DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

SMD# 17-004

RE: Medicaid Access to Care Implementation Guidance

November 16, 2017

Dear State Medicaid Director:

The purpose of this letter is to provide clarification and additional policy direction to states on compliance with the Social Security Act (the Act) and federal regulations issued by the Centers for Medicare & Medicaid Services (CMS). Specifically, this letter describes guidance on implementation approaches for the Medicaid access to care fee for service (FFS) requirements found at 42 CFR 447.203(b).

CMS is committed to working with states on targeted approaches to ensure Medicaid FFS rates meet federal requirements while minimizing state administrative burden. We are conducting a wholesale review of the regulatory access to care requirements and using the experience we have gained through reviews of states' access monitoring efforts to identify opportunities through new rulemaking to alleviate burden for states. Such opportunities could include exploring a regulatory exception for high managed care states, further codifying the thresholds described in this letter and providing additional policy clarifications based on our implementation experience thus far. In the interim, we are issuing this letter to offer the flexibilities available to us prior to finalizing new regulations.

Background:

Section 1902(a)(30)(A) of the Act requires states to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Federal regulations at 42 CFR 447.203(b) and 447.204 provide for a transparent process for states to document whether Medicaid FFS payments are sufficient to enlist providers consistent with the Act.

42 CFR 447.203(b) requires states to develop and submit to CMS an Access Monitoring Review Plan (AMRP) for a core set of services (primary care, physician specialist, behavioral health care, pre-and post-natal obstetric, and home health) that is updated at least every three years. In addition, the AMRP must cover additional types of services for which the state or CMS has received a significantly higher than usual volume of complaints from beneficiaries, providers, or other stakeholders. The AMRP must identify a data-driven process to review access to care and address: the extent to which beneficiary needs are fully met; the availability of care through enrolled providers; changes in beneficiary service utilization; the characteristics of the beneficiary population; and actual or estimated levels of provider payment available from other payers.

Additionally, §447.203(b)(6) requires a state to: (1) add services to its AMRP when reducing or restructuring FFS rates for other Medicaid services *in circumstances when the changes could result in diminished access* (emphasis added) and (2) develop a plan to monitor the effects of the rate reductions for at least three years. In such circumstances, §447.204(b) requires a state to submit to CMS with its state plan amendment (SPA) submission: the most recent AMRP (revised to include additional services to be monitored), an analysis of the effect the change in payment rates will have on access, and a specific analysis of the information and concerns expressed in input from affected stakeholders. As discussed in the Center for Medicaid & CHIP Services Informational Bulletin issued on June 24, 2016, stakeholder concerns may be submitted through the public notice process described at 42 CFR 447.205 or a separate process used to solicit feedback on the effect of rate changes on access to care as long as the public notice requirements are also met.

In addition to the requirements set forth in those regulations, CMS may request that states provide information that would allow CMS to compare the Medicaid population's access to care with that of the general population in the same geographic area.[1]

Policy Guidance:

States have requested clarification regarding the circumstances in which provider payment reductions would likely not result in diminished access to care, including: states that pay at or above the Medicare rate under FFS, are proposing relatively minor reductions to provider payment rates, or have high managed care penetration rates. In considering these situations, CMS is offering additional guidance to clarify circumstances that would likely not result in diminished access and, as such, would not require the analysis and monitoring procedures described in the regulations.

Nominal Reductions and Compliance with Federal Requirements:

There are circumstances, including certain types of provider rate reductions, which are unlikely to result in diminished access, and therefore, where states would not be required to conduct the analysis and monitoring procedures specified in the regulation. For example, circumstances where a state's Medicaid FFS payment rates remain at least as high as the Medicare rates (including the applicable cost-sharing) for the same specific service after the reduction is implemented would be unlikely to result in diminished access. In the absence of information to the contrary (such as a high volume of access complaints which would trigger the regulatory requirements) CMS has determined the following circumstances are unlikely to diminish access, and as such, would not invoke the requirements of §447.203(b)(6):

- Reductions necessary to implement CMS federal Medicaid payment requirements (e.g., federal upper payment limits and financial participation limits), but only in circumstances under which the state is not exercising discretion as to how the requirement is implemented in rates. For example, if the federal statute or regulation imposes an aggregate upper payment limit that requires the state to reduce provider payments, the state should consider the impact of the payment reduction on access.

[1] A recent 9th Circuit decision has interpreted section 1902(a)(30)(A) of the Act as requiring the Secretary, when reviewing a proposed SPA, to consider the state's Medicaid population's access to care "relative to that of the general public." *Hoag Mem'l Hosp. Presbyterian v. Price*, No. 15-56547, slip op. at 17 (9th Cir. Aug. 7, 2017).

