

TO: All Local District Commissioners, Medicaid Directors, Care At Home Coordinators

FROM: Mark L. Kissinger, Deputy Commissioner
Office of Long Term Care

SUBJECT: Increase for CAH I & II Monthly Budget Caps, Change in Assessment Interval and Change in Application Cover Sheet (Attachment)

EFFECTIVE DATE: Immediate

CONTACT PERSON: Bureau of Maternal Child Health
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The purpose of this GIS is to notify local districts of three changes related to administration of the Care At Home (CAH) Programs; the monthly budget caps are increased; the length of time between home assessments is increased; and the application coversheet has been revised to include a nursing prior approval reminder.

The monthly Medicaid budget cap for children enrolled in CAH I is increased from \$9,000 to \$16,000 a month and for CAH II the cap is increased from \$14,500 to \$19,500 a month. The increases are effective January 1, 2007. These increases are being made to accommodate the medically fragile nursing rate increases which will be retroactive to January 1, 2007. The budget caps for the OMRDD CAH waivers III, IV and VI are increased to \$16,000.

To enable better coordination with the home assessments required for prior approval of private duty nursing, as of April 1, 2007, Care At Home re-assessments will be required to be completed every six months instead of every 120 days (four months). The Plan of Care continues to be required every 180 days (six months) and the Pediatric Peer Review Instrument (PPRI) will continue to be completed yearly.

The Application Cover Sheet was updated; we have added a section for "Prior Approval" and "Nursing Providers" which can be found under Section 6A (copy attached).

**MEDICAID WAIVERS - CARE AT HOME PROGRAM
For Physically Disabled Children**

APPLICATION COVER SHEET

(To be completed for **new** applications only.)

Client Name: _____	District: _____
SSN: _____ CIN: _____	CAH I: _____ CAH II: _____
Date of Application: _____	

(1-5) LDSS obtains (County CAH Coordinator or designee). To be obtained and evaluated before involving case manager.

- 1. _____ Application Form Signed by Parent
- 2. _____ Proof of Medicaid Ineligibility
- 3. _____ Proof of Age/Birth Certificate
- 4. _____ Proof of Physical Disability

D.O.B.: _____

_____ DSS-639 Expiration Date: _____ Group I _____
Group II _____

Disability Listing(s):

- 5. _____ Verification of Length of Institutional Stay (e.g., Inpatient Bill; Insurance Statement) from Hospital on letterhead, explanation of benefits from Insurance Company. Also, must list admission and discharge dates.

(6 & 7) Assessing Nurse-from CASA, CHHA, Public Health, VNA or acceptable other. Visit done by nurse and case manager, when possible.

- 6. _____ Pediatric Patient Review Instrument
- 7. _____ Plan of Care (P.O.C.)
- _____ Path
- _____ Home Assessment Abstract
- _____ Fastep
- _____ MAA-CN-1-8
- 6A. For Private Duty Nursing has the following been identified:
 - _____ Nursing Provider(s)
 - _____ Prior Approval

(8 & 9) Case Manager

- 8. _____ M.D. orders
- 9. _____ Budget Sheet

(10) CAH Coordinator, DDSO or Private CAH - CM

- 10. _____ Case Manager: _____ / (_____) _____
Telephone Number
(_____) _____
Fax Number

- 11. _____ Other: Specify: _____