.

8. The plan language also specifies that individuals receiving Private Duty Nursing/Personal Care Services may not receive PCA services. Private Duty Nursing services (which may only be provided by a registered nurse or licensed practical nurse) are considered skilled services and PCA services are not. Please explain if the State is providing PCA services as a component of Private Duty Nursing.

9. The plan language also specifies that individuals receiving Home and Community based benefits, and Home Based Care Services may not receive consumer directed personal care. Please clarify if these are HCBS waiver programs.

Page 10(e)

10. Please clarify if Care Coordination Services and Skills training services are being billed as administrative services.

11. Are all of the services described in "C" also provided under traditional (non-consumer directed) services?

Page 10(g)

12. Per the plan page, consumer direction of PCA services is only available to individuals with levels 1 through 3. Please explain the rationale for limiting consumer direction to individuals with levels 1 through 3.

13. The plan page indicates Registered Nurses, Registered Occupational Therapist, certified Occupational Therapy Assistant and an attendant may provided consumer directed personal

care services. Please clarify if these individuals can provide all components of self direction PCA.

Page 10(h)

14. The plan page indicates a certified home health aide must have satisfactory completed a training program for a certified nurse assistant. Please clarify if home health aides must only complete the training or are they also required to be a certified nursing assistant.

15. The plan page states home health aides employed by a home health agency must have completed an agency orientation as defined by regulations governing licensure of home health care services. (1) Please clarify what agency orientation if being referenced (state agency, or the employer agency). (2) Are there Home health aides who are not employed by a home health agency and who work independently?

C. 4.19B Page

1. The TN number at the bottom of the page refers to a SPA which was withdrawn by the State. Please correct the transmittal number to accurately reflect the correct SPA for this reimbursement methodology.
2. Subparagraph 12 (a), Ambulance Services: Please include the full standard fee schedule language for this service, including the stipulation that private and governmental providers are paid the same rate. Also, please include the effective date of the fee schedule;
3. Subparagraph 12 (d)(1), please remove the language describing the cap on reimbursements; this language belongs in Section 3.1-A of the State plan. Also, please remove the reference to the MaineCare Benefits Manual and provide the standard fee schedule language including the statement that private and governmental providers are paid the same amount and, the effective date of the fee schedule.
4. Subparagraph 12 (d)(2): FFP is not available when the State includes personal care attendant (PCA) services as part of a bundle of services provided to beneficiaries in a private non-medical institution (PNMI). A bundled payment exists when a State makes a single payment for one or more of a group of different services furnished to an individual during a fixed period of time. The payment is the same regardless of the number of units of service, types of service or level of practitioners providing the service or the specific costs, or otherwise available rates, of those services. CMS has identified that bundled payments may violate two provisions of the Social Security Act: 1902(a)(30)(A) and 1902(a)(32).

D. Other Reimbursement Comments

1. 1902(a)(30)(A) requires that payments for services are economic and efficient. Generally, bundled payments are not economic and efficient because they can be made for services that may or may not actually be rendered to the beneficiary or for services that may not be covered by Medicaid.

2. 1902(a)(32) requires direct payment to the provider of the service. Many providers receiving bundled payments for rehabilitative services are not individual practitioners (e.g. residential treatment centers).

However, with the exception of outpatient hospital and clinic services, the only providers recognized in statute to provide non-institutional statutory services [i.e. those listed in 1905(a)] and be eligible for payment are individual practitioners.

3. It appears as though payments to PNMIs are bundled. CMS expects that States will develop bundled rates based upon actual service data maintained by providers. Therefore, Maine must ensure that PNMIs maintain data that supports a conclusion that the rate developed by MaineCare is economic and efficient. That data normally consists of information showing the provision by practitioner of the individual **covered** Medicaid services included in the bundled payment and the cost by practitioner and type of service actually delivered under the bundled rate. Maine must describe the development of the rate in the State plan. Costs related to room and board and other unallowable costs must clearly be excluded.

4. Additionally, 42 CFR 431.107 requires that each provider or organization furnishing services agree to keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Medicaid agency any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. The State Medicaid Manual in Section 2500.2(A) requires that a State Medicaid agency report "only expenditures for which all supporting documentation is available, in readily reviewable form, which has been compiled and which is immediately available when the claim is filed" on the CMS-64. This section continues by stating that "... supporting documentation includes as a minimum the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent or units of service; and the place of service." In accordance with these requirements, Maine must include language in the State plan identifying the data to be maintained by providers and must assure that the State will review that data in order to develop and revise as necessary, an economic and efficient rate.

5. Include in the State plan a description of the State's proposal for monitoring the provision of services paid under a bundled rate to ensure that beneficiaries receive the types, quantity and intensity of services required to meet their medical needs.