NHeLP
NATIONAL HEALTH LAW PROGRAM

211 N. Columbia St, 2nd Fl
Chapel Hill, NC 27514
(919) 968-6308
Fax (919) 968-8855

CMS Updates State Plan Amendment Process

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Prepared by Jane Perkins

The Centers for Medicare & Medicaid Services (CMS) has revised the Medicaid State Plan Amendment (SPA) review process. *See* CMS, Letter to State Medicaid Director/State Health Official Re: Revised State Plan Amendment Review Process (Oct. 1, 2010) (SMD #10-020) ("CMS Revised SPA Review Letter"), *at* www.cms.gov/smdl/smd/itemdetail.asp?itemid=CMS1239964. The new review process will also be applied to Children's Health Insurance Program plan amendments. *Id.* at 3. This memorandum discusses the guidance. For earlier discussion of the state plan review process, see NHeLP, State Medicaid Plans (Apr. 26, 2006), *available at* www.healthlaw.org.

Background

Federal law requires CMS to review and approve SPAs. *See, e.g.*, 42 U.S.C. § 1396-1. According to CMS, the review process can identify problems that need to be resolved but that are not integral to the pending SPA. In the past, the review process has required that any issue identified during the review process be resolved before CMS takes action on the SPA. After consulting with the states, CMS has now given states the option to use a separate process to resolve problems that are identified during the review of a submitted SPA but that are not integral to the SPA.

New CMS Procedure

If CMS identifies potentially non-compliant State plan provisions that are not related to the submitted SPA, it will give the State the option of resolving all issues during the review of the submitted SPA or of focusing solely on the provision being modified by the submitted SPA and using a separate process to address the non-integral issues (See below for examples).

If the state chooses a separate process and CMS needs additional information relating to the pending SPA, its request for information will be limited to information applicable to the SPA, and a decision on the SPA will not be delayed while the separate process is used. The decision letter will, however, note that additional issues are being reviewed through a separate process. CMS will identify the specific issues and/or questions related to the issues not addressed during the SPA review in a letter to the State on or before the date of the ultimate SPA decision. The letter will identify the specific statutory, regulatory, or guidance provision pertaining to the identified issue. Notably, CMS "will not pursue matters that are not based on statue, regulations, or generally available guidance." CMS Revised SPA Review Letter at 2. Within 90 days of the date of the letter, the State will need to provide information to explain why there is no inconsistency with federal law or a revised SPA to bring the state into compliance with the law.

CMS retains the authority to initiate formal compliance action at any time. *See* 42 C.F.R. § 430.35. However, according to this letter, CMS plans to delay action pending discussions with the State and may delay action if the state is making a good faith effort to come into compliance.

Examples of SPAs that can be approved before other issues are resolved

Example 1: State submits a SPA to reduce reimbursement for several different services. During review, CMS has questions about the existing reimbursement methodologies or coverage provisions for the affected services. These questions can be resolved through the separate process.

Example 2: State submits a SPA to reduce psychologist reimbursement from the current 100% of the physician fee schedule to 80%. During review, CMS finds that the State plan does not give an effective date for the physician fee schedule. This effective date questions can be resolved through the separate process.

Example 3: State submits a SPA to remove coverage of dentures. During review, CMS finds that rehabilitative services are described on the same page as the deleted denture service description and that the SPA does not define rehabilitative services or identify providers of those services. The issues with rehabilitative services can be resolved through the separate process.

Examples of SPAs that cannot be approved before other issues resolved

Example 1: State submits a SPA to eliminate adult dental services, but does not consult with federally-recognized Tribes and Indian Health providers even though the reduction will reduce benefits to eligible Indians. CMS will not approve the SPA because Executive Order 13175 and 42 U.S.C. § 1396a(a)(73) require such consultation.

Example 2: State submits a SPA to modify coverage of chiropractic services. During review, CMS finds no reimbursement methodology in the State plan or the proposed SPA for such services. CMS will not approve the SPA because the State has no authority to request federal funding absent an approved reimbursement methodology.

Example 3: State submits a SPA to modify reimbursement for nursing practitioners. During review, CMS finds no approved State plan for covering nurse practitioners. CMS will not approve the SPA because the State cannot claim federal funding for unapproved services.