

the results of the actual eligibility determination, and claim them appropriately.

[65 FR 33622, May 24, 2000]

§ 447.90 FFP: Conditions related to pending investigations of credible allegations of fraud against the Medicaid program.

(a) *Basis and purpose.* This section implements section 1903(i)(2)(C) of the Act which prohibits payment of FFP with respect to items or services furnished by an individual or entity with respect to which there is pending an investigation of a credible allegation of fraud except under specified circumstances.

(b) *Denial of FFP.* No FFP is available with respect to any amount expended for an item or service furnished by any individual or entity to whom a State has failed to suspend payments in whole or part as required by § 455.23 of this chapter unless—

(1) The item or service is furnished as an emergency item or service, but not including items or services furnished in an emergency room of a hospital; or

(2) The State determines and documents that good cause as specified at § 455.23(e) or (f) of this chapter exists not to suspend such payments, to suspend payments only in part, or to discontinue a previously imposed payment suspension.

[76 FR 5965, Feb. 2, 2011]

**Subpart B—Payment Methods:
General Provisions**

§ 447.200 Basis and purpose.

This subpart prescribes State plan requirements for setting payment rates to implement, in part, section 1902(a)(30) of the Act, which requires that payments for services be consistent with efficiency, economy, and quality of care.

[46 FR 48560, Oct. 1, 1981]

§ 447.201 State plan requirements.

(a) A State plan must provide that the requirements in this subpart are met.

(b) The plan must describe the policy and the methods to be used in setting payment rates for each type of service

included in the State's Medicaid program.

§ 447.202 Audits.

The Medicaid agency must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials.

§ 447.203 Documentation of access to care and service payment rates.

(a) The agency must maintain documentation of payment rates and make it available to HHS upon request.

(b) In consultation with the medical care advisory committee under § 431.12 of this chapter, the agency must develop a medical assistance access monitoring review plan and update it, in accordance with the timeline established in paragraph (b)(5) of this section. The plan must be published and made available to the public for review and comment for a period of no less than 30 days, prior to being finalized and submitted to CMS for review.

(1) *Access monitoring review plan data requirements.* The access monitoring review plan must include an access monitoring analysis that includes: Data sources, methodologies, baselines, assumptions, trends and factors, and thresholds that analyze and inform determinations of the sufficiency of access to care which may vary by geographic location within the state and will be used to inform state policies affecting access to Medicaid services such as provider payment rates, as well as the items specified in this section. The access monitoring review plan must specify data elements that will support the state's analysis of whether beneficiaries have sufficient access to care. The plan and monitoring analysis will consider:

(i) The extent to which beneficiary needs are fully met;

(ii) The availability of care through enrolled providers to beneficiaries in each geographic area, by provider type and site of service;

(iii) Changes in beneficiary utilization of covered services in each geographic area.

(iv) The characteristics of the beneficiary population (including considerations for care, service and payment

variations for pediatric and adult populations and for individuals with disabilities); and

(v) Actual or estimated levels of provider payment available from other payers, including other public and private payers, by provider type and site of service.

(2) *Access monitoring review plan beneficiary and provider input.* The access monitoring review plan must include an analysis of data and the state's conclusion of the sufficiency of access to care that will consider relevant provider and beneficiary information, including information obtained through public rate-setting processes, the medical care advisory committees established under § 431.12 of this chapter, the processes described in paragraph (b)(7) of this section, and other mechanisms (such as letters from providers and beneficiaries to State or Federal officials), which describe access to care concerns or suggestions for improvement in access to care.

(3) *Access monitoring review plan comparative payment rate review.* For each of the services reviewed, by the provider types and sites of service (e.g. primary care physicians in office settings) described within the access monitoring analysis, the access monitoring review plan must include an analysis of the percentage comparison of Medicaid payment rates to other public (including, as practical, Medicaid managed care rates) and private health insurer payment rates within geographic areas of the state.

(4) *Access monitoring review plan standards and methodologies.* The access monitoring review plan and analysis must, at a minimum, include: The specific measures that the state uses to analyze access to care (such as, but not limited to: Time and distance standards, providers participating in the Medicaid program, providers with open panels, providers accepting new Medicaid beneficiaries, service utilization patterns, identified beneficiary needs, data on beneficiary and provider feedback and suggestions for improvement, the availability of telemedicine and telehealth, and other similar measures), how the measures relate to the access monitoring review plan described in paragraph (b)(1) of this sec-

tion, baseline and updated data associated with the measures, any issues with access that are discovered as a result of the review, and the state agency's recommendations on the sufficiency of access to care based on the review. In addition, the access monitoring review plan must include procedures to periodically monitor access for at least 3 years after the implementation of a provider rate reduction or restructuring, as discussed in paragraph (b)(6)(ii) of this section.