- Reductions that will be implemented as a decrease to all codes within a service category or targeted to certain codes, but for services where the payment rates continue to be at or above Medicare and/or average commercial rates.
- Reductions that result from changes implemented through the Medicare program, where a state's service payment methodology adheres to the Medicare methodology (e.g. modifications to diagnostic related groups and the resource based relative value scale, adoption of new Medicare payment systems, consistency with value-based purchasing initiatives, etc.).

Anticipating Diminished Access:

For some nominal payment adjustments it may be difficult for states to determine whether proposed SPA changes may result in diminished access. In those instances, states should follow the public process described in §447.204(a) and consider the information received through that process to determine whether the proposed change is likely to diminish access. Examples of payment changes that may fall under this process include, but are not limited to:

- Reductions where the state has actively worked with provider groups to address concerns over a proposed rate change or modified the proposed rate change to address the concerns (e.g. as part of a delivery system re-design a state reduces volume-based supplemental payments and proposes to pay-for-performance based on quality measures, reducing the overall Medicaid revenue to providers. However, the provider industry works with the state legislature on the re-design effort).
- Reductions that are targeted to a small number of distinct codes or payments within a service category, where the overall change in net payments within that service category is nominal (e.g., less than 4% of overall spending for the service category – such as physician services, reductions to targeted supplemental payments affecting few providers, etc.).
- Nominal single-year rate freezes or inflationary changes that result in providers receiving less of an increase than anticipated for a given payment year.
- Nominally restructured payments or rate changes that are intended to address matters of program and financial integrity or to provide more efficient care (e.g., changes in standards of practice, documented over-utilization, up-coding, cost rebasing).
- Reductions where the affected services are primarily delivered through managed care and the individuals enrolled in FFS do not utilize the services or only utilize services before transitioning to managed care (e.g., during periods of retroactive eligibility or presumptive eligibility).

When contemplating nominal payment changes such as those described above, a state should document that it followed the public process as described in §447.204. If no probable access concerns are identified through that process or the state adequately addresses such concerns, the state would not need to include the access analysis or formal monitoring plan with its SPA submission because it is unlikely the changes would result in diminished access to care. Similarly, states that have engaged the provider community in the rate-setting process (including through the legislative process), and reached general agreement on the proposed changes would also not be required to submit the access analysis or formal monitoring plan as part of its SPA submission. In these situations, CMS strongly encourages states to use the ongoing beneficiary and provider feedback mechanisms to quickly identify any access issues that

may arise, even though the state is not required to include the affected services in its formal AMRP.

Clarification for States with High Managed Care Penetration:

States with high managed care penetration rates have raised concerns that the requirements of the regulations present unnecessary burden with little benefit. While CMS purposefully did not apply a percentage threshold to exempt states from the AMRP process described in the regulations, CMS did not intend for states to analyze and monitor FFS access in instances when the FFS system does not consistently provide services. The requirements of §447.203(b)(6) are intended to apply only to services that are carved out of the managed care delivery system and paid through FFS and for the populations that remain covered through FFS and utilize the affected services. States with high managed care penetration rates should scale the AMRP analysis and monitoring efforts to consider: only the services that are carved out of managed care and paid FFS, and the individuals who are enrolled in the FFS system beyond transition periods.

Some states have brought forward program specific data and information demonstrating that, prior to enrolling with a managed care plan, beneficiaries only receive FFS services for short transition periods based on presumptive or retrospective eligibility processes, or that the FFS service system includes only individuals in certain eligibility categories that rarely or never utilize services subject to the AMRP process. CMS urges states to present this information at the time of SPA submissions and to provide reasonable support that changes in rates are unlikely to affect access for populations eligible for FFS services and are consistent with section 1902(a)(30)(A) of the Act.

Expediting SPA Submission Process:

CMS is also committed to reviewing all SPAs in a timely manner. A primary purpose of the access to care requirements is to provide CMS with the information necessary to make timely approval decisions for SPAs that reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access. The regulations require states to provide the access analysis and monitoring procedures with SPA submissions so that, absent any additional concerns, CMS can make approval decisions on the first 90 day clock. To the extent states meet the submission requirements, CMS should be able to process rate reduction SPAs without requesting additional information on access to care. In addition, for rate changes that reduce provider payments but fall under the policies described in this letter, states should provide a description of applicable policy consideration as part of the SPA submission. This information will ensure that CMS has sufficient documentation that proposed SPA changes will not diminish access to care and will greatly expedite our review and approval.

If you have additional question, please contact Kristin Fan, 410-786-4581.

Sincerely,

/s/

Brian Neale
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

National Governors Association

American Public Human Services Association

Association of State and Territorial Health Officials

Council of State Governments

National Conference of State Legislatures

Academy Health

National Association of State Alcohol and Drug Abuse Directors