DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MAY -- 2 2011

Vivianne M. Chaumont, Director
Division of Medicaid and Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

RE: TN 10-019

Dear Ms. Chaumont:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 10-019. Effective for services on or after July 1, 2010, this State Plan amendment (SPA) proposes to revise the payment methodology for nursing facility (NF) and intermediate care facility for the mentally retarded (ICF/MR) services.

For NF services, this SPA provides for several updates to the prospective rate methodology. Specifically, it updates the rate period and base period, updates various cost containment provisions, clarifies base period cost report requirements, specifies the inflation methodology, and institutes a case mix reimbursement system based on the CMS RUG III 5.20 version. For ICF/MR services, this SPA updates the rate period and the base period, updates various cost containment provisions, specifies the inflation methodology, and adds provisions for completing the Long Term Care Cost Report.

We conducted our review of your submittal according to the statutory requirements at sections 1902 (a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of July 1, 2010. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Tim Weidler at (816) 426-6429.

Sincerely

Bill Hoesl

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations

May 2, 2011

Vivianne M. Chaumont, Director
Division of Medicaid and Long-Term Care
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

Dear Ms. Chaumont:

This letter is being sent as a companion to our approval of your Department's State Plan Amendment (SPA) NE 10-019. During our review of NE 10-019, it was also discovered that the Nebraska Medicaid program was covering durable medical equipment (DME) services under the home health benefit for residents of nursing facilities (NF) and intermediate care facilities for persons with mental retardation (ICF/MR) and was paying DME providers directly for these services on a fee-for-service basis. Our analysis of this arrangement has determined that Nebraska Medicaid program is not in compliance with statutory and regulatory requirements for home health services, as explained below.

The Social Security Act does not identify DME as a separate service for which Federal financial participation (FFP) is available. However, home health is a covered service at Section 1905(a)(7) of the Act and home health services are defined at 42 CFR 440.70 to include DME. Therefore, DME is only covered under the Medicaid program as a component of the home health service.

All covered elements of home health services are subject to the definition of home. The definition for home is specified at 42 CFR 440.70(c) as:

> A recipient's place of residence, for home health services, does not include a hospital, nursing facility, or intermediated care facility for the mentally retarded, except for home health services in an intermediate care facility for the mentally retarded that are not required to be provided by the facility under subpart I of part 483. For example, a registered nurse may provider short-term care for a recipient in an intermediate care facility for the mentally retarded during an acute illness to avoid the recipient's transfer to nursing facility.

Therefore, per regulation, DME cannot be provided to nursing facility residents. In order for FFP to be available for medical equipment for a NF resident, the equipment must be provided as part of the nursing facility service and must be a component of the nursing

facility service rate paid by the State Medicaid agency. There is no federally prescribed listing of what must, or must not, be in the nursing facility rate paid by the State Medicaid agency. However, nursing facilities are responsible to provide for all of a resident's needs and the need for many types of medical equipment are clear in the plan of care. Whether or not the State reimburses the nursing facilities specifically for these necessary costs is up to the State. But if the State wishes to continue to reimburse for medical equipment for NF residents, and receive FFP, the medical equipment must be provided as part of the NF service benefit and reimbursed through the NF reimbursement rate methodology. A number of methodologies are possible for this purpose.

Our discussion pertaining to NFs is also applicable to ICFs/MR. The caveat in the regulation at 42 CFR 440.70(c) regarding ICFs/MR does not appear to be applicable to medical equipment. The ICF/MR benefit is the most comprehensive benefit in the Medicaid program, so it is unlikely that a state would not include medical equipment costs in the rate methodology for ICFs/MR.

In order to continue to receive FFP for medical equipment in NFs and ICFs/MR the State should submit a State Plan amendment that complies with Federal Statute, regulation and policies by comprehensively describing the coverage and reimbursement policies for medical equipment as part of the NF and ICF/MR service benefit. In addition, prior to the effective date of the SPA, the State will need to satisfy the public process requirement for any change in rates and methodologies underlying the establishment of the rates, in accordance with section 1902(a)(13)(A) of the Act and guidance identified in the December 10, 1997 State Medicaid Director letter, prior to the effective date of the SPA.

Please respond to this letter by July 31, 2011 on the State plans to address the issues described above. The State may submit SPAs to address the inconsistencies within that period or submit a corrective action plan describing in detail how and when 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 day period, CMS will provide any technical assistance that is needed to resolve the issues described above. If you have any questions regarding this letter please contact Tim Weidler of my staff at (816) 426-5925.

Sincerely,

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations