

Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid, CHIP and Survey & Certification

SMD #10-020

October 1, 2010

Re: Revised State Plan Amendment Review Process

Dear State Medicaid Director:
Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing this letter to inform you of changes CMS is making in the State plan amendment (SPA) review process. These changes are being made to implement a more efficient process for the review of proposed modifications to the State Medicaid plan.

Background

Federal statute and regulations require CMS to review and approve SPAs for consistency with the requirements of Section 1902(a) of the Social Security Act (the Act) before a State may implement Medicaid program modifications. SPAs are generally transmitted to CMS as pages excerpted from the existing approved State plan containing the provisions that the State wishes to modify. CMS reviews the proposed specific amendment and all other provisions contained on the submitted State plan page(s). In addition, CMS reviews any related or corresponding State plan provisions contained elsewhere in the State plan that are integral to understanding the pages submitted. This review process may lead to the identification of existing State plan provisions that the State is not proposing to modify and that are not integral to the proposed SPA modifications but that appear to be contrary to Federal statute, regulations, or established guidance. In the past, the review process has required that any issue identified during the review of a SPA must be resolved in order to take action on the submitted SPA. In some instances, this practice has resulted in a delay in the State's authority to promptly implement the program change for which the amendment was originally submitted.

Recognizing States' need to advance modifications to their Medicaid programs, CMS has consulted with States and identified a process that will expedite the review of SPAs while ensuring that CMS and States resolve other questions that may arise. As described in detail below, States will now have the option to resolve issues related to State plan provisions that are not integral to the SPA through a separate process.

New Procedures for SPA Processing

CMS has a continuing obligation to review all provisions of a State plan amendment for compliance with Federal statute and regulations State plans, including those on submitted pages and corresponding provisions contained within the existing approved State plan. However, CMS will no longer require States to resolve those issues that may arise in the course of the review of the submitted SPA – but are not integral to the provision modified by the SPA – prior to taking action on the submitted SPA. Instead, CMS will follow the procedure described below.

- In the event that CMS identifies potentially non-compliant State plan provisions, we will discuss those provisions with the State during the initial stages of the SPA review. The State will have the option to resolve all issues during the review of the submitted SPA or to focus solely on the provision modified by the SPA, and resolve issues unrelated to the actual SPA change through a separate process.
- If the State chooses a separate process to resolve issues unrelated to the modifications proposed in the submitted SPA, and if CMS needs additional information relating to the SPA, a request for additional information (RAI) will be issued. The RAI will include only those questions or requests for information that are applicable to the SPA submitted. The SPA will not be delayed, but the decision letter communicating the disposition of the SPA will note that additional issues are being reviewed through a separate process.
- CMS will describe the specific issues and/or questions related to those provisions that are not addressed in the context of the SPA review, but are problematic, in a letter to the State Medicaid Director on or before the date of ultimate SPA disposition. In doing so, CMS will identify the statutory or regulatory provision or guidance pertaining to the issue identified. We will not pursue matters that are not based on statute, regulations, or generally available guidance. Within 90 days from the date of the letter, States should provide information that explains why the provision is consistent with Federal statute, regulation, and existing guidance, or should submit to CMS a SPA which will bring the State plan into compliance. During this time, CMS will provide technical assistance and respond to questions from the State.
- CMS may initiate formal compliance action as described in 42 CFR 430.35 at any time. However, CMS will ordinarily delay taking action pending the discussions with the State through the process described above, and may delay taking action if the State demonstrates good faith actions to come into compliance (for example, when there are implementation or State authority issues that must be resolved). As always, the formal compliance process offers States formal appeal rights through an established hearing process.

To further explain how this new process will work and to promote consistent application of the new policy, we have enclosed several examples in which the review of issues related to the State plan can be divorced from changes proposed in the submitted SPA. The examples are based on actual State plan issues we have faced and are intended to clarify how we envision this new process.

We hope you will find this information helpful. We believe this new approach will resolve many SPA processing issues and allow SPAs to be approved more quickly. We will also be taking this new approach in our review of SPAs related to the Children's Health Insurance Program (CHIP). We are committed to working with States to ensure that CMS carries out its responsibilities in ways that advance States' ability to carry out their responsibilities.

If you have any additional questions, please contact Ms. Dianne Heffron, Director, Financial Management Group, who may be reached at 410-786-3247.

Sincerely,

/s/

Cindy Mann
Director

Enclosure

cc:

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Enclosure

IMPLEMENTATION OF NEW SPA REVIEW PROCESS – EXAMPLES

The following examples represent common situations that have arisen during the review of SPAs in recent years. They are intended to provide a general overview of the review process described in the enclosed letter and to give examples of issues that are, and are not, considered integral to a SPA. The examples are not all-inclusive but are meant to give States concrete examples based on actual SPA review scenarios, and to ensure consistent implementation of the new procedures.

SECTION I – Proposed SPA Can Be Approved Before Resolution of Other Identified Issues

Example 1: A State submits a new, stand-alone reimbursement page describing a general rate reduction (or increase) for a number of different services. The submitted page may, or may not, specifically identify the services subject to the rate adjustment.

CMS Review Process - The new, stand-alone reimbursement page must list each of the specific services subject to the rate adjustment(s) and include the location (page numbers) in the State plan of the related reimbursement methodologies so that the proposed amendments can be cross-walked to the existing State plan provisions. If this information is not included, the SPA must be amended to include this information.

The underlying methodologies and related coverage provisions for the affected services will be reviewed. If CMS has questions regarding content on the related pages, e.g., existing reimbursement methodologies or coverage provisions for the affected services, these issues can be resolved through the separate process described in this letter.

Example 2: A State submits a 4.19B reimbursement page to modify the reimbursement methodology for psychologists. The existing methodology provides reimbursement to psychologists at 100 percent of the State’s physician fee schedule. The amendment reduces reimbursement for psychologist services to 80 percent of the physician fee.

CMS reviews the coverage provisions for psychologist services. CMS also reviews the coverage provisions for physician services and the existing State plan language that describes the physician reimbursement methodology. The existing physician reimbursement language in the State plan does not include the effective date of the physician fee schedule.

CMS Review Process - CMS can approve the reimbursement language for the psychologist services even though an effective date of the physician fee schedule is not included in the State plan language describing the reimbursement methodology for psychologist services. CMS will resolve the effective date issue in the State plan's physician reimbursement methodology (the fee schedule) through the separate process described in this letter.

Example 3: A State submits a SPA to amend coverage of nurse practitioner services. As part of the review, CMS examines the nurse practitioner reimbursement methodology. CMS discovers that the existing nurse practitioner reimbursement methodology is not comprehensive because it lacks the effective date of the fee schedule.

CMS Review Process - CMS will take action on the merits of the coverage amendment in the submitted SPA. The related issue concerning the reimbursement methodology will be addressed through the separate process discussed in this letter.

Example 4: A State submits a SPA to remove coverage of dentures from the State plan. Rehabilitative services are described on the same page as the deleted denture service description. The SPA does not define the rehabilitative services nor does it identify the providers of those services.

CMS Review Process - CMS can approve the SPA to remove dentures as a covered service based on its own merits. CMS will address issues with the rehabilitative services coverage and reimbursement through the separate process described in this letter.

Example 5: A State submits a SPA for a new inpatient supplemental payment. In response to the Standard Funding Questions in the RAI, CMS identifies a possibly unacceptable provider assessment that is the funding source for another supplemental payment identified on the submitted SPA page.

CMS Review Process - CMS will take action on the SPA based on the merits of the new supplemental payment. The issues identified concerning the other supplemental payment will be addressed through the separate process described in this letter.

Example 6: A State submits a SPA that changes one of the drug classes listed in its excluded drug coverage. CMS reviews all of the other excluded drug categories listed in the approved State plan and finds several non-drug items that are included on the list.

CMS Review Process - CMS will take action on the submitted SPA based on its own merits. The additional non-drug items included on the list will be addressed through the separate process described in this letter.

SECTION II – Proposed SPA Language Must be Modified Before Approval

Example 1: A State submits a coverage SPA eliminating adult dental services. This SPA requires tribal consultation because it will reduce benefits for eligible Indians and also will reduce reimbursements to Indian health providers that provide these services to eligible Indians. The State did not consult with the federally-recognized Tribes and Indian health providers prior to submission of the SPA.

CMS Review Process - CMS cannot approve the SPA until the required tribal consultation has occurred. To approve the SPA without the required consultation would violate Executive Order 13175 and the sec. 1902(a)(73) consultation requirements, as added by the Recovery Act.

Example 2: A State submits a SPA to modify coverage of chiropractic services. There is no reimbursement methodology in the approved State plan for chiropractic services.

CMS Review Process - CMS cannot approve this SPA until the State submits a reimbursement methodology. The State would have no authority to request Federal financial participation (FFP) for expenditures associated with chiropractic services without a reimbursement methodology in the State plan.

Example 3: A State submits a SPA to modify the reimbursement methodology for nurse practitioners. During the review process, CMS discovers that the approved State plan does not provide for coverage of nurse practitioners.

CMS Review Process - CMS cannot approve the reimbursement SPA until the State submits a State plan page authorizing the coverage of nurse practitioner services. States cannot claim FFP for expenditures for services that are not covered in the approved State plan.

Example 4: A State submits a SPA to increase fee schedule payments by 10 percent for a specific provider type. Neither the existing nor the newly submitted State plan language describing the reimbursement methodology includes the effective date of the fee schedule.

CMS Review Process – Because the State plan language that describes the reimbursement methodology for the specific service under review would not be considered a comprehensive reimbursement methodology, CMS cannot approve the SPA until the effective date of the fee schedule is included in the State plan language.

Example 5: A State submits a SPA to reimburse for services provided in schools. There is no comprehensive description of the reimbursement methodology in the State plan for these services; the methodology in the SPA states only that reimbursement is based on cost and is funded with certified public expenditures. The SPA contains only a brief description of the types of costs that will be certified.

CMS Review Process - CMS cannot approve the SPA until the State's cost-identification methodologies have been reviewed and determined to be appropriate for Medicaid certification. Because the funding of the payment is based on costs incurred by a political subdivision eligible

for participation in the funding of the Medicaid program, CMS must ascertain that the costs being matched are appropriately identified and allocated to the Medicaid program.

Example 6: A State submits a SPA to extend to additional Rural Health Centers (RHC) an existing Alternative Payment Methodology (APM) which recognizes hospital deliveries as an RHC service. Payment to RHCs for hospital deliveries is inconsistent with Federal regulatory requirements because a hospital delivery is not considered an RHC service. Therefore, the SPA cannot be approved. Upon learning this, the State withdraws the SPA.

CMS Review Process - CMS may pursue a compliance action with respect to the existing problematic reimbursement methodology following the process described in 42 CFR 430.35.