(5) *Access monitoring review plan timeframe.* Beginning October 1, 2016 the State agency must:

(i) Develop its access monitoring review plan by October 1 of the first review year, and update this plan by October 1 of each subsequent review period;

(ii) For all of the following, complete an analysis of the data collected using the methodology specified in the access monitoring review plan in paragraphs (b)(1) through (4) of this section, with a separate analysis for each provider type and site of service furnishing the type of service at least once every 3 years:

(A) Primary care services (including those provided by a physician, FQHC, clinic, or dental care).

(B) Physician specialist services (for example, cardiology, urology, radiology).

(C) Behavioral health services (including mental health and substance use disorder).

(D) Pre- and post-natal obstetric services including labor and delivery.

(E) Home health services.

(F) Any additional types of services for which a review is required under paragraph (b)(6) of this section;

(G) Additional types of services for which the state or CMS has received a significantly higher than usual volume of beneficiary, provider or other stakeholder access complaints for a geographic area, including complaints received through the mechanisms for beneficiary input consistent with paragraph (b)(7) of this section; and

(H) Additional types of services selected by the state.

(6) *Special provisions for proposed provider rate reductions or restructuring—(i) Compliance with access requirements.* The

State shall submit with any State plan amendment that proposes to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access, an access review, in accordance with the access monitoring review plan, for each service affected by the State plan amendments as described under paragraph (b)(1) of this section completed within the prior 12 months. That access review must demonstrate sufficient access for any service for which the state agency proposes to reduce payment rates or restructure provider payments to demonstrate compliance with the access requirements at section 1902(a)(30)(A) of the Act.

(ii) *Monitoring procedures.* In addition to the analysis conducted through paragraphs (b)(1) through (4) of this section that demonstrates access to care is sufficient as of the effective date of the State plan amendment, a state must establish procedures in its access monitoring review plan to monitor continued access to care after implementation of state plan service rate reduction or payment restructuring. The frequency of monitoring should be informed by the public review described in paragraph (b) of this section and should be conducted no less frequently than annually.

(A) The procedures must provide for a periodic review of state determined and clearly defined measures, baseline data, and thresholds that will serve to demonstrate continued sustained service access, consistent with efficiency, economy, and quality of care.

(B) The monitoring procedures must be in place for a period of at least 3 years after the effective date of the state plan amendment that authorizes the payment reductions or restructuring.

(7) *Mechanisms for ongoing beneficiary and provider input.* (i) States must have ongoing mechanisms for beneficiary and provider input on access to care (through hotlines, surveys, ombudsman, review of grievance and appeals data, or another equivalent mechanisms), consistent with the access requirements and public process described in § 447.204.

(ii) States should promptly respond to public input through these mechanisms citing specific access problems, with an appropriate investigation, analysis, and response.

(iii) States must maintain a record of data on public input and how the state responded to this input. This record will be made available to CMS upon request.

(8) *Addressing access questions and remediation of inadequate access to care.* When access deficiencies are identified, the state must, within 90 days after discovery, submit a corrective action plan with specific steps and timelines to address those issues. While the corrective action plan may include longer-term objectives, remediation of the access deficiency should take place within 12 months.

(i) The state's corrective actions may address the access deficiencies through a variety of approaches, including, but not limited to: Increasing payment rates, improving outreach to providers, reducing barriers to provider enrollment, providing additional transportation to services, providing for telemedicine delivery and telehealth, or improving care coordination.

(ii) The resulting improvements in access must be measured and sustainable.

[43 FR 45253, Sept. 29, 1978, as amended at 80 FR 67611, Nov. 2, 2015; 81 FR 21480, Apr. 12, 2016]

§ 447.204 Medicaid provider participation and public process to inform access to care.

(a) The agency's payments must be 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 those services are available to the general population. In reviewing payment sufficiency, states are required to consider, prior to the submission of any state plan amendment that proposes to reduce or restructure Medicaid service payment rates:

(1) The data collected, and the analysis performed, under § 447.203.

(2) Input from beneficiaries, providers and other affected stakeholders on beneficiary access to the affected