DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202

Division of Medicaid & Children's Health, Region VI

June 13, 2011

Our Reference: SPA-NM-11-01

Ms. Julie Weinberg, Division Director
New Mexico Human Services Department
Medical Assistance Division
Post Office Box 2348
Santa Fe, New Mexico 87504-2348

Dear Ms. Weinberg:

This letter is being sent as a companion to our approval of New Mexico SPA TN 11-01 which amends the reimbursement methodology for durable medical equipment items not included in the established fee schedule. The State currently reimburses these items at the invoice cost plus a percentage. This SPA reduces the percentage allowed above the invoice price by 5 percent. This SPA also addresses issues raised in the companion letter for New Mexico SPA TN 10-08.

CMS reviewed the submitted reimbursement methodology and the corresponding coverage pages for clinical diagnostic laboratory services, home health-Durable Medical Equipment (DME), eyeglasses, dentures and prosthetics/orthotics. Based on that review, we have determined that these reimbursement methodologies and coverage pages, as currently described in the State plan, do not meet Medicaid statutory and regulatory requirements. At the State's request we are issuing a companion letter so that the State may address CMS' concerns.

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that States have methods and procedures in place to ensure payments are consistent with economy efficiency and quality of care. The overall requirement of section 1902(a) of the Act for a State plan and the specific requirement at section 1902(a)(30)(A) of the Act for methods and procedures related to payment are implemented in the Code of Federal Regulations (CFR) at 42 CFR 430.10 and 42 CFR 447.252(b). These regulations require that the State plan include a comprehensive description of the methods and standards used to set payment rates and provide a basis for Federal Financial Participation (FFP). To be comprehensive, payment methodologies should be understandable clear and unambiguous. In addition, because the plan is the basis for FFP, it is important that the plan language provide an auditable basis for determining whether payment is appropriate.

The reimbursement methodology for home health services does not meet these requirements because the language describing it is not comprehensive. Specifically, it does not include a

description of all of the required components of this service. Home health, as defined at 42 CFR 440.70, consists of required nursing services, home health aide and medical supplies. Therapy services may also be provided at the option of the State. The State has indicated in their coverage pages that the home health benefit includes nursing services, home health aide, medical supplies and therapy services. However, while the State describes the reimbursement methodology for medical supplies, including DME, the reimbursement methodology for nursing services, home health aide and therapy services are not included in Attachment 4.19-B of the State Plan. Please amend Attachment 4.19-B to include information that comprehensively describes the payment methodology for the home health benefit.

Furthermore, CMS has also identified coverage items that do not meet Medicaid statutory and regulatory requirements. Under the home health benefit, on page 11, item 7a, State Supplement A to Attachment 3.1-A, the State indicates that to be eligible for all home health services, the recipient must be determined to be "physically unable or has great difficulty leaving the home to obtain necessary medical care and treatment or that the medical need for care at home is more appropriate and cost-effective and will prevent or delay institutionalization." Unlike Medicare, Medicaid does not require that a person be "confined to the home" ("homebound") as a condition for receipt of home health services and a State cannot limit medically necessary home health services based on criteria that an individual be homebound. Medicaid only requires that an individual be determined to need home health nursing services; home health aide services; medical supplies, equipment, and appliances; or therapies. Accordingly, please revise the State plan page to remove the homebound requirement. Please also remove the word "homebound" from item 12 of the list of excluded services on page 11a.

We also request that the State confirm that it is in compliance with CMS guidance issued pursuant to the DeSario v. Thomas decision. That guidance requires that States have a process in place whereby recipients may request items of medical equipment that are not included in a State's pre-approved list. If a recipient's request for an item were denied, the guidance also requires that the recipient be informed of, and have access to, a fair hearing.

In accordance with section 1902(a)(23), all providers must be qualified to perform the services within their scope of practice. Based on our review of the therapies under item 7d of home health services, we are aware that the State allows occupational therapy assistants to work under the direction of an occupational therapist. It is unclear, however, whether the State also allows other practitioners to work under the direction of physical therapists, speech pathologists, and audiologists, and, if so, whether they are qualified. Please include in the State plan any practitioners who work "under the direction" of the therapists, their qualifications, and a brief description of the State's "under the direction" of arrangements.

Additionally, CMS reviewed the State's EPSDT language in item 4b of Attachment 3.1-A. It is not clear if the State is providing what is required under 1905(r) of the Act. Currently, the State plan does not include a statement that provides CMS with the assurance that the State will furnish any service under 1905(a) of the Act that is medically necessary regardless of whether the service is otherwise included in the Medicaid State plan. Please add a more precise statement in item 4b that provides the assurance that "under 1905(r) of the Act any limitation of services for children under age 21 may be exceeded based on medical necessity for EPSDT services."

The State has 90 days from the date of this letter, to address the issues described above. Within that period the State may submit SPAs to address the inconsistencies or submit a corrective action plan describing in detail how the State will resolve the issues identified above in a timely manner. Failure to respond will result in the initiation of a formal compliance process. During the 90 days, CMS will provide any required technical assistance. If you have any questions, please contact Suzette Seng at (214) 767-6478 or suzette.seng@cms.hhs.gov.

Sincerely,

Bill Brooks
Associate Regional Administrator

Enclosures