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State/Territory Name: New Mexico

State Plan Amendment (SPA) #: 16-0004

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

February 14, 2017

Our Reference: SPA NM 16-004

Ms. Nancy Smith-Leslie, Director
Medical Assistance Division
New Mexico Department of Human Services
P.O. Box 2348
Santa Fe, New Mexico 87504

Dear Ms. Smith-Leslie,

Enclosed is a copy of approved New Mexico State Plan Amendment (SPA) No. 16-004, with an effective date of July 1, 2016. This amendment eliminates the Primary Care Provider Enhanced Payments.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act (the Act) and the implementing Federal regulations at 42 CFR 447 Subpart C.

Because the proposed SPA would reduce or restructure provider payment rates, New Mexico is required to provide documentation in support of its determination that the payments are consistent with efficiency, economy and quality of care and sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that these services are available to the general population, as established in Section 1902(a)(30)(A) of the Act and codified in 42 CFR 447.203(b)(6) and 42 CFR 447.204. To demonstrate compliance with these requirements, the state submitted the following to the Centers for Medicare & Medicaid Services (CMS) with the proposed SPA:

1. With respect to the public process requirements at 42 CFR 447.204(a)(2), New Mexico provided documentation to show that the state considered input from beneficiaries, providers and other affected stakeholders on beneficiary access to the affected services, and the impact of the proposed rate change. The notice of rate reductions and request for public comment was published in both the Albuquerque Journal and the Las Cruces Sun News on April 30, 2016. The state notified Medicaid providers of the proposed payment reductions and requested public comment, in a Medical Assistance Program Manual Supplement sent on April 29, 2016. The state created a dedicated website and email address for accepting comment on the proposed rate reductions. The state mailed a letter on April 28, 2016, to tribal leadership, Indian Health service (IHS), and tribal health providers notifying them about the proposed reductions and

requesting their comments. Additionally, the New Mexico Human Services Department (HSD) held an open forum and comment period concerning the proposed reductions during the May 9, 2016, Medical Advisory Committee (MAC) meeting, and conducted an in-person tribal consultation on June 6, 2016, in response to requests from tribal leadership. To allow for additional time to comment after the tribal consultation, HSD extended the tribal comment timeframe to June 15, 2016. No comments were received indicating that provider participation or access would be negatively affected by the termination of primary care enhanced provider payments.

2. With respect to requirements at 42 CFR 447.204(b), New Mexico submitted an analysis of the effect of the change in payment rates on access, and an analysis of the information and concerns expressed through stakeholder input. The impact of this reimbursement change applies only to Medicaid fee-for-service (FFS) payments. Most providers of primary care for Medicaid FFS recipients, including outpatient IHS and other tribal health care facilities, FQHCs and Rural Health Clinics, were ineligible for enhanced primary payments under federal rules because most services are paid Office of Management and Budget or other encounter rates. Therefore, the impact on beneficiary utilization is projected to be minimal. HSD conducted an analysis of the primary care enhanced payments and concluded that the payments were not sufficiently broad-based or large enough for most providers to have any noticeable impact on either a provider's viability or willingness to participate in the Medicaid program.

3. The state established procedures to monitor continued access to care after implementation of these rate reductions, consistent with 42 CFR 447.203(b)(6). The state established baseline data and thresholds against which analyses can be performed to monitor FFS recipient access. Additionally, HSD is including access as a standing agenda topic in its bi-weekly discussions with IHS and tribal health care facilities. Access is also a regular agenda item for the state's Native American Technical Advisory Committee.

   The impact of this reimbursement change applies only to Medicaid FFS payments. In New Mexico, most Medicaid recipients (approximately 90 percent) are enrolled in the Centennial Care managed care program and 99 percent of FFS recipients in New Mexico are Native American. Rates paid to IHS and tribal facilities are not being reduced; therefore, the impact on beneficiary utilization is projected to be minimal.

4. The state also demonstrated that it has ongoing mechanisms for beneficiary and provider input on access to care. The HSD maintains a Medicaid call center and website that recipients and providers can use to express concerns about access, and a complaint and grievance tracking system is maintained to insure that concerns are addressed. Such concerns can also be raised by IHS or tribal facilities during regularly scheduled bi-weekly calls with HSD.

CMS is approving this SPA as the state has reasonably substantiated its conclusion that access for these services is sufficient through a process consistent with the requirements of 42 CFR 447.203 and conducted the public process and notice described in 42 CFR 447.204 and 42 CFR 447.205. Consistent with the aforementioned regulations, the state has committed to monitoring access and CMS will be periodically contacting the state to understand how the state's monitoring activities are progressing. If access deficiencies are identified, the state will submit a corrective action plan within 90 days of identification.

This letter affirms that the New Mexico Medicaid state plan amendment 16-004 is approved effective July 1, 2016 as requested by the state.

We are enclosing the HCFA-179 and the following amended plan pages.

- Attachment 4.19-B page ii.d
- Attachment 4.19-B, page ii.e
- Attachment 4.19-B, page ii.f

If you have any questions please contact Ford Blunt of my staff. Mr. Blunt may be reached at (214) 767-6381 or by e-mail at Ford.Blunt@cms.hhs.gov.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator

cc: Jennifer Mondragon

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	16-004	2. STATE New Mexico
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2016	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447 Subpart F	7. FEDERAL BUDGET IMPACT: for FFY 2016: (-322,400) - a reduction for FFY 2017: (-1,289,600) – a reduction
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19B pages ii.d, ii.e, ii.f	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19B pages ii.d, ii.e, ii.f

10. SUBJECT OF AMENDMENT:
Terminating the increased Primary Care Service Payments to Medicare rates for primary care services provided by physicians services – as described in the public notice included in SPA packet

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Authority Delegated to the Medicaid Director.

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: Nancy Smith-Leslie, Director Medical Assistance Division P.O. Box 2348 Santa Fe, NM 87504 – 2348
13. TYPED NAME: Nancy Smith-Leslie	
14. TITLE: Director, Medical Assistance Division	
15. DATE SUBMITTED: June 30, 2016 rev 11/22/2016	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 30, 2016	18. DATE APPROVED: February 14, 2017
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2016	20. SIGNAT[redacted]CIAL:
21. TYPED NAME: Bill Brooks	22. TITLE: Associate Regional Administrator Division of Medicaid and Children's Health

23. REMARKS:

FORM HCFA-179 (07-92)

State: New Mexico
Date Received: 06-30-2016
Date Approved: 02-14-2017
Date Effective 07-01-2016
Transmittal Number: NM 16-0004

Physician Services
Increased Primary Care Service Payment
42 CFR 447.405, 447.410, 447.415 for dates of service beginning January 1, 2015
Through June 30, 2016

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

Through dates of service June 30, 2016, the state continues to reimburse for services provided by physicians meeting the requirements of 42 CFR 447.400(a) (with the exceptions noted below) at no less than the Medicare Part B fee schedule rate using the CMS Medicare physician fee schedule rate in effect for the date of service. If there is no applicable rate established by Medicare for the service, an enhanced primary care service payment rate is not applied.

☑ The rates reflect all Medicare site of service and locality adjustments.

☐ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☐ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

Attestation Requirements:

For the Physician Services Increased Primary Care Services Payment, the state agency continues to follow the provider qualifying circumstances as described in 42 CFR 447.400(a) and used for the 2013-2014 increased payment program; that is, specified board certification or meeting the 60% threshold of services being primary care services identified by procedure codes.

Board Certification

New Mexico Medicaid-enrolled providers who attested and were approved for the 2013 and/or 2014 primary care provider (PCP) enhanced payments whose attestation is still in effect on December 31, 2014, who qualified because they met the board specialty requirements, and who continue to be an approved provider for the New Mexico Medicaid program, will continue to receive PCP enhanced payments until their board certification expires, at which point they will be required to submit documentation of their renewed board certification if the state agency cannot verify their renewal with their board.

Sixty Percent Claims Threshold

To facilitate provider attestation for 2013 and 2014, the state agency produced reports that measured the percent of the provider's Medicaid billing history, including both fee for service and managed care paid claims. These reports showed the percent of the provider's billing that was for the primary care E&M procedure codes, including vaccinations, as a percent of all claims. The state agency will perform this same calculation based on 2014 claims for providers whose approved 2013/2014 attestation was still in effect on December 31, 2014. Any currently attested provider who continues to be an approved provider for the New Mexico Medicaid program will continue to receive the PCP enhanced payment because of their previous attestation and agency approval as long as the provider continues to meet the threshold percentage of 60% primary care codes. This calculation would be performed again in each of the subsequent time periods in which the enhanced payment program is in effect.

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Any currently attested provider who does not meet the 60% threshold requirement will be notified that he or she must re-attest and must be re-approved as meeting the criteria in order to receive the PCP enhanced payment. This same process will be performed each time period that the PCP enhanced payment program continues subsequent to 2015.

Enhanced payment for primary care services is limited to providers who have enrolled through the state agency as approved providers for the Medicaid fee for service program, the Medicaid managed care programs, or both.

New Providers and Providers Attesting for the First Time:

Any provider not having an approved attestation in effect on December 31, 2014 must file a new attestation and be approved prior to receiving PCP enhanced payments for 2015. Any provider attesting for the first time for 2015 or subsequent time periods will not receive PCP enhanced payments for 2013 or 2014.

Attestation Timing Requirements:

A provider will receive increased PCP payments for dates of service beginning the first day of the month following the date the attestation is accepted by MAD.

Approvals of attestations for increased physician primary care services payment will end after May 31, 2016.

Provider Qualifications

Providers not previously allowed to qualify for the enhanced primary care payment increase per 42 CFR 447.400(a) will not be allowed to receive enhanced payments in 2015 or subsequent years, including:

- Providers whose services are reimbursed on the basis of an encounter rate, such as federally qualified health centers, rural health clinics, Indian health service and tribal 638 facilities, unless the service was paid at a fee schedule rate;
- Physician extenders, identified as physician assistants certified nurse practitioners, pharmacist clinicians, and certified nurse midwives unless their supervising physician attests to practicing in one of the specialty designations and qualifies with a board certification or meets the 60% primary care threshold. In the attestation, the supervising physician must accept professional responsibility and legal liability for the extenders; this is verified on the attestation form. The supervising physician must identify his or her NPI number and the form must have the supervising physician's signature.

Method of Payment

The state reimburses a supplemental amount equal to the difference between the Medicaid payment rate in effect on the date of service as published in the agency's fee schedule described in the State Plan Attachment 4.19B, pages 1 and 2, item I (Fee Schedule Pricing for Professional Services - Physician Services) and the CMS Medicare fee schedule in effect for the date the service was rendered. Initially, for calendar year 2015, the 2015 CMS Medicare fee schedule will be used. For each subsequent year this state plan provision is in place, the agency's fee schedule in effect for the date of service and the CMS Medicare fee schedule in effect for the date of service will be used.

All increased physician primary care services payment end for dates of service after June 30, 2016. Increased payments on claims for services rendered prior to July, 2016, meeting all other requirements for increased payment, will be made when the claims are paid prior to October 1, 2016.

The funding for the primary care increase made in these extension years will be at the federal match rate associated with the category of eligibility of the recipient receiving the service and the service.

Supplemental payment is made: ☐ monthly ☑ quarterly

Initially, the enhanced payment amounts will be made as a lump sum payment to the provider until such time that (1) the fee for service enhanced payment can be added on to the claim at the time of payment, and (2) the enhanced payment rate can be incorporated into the managed care capitation rate which will include obtaining federal approval for both the rates and the process.

Primary Care Services Affected by this Payment Methodology

The codes that qualify for the PCP enhanced payment are those that are a covered benefit of the state Medicaid program in the Evaluation and Management Current Procedural Terminology (CPT) code range 99201 through 99499.

These are the codes that were included in the 2013 and 2014 primary care enhanced payment and will continue to receive the enhanced payment in 2015 and subsequent time periods when they are a benefit of the Medicaid program.

Effective Date of Payment

E & M Services

This reimbursement methodology applies to services delivered on and after January 1, 2015 *through dates of service June 30, 2016.* All rates are published at http://www.hsd.state.nm.us/providers/fee-for-service.aspx under the 'Fee Schedules' section of the 'Provider' section of the website.

Vaccine Administration

The state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the state regional maximum administration fee set by the Vaccines for Children (VFC) program and therefore vaccine administration is not included as a primary care increase but is included in counting toward the 60% primary care services volume required for providers who do not meet the board certification requirements.

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